Item #7

Attachment 7.B

2019 QI Work Plan Mid-Year Evaluation
Work Plan Evaluation

CalViva Health
Quality Improvement
Work Plan 2019
Mid Year Evaluation

9.10.19

CalViva Health 2019 Quality Improvement Work Plan

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CalViva Health 2019 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 2019. The development of this document requires resources of multiple departments.

CalViva Health 2019 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 Q2 - MY2019 Survey Prep Q3 – MY2018 Survey Results	CVH/HN

Review and update the Appointment Access & Provider Availability P&P as needed to reflect all regulatory and accreditation requirements and submit for approval	P	Q1	CVH/HN
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)
• MY2019 PAAS Survey: Survey being conducted by Sutherland Global beginning in September 2019. • Provider Updates: MY2018 Appoint Access and After-Hours Survey Results scheduled to go out August 2019. MY2019 PAAS and After-Hours Survey Prep distributed June 2019. • P&P PV-100 Accessibility of Providers and Practitioners): Updated required for TAR filing in Q1 2019. Updates approved at May Access WG meeting. • MY2018 CAP packets distributed to noncompliant providers and PPGs on 8/15/19. As part of this year's CAP, noncompliant providers and PPGs area being asked to attend a one session of the Timely Access to Care Provider Focused Training. An invitation was sent out to all PPGs and providers to attend one of three sessions that were offered in August and an additional three session are being offered November and two sessions in December. Additionally, providers who were noted as noncompliant last year will be subject to an in-office or phone audit during October/November to educate providers and ensure deficiencies have been corrected. • New QI Provider Toolkit published in May 2019 which replaced the Patient Experience Toolkit. New QI Toolkit will be sent out with all CAP packets..	

• Provider Onsite Audits – to take place in October 2019. Noncompliant providers subject to audit will be notified in September 2019. • RY2018 Results: Rates for RY 2019 cannot be compared to RY2018 due to change in survey methodology by DMHC. Metrics for RY19 include 11 measures overall, nine from PAAS and two from PAHAS. Five of the nine PAAS metrics were below the 80% threshold. One of the After Hours (PAHAS) measures was below the 90% threshold and one was above.	

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 2018	Rate RY 2019 (populated mid-year)	Baseline Source	Baseline Value
Access to Non-Urgent Appointments for Primary Care – Appointment within 10 business days of request	80%	Overall= 90.1% Fresno= 87.7% Kings= 97.7% Madera= 94.9%	Overall= 82.1% Fresno= 85.7% Kings= 85.2% Madera= 62.5%	CVH Performance RY2018	Improvement over CVH Performance RY2018
Access to Non-Urgent Appointments with Specialist – Appointment within 15 business days of request	80%	Overall= 64.0% Fresno= 68.8% Kings= 65.2% Madera= 55.5%	Overall= 68.1% Fresno=72.2% Kings= 73.7% Madera= 43.1%	CVH Performance RY2018	Improvement over CVH Performance RY2018
Access to Urgent Care Services that do not require prior authorization (PCP) – Appointment within 48 hours of request	80%	Overall= 82.9% Fresno= 82.9% Kings= 81.4% Madera= 84.6%	Overall= 71.4 % Fresno= 74.2% Kings= 59.3% Madera= 81.3%	CVH Performance RY2018	Improvement over CVH Performance RY2018
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%	Overall= 62.8% Fresno= 68.0% Kings= 44.4% Madera= 53.2%	CVH Performance RY2018	Improvement over CVH Performance RY2018

Access to First Prenatal Visit (PCP) – Within 10 business days of request	80%	Overall= 100% Fresno= 100% Kings= 100*% Madera= NR%	Overall= 90.3% Fresno= 94.4% Kings= 90.0% Madera=66.7*%	CVH Performance RY2018	Improvement over CVH Performance RY2018
Access to First Prenatal Visit (SCP) – Within 10 business days of request	80%	Overall= 80.0% Fresno= 100% Kings= NR Madera= 33.3*%	Overall= 88.9% Fresno= 87.5% Kings= 100*% Madera= 100*%	CVH Performance RY2018	Improvement over CVH Performance RY2018
Access to Well-Child Visit with PCP – within 10 business days of request	80%	Overall= 84.1% Fresno= 86.9% Kings= 60.0*% Madera= 66.7*%	Overall= 73.6% Fresno= 69.8% Kings= 85.2% Madera= 68.8%	CVH Performance Ry2018	Improvement over CVH Performance RY2018
Access to Physician Exams and Wellness Checks – within 30 calendar days of request	80%	Overall= 91.3 % Fresno=93.4% Kings= 60.0*% Madera= 100*%	Overall= 88.5% Fresno= 85.2% Kings= 92.6% Madera= 93.8%	CVH Performance RY2018	Improvement over CVH Performance RY2018
Access to Non-Urgent Ancillary services for MRI/Mammogram/Physical Therapy – Appointment within 15 business days of request	80%	Overall= 89.0% Fresno= 83.3*% Kings= 100*% Madera=NR	Overall= 66.7*% Fresno= 60.0*% Kings= 100*% Madera=NR	CVH Performance RY2018	Improvement over CVH Performance RY2018
Appropriate After-Hours (AH) emergency instructions	90%	Overall= 94.3% Fresno= 93.6% Kings= 95.7% Madera= 98.2%	Overall= 93.9% Fresno= 95.2% Kings= 95.0% Madera= 80.5%↓	CVH Performance RY2018	Improvement over CVH Performance RY2018

