CalViva Health
2018
Quality Improvement
Mid-Year Work Plan Evaluation

Updated 9/12/2018 ARS

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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.

Glossary of Abbreviations/Acronyms

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

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

Aim and Goals 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.

Timely Appointment Access to Primary Care Physicians and Specialists is measured through eight 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 Availability 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 Q2 - MY2018 Survey Prep Q3 – MY2017 Survey 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 the Patient Experience Toolkit, After-Hours Script, Guidelines for Compliance and Monitoring and Appointment Access 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) If Activities Not Met: Include Barriers Encountered

- MY2018 PAAS Survey: Survey being conducted by Sutherland Global beginning in August 2018.
- Provider Updates: MY2017 Appoint Access and After-Hours Survey Results scheduled to go out August 2, 2018. MY2018 PAAS and After-Hours Survey Prep distributed June 14.
- P&P P&P PV-100 Accessibility of Providers and Practitioners): Red-line edits reviewed at July Access WG meeting.
- MY2018 PAHAS Survey - After-Hours survey being conducted by SPH Analytics beginning in September 2018.
- MY2017 CAP packets to be distributed to noncompliant provider's in September 2018.
- Review of Patient Experience Toolkit – major overhaul of this piece to take place in 2019. For this year's CAP packets created a Tips and Guidelines for Improving Access to Care brochure highlighting key areas: Patient Access, Access Standards, After-Hours Access, etc. Brochure will be completed in August 2018 and will be distributed with CAP packets in September 2018
- Provider Onsite Audits – to take place in October. Noncompliant providers subject to audit will be notified in September with their CAP packets.

Section C: Measures & Goals

Specific Measure(s)	Goal (Source of Goal)	Prior Reporting Year Rate 2017	Current Reporting Year Rate 2018 (populate mid-year)
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= 90.1% Fresno= 87.7% Kings= 97.7% Madera= 94.9%
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= 64.0^% Fresno= 68.8^% Kings= 65.2^% Madera= 55.5^%
Access to Urgent Care Services that do not require prior authorization (PCP & SCP) – Appointment within 48 hours of request	80%	Overall=76.8% Fresno=79.2% Kings=55.5% Madera=77.7%	Overall= 82.8% Fresno= 82.9% Kings= 81.4% Madera= 84.6%
Access to Urgent Care Services that require prior authorization (SCP) – Appointment within 96 hours of request	80%	Overall= N/A Fresno= N/A Kings=N/A Madera= N/A	Overall= 64.0^% Fresno= 68.3^% Kings=52.3^% Madera= 50.8^%
Access to First Prenatal Visit (PCP & SCP) – Within 10 business days of request	80%	Overall=94.2% Fresno=92.5% Kings=100% Madera=100%	Overall= 100% Fresno= 100% Kings= 100*% Madera= 33.3*%
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= 84.0% Fresno= 86.9% Kings= 60.0*% Madera= 66.7*%
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= 91.3 % Fresno=93.4% Kings= 60.0*% 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= 88.8*% Fresno= 83.3*% Kings= 100*% Madera=N/A
Appropriate After-Hours (AH) emergency instructions	90%	Overall=94.1% Fresno=94.5%	Overall= 94.3% Fresno= 93.6%

		Kings=92.7% Madera=93.8%	Kings= 95.7% Madera= 98.2%
AH physician callback: Member informed to expect a call-back from a qualified health professional within 30 minutes (Per P&P)	90%	Overall=83.1% Fresno=84.1% Kings=74.0% Madera=93.8%	Overall= 78.7% Fresno= 76.7% Kings= 87.0% Madera= 82.1 %
^ROC cannot be compared to MY2016 due to change in methodology. *Denominator less than 10. Rates should be interpreted with caution due to the small denominator.			

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Initiative Continuation Status (Populate at year end)	☐ **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**	☐ **Member Experience**

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

Aim and Goals 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 Medi-Cal 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.

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. This survey is a 3-year data cycle. A CAHPS scaled-back survey is conducted annually and survey results will be reflected on the table in Section C below in off-cycle years.

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	Q2 2019	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 of Intervention Implementation (due Q3) If Activities Not Met: Include Barriers Encountered

- Review of Patient Experience Toolkit – A major overhaul of this piece to take place in 2019. For this year's CAP packets created a Tips and Guidelines for Improving Access to Care brochure highlighting key areas: Patient Access, Access Standards, Interpreter and Advice Nurse Services, Appointment Scheduling Tips, After-Hours Access and sample after-hours scripts. Brochure will be completed in August and will be distributed with CAP packets in September.
- Appointment Scheduling Tip Sheet reviewed and no updates needed. Talking With My Doctor will be reviewed as part of Patient Experience Toolkit overhaul.
- Interpreter Services piece will be reviewed and included in the Tips and Guidelines for Improving Access to Care brochure.
- Member newsletter article on access standards published in Winter 2018.
- Nurse Advice line piece will be reviewed and included in the Tips and Guidelines for Improving Access to Care brochure.
- CAHPS Scaled-back member survey was conducted in March 2017 and results listed in section C below. Scaled back survey conducted annually.

Section C: Measures & Goals

Specific Measure(s)	Goal (Source of Goal)	Prior Reporting Year Rate 2017	Current Reporting Year Rate (populate mid-year)
Got urgent care as soon as needed	CAHPS Scaled-back member survey	79%	78%
Got routine care as soon as needed	CAHPS Scaled-back member survey	66%	68%
Easy to see specialist	CAHPS Scaled-back member survey	59%	54%
Ancillary services	CAHPS Scaled-back member survey	75%	76%
CAHPS metric: Getting Needed Care	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 81.35%	78%	N/A*
CAHPS metric: Getting Care Quickly	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 81.55%	74%	N/A*
CAHPS metric: Rating of All Health Care	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 72.82%	69%	N/A*
CAHPS metric: Rating of Personal Doctor	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 80.00%	77%	N/A*
CAHPS metric: How well doctors communicate	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 90.70%	90%	N/A*
			***3 yr data cycle; DHCS survey data available in 2019**

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Initiative Continuation Status (Populate at year end)	☐ **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**	☐ **Member Experience**

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

Aim and Goals of Initiative

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

Rationale: 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.

[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	P	Q1-Q2	CVH/HN

documentation, best practices, and recommended treatment guidelines.			
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	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) If Activities Not Met: Include Barriers Encountered

In Q1 2018, the health plan participated in the Alliance Working for Antibiotic Resistance Education (AWARE) initiative in which toolkits were mailed to the highest 20% of prescribing providers in Fresno, Kings, and Madera Counties. In an effort to ensure all prescribing practitioners are included in educational efforts, CalViva Health drilled further into the data to identify mid-level clinicians who may also be high prescribers of antibiotics. Furthermore, CalViva Medical Management team enlisted the support of the Provider Relations Representatives to hand deliver the AWARE Toolkits and AAB Tip Sheet to the physicians and mid-level clinicians identified.

