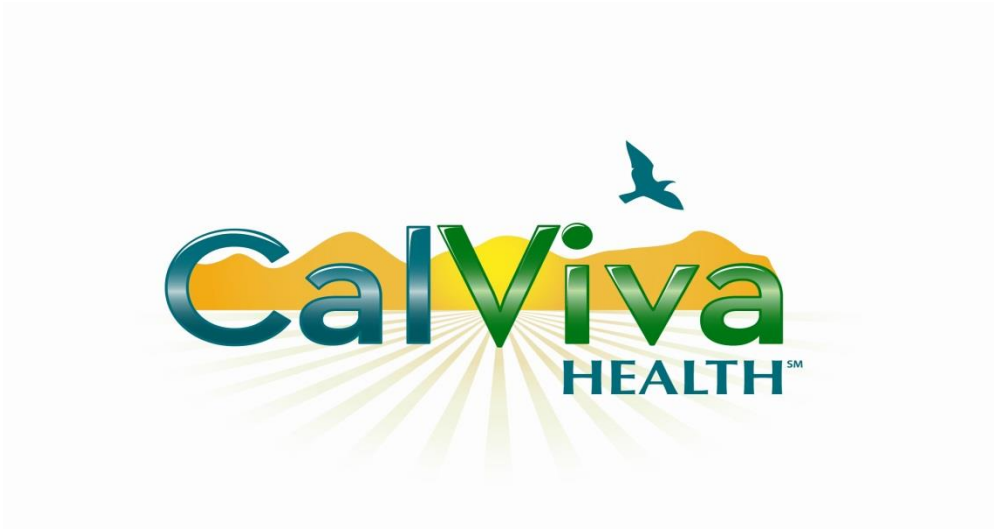

CalViva Health
2018
Quality Improvement
End of Year Evaluation

Updated 02-15-2019

CalViva Health 2018 Quality Improvement Work Plan

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CalViva Health 2018 Quality Improvement Work Plan

I. Purpose

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

II. CalViva Health Goals

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

III. Scope

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

CalViva Health 2018 Quality Improvement Work Plan

Glossary of Abbreviations/Acronyms

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

I. ACCESS, AVAILABILITY, & SERVICE

Section A: Description of Intervention (due Q1)				
1-1: Improve Access to Care- Timely Appointments to Primary Care Physicians, Specialist, Ancillary Providers and After Hours Access				
☐ New Initiative ☒ Ongoing Initiative from prior year				
Initiative Type(s)	☒ Quality of Care	☒ Quality of Service	☐ Safety Clinical Care	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

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

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

Timely Appointment Access to Primary Care Physicians and Specialists is measured through 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 ICE-DMHC PAAS Tool.

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

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)

Implement Provider Appointment Access Survey (PAAS) to monitor appointment access at the provider level to comply with DMHC and continue conducting Medi-Cal Appointment Access Survey to comply with DHCS requirements	P	Q3- Q4	CVH/HN
Develop and distribute provider updates, as applicable, informing providers of upcoming surveys, survey results, and educational information for improvement.	P	Q1 - Q4	CVH/HN
Review and update the Appointment Access & Provider Availability P&P as needed to reflect all regulatory and accreditation requirements and submit for approval	P	Q1 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 Patient Experience Toolkit, After-Hours Script, Guidelines for compliance and Monitoring and Appointment Scheduling Tip sheet	P	Q1-Q4	CVH/HN
Conduct provider onsite office audits for all repeat noncompliant providers	P	Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	**Section B: Analysis of Intervention Implementation (due end of Q4)**
• 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 Survey was conducted by Sutherland Global and began August 2018 and concluded on December 31, 2018. • Provider Updates: MY2017 Appoint Access and After-Hours Survey update published August 28, 2018. MY2018

MY2018 PAAS and After-Hours Survey Prep distributed June 14. • 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. •	PAAS and After-Hours Survey Prep published June 14, 2018. • P&P PV-100 Accessibility of Providers and Practitioners): Red-line edits reviewed and approved at July Access WG meeting. • MY2018 PAHAS Survey - After-Hours survey conducted by SPH Analytics and began September 2018 and concluded on December 31, 2018. • MY2017 CAP packets were distributed as follows: ○ 15 PPG packets were sent on September 20, 2018 ○ 12 direct network provider packets were sent on August 31, 2018 ○ 19 ChildNet provider packets were sent out on September 17, 2018 ○ 116 provider educational packets sent out on September 21, 2018 This reflects a slight decrease in the number of CAPS sent out as compared to MY2016. All Improvement Plans were received by December 31, 2018 and the CAP was closed out. • CAP packets included a *Tips and Guidelines for Improving Access to Care* brochure • 22 Provider Phone audits were conducted for repeat noncompliant providers from November 5-9, 2018. This reflects a 60% decrease as compared to MY2016. Two providers failed the initial audit for After-Hours physician callback within 30 minutes. Education was provided and a repeat audit was conducted on November 15, 2018. Both providers passed and audits were closed out.
Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1) **Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)** **Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2018)**	

Measure(s)	Specific Goal	Rate RY 2017	Rate RY 2018	Baseline Source	Baseline Value
Access to Non-Urgent Appointments for Primary Care – Appointment within 10 business days of request	80%	Overall=90.0% Fresno=89.6% Kings=91.3% Madera=92.3%	Q2 2019	CVH Performance RY2017	Overall=90.0% Fresno=89.6% Kings=91.3% Madera=92.3%
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%	Q2 2019	CVH Performance RY2017	Overall=81.4% Fresno=84.0% Kings=60.0% Madera=81.8%
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%	Q2 2019	CVH Performance RY2017	Overall=76.8% Fresno=79.2% Kings=55.5% Madera=77.7%
Access to Urgent Care Services that require prior authorization (SCP) – Appointment within 96 hours of request	80%	Overall= 60.7% Fresno=68.3% Kings=52.3% Madera=50.8%	Q2 2019	CVH Performance RY2017	Overall= 60.7% 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%	Q2 019	CVH Performance RY2017	Overall=94.2% Fresno=92.5% Kings=100% Madera=100%