AH physician callback: Member informed to expect a call-back from a qualified health professional within 30 minutes (Per P&P)	90%	Overall= 78.7% Fresno= 76.7% Kings= 87.0% Madera= 82.1 %	Overall= 82.0% Fresno= 82.3% Kings= 77.8% Madera= 85.0%	CVH Performance RY2018	Improvement over CVH Performance RY2018

*Denominator less than 10. Rates should be interpreted with caution due to the small denominator

↑↓ Statistically significant difference between RY2018 vs RY2017, p<0.05

NR – No reportable data

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

Analysis: Intervention Effectiveness w Barrier Analysis	
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 Experience for CalViva is monitored in two ways:

1. DHCS conducts a CAHPS survey every 3 years; results are posted the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfCAHPS.aspx
2. HNCA QI CAHPS team helps to administer a scaled-back CAHPS survey to assess access areas of opportunity. This CalViva Access Survey is administered through SPH Analytics/Morpace. Final results are shared with PNM.

Member satisfaction is affected by member interaction with the providers, provider office staff, the plan, and vendor partners. Results are also impacted by member demographics and individual health status.

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

Through the DHCS-admnistered CAHPS survey, the following measures are evaluated:

- Rating of Health Plan
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Getting Needed Care (composite measure)
- Getting Care Quickly (composite measure)
- How Well Doctors Communicate (composite measure)
- Customer Service (composite measure)
- Shared Decision Making (composite measure)

Our goal for the CAHPS survey is to be at or above the Quality Compass 50th percentile.

On an annual basis, the CalViva Access Survey collects information on the following measures:

- Access to Urgent Care
- Access to Routine Care
- Access to Specialist Appointment
- Ease of Getting Care/Tests/Treatment

Our internal goal for the CalViva Access survey is to exceed previous year's performance

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	Q3-Q4 2019	CVH/HN
Annually, review update and distribute Appointment Scheduling Tip Sheet and Quick Reference Guide	P	Q3-Q4 2019	CVH/HN
Annually, review update and distribute the "Talking with my Doctor" agenda setting form as part of the PE	P/M	Q3-Q4 2019	CVH/HN

Toolkit to educate and empower members and improve their overall experience			
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	Q3-Q4 2019	CVH/HN
Create article and distribute in Member newsletter highlighting access standards and interpreter services	M	Q3-Q4 2019	CVH/HN
Annually, review and update and enhance materials on the Nurse Advice Line to encourage use of this service by members	P/M	Q3-Q4 2019	CVH/HN
Update and conduct scaled-back member survey to assess effectiveness of interventions implemented	M	Q3 2019	CVH/HN

Section B: Mid-Year Update on Intervention Implementation (due Q3)	**Section B: Analysis of Intervention Implementation (due end of Q4)**
• The DHCS Administered CAHPS survey, results are not available to assess activities. • In Q1 and Q2 the toolkit materials were reviewed, and redundancies were identified in the materials. In order to simplify and streamline the information sent to providers, the materials were revised. The newly revised materials will be finalized in Q3 and distributed in Q4. • The CalViva Access survey, rates slightly improved except for getting urgent care and getting routine care. As resources allow, there will be a deeper dive into the access and availability of certain provider groups, and an assessment will be completed of which provider offices have Open Access Scheduling.	