In Q1, the *Avoidance for Antibiotic Treatment in Adults with Acute Bronchitis* Provider Tip Sheet was made available through the Provider Portal. The tip sheet includes the HEDIS definition for AAB, medical record documentation and best practice tips, and exclusions to the AAB HEDIS measure.

In Q1-Q2, CalViva Health identified high volume, low compliance providers and mid-level clinicians in Madera county that would be targeted for an intervention. In Q2, a pilot prescription pad program was launched with the identified one high volume prescribing provider who had an AAB compliance rate of 18.75% (6/32), In an effort to promote member education regarding appropriate treatment for bronchitis, the *Relief for a Cold or the Flu* member education material from the AWARE toolkit was converted into a prescription pad with non-carbon reproducing (NCR) paper. This document outlines self-care instructions, ways to avoid the flu or cold, and has a designated space to document any prescriptions or medications that may have been ordered. The prescription pads were translated into Spanish, Punjabi, and Hmong to support education among non-English speaking members. The pilot project was implemented for the month of April with the high prescribing provider. The provider did not utilize the Rx pad during the pilot. A new implementation plan will be developed. The Final RY2018 rate was marginally below the MPL and therefore the health plan will continue with the Rx Pilot Program as well as implement an intervention which complies with the State mandated PDSA cycle to improve the rate for Final RY2019.

Section C: Measures & Goals

Specific Measure(s)	Goal (Source of Goal)	Prior Reporting Year Rate 2017	Current Reporting Year Rate (populate mid-year)
HEDIS Appropriate Treatment for Adults with Acute Bronchitis (AAB)	Directional improvement to meet or exceed the MPL 24.91% (RY 2018)	Madera: 18.26%	Madera: 24.58%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Initiative Continuation Status (Populate at year end)	☐ 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	☐ Member Experience

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

Rationale and Aim Goals 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.

Centers for Disease Control and Prevention. (2012, October 2). Medication 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 Overcoming Barriers to Medication Adherence: A Review of Research Priorities. Journal of Managed Care and Specialty Pharmacy, 775-783.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions.

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 of 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	Q1 to Q2	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3) If Activities Not Met: Include Barriers Encountered

In Q1 2018, the health plan targeted a high volume, low compliance provider group in Madera County to distribute a modified Provider Profile to identify the list of non-compliant members who needed to complete their annual laboratory testing for MPM. In Q1 2018, 57.7% (64/111) of the targeted members completed their annual laboratory testing which exceeded the SMART Aim of 50%.

In Q2, the health plan distributed to the same high volume, low compliant provider a Provider Profile and included SMS text messaging to reminder members to complete their labs and to attend their scheduled appointment. In addition, the text message informed members that they were eligible to receive a $25 member incentive card upon completion of their labs. In Q2 2018, 58.3% (54/108) of the targeted members completed their annual laboratory testing which exceeded the SMART Aim of 50%. In addition, 80 members out of 100 members with active mobiles had received the text messages sent on behalf of the health plan.

Conducted bi-weekly multi-disciplinary MPM Improvement Team meetings to discuss the success and challenges in the process, barriers, results, and any issues identified.

The Final RY2018 rates for ACE/ARBs and Diuretics were slightly below the MPL; therefore the health plan will continue working the high volume low performing clinic on a series of interventions which complies with the State mandated PDSA cycle to improve the rates for Final RY2019.

Section C: Measures & Goals

Specific Measure(s)	Goal (Source of Goal)	Prior Reporting Year Rate 2017	Current Reporting Year Rate (populate mid-year)
HEDIS® Monitoring Persistent Medications: ACE/ARB	Meet or Exceed DHCS MPL update 85.63% (RY 2017)	Madera: 82.64%	Madera: 84.74%
HEDIS® Monitoring Persistent Medications: Diuretics	Meet or Exceed DHCS MPL update 85.18% (RY 2017)	Madera: 82.20%	Madera: 84.88%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Initiative Continuation Status (Populate at year end)	☐ **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	☐ Member Experience

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

Aim and Goals 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.

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) If Activities Not Met: Include Barriers Encountered

A high volume, low compliance clinic in Madera County was identified and targeted for an improvement project. A training for providers and mid-level clinicians was implemented to further educate providers on the clinical guidelines and best practices for the *Use of Imaging Studies for Low Back Pain (LBP) measure.* The health plan developed a presentation on the Use of Imaging Studies for Low Back Pain which included the HEDIS definition, clinical guidelines, "red flag" symptoms to document the justification for ordering an imaging study, and provider and member resources.

The health plan implemented an on-site provider training with the identified clinic. The providers and mid-level clinician's who received a training which and the intervention was measured with a pre-test and post-test. The gain in knowledge was determined through score changes between the pre-and post-test. Result from the training identified that 77.3% (17/22) of the clinicians has scored 100% on their post-test, thereby meeting the SMART Aim that over 50% of the clinician's would demonstrate an increase in knowledge upon receiving the training.
The data was monitored monthly to determine if attending the training had translated into fewer imaging tests being ordered for the diagnosis of uncomplicated low back pain.

In Q1 2018, the *Use of Imaging Studies for Low Back Pain* Provider Tip Sheet was made available through the Provider Portal. The Tip Sheet includes the HEDIS definition for LBP and suggests best practice approaches to increasing the number of compliant members for the LBP measure.

In addition, CalViva Health has conducted bi-weekly multi-disciplinary LBP Improvement Team meetings to discuss the successes and challenges in the process, barriers, results, and any issues identified. On a monthly basis, the health plan reviewed with the clinic leadership the data of members who received an imaging study for the diagnosis of uncomplicated low back pain. The clinic leadership was able to confirm results and make necessary corrections or clarifications such as if a member were assigned to the clinic but was seen in the emergency department when the diagnosis was made and the imaging study performed. The health plan was able to successfully meet the MPL for this measure.