Access to Well-Child Visit with PCP – within 10 business days of request	80%	Overall=84.3% Fresno=83.9% Kings=100% Madera=70.0%	Q2 2019	CVH Performanc e Ry2017	Overall=84.3% Fresno=83.9% Kings=100% Madera=70.0%
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%	Q2 2019	CVH Performanc e RY2017	Overall=82.2% Fresno=81.2% Kings=100% Madera=70.0%
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	Q2 2019	CVH Performanc e RY2017	Overall=100% Fresno=100% Kings=100% Madera=N/A
Appropriate After-Hours (AH) emergency instructions	90%	Overall=94.1% Fresno=94.5% Kings=92.7% Madera=93.8%	Q2 2019	CVH Performanc e RY2017	Overall=94.1% Fresno=94.5% Kings=92.7% Madera=93.8%
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%	Q2 2019	CVH Performanc e RY2017	Overall=83.1% Fresno=84.1% Kings=74.0% Madera=93.8%
Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered					

Overall CVH did well this measurement year and was noncompliant for three standards:

1. Access to Urgent Care Services that require prior authorization (SCP) – Appointment within 96 hours of request
2. Access to Non-Urgent Appointments with Specialist – Appointment within 15 business days of request
3. AH urgent care – ability to contact an on-call provider (PCP) within 30 minutes for urgent issues

CAPs were issued to noncompliant PPGs in September 2018. This included 15 PPGs and 31 direct network providers. These numbers reflect a downward trend of the number of CAPs being issued – PPG = 13.3% decrease and Direct = 48.4% decrease

Phone audits were conducted in November 2018 for providers who were noncompliant for two consecutive years. 22 phone audits were conducted which is a decrease of 60% as compared to MY2016. Two providers failed the initial phone audit for After-Hours messaging. Both passed on the secondary audit.

The After-Hours initiative will be relooked at for MY2018. Possibility of breaking out the After-Hours survey from the PAAS survey and providing monitoring on After-Hours more than once a year.

Initiative Continuation Status (Populate at year end)	☐ **Closed**	☐ **Continue Initiative Unchanged**	☒ **Confirmed box should be checked. Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)				
1-2: Improve Member Satisfaction				
☐ **New Initiative** ☒ **Ongoing Initiative from prior year**				
Initiative Type(s)	☒ **Quality of Care**	☒ **Quality of Service**	☒ **Safety Clinical Care**	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Member Satisfaction by DHCS was last evaluated in RY 2014 and results were aligned close to the Medicaid State Average. Member perception of quality of care and care coordination is multifaceted and affected by the provider, the plan, member demographics and individual health status and experience so evaluation and intervention are directed towards touchpoints by the member.

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

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

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

The goal for member satisfaction is to reach the Quality Compass 50th percentile. 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 on Intervention Implementation (due Q3)	**Section B: Analysis of Intervention Implementation (due end of Q4)**

• 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.
• Full CAHPS survey was conducted in March 2017 and results listed in section C below. Scaled back survey conducted annually.
	• Review of Patient Experience Toolkit – A major overhaul of this piece to take place in 2019. Will include review of the following pieces:
	  ○ Appointment Scheduling Tip Sheet
	  ○ Talking With My Doctor
	  ○ Interpreter Services
	  ○ Nurse Advice Line
	• Member newsletter article on access standards published in Winter 2018.
	• Scale back CAHPS Survey was conducted in March 2017 and results listed in section C below. Full survey will conducted in 2019.

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

Measure(s)	Specific Goal	RY Rate 2017	RY Rate 2018	Baseline Source	Baseline Value

Got urgent care as soon as needed	CAHPS Scaled-back member survey	79%	78%	RY 2017 CVH results	79%
Got routine care as soon as needed	CAHPS Scaled-back member survey	66%	68%	RY 2017 CVH results	66%
Easy to see specialist	CAHPS Scaled-back member survey	59%	54%	RY 2017 CVH results	59%
Ancillary services	CAHPS Scaled-back member survey	75%	76%	RY 2017 CVH results	75%
CAHPS metric: Getting Needed Care	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 81.35%	78%	N/A*	RY 2017 CVH results	78%
CAHPS metric: Getting Care Quickly	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 81.55%	74%	N/A*		74%
CAHPS metric: Rating of All Health Care	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 72.82%	69%	N/A*		69%
CAHPS metric: Rating of Personal Doctor	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 80.00%	77%	N/A*		77%

CAHPS metric: How well doctors communicate	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 90.70%	90%	N/A*		90%
					***3 yr. data cycle; DHCS survey data available in 2019**

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness w Barrier Analysis	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. CAHPS Scaled-back member survey was conducted in March 2017 and results listed in section C above. Scaled back survey is conducted annually and a Full Survey will be completed in 2019. PPG Dashboard is being rolled out in 2019 illustrating various Access measures and the PPG results. Focus on improving the customer experience.
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

II. QUALITY & SAFETY OF CARE

Section A: Description of Intervention (due Q1)				
2-1: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)				
☐ New Initiative ☒ Ongoing Initiative from prior year				
Initiative Type(s)	☒ Quality of Care	☒ Quality of Service	☐ Safety Clinical Care	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