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 2018	RY Rate 2019	Baseline Source	Baseline Value
Got urgent care as soon as needed	Improve YOY	81%	76%	RY 2018 Rate	81%

Got routine care as soon as needed	Improve YOY	68%	65%	RY 2018 Rate	68%
Ease to get specialist appointment	Improve YOY	55%	59%	RY 2018 Rate	55%
Ease of getting care/test/treatment	Improve YOY	74%	77%	RY 2018 Rate	74%
CAHPS Survey Measures	**Specific Goal**	**RY Rate 2016 (% always/usually)**	**RY Rate 2019 (% always/usually)**	**Baseline Source**	**Baseline Value**
Getting Needed Care	Exceed RY201 All Plans Medicaid Average 50th Nat'l = TBD	78%	Q4 2019	National Benchmark (50th Percentile)	TBD
Getting Care Quickly	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	74%	Q4 2019	National Benchmark (50th Percentile)	TBD
How well doctors communicate	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	90%	Q4 2019	National Benchmark (50th Percentile)	TBD
Customer Service	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	TBD	Q4 2019	National Benchmark (50th Percentile)	TBD
Shared Decision Making	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	TBD	Q4 2019	National Benchmark (50th Percentile)	TBD
Rating of All Health Care	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	69%	Q4 2019	National Benchmark (50th Percentile)	TBD
Rating of Personal Doctor	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	77%	Q4 2019	National Benchmark (50th Percentile)	TBD

Rating of Health Plan	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	TBD	Q4 2019	National Benchmark (50th Percentile)	TBD
Rating of Specialist	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	TBD	Q4 2019	National Benchmark (50th Percentile)	TBD
Analysis: Intervention Effectiveness w Barrier Analysis					
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**				

Section A: Description of Intervention (due Q1)				
2-1: 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: 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."[3] Moreover, the CDC estimates 30 percent of unnecessary antibiotics are prescribed in outpatient clinics.[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.[4] 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. (2017). Antibiotic use in the United States, 2017: Progress and Opportunities. Atlanta, GA: US Department of Human Services. Retrieved from https://www.cdc.gov/antibiotic-use/stewardship-report/index.html.
[3]Centers for Disease Control and Prevention (CDC), Antibiotic/Antimicrobial Resistance. Accessed January 12, 2017 at /www.cdc.gov/drugresistance.
[4]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 2017 was 18.26% and RY2018 was 24.58% which was 0.33% below the MPL (181 numerator events out of the 240 in the denominator).			
Planned Activities			
Activities	**Target of Intervention: Member (M) / Provider (P)**	**Timeframe for Completion**	**Responsible Party(s)**
Work with a high volume, low compliance clinic in Madera County to initiate targeted interventions to improve AAB rate. (Submit PDSAs)	P	Q1, Q2	CVH/HN
Conduct regular meetings with the Madera County clinic to share results and receive updates on improvement activities. (Submit PDSAs)	P	Q1, Q2	CVH/HN
Mail 2019 AWARE toolkit containing provider and member educational resources on appropriate antibiotic use. Mailed by AWARE offices (Physicians For A Healthy California) to top 20% of antibiotic prescribers (MDs) identified in Fresno, Kings, and Madera Counties.	P	Q2, Q3	CVH/HN
Provider Relations to distribute AWARE Toolkit to targeted providers and mid-level clinicians identified as high prescribing for two or more consecutive years.	P	Q2, Q3	CVH/HN
Work with a high volume, low compliance clinics in Fresno County to initiate targeted interventions to improve AAB rate. (Submit PDSAs)	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-Q2 2019, Medical management continued efforts with high volume, low compliance clinic in Madera County to monitor providers' compliance with measure and initiate follow up. • Regular meetings of the AAB Improvement team continue in the first six months of 2019 to review results of monitoring and evaluate the success of interventions and initiate modifications when indicated. • CalViva Medical Management 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. • CalViva Medical Management team enlisted the support of the Provider Relations Representatives to hand deliver the AWARE Toolkits and to the high volume, high prescribing physicians and mid-level clinicians identified in Madera and Fresno Counties. • In Q2, it was determined that the minimum performance level was exceeded in Madera County for the AAB measure (32.55%, which is above the 50th percentile 31.97) and the Robert Wood Johnson Virtual Clinic presentation had been provided to all larger provider groups in Madera who were identified as high prescribers. • Additionally, Fresno County was identified to have declining rates year over year for this measure (25.93%) and the potential to target several high-volume providers. Therefore, CalViva Health obtained approval from DHCS to move improvement efforts from Madera County to Fresno County in order to proactively address this measure through replication of interventions that were successful in Madera. This measure is not part of the 2020 MCAS	