Section C: Measures & Goals

Specific Measure(s)	Goal (Source of Goal)	Prior Reporting Year Rate 2017	Current Reporting Year Rate (populate mid-year)
HEDIS® Low Back Pain	Meet or Exceed DHCS MPL RY2018 66.23%	Madera: 66.67%	Madera:75.64%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Initiative Continuation Status (Populate at year end)	☐ Closed	☐ Continue Initiative Unchanged	☐ Continue Initiative with Modification

III. PERFORMANCE IMPROVEMENT PROJECT

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	☐ Member Experience

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

Aim and Goals 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 h **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]

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[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).
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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 & 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 Hemophilic 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,	CVH/HN
Childhood immunizations reminder campaign: IVR, email or SMS.	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	CVH/HN
Provider Tip Sheets will be hand-delivered to CVH provider groups.	P	Q2	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3) If Activities Not Met: Include Barriers Encountered

In Q1 and Q2, CalViva Health established a multi-disciplinary Childhood Immunization (CIS-3), Performance Improvement Team in collaboration with two high volume, low compliance clinics in Fresno County and completed process mapping activities aimed at improving childhood immunization rates. A Failure Modes Effects Analysis (FMEA) was also completed with the clinic staff, to prioritize gaps in processes and identify potential interventions.

Using the process map and FMEA tool the clinic staff, providers and the CalViva Health team established the first intervention to address the highest priority gap identified. These activities completed Module 3.

The team implemented the first intervention of eliminating the double-booking option from provider scheduling templates (Monday through Friday) until the start of the work day. This is anticipated to allow space for patients to schedule same-day appointments for their needed immunizations. The clinics are also accommodating walk-in patients with designated “Walk-in Only Clinics” on Saturdays. It is estimated that more people will use the walk-in and “fast track” option over scheduling an appointment. Data will be gathered to evaluate outcomes.

A second intervention is in development and will be member based.

Section C: Measures & Goals

Specific Measure(s)	**Goal (Source of Goal)**	**Prior Reporting Year Rate 2017**	**Current Reporting Year Rate (populate mid-year)**
Childhood Immunization Combo 3	Meet or Exceed SMART Aim Goal of 70%	N/A	N/A

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Initiative Continuation Status (Populate at year end)	☐ **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**	☐ **Member Experience**	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**		

Aim and Goals of Initiative

Overall Aim: Improve maternal health in Fresno County.

Rationale: Postpartum care continues to be a priority in the 2018 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.

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[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	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	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3) If Activities Not Met: Include Barriers Encountered

In Q1 CalViva Health established a multi-disciplinary Postpartum (PPC) Performance Improvement Team in collaboration with a high volume, low compliance clinic with an identified disparity in Fresno County. The PPC PIP team completed a detailed Process Map depicting the steps, from a member perspective, to scheduling and completing a postpartum care visit at the designated clinic. A Failure Modes and Effects Analysis, (FMEA), was also completed with the clinic staff in order to prioritize gaps in processes and identify potential interventions. Using the Process Map and FMEA the clinic staff, providers and CalViva Health team developed interventions to address the highest priority gaps identified in the FMEA.

The team implemented the first intervention, a color-coded, electronic medical record (EMR) Alert, after staff training. The Alert is created by the Medical Assistant for pregnant women at 35 weeks gestation and is visible to clerical and clinical staff who schedule postpartum visits. The Alert reminds staff of the 21-56-day timeframe for postpartum visit completion. Compliance data will be collected.

A second intervention will include modification of a pre-natal documentation (ACOG form) to include questions regarding customs, traditions, and cultural beliefs that may impact health care decisions around postpartum care. Education on cultural diversity will be provided to clinic staff along with the new ACOG form. This will be an opportunity for the clinic staff to gain insight into the cultural beliefs of their patients and ultimately improve the postpartum visit rates in Fresno County.

Section C: Measures & Goals

Specific Measure(s)	Goal (Source of Goal)	Prior Reporting Year Rate 2017	Current Reporting Year Rate (populate mid-year)
Postpartum Care Visits	Meet or Exceed SMART Aim Goal of 64%	N/A	N/A

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Initiative Continuation Status (Populate at year end) ☐ **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)*

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	They are included in new member welcome packets. It is an ongoing activity	☐		
2. Adopt, Disseminate Medical Clinical Practice Guidelines (CPG)	CVH/HN	Approved by QIUM Committee and distributed via Provider Updates	☐		
CHRONIC CARE/ DISEASE MANAGEMENT					
1. Monitor Disease Management program for appropriate member outreach	CVH/HN	A current program continues. Program monitoring continues through monthly reporting. Transition to new vendor in planning phase with implementation eminent.	☐		
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE					
1. C&L Report: Analyze and report Cultural and Linguistics (C&L)	CVH/HN	C&L completed and received approvals during Q2 2018 on the 2017 end of year language assistant program and end of year work plan reports. The 2018 Program description and 2018 work plan reports were also submitted and approval received during Q2 2018.	☐		
2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s) and/or CCHRI	CVH/HN	MY2018 PAAS survey to be conducted by Sutherland Global in August 2018 MY2018 PAHAS survey to be conducted by SPH Analytics in September 2018	☐		
3. Complete and submit DMHC Timely Access Reporting (TAR) by April 30 filing due date	CVH/HN	TAR filing submitted timely- March 31, 2018	☐		
4. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances	CVH/HN		☐		
5. Group Needs Assessment Update– Evaluating membership's health risks and identifying their health care needs will help to prioritize, develop and implement Cultural & Linguistics health education materials, services and Quality Improvement (QI) programs.	CVH/HN	GNA Report is due every five years. The next GNA is scheduled for 2021. C&L continues to use the findings from the GNA Report to establish C&L priorities to ensure members, providers and staff have access to culturally and linguistically appropriate services, trainings and resources inclusive of language services.	☐		

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
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	C&L Geo Access report was completed in 2017. Next report is scheduled to be completed in 2019.	☐		
7. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report	CVH/HN	Ongoing IHA 3 pronged outreach is reported quarterly basis	☐		
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: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	CVH/HN	Information is presented in the Key Indicator Report and also in the quarterly Case Management reports presented to the QI workgroup.	☐		
CREDENTIALING / RECREDENTIALING					
1. Credentialing/Recredentialing Practitioners/Providers – Achieve and maintain a 100% timely compliance and 100% accuracy score	CVH/HN	Credentialing reports continue to be submitted on a regular bases and are monitored for potential improvements	☐		
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	Quarterly reports being submitted and reported to the QI/UM Committee.	☐		
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 and 15-023	CVH/HN	Ongoing monitoring is conducted. Bi-Annual report of quarterly monitoring of FSR/MRR to QI.	☐		
2. Evaluation of the QI program: Complete QI Work Plan evaluation annually.	CVH/HN	Ongoing monitoring in progress	☐		
CLINICAL DEPRESSION FOLLOW-UP					
3. Development and distribution of provider educational resources on screening for clinical depression and follow	CVH/HN	Provider updates are currently in the updating process. A provider tool is also	☐		

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
up (12 years and older)		in development to help providers understand the flow of screening for depression and referring members with positive screens.			