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

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

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

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[1]Centers for Disease Control and Prevention (CDC). Antibiotic Resistance Threats in the United States, 2013. April 2013. Available at http://www.cdc.gov/drugresistance/threat-report-2013/pdf/ar-threats-2013-508.pdf. Downloaded January 17, 2014.
[2]Centers for Disease Control and Prevention (CDC, Antibiotic/Antimicrobial Resistance. Accessed January 12, 2017 at /www.cdc.gov/drugresistance.
[3]Costelloe C, Metcalfe C, Lovering A, Mant D, Hay AD. 2010. Effect of antibiotic prescribing in primary care on antimicrobial resistance in individual patients: systematic review and meta-analysis. BMJ. 2010 May 18; 340:c2096.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.			
The HEDIS measure, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription (a higher rate indicates appropriate treatment of adults with acute bronchitis). Madera county baseline HEDIS result for RY 2016 was 19.69% and RY2017 was 18.26% which was 3.86% below the MPL (188 numerator events out of the 230 in the denominator).			
Planned Activities			
Activities	**Target of Intervention: Member (M) / Provider (P)**	**Timeframe for Completion**	**Responsible Party(s)**
Identify a high volume, low compliance provider in Madera County to drill down to identify physicians and mid-level providers for targeted interventions. (Submit QI Summaries)	P	Q1, Q2, Q3, Q4	CVH/HN
AAB Provider Tip Sheet will be available through the Provider Portal and hand-delivered by Provider Relations staff. The tip sheet covers HEDIS documentation, best practices, and recommended treatment guidelines.	P	Q1-Q2	CVH/HN
Mail 2018 AWARE toolkit containing provider and member educational resources on appropriate antibiotic use Mailed by AWARE offices (CMAF) to top 20% of antibiotic prescribers (MDs) identified in Fresno, Kings and Madera Counties.	P	Q1	CVH/HN
Provider Relations to distribute provider education materials to targeted providers identified as high prescribing for two or more consecutive years. Materials will include the new AWARE toolkit and Tip Sheet, and Choosing Wisely® resources on the appropriate use of antibiotics and best practices to avoid overprescribing antibiotics.	P	Q2/Q3	CVH/HN
Participate in 2018-2019 AWARE toolkit revision planning.	P	Q3/Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
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	In Q3, a high volume, low compliance clinic in Madera County was identified and targeted for an improvement project to comply with the state mandated PDSA cycle. Training for providers and mid-level clinicians was implemented to further educate providers on the clinical guidelines and best practices for the *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)* measure. The health plan developed a presentation on AAB which included the HEDIS definition, appropriate treatment for acute bronchitis, clinical guidelines, diagnoses that may indicate need for an antibiotic, barriers to guideline adherence, and methods to reduce antibiotic prescribing. The short-term desired outcome was an increase in clinician awareness of guidelines for appropriate treatment of acute bronchitis and why antibiotics may not be helpful. The long-term outcome is improved compliance with HEDIS guidelines (fewer antibiotics filled) in Q4 MY2018 and MY2019. In September 2018, the health plan implemented an on-site provider training with the identified clinic. The intervention for providers and mid-level clinicians who received a training was measured with a pre-test and post-test. The gain in knowledge was determined through results from the post-test indicated that 100% (15/15) of the clinicians who submitted a post-test had scored 80% or higher on their post-test. Furthermore, the Robert Wood Johnson Foundation Virtual Clinic simulation was utilized as part of the training, which led to increased dialogue and acknowledgement of the difficulties with AAB and demonstrated the value of the simulation tool. For the next PDSA cycle, CalViva Health Medical Management staff will review Q4 MY 2018 data to determine if attending the training translated into fewer antibiotics prescribed for acute bronchitis. Continuation of data monitoring will be shared with

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.	Camarena Health leadership and QI staff in order to identify any patterns or trends that might be site or provider specific. In addition, the health plan monitored high prescribers in Madera County. A high volume, low compliance provider that was identified in Q1-Q2 continued to inappropriately prescribe antibiotics and was resistant to multiple outreach and provider education attempts. In Q4, the health plan distributed communications from Medical Management to notify the provider of low compliance and required actions to improve. The provider's response is pending and prescribing practices will continue to be monitored in 2019 to determine if additional corrective action is needed. In Q4, an educational AAB texting campaign for all Madera members was planned to launch during Antibiotics Awareness week. The texting campaign was put on hold pending DHCS's review and approval of a texting policy and procedure and is expected to launch in Q1 2019.

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

Measure(s)	Specific Goal	Rate 2017	Rate 2018	Baseline Source	Baseline Value
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%	RY 2017 CVH results	Madera: 18.26%

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

Analysis: Intervention Effectiveness w Barrier Analysis	**Successes:** • CalViva Health gained the support of the targeted high volume, low compliance clinic in Madera County and the training was well attended by mid-level clinicians. Moreover, the Robert Wood Johnson simulation was included in the training to address the barrier of perceived patient demand and help providers engage in difficult conversations around the proper use of antibiotics. **Barriers:** • Perceived patient demand and provider resistance to change prescribing patterns continues to be the main barriers for AAB. The Robert Wood Johnson Foundation Virtual Clinic simulation tool provides an opportunity to address patient demand and build skills for challenging conversations with members around appropriate antibiotic use. • A high volume, high prescribing provider was resistant to education and appropriate antibiotic prescribing. An effective strategy is needed for engaging resistant providers. • There is a data lag and also data gaps with prescribing provider and prescriber setting (e.g., urgent care). Additional analysis is needed to identify key information needed for action. • NCQA changes to NDC codes were loaded in Q4 and significantly impacted the AAB measure. There is an opportunity to predict and plan for how changes to the measure will impact the rates. **Lessons Learned:** • High pre-test scores for the clinic training indicate that providers are aware of the current recommended treatment guidelines for acute bronchitis. Pre-test results and dialogue that occurred during the training highlighted the clinic's main barriers are patient demand for antibiotics and patient adherence to recommended treatment for acute bronchitis. Therefore, additional interventions are needed to address patient demand and adherence. • Monthly monitoring of provider prescribing practices is needed to take action prior to the cold and flu season. Ongoing monitoring and trending revealed that interventions need to be targeted around the cold and flu season due to the seasonality of this measure. • Organizational barriers with the texting policy and procedure delayed the texting campaign. An opportunity is to collaborate with Compliance and Privacy during the planning stages of a project to overcome organizational barriers and prevent delayed implementation. • Low volume providers who have infrequent contact with patients, and did not attend training have been identified as non-compliant.

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

Section A: Description of Intervention (due Q1)

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

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

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

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

Rationale and Aim(s) of Initiative

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

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

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. Includes improvement goals and baseline & evaluation measurement periods.

The HEDIS Measure, Annual Monitoring for Patients on Persistent Medications (MPM) will be used to evaluate the effectiveness of the interventions implemented for this measure. The measure evaluates the percentage of adults 18 years and older who have received at least 180 treatment days of ambulatory medication therapy of either ACE/ARBs or diuretics. Madera County's baseline HEDIS result for ACE/ARBs in RY 2016 was 83.98% and in RY 2017 was 82.64%. The baseline HEDIS results for diuretics in RY 2016 was 83.57% in RY 2017 was 82.20%. The SMART AIM goal is that 50% or more 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, Q3, Q4	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
Distribution of revised MPM Provider Tip Sheet.	P	Q3	CVH/HN
Implement in-home screening program MedXM to complete required MPM laboratory testing.	M	Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	**Section B: Analysis of Intervention Implementation (due end of Q4)**
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	In Q3 and Q4, the health plan continued their collaboration with the targeted high volume, low compliance clinic in Madera County to improve the MPM rates for both ACE/ARBs and

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.	diuretics. The health plan coordinated a bundled approach to appointment scheduling which included a Provider Profile, text messages to members, and a point of service member incentive gift card. In Q3, the clinic staff implemented “Lab Concierge” in which members were walked to the in-house laboratory to complete their required MPM labs prior to leaving their appointment. In Q3, 60.1% (183/203) of members completed their annual laboratory testing which exceeded the SMART Aim of 50%. In addition, 192 members out of 222 members with active cell phones had received messages sent on behalf of the health plan. In Q4, in effort to continue outreaching to members who had not responded to telephone or text messages, the clinic initiated standing lab orders for eligible members (established with their PCP and seen within six months) which included mailing labs slips directly to members. An additional 67 members had closed the gap for MPM through standing lab orders in which 23 of those lab slips were mailed. In Q4, through the adopted bundle approach and initiation of standing lab orders, 90.4% (226/250) of members had completed their annual laboratory testing for MPM by December 31, 2018 thereby exceeding the SMART Aim of 50%. In an effort to continue to support providers, a revised MPM Provider Tip Sheet was made available to providers via the health plan’s portal. The health plan continued with bi-weekly multi-disciplinary MPM Improvement Team meeting to discuss the success and challenges in the process, barriers, results, and any other identified issues.