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 RY2018	Rate RY2019	Baseline Source	Baseline Value
HEDIS Appropriate Treatment for Adults with Acute Bronchitis (AAB)	Directional improvement to meet or exceed the MPL 27.63% (RY 2019)	Madera: 24.58%	Madera: 32.55%	RY 2017 CVH results	Madera: 18.26%
Analysis: Intervention Effectiveness w Barrier Analysis	The AAB measure is no longer on the DHCS MCAS and the project closed mid-year. **Successes**				

	• Outcome monitoring over time (6 months) revealed a change in prescribing practices at our targeted clinic and Madera County overall. A recent analysis of AAB non-compliant providers in Madera County in MY2019 revealed no trends and only singular cases not lending themselves to the simulation training which has been our major improvement initiative. **Barriers** • Per Diem providers are difficult to train due to irregular office hours, and limited engagement with clinic administration. • In Fresno, the providers were sensitive to the trainer providing the simulation trainings; it was suggested by providers that training is conducted by clinical staff.
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: High blood pressure is asymptomatic and is often dubbed as the "silent killer" (Association, 2018). The American Heart Association defines normal blood pressure as less than 120/80 mm Hg (Association, 2018)**.** In managing blood pressure, members are advised to adopt positive life style modifications which include making dietary changes and increasing physical activity for maintaining a healthy weight, limiting alcohol intake, and engaging in smoking cessation programs (Center for Disease Control and Prevention, 2018). However, for patients managing chronic diseases such as hypertension medication adherence is paramount in improving overall health benefits. Some of those medications include angiotensin converting enzyme inhibitors (ACE inhibitors or ACE-I) and angiotensin receptor blockers (ARBs) and diuretics. 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 our members advance in age, there is a likelihood that they will take more medications to care for their chronic diseases. 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.

Association, A. H. (2018,). *American Heart Association - Monitor Your Blood Pressure*. Retrieved December 29, 2018, from American Heart Association: https://www.heart.org/en/health-topics/high-blood-pressure/the-facts-about-high-blood-pressure

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

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 2017 was 82.64% and in RY 2018 was 84.74%. The baseline HEDIS results for diuretics in RY 2017 was 82.20% in RY 2018 was 84.88%.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Work with high volume, low compliance clinic in Madera County to improve MPM rates (submit PDSA).	P	Q1-Q2	CVH/HN
Conduct regular meetings with the clinic in Madera County to receive updates on improvement rates for MPM.	P	Q1, Q2	CVH/HN
Continue with in-home screening program MedXM to complete required MPM laboratory testing.	M	Q1-Q2	CVH/HN
Continue with member incentive to improve MPM laboratory rates countywide.	M	Q1-Q2	CVH/HN
MPM Provider Tip Sheets available through the Provider Portal. The tip sheet outlines HEDIS Specifications, 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)

• In Q1 & Q2 2019, Medical Management continued working with a high-volume, low compliance clinic in Madera County to improve final RY19 rates for MPM (ACE/ARBs and diuretics). The bundled approach to improvement was continued, which included appointment scheduling through utilization of the Provider Profile, text messaging to members, and point of service member incentive gift card. In addition, the clinic began placing test orders in the EMR and mailing lab slips to established patients who had been seen by their provider within the last six months and required testing only. • Medical Management continued with bi-weekly multi-disciplinary MPM Improvement Team meetings to discuss the success and challenges in the process, barriers, results, and other identified issues. • Medical Management also continued with the MedXM in-home screening program to assist members in completing their required laboratory screening. A seven MPM labs were completed through MedXM. • Through these PDSA interventions, 57.9% (22/38) members completed their annual laboratory testing which exceeded the SMART Aim of 40% • In an effort to continue supporting providers, the MPM Provider Tip Sheet was made available to providers via the health plan's portal. • Final RY19 HEDIS compliance rates indicate that ACE/ARBs exceeded the 50th percentile at 89.13% and diuretics exceeded the 50th percentile at 90.37%.	