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Last updated: August 27, 2018

Health Net

CalViva HEALTH

CalViva Health
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Fresno-Kings-Madera Regional Health Authority Approval

The Fresno-Kings-Madera Regional Health Authority Commission has reviewed and approved this Work Plan.

David Hodge, MD, Fresno County
Regional Health Authority Commission Chairperson

Date

Patrick Marabella, MD, Chief Medical Officer
Chair, CalViva Health QI/UM Committee

Date

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Last updated: August 27, 2018

1. Compliance with Regulatory & Accreditation Requirements

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support UM decisions.	☒ Medi-Cal	Qualified licensed and trained professionals make UM decisions.	HN has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions. HN HCS (for nurses) National Credentialing (for physicians) and Pharmacy (for pharmacists) maintain records of health professionals' licensure and credentialing. 100% compliance with maintaining records of professional licenses and credentialing for health professionals.	Provide continuing education opportunities to staff. Conduct Medical Management Staff new hire orientation training. Review and revise staff orientation materials, manuals and processes. Current process of verification of CME standing, verification of certification, participation in InterQual training and IRR testing. Conduct training for RNs	Monthly As needed Ongoing Ongoing Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The following monthly clinical education (CE) and Quality Improvement (QI) in-services were offered to all nurse and MD reviewers and additional sessions have been scheduled for the second half of the year: • Protective Bundle (CE) • CAHPS/HOS & Talking with Older Adults (QI) • Palliative Care (CE) • SNP Model of Care (QI) • Hepatitis C (CE) • Mental Health Stigma (QI) Continued new hire training, review revision of staff orientation materials, manuals and processes. Current process of verification of CME standing, verification of certification, participation in InterQual training and IRR testing in place and up to date.	None identified	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
1.2 Review and coordinate UM compliance with California legislative and regulatory requirements	☒ Medi-Cal	Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations. This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance.	Review and report on legislation signed into law and regulations with potential impact on medical management Appropriate and timely changes are made to Medical Management processes to accommodate new legislation as appropriate. 100% compliance of UMCM staff and processes with all legislation and regulations.	Review new legislation and regulations, either through e-mail or department presentation. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Reviewed new legislation and regulations, either through e-mail or department presentation. Participated in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participated in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	None identified	Continue to assess implications of changes in regulation and update our policies and procedures as needed.	Ongoing Ongoing Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Created: March 5, 2018, March 8, 2018
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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
1.3 Separation of Medical Decisions from Fiscal Considerations	☒ Medi-Cal	DHS, DMHC, and CMS, at a minimum, require that Medical Decisions made by MDs and Nurse reviewers are free from fiscal influence.	Affirmative statement about incentives is distributed to employees and communicated to members in member mailings and to practitioners/providers in Provider Updates. 100% compliance with distribution of affirmative statement about financial incentives to members, practitioners, providers and employees.	Circulate to all MDs and Nurse reviewers an attestation that states: ▪ Utilization Management decisions are based on medical necessity and medical appropriateness. ▪ Health Net and CalViva do not compensate physicians or nurse reviewers for denials. ▪ Health Net and CalViva do not offer incentives to encourage denials of coverage or service. Management Incentive Plan (MIP) Goals will not be created that benefit MDs or Nurse reviewers based on any potential to deny care.	Ongoing

Created: March 5, 2018, March 8, 2018
Last updated: August 27, 2018

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Annual attestations to be circulated in December 2018. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	None	Corrected "RN" reference to be inclusive of all "Nurse reviewers"	December
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Created: March 5, 2018, March 8, 2018
Last updated: August 27, 2018

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
1.4 Periodic audits for Compliance with regulatory standards	☒ Medi-Cal	Ensure compliance with regulatory standards.	Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turnaround time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision.	Conduct File Reviews for compliance with regulatory standards. Provide ongoing education and/or UM process improvement with HNCS staff on issues revealed during the file review process. File Audits completed the month following each quarter	Ongoing April 2018, July 2018, October 2018, January 2019

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Ongoing monthly regulatory standard auditing continues. When a variance from compliance standards are identified, CAP submission and staff education completed as evidenced by CAP tracking within the Compliance and Auditing departments. Auditing results presented PMR meeting.	None identified	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS).	☒ Medi-Cal	HN MDs interact with the MMCD Division of DHCS: ▪ MMCD Medical Directors Meetings ▪ MMCD workgroups ▪ Quality Improvement workgroup ▪ Health Education Taskforce There are benefits to HN MD participation: ▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program ▪ Provides HN with in-depth information regarding contractual programs ▪ Provides HN with the opportunity to participate in policy determination by DHCS.	HN Medical Directors and CalViva Health Chief Medical Officer participate on DHCS workgroups, task forces and meetings Ensures participation by MDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each MD. HN and CalViva remain a strong voice in this body with participation on key workgroups	The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2018. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Monthly and quarterly reports to CalViva and Medical Director and Chief Medical Officer continue. Health Net Medical Directors and the CalViva Chief Medical Officer participated in the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for quarters in the year.	None identified	None	Ongoing Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
1.6 Review, revision, and updates of CalViva UM /CM Program Description, UMCM Work plan, and associated policies and procedures at least annually.	☒ Medi-Cal	State Health Programs Health Services reviews/ revises Medi-Cal UM/CM Program Description and UMCM Policies and Procedures to be in compliance with regulatory and legislative requirements.	Core group comprised of State Health Programs CMD, Regional Medical Directors, Director of Health Services and Health Services Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2018 UMCM Program Description Write and receive CalViva approval of 2017 UMCM Work Plan Year-End Evaluation Write and receive CalViva approval of 2018 UMCM Work Plan. Write and receive CalViva approval of 2018 UMCM Work Plan Mid-Year Evaluation Prepare and Submit UMCM Program Description and Work plan to CalViva QIUM Committee and CalViva RHA Commission annually, providing mid-year updates and any ad hoc queries from CalViva Health leadership. Continue to monitor and revise policies and procedures based on DHCS and DMHC requirements.	Q 1 2018 Q 1 2018 Q 1 2018 Q 3 2018 Ongoing Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The 2018 UMCM Work plan and Program Description and 2017 YE Evaluation were approved in Q1. Health Net continues to monitor and revise policies and procedures based on DHCS and DMHC requirements.	None identified	Continue to review and revise UMCM program description and work plan as required to reflect regulatory guidelines.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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2. Monitoring the UM Process

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
2.1 The number of authorizations for service requests received	☒ Medi-Cal	Provide oversight, tracking, and monitoring of authorization requests and evaluate opportunities to modify prior authorization requirements. Track and trend all types of prior authorization and concurrent review activities based on requirements.	Track and Trend authorization requests month to month. Tracking includes number of prior authorization requests submitted, approved, deferred, denied, or modified. Turnaround times (TAT) Number of denials appealed and overturned	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of Prior Authorization process. Assess staffing needs for prior authorization process completion and ensure staffing is included in annual budget and quarterly budget revisions.	Ongoing