	In Q4, the health plan launched an in-home screening program to assist members in completing their required laboratory screening, and improve the overall HEDIS rates for MPM. Of the 387 members outreached, 7 completed their services with the MedXM in-home screening program.

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

Measure(s)	Specific Goal	Rate RY2017	Rate RY2018	Baseline Source	Baseline Value
HEDIS® Monitoring Persistent Medications: ACE/ARB	Meet or Exceed DHCS MPL update 85.97% (RY 2018)	Madera: 82.64%	Madera: 84.74%	RY 2017 CVH results	Madera: 82.64%
HEDIS® Monitoring Persistent Medications: Diuretics	Meet or Exceed DHCS MPL update 86.06% (RY 2018)	Madera: 82.20%	Madera: 84.88%	RY 2017 CVH results	Madera: 82.20%

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

Analysis: Intervention Effectiveness w Barrier Analysis	**Successes:** • The implementation of standing lab orders and mailing members their lab slips improved Camarena Health Clinic's MPM rates and thereby contributed positively to Madera County's MPM HEDIS® scores as well. • Placing standing lab orders and mailing members' their lab slip further enhanced member outreach, reduced barriers associated with scheduling appointments, and helped streamline the clinic's lab process. • During this PDSA cycle, more members were able to receive the second text (appointment reminder) which may have allowed for more appointments to be kept and labs to be completed. • A clinical champion and the support of leadership for quality initiatives improved implementation for all initiatives.

	• Regular Data Check-ins continues to be a positive strategy for facilitating ongoing communication between the Plan and the providers regarding project progress throughout the intervention period. Regular team meetings improve communication among the team members and provide an opportunity to identify and address barriers along the way. **Barriers** • Lag time in processing claims data and obtaining up-to-date data on completed screening/tests. Members may not answer their phone or their voice mail is full. • Members may experience barriers with transportation. • MedXM in-home screening program had low engagement from members. Low engagement is potentially due to the time of year the program was implemented (holiday season), when members are less inclined to schedule appointments at their home, have other obligations, or are not home. The appointment times were also limited by the holidays. The plan will explore continuation of the program into 2019, which improvements to communications to members, and better collaboration with providers in the county. **Lessons Learned:** • Provide targeted education such as text messages, newsletter, CalViva website, and phone calls to maximize member outreach opportunities. • Use phone calls and text messages to remind members of scheduled appointments. • Reconcile the data against eligibility and claims prior to sending to the clinic. • Use Provider Profile to gather data on barriers and opportunities for MPM in Madera clinic. • Opportunity to close the gap by placing standing orders for annual lab test for patients on ACE/ARBs or diuretics.
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)				
2-3: Use of Imaging Studied for Low Back Pain (LBP)				
☒ **New Initiative** ☐ **Ongoing Initiative from prior year**				
Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**	☒ **Safety Clinical Care**	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**
Rationale and Aim(s) of Initiative				

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

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

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

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

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

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Implement provider training on best practices, recommended clinical guidelines, with a pre and post-test to assess knowledge gained from the presentation. Distribute member and provider education resources at the end of the training. (Submit PDSA)	P	Q1	CVH/HN

Work with a high volume, low compliance provider in Madera County to initiate targeted interventions to improve LBP rate (Submit PDSAs)	P	Q1, Q2	CVH/HN
Conduct regular meetings with the Madera County provider to share results and receive updates on improvement activities.	P	Q1, Q2	CVH/HN
LBP Provider Tip Sheet will be emailed to CVH providers and uploaded through the Provider Portal. The tip sheet covers HEDIS documentation, best practices, and recommended treatment guidelines.	P	Q1	CVH/HN

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

In addition, the preliminary year-to-date LBP compliance rate (based on claims received through October 31, 2018) for Madera County exceeded the 75th percentile. Therefore, the improvement project was effective and the health plan was able to successfully meet the specific goal of exceeding the MPL.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2017)

Measure(s)	Specific Goal	Rate RY2017	Rate RY2018	Baseline Source	Baseline Value
HEDIS® Low Back Pain	Meet or Exceed DHCS MPL RY2018 66.23%	Madera:66.67%	Madera:75.64%	RY 2017 CVH results	Madera: 66.67%

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

Analysis: Intervention Effectiveness w Barrier Analysis	**Successes:** • The desired outcome of the improvement project was achieved and the majority of providers at the high volume, low compliance clinic followed the practice guidelines for ordering imaging studies for initial episode of uncomplicated LBP. There was a reduction in the number of imaging studies ordered at the targeted clinic within the first 28 days of diagnosis of uncomplicated low back pain through continued emphasis on practice change and desired outcome in follow-up to training. • The CVH Medical Management team gained the support of clinic leadership and as a result, the training was mandatory and well-attended. • Preliminary year-to-date RY 2019 LBP compliance rate (based on claims received through October 31, 2018) has exceeded the 75th percentile. **Barriers:** • Ongoing training of new providers was addressed through modification of initial training materials. In addition, continued emphasis the practice guidelines for ordering imaging studies for initial episode of uncomplicated LBP is need for low compliance providers. • Provider profiling revealed data gaps for both ordering physician and imaging study setting (e.g., emergency department). Therefore, additional analysis is needed to drill down to the ordering physician and setting. The care gap reports that are regularly available to providers only provide data on assigned PCP and not ordering physician. **Lessons Learned:** • Gaining the support of clinic leadership is critical to a successful and well-attended training. Moreover, active participation of the clinic CMO and QI lead in the training sessions served to model provider behavior change. • Continued monitoring of LBP compliance rate is needed to sustain the improvement.
Initiative Continuation Status	☒ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

2-4: Breast Cancer (BCS)				
☒ New Initiative ☐ Ongoing Initiative from prior year				
Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**	☒ **Safety Clinical Care**	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department** and Health Net Health Education Department

Rationale and Aim(s) of Initiative

Overall Aim: To increase and improve the survival rates of CalViva members in Fresno county who are diagnosed with breast cancer through early detection.