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 RY2018	Rate RY2019	Baseline Source	Baseline Value
HEDIS® Monitoring Persistent Medications: ACE/ARB	Meet or Exceed DHCS MPL update 85.97%	Madera: 84.74%	89.13%	RY 2017 CVH results	Madera: 82.64%

	(RY 2018)				
HEDIS® Monitoring Persistent Medications: Diuretics	Meet or Exceed DHCS MPL update 86.06% (RY 2018)	Madera: 84.88%	90.37%	RY 2017 CVH results	Madera: 82.20%

Analysis: Intervention Effectiveness w Barrier Analysis	The MPM measure is no longer on the DHCS MCAS and the project closed mid-year. **Successes** • The placement of the "HTN Lab" alerts in the clinic's scheduling system not only improved Camarena's MPM rates but also facilitated continued outreach for CVH members on a measure that will no longer be reported in RY2020, but remains a standard of care for medication safety. • The "HTN Labs" alert provided a methodology for the clinic to continue identifying their patients who require annual testing and monitoring completion rates over time. • A clinical champion and the support of Clinic leadership for quality initiatives improved implementation and the development of an internal clinic process to sustain the activity after the project ended. • Regular Data Check-ins continued to be a positive strategy for facilitating ongoing communication between the Plan and the providers regarding project progress toward goals throughout the intervention period. • Regular team meetings improved communication among the team members and provided an opportunity to identify and address barriers along the way. **Barriers** • The project required the clinic to validate members assigned at time delaying progress of the project. • Completion of testing required members to come in regularly causing patient fatigue, and required continuous communication with the members. • Continued outreach to some CVH members proved difficult as well as access to care which initiated the clinic to mail laboratory slips to members who had established care with their provider within six months.
Initiation Continuation Status	☒ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

2-3: 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%).
- Eye exam (retinal) performed.
- Medical attention for nephropathy.

- HbA1c control (<8.0%).
- HbA1c control (<7.0%) for a selected population*****.
- BP control (<140/90 mm Hg).

Fresno County baseline HEDIS results for HbA1c in RY 2017 were 84.91% and in RY 2018 was 83.21%. The baseline HEDIS results for Medical Attention to Nephropathy in RY 2017 was 90.51% in RY 2018 was 87.10%.

Planned Activities			
Activities	**Target of Intervention: Member (M) / Provider (P)**	**Timeframe for Completion**	**Responsible Party(s)**
Work with a high volume, low compliance provider in Fresno County to improve CDC rates for Hemoglobin A1c (HbA1c) and nephropathy testing (submit PDSA).	P	Q1-Q2	CVH/HN
Conduct regular meetings with Fresno County provider to receive updates on improvement rates for CDC HbA1c and nephropathy testing.	P	Q1, Q2	CVH/HN
Implement Provider Incentives to close the Care Gaps and Improve HEDIS rates for CDC sub HbA1c testing, and urine analysis.	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)**
• In Q1 & Q2 2019, Medical Management worked with a high volume, low compliance provider in Fresno County to improve CDC rates for Hemoglobin A1c (HbA1c) and nephropathy testing. • Medical Management continued during this same period to conduct bi-weekly meetings with the multidisciplinary Diabetes Improvement team in order to receive updates on progress with activities and modify these activities as needed. • In Q1, Medical Management completed its first PDSA cycle in which members either completed their testing or had an appointment scheduled to complete testing s through utilization of the Provider Profile and a member incentive. Through this intervention, 77% (66/90) of members completed their annual diabetic testing or scheduled an appointment which exceeded the SMART Aim of 50%.	

- At the start of the next PDSA cycle, the Diabetes Improvement Team utilized recommendations from the IHI Chronic Disease Toolkit "Partnering in Self-management". The team utilized the Diabetes Toolkit to implement its second PDSA cycle with a focus on "The Planned Care Visit". This approach emphasizes preparing the diabetic patient for a successful office visit. The Planned Care Visit approach consists of Utilization of the Diabetes Call Script, CDC HEDIS Workflow for Nephropathy, and the Orange and Butler Planned Care Visit Workflow. Through this intervention, 82% (45/55) of the members contacted for a Planned Care Visit by using the Diabetes Call Script had an appointment scheduled, labs drawn, or ordered. This exceeded the SMART Aim of 80%.

- RY19 HEDIS results indicate that the Nephropathy MPL of 88.56% was exceeded in Fresno County at 89.29%. However, efforts to meet the MPL for HbA1c testing will continue in Fresno County. The RY19 final result for Fresno County although improved over RY18 results at 84.43%, did not exceed the slightly higher MPL of 84.93% 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 RY2018	Rate RY2019	Baseline Source	Baseline Value
HEDIS® Comprehensive Diabetes Care – HbA1c Testing	Meet or Exceed DHCS MPL update 84.93% (RY 2018)	Fresno: 83.21%	84.43%	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: 87.10%	89.29%	RY 2017 CVH results	Fresno: 90.51%

Analysis: Intervention	

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

Section A: Description of Intervention (due Q1)

2-4: Breast Cancer Screening (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 woman 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 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