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The Management team reviews monthly reports to discuss and review 2018 expectations. Trends and results are discussed in the Medical Management Department KPI meeting. Activities are all on target for 2018, with exception to issue that occurred with providers utilizing the incorrect authorization form in Q1.	Providers using the incorrect authorization form caused authorizations to be misrouted and not meet TAT.	The issue with providers using the incorrect authorization form was resolved in April 2018 and is no longer adversely impacting TAT. Issue was resolved with provider communication and education.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request. (Turn Around Times =TAT)	☒ Medi-Cal	TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications). Provide oversight, tracking, and monitoring of turnaround times for authorization requests.	Track and Trend authorization requests month to month in all categories and report monthly in the Key Indicator Report.	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of turnaround times (TATs). Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining	Ongoing UM TAT Summaries due the month following on the 10th of each month.

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	CalViva TAT 2018 • January 99.0% • February 93.0% • March 90.0% • April 96.7% • May 97.5% • June 97.7% Average = 95.65%	In February 2018 approximately 90,000 members transitioned causing an influx of authorization requests. Some providers for these members used incorrect authorization forms which caused referrals to be misrouted. These misroutes caused delays in processing and contributed to lower TAT scores.	Providers were given education by staff to utilize the appropriate referral form to prevent misrouting. This issue was resolved April 9th, 2018 following education to providers. Providers are now utilizing the correct authorization forms. There are no known issues adversely contributing to TAT. Formal CAP in place based on historical TAT data. TAT updates are delivered the 10th of every month.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making	☒ Medi-Cal	Consistency with which criteria are applied in UM decision-making is evaluated annually. Opportunities to improve consistency are acted upon.	HN administers McKesson InterQual® IRR Tool to physician and non-physician UM reviewers annually Physician and non-physician UM reviewers achieving ≥ 90% passing score on InterQual® IRR Tool	<u>Physician IRR</u> Administer Physician IRR test using case review method and McKesson InterQual® IRR tool in Q3-4 2018 <u>Non-Physician IRR</u> Administer annual non-physician IRR test using McKesson InterQual® IRR tool in Q3-4 2018	Q3-4 2018 Q3-4 2018

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	On Track - Training department Supervisor and Clinical Trainers are working with the Centene Corp Training Team to go over the changes once received (estimated by 7/30). The training team will be scheduling and advertising sessions in Cornerstone Sept – October. It will be the responsibility of the leadership team to schedule their staff. Please see schedule of events below: ➢ InterQual 2018 Updates will be in the train environment mid to late August ➢ Initial testing will start 2-4 weeks after it goes into train environment ➢ Initial testing is a four week period ➢ There is a one week break for retraining/remediation between the initial testing period and test retake period ➢ Retake testing period will be the next four weeks after the one week break	None identified	None	12/30/2018
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals.	☒ Medi-Cal	Track the number of clinical appeals received for authorization decisions and also the number upheld and overturned to determine where modifications in authorization process are appropriate.	Measure UM Appeals volume as a percentage of the total authorization requests. Measure the number upheld and overturned, as well as Turn Around Times.	Appeals data, the numbers received, timeliness of completion of appeals reported to HNCS UM/QI Committee bimonthly Collaborate with QI Department for review of Appeals at least annually, including an analysis of trends. Identify opportunities for removing or adjusting prior authorization requirements or criteria based on appeals that are regularly overturned Bring this analysis to UM/QI committee for discussion and input from community practitioner committee members. Ensure appeals are processed by specialty matched physicians, which at a minimum requires pediatricians or family practitioners to evaluate all medical necessity appeals for members under age 21, and family practitioners or internists to evaluate all medical necessity appeals for members over age 21.	Ongoing

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<tr><th>Report Timeframe</th><th>Status Report/Results</th><th>Barriers</th><th>Revised/New Interventions</th><th>Target Completion Date</th></tr>
<tr><td>Mid-Year Report

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td><td>Appeals data is a consistent component of UM/QI and tracked on a routine and ongoing basis. Activity will be ongoing to ensure quality outcomes are met.

Turnaround Time Compliance for resolved expedited and standard appeals = 97.59% or 283 out of 290.

<table>
<tr><th colspan="3">2018 Semi-Annual Appeals January – June 2018</th></tr>
<tr><th>Appeal Type</th><th>Case Count</th><th>Percentage</th></tr>
<tr><td>Overturn</td><td>98</td><td>33.79%</td></tr>
<tr><td>Partial Uphold</td><td>6</td><td>2.07%</td></tr>
<tr><td>Uphold</td><td>184</td><td>63.45%</td></tr>
<tr><td>Withdrawal</td><td>2</td><td>0.69%</td></tr>
<tr><td>Total Cases</td><td colspan="2">290</td></tr>
</table>
</td><td>None identified</td><td>None</td><td>Ongoing</td></tr>
<tr><td>Annual Evaluation

☐ MET OBJECTIVES

☐ CONTINUE ACTIVITY IN 2019</td><td></td><td></td><td></td><td></td></tr>
</table>

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3. Monitoring Utilization Metrics

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance	☒ Medi-Cal	Health Net Central Medical Directors and Health Care Services manage the non-delegated shared risk PPGs and a sizable FFS membership.	Health Net manages shared risk non-delegated PPGs and FFS inpatient UM. Data reported quarterly at State Health Programs UM/QI Committee meeting ▪▪▪▪▪▪▪▪▪▪▪▪▪▪▪ Key Metrics (SPD, Non-SPD, MCE) Bed days/k ALOS Admit /K All cause readmits within 30 days <u>2018 Goals</u>: Bed Days/K SPD: 1129.7 MCE: 325 TANF: 216.6 Average length of acute care stays SPD: 5.1 MCE: 4.7 TANF: 4.8 Admit/KSPD: 241.4 MCE:62.1 TANF:49.6	Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services and community resource needs and Transition Care Management and Discharge Programs. Use data to identify high cost/high utilizing members to target for care management. Track effectiveness of various case management programs on readmissions, hospital utilization, including case management, Integrated Case Management, Pharmacy interventions, ESRD program, Disease Management, concurrent review rounds process. These benchmarks are currently under development. All internal thresholds will be reviewed and possibly revised for 2018.	Ongoing

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<tr>
<td>Mid-Year Report

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>Care management activities are on target

CCR team continues in collaboration with Case Management for early intervention in establishing a medical home for members with frequent admissions