Rationale: Breast Cancer Screening tests are used to find cancer before a person has any symptoms. The American Cancer Society recommends the following cancer screening guidelines for most adults:

Women age 45 to 54 should get mammograms every year; women 55 and older should switch to mammograms every 2 years, or can continue yearly screening; and screening should continue as long as a women is in good health and is expected to live 10 more years or longer.[1]

Multiple barriers limit screening mammography among minority women. Pain and embarrassment associated with screening mammography, low income and lack of health insurance, poor knowledge about breast cancer screening, lack of physician recommendation, lack of physician recommendation, lack of trust in hospitals and doctors, language barriers, and lack of transportation were the most frequently identified barriers. Recognizing predictors of screening among minority women and addressing culturally specific barriers may improve utilization of screening mammography among these women.[2]

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[1] American Cancer Society. American Cancer Society Guidelines for the Early Detection of Cancer. May 2018. Available at: https://www.cancer.org/healthy/find-cancer-early/cancer-screening-guidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html.

[2] Journal of the National Medical Association. (March 2010). Barriers related to mammography use for breast cancer screening among minority women. Available at: https://www.ncbi.nlm.nih.gov/pubmed/20355350

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.
The HEDIS® measure, Breast Cancer Screening (BCS), will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of women 50-74 years of age who had a mammogram to screen for breast cancer. The baseline HEDIS® results for RY 2018 was 52.71%. The SMART Objective: By January 31st, 2019 at least 15% (58/385) of the targeted members for the targeted site will have their breast cancer screening test completed as a result of the CVH Medical Management staff coordinating mobile mammography at the clinic.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Identify a high volume, low compliance provider in Fresno County to drill down for targeted interventions.	P	Q3, Q4	CVH/HN
Mobile Mammography Coach at Clinic Site	M	Q4	CVH/HN
Health Education to distribute educational materials on the importance of breast cancer screening.	M	Q4	CVH/HN
Implement member incentive to close the Care Gaps and Improve HEDIS® rates for breast cancer screening.	M	Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
	In Q3, a high volume, low compliance clinic in Fresno County was identified and targeted for an improvement project for breast cancer screening (BCS). After reviewing the clinic data and performing a barrier analysis, the team identified a cultural disparity negatively impacting the clinic's BCS compliance rates among the Hmong speaking membership. A project team consisting of health plan staff and clinic staff began meeting bi-

	weekly to develop a comprehensive improvement plan. Throughout Q3 and Q4 the health plan collaborated with the clinic to address the low compliance, through a bundled approach to appointment scheduling and completion. The bundled approach included: a non-compliant member scheduling (Provider Profile) tool, reminder calls, and a mobile mammography event with coordinated support services and point of service member incentive. In Q4, a mobile mammography event was held at the clinic site on December 12th. Of the 47 members scheduled, 28 members (59.6%) completed their breast cancer screening. Prior to the event, members were reminded of their appointment and provided phone education about breast cancer screening. The event was supported by interpreters for members whose primary languages were Hmong, Spanish, Cambodian and Laotian. Transportation services were also coordinated for membership who requested support in traveling to their appointment. Lastly a gift card was given out to members who completed their appointment at the point of care. Due to the success of the event, the bundled mobile mammography activity will continue in Q1of 2019. The health plan will also continue with bi-weekly multi-disciplinary BCS Improvement Team meetings to discuss the success and challenges in the process, barriers, results, and any other identified issues.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2017)

Measure(s)	Specific Goal	Rate RY2017	Rate RY2018	Baseline Source	Baseline Value

HEDIS® Breast Cancer Screening	Meet or Exceed DHCS MPL 52.71%	N/A	51.1%	RY 2017 CVH Results	48.0%

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

Analysis: Intervention Effectiveness w Barrier Analysis

Successes:

- Multidisciplinary teams continue to be critical to the success of a project.
- Effective collaboration and clinic engagement contributed to the success of the mobile mammography project.

Barriers:

- Mobile Mammography Coach Availability.
- Language barriers exist regarding some medical procedures and it may require several attempts to fully communicate to a member what a mammogram is and why it is important.
- Fear of the breast cancer screening test.

Lessons Learned:

- Culture and language are important factors to consider when planning a health screening event such as BCS. Preparation is critical to success.
- Including Culture and Linguistic, Health Education, and Provider Relations on our team allowed us to address potential barriers ahead of time.
- Flexibility is important, often members do not arrive at their scheduled time and the team needs to be prepared to adjust the schedule to fit them in. Many members arrived in the morning regardless of appointment time and were accompanied by family.

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

Section A: Description of Intervention (due Q1)				
2-5: Comprehensive Diabetes Care (CDC))				
☒ **New Initiative** ☐ **Ongoing Initiative from prior year**				
Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**	☒ **Safety Clinical Care**	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	Health Net QI Department and Health Net Health Education Department

Rationale and Aim(s) of Initiative

Overall Aim: To help members with diabetes maintain control over their blood sugar and minimize the risk of complications associated with this highly prevalent chronic disease through lifestyle changes, healthy behaviors and medication management.
Rationale: Diabetes occurs when the body has an inability to produce enough insulin to properly control blood sugar. When left untreated, this complex disease can increase the risk for heart disease, stroke, blindness, kidney disease and more (Comprehensive Diabetes Care, 2018). In managing chronic conditions such as diabetes, members are advised to adopt positive life style modifications which include making dietary changes and increasing physical activity for maintaining a healthy weight and managing their blood sugar, limiting alcohol intake, and engaging in smoking cessation programs (Control, 2018). A simple test to measure one's hemoglobin A1c can help identify if one has type 1 or type 2 diabetes (Mayo Clinic A1c Test) and can be the first step in managing this chronic condition. For people with diabetes, it is crucial to not only manage one's blood sugar but to manage their blood pressure in effort to prevent the onset of kidney disease known as diabetic nephropathy (Mayo Clinic A1c Test). Diabetes care involves many facets and applying the multi-disciplinary approach which involves the member, provider, family members, and other health care professionals are part of the treatment plan in helping one manage their diabetes for long-term (Diabetes Care, January)

Comprehensive Diabetes Care. (2018). Retrieved December 30, 2018, from NCAQ - National Committee for Quality Assuarance: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/

Control, C. f. (2018). *Effective Diagnosis, Treatment, and Monitoring of Hypertension in Primary Care - Participant Guide Treatment of Hypertension.*

Diabetes Care. (January, 14 2018). Retrieved 30 December, 2018, from American Diabetes Association: http://care.diabetesjournals.org/content/41/Supplement_1/S28

Mayo Clinic A1c Test. (n.d.). Retrieved December 2018, 30, from Mayo Clinic: https://www.mayoclinic.org/tests-procedures/a1c-test/about/pac-20384643

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

The measure evaluates the percentage 18-75 years of age with diabetes (type 1 and type 2) who have had each of the following:

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- HbA1c control (<7.0%) for a selected population*****.
- Eye exam (retinal) performed.
- Medical attention for nephropathy.
- BP control (<140/90 mm Hg).

Fresno County baseline HEDIS results for HbA1c in RY 2016 were 80.29% and in RY 2017 was 84.91%. The baseline HEDIS results for Medical Attention to Nephropathy in RY 2016 was 87.83% in RY 2017 was 90.51%. The SMART AIM goal is that 50% or more of the members at the targeted high volume, low performing clinic will have completed testing for HbA1c and/or Nephropathy thereby meeting or exceeding the MPL.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Collaborate with a Panel Manager at a high volume; low compliance clinic in Fresno County to distribute a Provider Profile to schedule appointments for Hemoglobin A1c (HbA1c) and nephropathy testing (submit PDSA).	P	Q3, Q4	CVH/HN
Conduct regular meetings with Fresno County provider to receive updates on improvement activities and status check on screening/test completion for CDC HbA1c and nephropathy testing.	P	Q3, Q4	CVH/HN
Implement Member Incentive program with high volume, low compliance provider in Fresno County to improve CDC rates.	M	Q4	CVH/HN
Provider level incentive for PCPs to close Care Gaps and improve HEDIS scores for HbA1c testing	P	Q1-Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
Comprehensive Diabetes Care is a new initiative launched in Q3 2018 and analysis of the intervention and effectiveness with barrier analysis will be discussed in more detail in the mid-year report for 2019.	In Q3, the health plan reviewed the Fresno County compliance data for HbA1c and urine analysis testing to identify a high volume, low compliance clinic to conduct the PDSA activity. The health plan collaborated with a Panel Manager to improve the CDC rates for HbA1c testing and medical attention to nephropathy. In Q4, members were offered an incentive of $25 for completing their HbA1c and urine analysis testing and $25 for completing their DRE exam totally to $50 for the completion of all three CDC sub measures. The health plan continued with bi-weekly multi-disciplinary CDC Improvement Team meetings to discuss the successes and challenges in the process, barriers, results, and any other identified issues. In 2018, 51 providers were offered an incentive to close the Care Gaps and improve HEDIS rates for HbA1c testing.

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

Measure(s)	Specific Goal	Rate RY2017	Rate RY2018	Baseline Source	Baseline Value
HEDIS® Comprehensive Diabetes Care – Hemoglobin A1c Testing	Meet or Exceed DHCS MPL update 84.93% (RY 2018)	Fresno: 84.91%%	Fresno: 83.21%	RY 2017 CVH results	Fresno: 84.91%

HEDIS® Comprehensive Diabetes Care – Medical Attention for Nephropathy	Meet or Exceed DHCS MPL update 88.56% (RY 2018)	Fresno: 90.51%	Fresno: 87.10%	RY 2017 CVH results	Fresno: 90.51%

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

Analysis: Intervention Effectiveness w Barrier Analysis

Successes:

- Collaboration with motivated staff and proactive provider resulted in many members completing their required testing for HbA1c and/or urine analysis.
- Panel Managers and the support of leadership for quality initiatives improved implementation for all.

Barriers:

- Drilling down the data for accurate member assignment. Several members who needed to complete their required CDC sub measure testing were assigned to another clinic within the same clinic system.

Lessons Learned:

- Panel manager was proactive in scheduling members who were not part of the PDSA cohort to complete their required HbA1c and/or urine analysis testing at the other assigned clinics.
- Bi-weekly meetings enhanced communication with the clinic to achieve the PDSA goals as well as to highlight successes and address barriers.

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

Section A: Description of Intervention (due Q1)

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

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

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

Rationale and Aim(s) of Initiative

Overall Aim: To improve child health in Fresno County.

Rationale: Childhood immunizations are critical to community health, and favorably impact overall health outcomes. The increase in life expectancy during the 20th century is largely due to improvements in child survival. This increase is associated with reductions in infectious disease mortality due to immunizations. Childhood immunizations are proven to help a child stay healthy, protect them from serious illnesses such as polio, tetanus, and hepatitis, and avoid the potentially harmful effects of diseases like mumps and measles. According to HealthyPeople.gov, each birth cohort vaccinated with the routine immunization schedule saves 33,000 lives, prevents 14 million cases of disease, reduces direct health care costs by 9.9 billion, and saves 33.4 billion dollars in indirect costs.[1]
Therefore, CalViva Health has selected Childhood Immunizations Status – Combination 3 (CIS-3) in Fresno County for a Performance Improvement Project (PIP) topic. Childhood immunizations is a component of the seven priority focus areas (Foster Healthy Communities) identified by DHCS for the Medi-Cal Quality Strategy.[2] Although the CIS-3 measure in Fresno County is not under the MPL, the rate has declined by almost 3% in RY 2017, while both Madera and Kings Counties have demonstrated improved rates. The continue decline in immunization rates in Fresno County leave more children vulnerable to measles, pertussis, and other vaccine-preventable diseases.

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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).
Age demonstrated improved rates. The continued decline in immunization rates in Fresno County leave more children vulnerable to measles, pertussis, and other vaccine-preventable diseases.

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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 and baseline & evaluation measurement periods.