Medical Director, CCR. CM using data to identify high cost/high risk members and targeting for CM
<table>
<tr><th>Bed Days/K</th><th>2018 Goal</th><th>Jan-Jun 18 Actual</th></tr>
<tr><td>MCE</td><td>335.0</td><td>349.8</td></tr>
<tr><td>SPD</td><td>980.0</td><td>943.1</td></tr>
<tr><td>TANF</td><td>102.4</td><td>110.9</td></tr>
</table>
<table>
<tr><th>ALOS</th><th>2018 Goal</th><th>Jan-Jun 18 Actual</th></tr>
<tr><td>MCE</td><td>5.1</td><td>5.2</td></tr>
<tr><td>SPD</td><td>5.0</td><td>5.5</td></tr>
<tr><td>TANF</td><td>3.8</td><td>3.8</td></tr>
</table>
<table>
<tr><th>Admit/K</th><th>2018 Goal</th><th>Jan-Jun 18 Actual</th></tr>
<tr><td>MCE</td><td>65.0</td><td>67.9</td></tr>
<tr><td>SPD</td><td>177</td><td>170.1</td></tr>
<tr><td>TANF</td><td>27.1</td><td>29.2</td></tr>
</table>
<table>
<tr><th>% Re-admit</th><th>2018 Goal</th><th>Jan-Jun 18 Actual</th></tr>
<tr><td>MCE</td><td>13.0</td><td>13.6</td></tr>
<tr><td>SPD</td><td>21.0</td><td>21.4</td></tr>
<tr><td>TANF</td><td>8.0</td><td>8.1</td></tr>
</table>
</td>
<td>Increase in TANF utilization was noted in first quarter 2018. The increase in admissions seems to correlate to an overall increase in Homelessness and Substance abuse based on the top ten admission diagnoses for 2017/18 with an accompanying increase in ED utilization as well.

ED visits for Influenza increased in occurrence advancing to the top eight diagnoses for ED visits for 2018 where it had not been in the Top Ten ED Diagnosis in previous years.

Admissions and bed days also increased in response to this unusual flu season.</td>
<td>Aid code assignments have been remapped and membership restated 7/25/18 using claims data.

Onsite CCR team making immediate referrals to CM following High level screening upon hospital admission

Medical Director working with Direct contract physicians and hospitals to ensure seamless post -follow up care.

Utilization goals for 2018 have been re-stated based on Acute Inpatient performance over the past 3 years.

The Utilization team will continue to monitor, track and trend inpatient utilization in general and ED utilization in particular for opportunities to impact admissions and improve overall care.</td>
<td>7/25/18

Ongoing

Initiated 6/2018 ongoing

9/1/208</td>
</tr>
</table>

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3.2 Over/under utilization	☒ Medi-Cal	HN ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non-SPD members. Fraud, Waste and Abuse of medical services is monitored and reported. PPG Reports are used internally and externally with medical groups to develop member and population level interventions. Quarterly reports are made available for PPGs with member Non-SPD >1000 and SPD greater than 500 members. And MCE members >1000.	The UM metrics will be reported quarterly and the procedure metrics will be reported annually for PPGs with greater than 1,000 non-SPD, greater than 1,000 MCE or 500 SPD Medi-Cal Members. Metrics include: 1. Acute bed days per thousand 2. Average length of acute care stays 3. ER visits/K 4. All Cause Readmits within 30 days 5. Aggregate Specialty Referrals using NPI #'s compared to NPAS 6. CCR Goals are: SPD:20 MCE:10 TANF:7 7. % 0-2 day admits 8. C-Section Rates PPG profile reports are made available quarterly and one metric for over utilization (ER/K), and two metrics for underutilization, (All Cause Readmits w/in 30 days) and Specialty referrals are assessed on a biannual basis	Continue to enhance provider profile. Identify PPG PIP, outcome results and barriers on a biannual basis and present aggregated results to CalViva. (Over and Under Utilization reports) Identify possible fraud, waste and abuse issues. Report any issues to the SIU and Compliance Department Thresholds for 208 are under evaluation. <u>Referral Rates: Specialist</u> Average PM/PY referral rates are calculated from claims and set as internal thresholds for SPD, Non-SPD and MCE members by PPG. Average referral rates are determined and the bottom 10% are identified as outliers. (*pending approval from DHCS/DHMC.) PPG's are identified as potential outliers for the metrics measured undergo further analysis by the MD to determine if a Quality Improvement Plan is indicated. The Quality Improvement Plans, if applicable are reviewed at the regional team meetings lead by the Medical Directors.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The CVH PPG specific data Dashboard Reports were developed and are produced quarterly. The data is presented at the CalViva Management Oversight meeting. The reports are derived from claims data and have a time lag of approximately four to five months.	None identified	ER Visits/K and 30-day all-cause readmission rates added to current metrics. The updated UM metrics will be: Bed Days/K, Admits/K, ALOS, ER Visits/K, and 30-day all-cause readmission rates. The reported metrics by PPG will be presented by aid type (SPD, Non-SPD, and MCE) and compared to established benchmarks. The analysis of the data will include: 1) Current status compared with benchmarks; 2) Changes and trends with causal analysis; and 3) Action plan including performance improvement plans.	End of 2018Q3 End of 2018Q3 Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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3.3 PPG Profile	☒ Medi-Cal	Profiles provide PPGs threshold data based on CalViva data and comparative performance data to help them measure and improve their UM and QI performance.	Medi-Cal PPGs with greater than 1,000 non-SPD, 1000 MCE or 500 SPD Medi-Cal members are produced quarterly and evaluated .bi-annually for possible over/under utilization. Metrics include: 1. Acute bed days per thousand 2. Average length of acute care stays 3. ER visits/K 4. All Cause Readmits within 30 days 5. Aggregate Specialty Referrals using NPI #'s compared to NPAS 6. % of 0-2 day admissions 7. C-section rates	CalViva PPG profile reports are made available quarterly and at least one metric for over utilization (ER/K), and at least two metrics for underutilization, (All Cause Readmits w/in 30 days) and specialty referral are assessed on a biannual basis Results will be compared to HN internal thresholds which are under re-evaluation for 2018. PPG's are identified as potential outliers for the metrics measured undergo further analysis by the MD to determine if a CAP is indicated. CAPS are monitored by delegation oversight then to document implementation and need for follow up <u>Referral Rates: Specialist</u> Average PM/PY referral rates are calculated from claims and set as internal thresholds for SPD, Non-SPD and MCE members by PPG. Average referral rates are determined and the bottom 10% are identified as outliers (*pending approval from DHCS/DHMC.)	Ongoing