The HEDIS measure, Childhood Immunization Status - Combination 3 (CIS-3), will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of members who turn 2 years old who have been identified for completing the following vaccinations: four diphtheria, tetanus, and pertussis (DTaP); three inactivated poliovirus (IPV); one measles, mumps, and rubella (MMR), three 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, Q3, Q4	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
Childhood Immunizations article was published within a newsletter that went out to members.	M	Q3	CVH/HN

Continue direct member incentive for completion of childhood immunizations to improve rates	M	Q2	CVH/HN
Implementation of intervention: Eliminate Double Booking Option for Providers (Module 4)	M	Q3, and Q4	CVH/HN
Implementation of intervention: Member Incentive for Completing Immunization (Module 4)	M	Q3, and Q4	CVH/HN
Follow-up with CalViva Health on 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)	**Section B: Analysis of Intervention Implementation (due end of Q4)**
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. The team developed a SMART AIM Goal for the project: "By June 30, 2019, increase the rate of childhood immunizations (CIS-3) among members that belong to low compliance clinics in Fresno County, from 62.5% to 71.0%. 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.	In Q2, Q3, and Q4, the health plan and the clinic met bi-weekly to address issues, barriers, and compliance rates. The first intervention implemented was the "Elimination Double Booking Option for Providers" and is focused on eliminating double-booking in the provider scheduling template to allow time for walk-ins/same-day and scheduled appointments for immunizations. Additionally, the "nurse only" visit, a previously established visit type was encouraged. It was anticipated that there would be increased attendance with scheduling appointments with RN. In Q3, 31.3% (36/115) completed their childhood immunizations; and the rate increased in Q4, 48.2% (68/141) of the members completing their childhood immunizations. In Q4, the clinics reported that no parent chose to walk-in, but scheduled an appointment instead. Panel Managers/RNs

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.	performed direct outreach and follow-up with members on the Provider Profile and offered an appointment time with the RN or the provider that was convenient for the patient's parent. The rate of "No Shows" remained low due to the convenient appointment times for the parents. The manager/RN also explained the importance of immunizations to parents during scheduling, which likely had a positive impact on appointment completion. In Q4, a second intervention, distributing a member incentive of $25 per member/per visit at the point of care, was implemented. Five gift cards incentives were distributed to members in December. The effectiveness of the intervention will be evaluated in 2019, but it is anticipated that the incentive motivate parents to bring their children in for subsequent immunizations in the series. A Childhood Immunizations article was published in the fall of 2018 in the member a newsletter that went out to 192,775 CVH members that discussed the importance of receiving immunizations; including the timeframe for the immunizations. It was recommended all members 6 months old or older receive a flu shot every year. Due to difficulty contact members the health plan cancelled the childhood immunization reminder campaign (IVR, email or SMS) as well as the mailing of the fotonovela booklets. The Plan engaged providers through a provider level incentive for each CIS Care Gap closed. In 2018, 34 providers in Fresno; 0 providers in Kings, and 5 providers in Madera received the incentive for closing care gaps for CIS-3. The plan continued to support providers through the distribution of the Childhood Immunizations, Combination 3 hand-delivered Provider Tip sheets, which were made available to providers via the provider portal.

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

Measure(s)	Specific Goal	Rate RY2017	Rate RY2018	Baseline Source	Baseline Value

Childhood Immunization Combo 3	Meet or Exceed SMART Aim Goal of 60%	60.0%	50.0%	RY 2017 CVH Results	51.0%

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

Analysis: Intervention Effectiveness w Barrier Analysis

Successes:

- Childhood Immunizations rates at the targeted clinics have steadily increased: (18.8%) August 2018; (31.3%) September 2018' and (48.2%) October. For November, only one of the two clinics reported data and a 53.1% compliance rate.
- Clinics provided outreach to identified patients (parents) to remind of and schedule appointments for their required immunizations before the end of Q3, 2018.

Barriers:

- Staff turnover at the clinics requires new training for improvement projects.
- Difficulty in reach members due to messages being left with no return call, disconnected phone numbers, and outdated member contact information. The plan will continue to explore additional resources to update member contact information.

Lessons Learned:

- The team anticipated that once parents were notified that immunizations were offered on a walk-in basis, then the majority would choose this option over scheduling an appointment.
- RN visits only were scheduled and offered to members.
- The clinic reported fewer "no shows" due to accessibility of convenient appointments times that fit parent schedules.

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

Section A: Description of Intervention (due Q1)				
3-2 Addressing Postpartum Visit Disparities				
☒ **New Initiative** ☐ **Ongoing Initiative from prior year**				
Initiative Type(s)	☒ **Quality of Care** ☐ **Quality of Service** ☐ **Safety Clinical Care**			
Reporting Leaders	**Primary**	**CalViva Health Medical Management**	**Secondary**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: Improve maternal health in Fresno County.

Rationale: Postpartum care continues to be a priority in the 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, Q2, Q3, Q4	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
Intervention implementation of OB Alert in EMR (Module 4)	M	Q3,Q4	CVH/HN
Intervention implementation of revised ACOG form (Module 4)	M	Q3, Q4	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	M	Q1, Q2	CVH/HN

Postpartum Care Notification Form from their provider in all CVH Counties			
Key Informant interviews	M	Q4	CVH/HN
Social Determinants of Health	M	Q4	CVH/HN
Formative Research	M	Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	**Section B: Analysis of Intervention Implementation (due end of Q4)**
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	In Q2, Q3, and Q4, the health plan and the clinic met bi-weekly to address issues, barriers, and compliance rates. The first intervention implemented was the “EMR Alert” which focuses on placing an OB Alert for the 21-56 day Postpartum Visit in the clinic HER to increase the number of visits completed within the HEDIS timeframe. In Q3, the clinic staff was educated on the new EMR Alert process, and the implementation of the EMR Alert went live. The compliance data: as August 28, 2018 (65.2%) 15/23; September 4, 2018 (57.1%) 12/21; September 21, 2018 (84.0%) 21/25; October 9, 2018 (68.6%) 24/35; October 23, 2018 (70.3%) 26/37; and November 20, 2018 (52.6%) 20/38 of the women over 35 weeks received the alert. The profile was modified to include estimated gestational age, and CIN as recommended by the clinic. The second intervention, in Q4, The compliance rate was 15.4%; 44.4%; and increased to 63.3% for the cultural sections completed. The data collection from August 2018 through November 2018 reflected some variation, but generally positive results for the number of OB Alerts created. However, the team noted a sharp decline in the rates in November which prompted discussion with the clinic. It was determined that the implementation of a new Electronic Health Record was underway causing a shift in focus