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Dashboard reports are in place. Narrative report for Q1 reviewed at MOM meeting on 6/4/2018. CalViva PPG profile reports are made available quarterly and at least one metric for over utilization (IP/K), and at least two metrics for underutilization, (All Cause Readmits w/in 30 days) and specialty referral are assessed on a biannual basis Results will be compared to HN internal thresholds which are under re-evaluation for 2018. Further analysis will be initiated by the RMD for PPG's identified to be potential outliers and a Corrective Action Plan (CAP) will be requested when indicated. CAPS are monitored by the Delegation Oversight team to insure actions are implemented and documentation and follow up are completed.	Membership growth and changing regulations	Internal thresholds under review	Ongoing Ongoing Ongoing Ongoing Ongoing
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4. Monitoring Coordination with Other Programs and Vendor Oversight

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4.1 Integrated Case Management Program (ICM)	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner optimizes physical and emotional health and well-being and improves quality of life. Assisting members with complex and serious medical conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report to track and trend Integrated Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of RNs, CM Assistants, and LCSWs to perform ICM Implement report to monitor new member referrals to ICM based on information from the Health Information Form. Implement use of ImpactPro as the predictive modeling tool to identify high risk members for referral to ICM. Review outcome measures quarterly.	Ongoing

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Referrals to CM based on completed HIFs was implemented in Q1. 2017 HIF: 2012 forms received through 3/31, 10 members referred to CM. Through Q2 746 2018 HIFs were loaded & 108 members were referred to CM. Implemented use of ImpactPro in Q1 to identify high risk members for referral to ICM. Through Q2 90 referrals were made to a CM program. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in PH CM & 90 days after enrollment. Q1 results include members with active or closed case on or between 1/1/2018 & 3/31/2018 & remained eligible 90 days after case open date. 129 members met criteria. Results of members managed: • Admissions & readmissions were lower • 20.10% decline in readmissions • Volume of ED claims/1000/yr decreased by 279 • Reduction total health care costs primarily related to decreased inpatient costs, slight decrease in outpatient services & increase in pharmacy costs • 20 members successfully contacted to complete survey. 95% (19/20) of respondents satisfied with help they received from the CM. 95% (19/20) reported goals they worked on improved understanding of their health. 17/20 respondents indicated 59% improvement in overall health or ability to care for family post CM vs pre CM & 88.2% (18/20) reported CM exceeded their expectations.	January 2018 CalViva new member mailings included the 2017 HIF form. 2018 HIF was included in the New Member Welcome Packet in February. Small volume of member satisfaction surveys completed.	Continue existing interventions. Re-evaluating outreach process to complete surveys in effort to increase completion volume. Program metrics formerly included Transitional Care Management (TCM) referrals. ICM and TCM reported separately as of June. Palliative care program monitoring was initiated in Q1 and monitoring continues.	Ongoing

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Case Management	☒ Medi-Cal	Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes.	Notify PCP's or PPG's of patients identified for program . Measure program effectiveness based on the following measures: o Member compliance with completing • 1st prenatal visit within the 1st trimester and • post-partum visit between 21 and 56 days after delivery compared to pregnant members who were not enrolled in the program	PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms. Expand Pregnancy Program activities to include consolidation of provider forms used to identify high risk members, increase outreach to high risk member through education packets, text reminders, etc. Implement use of the Notification of Pregnancy (NOP) form by members, and related reports to increase identification of moderate and high risk members for referral to the Pregnancy Program. Monitor volume of referrals based on NOP activity. Review outcome measures quarterly.	Ongoing

Created: March 5, 2018, March 8, 2018
Last updated: August 27, 2018

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date

Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Referrals to PCM primarily based on Perinatal Notification Incentive Program (PNIP) referral from PCP and NOP assessments. Referrals increased from 169 in Q1 to 217 in Q2. Through Q2 120 members managed in PCM program, exceeding 2017 volume. Quarterly average engagement rate decreased from 30% in Q1 to 23% in Q2. Decrease in Q2 driven by sharp decline in engagement rate in June. Hard copy program materials have been branded and approved; distribution pending approval of program text messaging content by DHCS. Outcome measures based on member's compliance with completing 1st prenatal visit within 1st trimester & post-partum visit between 21 & 56 days after delivery compared to pregnant members who were not enrolled in the program. Q1 results demonstrated greater compliance in managed members for both measures. • 25 members met the outcome inclusion criteria • Members enrolled in the High Risk Pregnancy Program demonstrated: o 6% greater compliance in completing the first prenatal visit within their first trimester o 8.2% greater compliance in completing their post-partum visit	Delay in distribution related to approval of text messaging as referenced in hard copy materials.	Distribution to be initiated once text messaging component approved by DHCS.	Q4
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
4.3 Disease Management	☒ Medi-Cal **Diabetes Age Groups** 0-21 CCS Referral (100%) >21 Enrolled in program	The Managed Care Plan is responsible for initiating and maintaining a Disease Management program for high volume, common conditions, where guidelines and proven timely intervention have been shown to improve outcomes.	Eligibility data from sources such as: pharmacy/ encounter claims, health appraisal results, data collected through the UM or case management process, and member or provider referrals. Evaluation of outcome data from HEDIS® -like measures. Review/analyze DM partner annual report	Transitioning to new vendor and continuing to concentrate on three conditions: asthma, diabetes, and heart failure. Notify PCPs of their patients identified or enrolled in the disease management program. Focus on streamlining hand-off between Disease Management and the Integrated Case Management programs. Review of member materials and scripts by the Compliance and Cultural & Linguistics departments and DHCS before going to press. Ongoing program monitoring to assure that reporting needs are met. Monitor the monthly reports and enrollment statistics.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Plans continue with in source of DM programs. Statement of Work with CalViva Health in approval phase. Program will include notification material to providers upon member enrollment and will include care coordination between DM and CM. Collateral materials approved. Program monitoring of current DM program continues.	Regulator approval of Statement of Work pending New privacy requirements required rework	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Created: March 5, 2018, March 8, 2018
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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2018 Planned Interventions	Target Completion Date
4.4 MD interactions with Pharmacy	☒ Medi-Cal	Medi-Cal formulary is a closed formulary consisting of primarily generic medications. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to refine the formulary and injectable guidelines to facilitate member and provider efficiencies; to ensure adequate and current medications are included, and to ensure appropriate utilization. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to remove unnecessary PA obstacles for practitioners and pharmacists SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to improve CCS ID using pharmacy data SHP MD's and Pharmacy continue to mirror the DHCS narcotic prescribing quantity limits. This is to	Monthly check write review Monthly report of PA requests	Continued active engagement with pharmacy Continue narcotic prior authorization requirements Consider implementation of opioid edits based on updated CDC guidelines for prescribing opioids.	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2018 Planned Interventions	Target Completion Date
		prevent fraud and abuse, and prevent adverse selection to the CalViva Medi-Cal plan.			

Health Net

CalViva HEALTH

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2018 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	• Continued active engagement with pharmacy through Quarterly QI meetings. No significant ongoing issues or frequently encountered problems have been identified in the first two quarters of 2018. • Prior Authorization requirements remain in effect • Opioid policies remain in line with State FFS plan as required. New guidance on opioids reviewed at P&T 7/17/2018. New guidance and recommendations will be enacted Q3 2018.	None Identified	None	Ongoing Ongoing Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Created: March 5, 2018, March 8, 2018
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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2018 Planned Interventions	Target Completion Date
4.5 Manage care of CalViva members for Behavioral Health	☒ Medi-Cal	CalViva collaborates with Behavioral Health practitioners to improve coordination between medical and behavioral health care members.	Total number of registrations and referrals	Review data that indicates when a member was referred to the County for services to ensure that MHN staff are facilitating coordination of care. Each month is compared to data from previous months to ensure the number of referrals to County follows an acceptable trend. For example, a consistent drop in referrals may indicate the need for additional staff training. Review data that indicates when a PCP has referred a member to a BH provider. Each month's data is compared to those from previous months to ensure that coordination of care between medical and behavioral health is occurring. For example, a drop in these referrals may indicate a need for enhanced medical provider training on the services that MHN provides.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	MHN continues the bidirectional referral process with Fresno, Kings and Madera counties. Referrals were based on acuity of clinical presentation and member need for particular behavioral health services. MHN Care and Case Managers continue weekly rounds with HN medical case management staff and Medical Directors with the purpose of integrating medical and behavioral health services and ensuring that members receive optimal care. PCPs are also offered opportunities to collaborate with MHN MDs for guidance on treating routine psychiatric conditions. 1000 calls from members 1/1/18 – 6/30/18 198 of 1000 calls were sent to clinical care managers for assessment. Of these, 8 of 198 were referred to the County for Specialty Mental Health Services	None identified	Continue monitoring, tracking, and revising metrics. as needed, to ensure coordination, continuity and integration of care Behavioral health complex case management was initiated through the HN CM department beginning late Q2.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2018 Planned Interventions	Target Completion Date
4.6 Behavioral Health Performance Measures	☒ Medi-Cal	CalViva collaborates with Behavioral Health practitioners to improve performance measures for the CalViva behavioral health care members.	Performance Measures to be monitored: Appointment Accessibility by Risk Rating Authorization Decision Timelines Potential Quality Issues Provider Disputes Network Availability Network Adequacy: Member Ratios Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder.	Participate in cross functional team to improve quality of behavioral health care.	Ongoing

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Health Net

CalViva HEALTH

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Performance measures monitored. Participated in cross functional team to improve the quality of behavioral health care. • Provider Appointment Availability Survey (PAAS): Q1 appointment access standards were met. • Timeliness: Prior authorizations for autism and single case agreements in Q1 were all compliant with timeliness standards. • PQI: no PQI's in Q1. • Provider disputes: Out of 7 provider disputes in Q1 all were resolved timely. • Network Availability and Adequacy: All availability and adequacy metrics met standard in Q1. • Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder. Survey will be administered Aug-Dec 2018. Due to low response rate in 2017 provider outreach was completed and overall results confirmed appointment availability and capacity for additional clients. • Behavioral health complex case management was initiated through the HN CM department beginning late Q2.	None identified	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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5. Monitoring Activities for Special Populations

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
5.1 Monitor of CCS identification rate.	☒ Medi-Cal	CASHP will monitor Medi-Cal CCS identification rate YTD.	All HN SHP staff will work with Public Programs Coordinators and UM staff to identify potential CCS cases and refer to county for approval. Based on the standardized formula, monthly report indicates CCS %. Goal: HN identifies 5% of total population for CCS eligibility.	CCS identification and reporting continues to be a major area of focus for SHP. Continue current CCS policies and procedures. Identification through claims review, concurrent review, prior authorization, case management, pharmacy, and member services (welcome calls and CAMHI screening tool) Improve coordination with CCS between specialists and primary care services. Continue to distribute quarterly provider letters based upon DHCS Corrective Action Plans.	Ongoing

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<table>
<tr><th>Report Timeframe</th><th>Status Report/Results</th><th>Barriers</th><th>Revised/New Interventions</th><th>Target Completion Date</th></tr>
<tr><td>Mid-Year Report

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td><td>Teams are continuing current CCS policies and procedures including identification and referral of cases through identified resources.

An annual notification mailing was first released March 2018 to all PCP’s per 2017 efforts to automate CCS related provider letter generation. The following additional events have triggered letters distributed weekly to the members assigned PCP throughout 2018:
• A new member becomes eligible with the health plan and has an existing CCS condition
• An existing member has a new CCS approved condition
• An existing member with an approved CCS Condition changes PCP’s

% of CCS Eligible by County Jan-June 2018:
<table><tr><th></th><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th></tr><tr><td>Fresno</td><td>8.16%</td><td>8.06%</td><td>8.13%</td><td>8.12%</td><td>8.18%</td><td>8.14%</td></tr><tr><td>Kings</td><td>6.50%</td><td>6.34%</td><td>6.51%</td><td>6.47%</td><td>6.52%</td><td>6.55%</td></tr><tr><td>Madera</td><td>6.30%</td><td>6.18%</td><td>6.31%</td><td>6.32%</td><td>6.43%</td><td>6.41%</td></tr></table></td><td>None identified</td><td>A work group has been assigned to assess opportunities to improve internal processes for CCS including early identification, referrals and collaboration with providers.</td><td>Ongoing</td></tr>
<tr><td>Annual Evaluation

☐ MET OBJECTIVES

☐ CONTINUE ACTIVITY IN 2019</td><td></td><td></td><td></td><td></td></tr>
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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2018 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements.	☒ Medi-Cal	California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management.	All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UMCM program. Monitor HRA completions	Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into the appropriate program, such as Integrated Case Management, the Pharmacy Program, the Pregnancy Program, or a Disease Management Program. Continue to meet all requirements for SPDs and utilize all programs to support them, including Integrated CM, Disease Management and Care Coordination.	Ongoing

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Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	Member stratification being conducted monthly using Impact Pro to identify members for ICM as noted under 4.1. 105 SPD members have been managed 2018 through Q2. This includes PH CM, BH CM, & OB CM, as well as, both Care Coordination & Complex CM. HRA completion not meeting expectations.	Health Net IT migration prevented data exchange. Vendor required staffing revision to meet call requirements.	Continue monthly stratification/referrals to ICM. Root cause analysis and detailed action plan in place. Hiring and retention strategies now in place.	Q4 Q4
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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