into the cultural beliefs of their patients and ultimately improve the postpartum visit rates in Fresno County.	and training. A new "Tickler Alert" will be added to the recently implemented EHR system; and staff training on the new Workflow will begin as soon as IT approval is received. In Q4, the second intervention implemented was designed to facilitate integration of the mother's cultural preferences regarding the postpartum period into the plan of care. A revised OB History (ACOG) form was developed to prompt staff and providers to inquire about cultural preferences after delivery and document responses on the OB History form which follows the mother from diagnosis to delivery. The selected intervention was developed after barrier analysis was performed during several meetings with clinic patients, staff, and providers. From these meetings, it was determined that there was minimal cultural awareness related to postpartum practices among the clinic staff and providers. These beliefs and practices may significantly impact appointment attendance during the postpartum period. The Mendota community has a large El Salvadorian population and results from Focus Groups reflected that many women follow the *la cuarentena*, which is a 40-day quarantine and could interfere with women attending the postpartum visit. Monthly on-site medical record reviews of 30 random records were done to evaluate the compliance rates for the revised ACOG form. Compliance data: October 2018 (15.4%) 4/26; November 2018 (44.4%) 12/27; and December 2018 (63.3%) 19/28. The Plan engaged providers through a provider level incentive of for each PPC Prenatal Care Gap, and for each PPC Postpartum Care Gap closed. In 2018, Fresno County providers submitted 3110 prenatal forms and Madera County providers submitted 135 prenatal forms. In 2018, Fresno County providers, submitted 1,158 postpartum paid forms, and Madera County providers submitted 69 postpartum forms. A large Kings County provider group opted out of the prenatal and postpartum incentive.

	There were a total of 1,979, $25 postpartum member incentives sent to members in Fresno, Kings and Madera counties.

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

Measure(s)	Specific Goal	Rate RY2017	Rate RY2018	Baseline Source	Baseline Value
Postpartum Care Visits	Meet or Exceed SMART Aim Goal of 64%	50.0%	59.0%	RY 2017 CVH Results	50.0%

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

Analysis: Intervention Effectiveness w Barrier Analysis

Successes:

- The provider profile is capturing the information needed to evaluate compliance rates with the new OB Alert; the SMART Aim goal of 64.0% was met or exceeded the rate. In September 2018, the postpartum visit rate increased to 84.0%.
- The Run Charts displays we have exceeded the goal and RY 2018 data since the implementation of the interventions.
- Used Hospital notification unit to forward deliveries for CVH members at the hospital.
- Community Advisory Group has been formed in Mendota to create a forum to address issues and improve communication.

Barriers:

- A new electronic medical record software system is being implemented by the clinic which temporarily caused the rates to decline; the clinic staff will need additional training for the new EMR software.
- Staff turnover at the clinic and medical assistants have changed their teams, they were also assigned to different physicians.

	• Several members did not receive the OB Alert; administrative capture may be the reason, clinic manager to follow up. • Gathering delivery dates of pregnant women who delivered at the hospital. • Communicating with the culturally disparate individuals. • Awaiting IT response regarding the use of new “tickler alert” **Lessons Learned:** • The provider profile was modified to include estimated gestational age and CIN as recommended by the clinic; requesting hospital delivery report for more current reporting. • Disparity data has been gathered to identify cultural barriers, and now the plan is determining how to improve processes to better communicate between staff and members. • Postpartum practices related to cultural beliefs may interfere with timely completion of postpartum visits. • Providers and staff at rural Fresno County clinic are beginning to identify patient preferences related to cultural beliefs which may result in changes in the plan of care/services in order to increase compliance with postpartum visits.
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

IV. CROSSWALK OF ONGOING WORKPLAN ACTIVITIES

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
WELLNESS/ PREVENTIVE HEALTH					
1. Distribute Preventive Screening Guidelines (PSG) to Members	CVH/HN	They are included in new member welcome packets. It is an ongoing activity	☒	November 2018	
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.			Ongoing. Will repeat activity anew in 2019
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.	☒		C&L submitted and received approvals during Q3 2018 on the 2018 midyear language assistant program and midyear year work plan evaluation report.
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	☒	PAAS - 12/11/18 PAHAS – 11/8/18	Results for MY2018 will be available in Q2 2019
3. Complete and submit DMHC Timely Access Reporting (TAR) by April 30 filing due date	CVH/HN	TAR filing submitted timely- March 31, 2018	☒	3/31/18	Filed timely
4. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances	CVH/HN		☒		A&G will continue to monitor for trends, report trends during monthly dashboard and quarterly UMQI reports. A&G will continue to work with providers and internal departments as needed to help resolve member appeals and grievances.
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	☒	April 2018	C&L continues to promote cultural and linguistic services and resources to members, providers and staff to ensure they have access to culturally and linguistically appropriate services,

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
		priorities to ensure members, providers and staff have access to culturally and linguistically appropriate services, trainings and resources inclusive of language services. Health Education incorporates GNA findings in annual work plan development.			trainings and resources inclusive of language services.
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.	☐		C&L will utilize 2018 provider and membership data for the next C&L Geo Access report anticipated to be completed by Q3 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	☒		IHA continues to be monitored to insure compliance has been met. 2018 quarterly reports for Q1 thru Q3 have been completed. Q4 to be completed in Q2 of 2019.
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.	☒		Outcomes continue to be measured quarterly. Through Q3 utilization of members managed in CM 1/1/18-9/30/18 demonstrated a reduction in total health care costs. The reduction was primarily related to reduction in inpatient costs and slight decrease in outpatient services. ED utilization for these members also demonstrated a reduction in volume of ED claims/1000/year. Through Q4 over 81% of respondents reported CM exceed their expectations.
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	CVH/HN	Ongoing monitoring is conducted. Bi-Annual report of quarterly monitoring of FSR/MRR to QI.	☒	12/31/18	

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
Physical Accessibility Review Survey per MMCD Policy Letter 12-006 and 15-023					
2. Evaluation of the QI program: Complete QI Work Plan evaluation annually.	CVH/HN	Ongoing monitoring in progress	☒		Mid-Year evaluation completed, 2018 work plan is completed.
CLINICAL DEPRESSION FOLLOW-UP					
1. Development and distribution of provider educational resources on screening for clinical depression and follow up (12 years and older)	CVH/HN	Provider updates are currently in the updating process. A provider tool is also in development to help providers understand the flow of screening for depression and referring members with positive screens.	☒	12/14/18	The provider update was distributed 12/14/18. The communication was faxed to 700 CVH providers and mailed to 230 CVH providers. The provider tool providing the flow of screening has been postponed given that there have been new changes to the technical specifications (e.g., CPT codes were removed). The provider communication will be done once-year. The additional provider tool will be implemented in 2019.