1 American Cancer Society. American Cancer Society Guidelines for the Early Detection of Cancer. Breast 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. Accessed January 3, 2019 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 result for RY 2018 was 52.71%.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Continue to work with a high volume, low compliance provider in Fresno County to implement targeted BCS interventions and monitor effectiveness.	P	Q1-Q4	CVH/HN
Organize Mobile Mammography Coach at high volume, low compliance clinic site in Fresno County.	M	Q1Q4	CVH/HN
Health Education to distribute educational materials on the importance of breast cancer screening	M	Q1Q4	CVH/HN
Implement Provider Incentives to close the gaps and Improve HEDIS rates for breast cancer screening.	P	Q1-Q4	CVH/HN
Implement direct member incentive for completion of breast cancer screening to improve rates	M	Q1-Q4	CVH/HN
Deploy cultural and linguistic strategies at targeted convenient and culturally competent clinic site to support members in accessing their breast cancer screening services. Strategies include: geo mapping analysis specific regions and zip codes where disparity is occurring, on site interpreters, transportation services, etc.	M	Q1-Q4	CVH/HN
Alternative or create partnership with imaging center.	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)
• In Q1 and Q2, 2019 Medical Management led a quality improvement project to address breast cancer screening in Fresno County. This Project is in collaboration with one high volume, low compliance clinic in Fresno County. • Initially, a high volume, low compliance clinic was identified and approached to engage in the project. Once the clinic leadership approved the project, the team identified use of a mobile mammography unit at the clinic site as a first intervention.	

- However as further analysis was conducted on the targeted clinic's membership as part of our usual practice, a disparity was identified for the Hmong population. This sub-group was found to have an 18% BCS completion rate compared to others and the MPL which is at 58%. After learning about the barriers that exist for women at this clinic through barrier analysis and Focus Groups with the assistance of C & L and Health Ed Staff, we decided to create a member-friendly approach that might be applicable to other clinics and counties. The goal for this PDSA Cycle was to determine if using a Member Centered Approach* while at mobile mammography events would improve rates in Fresno County.

- The multidisciplinary BCS Improvement Team met bi-weekly to develop the approach, plan events and review and evaluate results of interventions tested.

- For the total of the 9 Events: 224/310 (72.3%) patients completed their BCS.

- A survey to identify the reason why the member completed their exam was implemented at the conclusion of each exam performed. The top three responses were:
    1) a doctor recommended that I attend;
    2) it was convenient for me (time, location); and
    3) the support from staff.

**Member Centered Approach-. We provided refreshments and had in-person interpreters according to preferred languages to greet patients as they arrived; interpreters assisted in completing registration paperwork; patients were taken to a private room with an interpreter to discuss the breast history form, if needed; and patients were walked over to the mobile mammography coach where the interpreter remained available for any questions*

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 RY2018	Rate RY2019	Baseline Source	Baseline Value
HEDIS® Breast Cancer Screening	Meet or Exceed DHCS MPL update 58.0%	51.78%	82.0%	RY 2018 CVH results	Fresno: 51.0%
Analysis: Intervention Effectiveness w Barrier Analysis					
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**				

III. PERFORMANCE IMPROVEMENT PROJECTS

Section A: Description of Intervention (due Q1)				
3-1: Improving Childhood Immunizations (CIS-3)				
☐ New Initiative ☒ Ongoing Initiative from prior year				
Initiative Type(s)	☐ Quality of Care	☒ Quality of Service	☐ Safety Clinical Care	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: To improve child health in Fresno County.

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

Therefore, CalViva Health has selected Childhood Immunizations Status – Combination 3 (CIS-3) in Fresno County for a Performance Improvement Project (PIP) topic. Childhood immunizations is a component of the seven priority focus areas (Foster Healthy Communities) identified by DHCS for the Medi-Cal Quality Strategy.2 The CIS-3 measure in Fresno, Madera, and Kings Counties are at/above the MPL RY 2018 (71.3%).

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 one high volume, low preforming clinics in Fresno County.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Continue interventions with high volume, low compliance clinic, to address high priority gaps identified in FMEA (Module 4), and monitor intervention effectiveness (Module 5).	P	Q1-Q2,Q3	CVH/HN
Member newsletter article: Childhood Immunizations	M	Q3	CVH/HN
Implement direct member incentive for completion of childhood immunizations series to improve rates	M	Q1,-Q2,Q3	CVH/HN
Elimination of the double bookings option/implementation of walk-in/RN visits	M	Q1,Q2,Q3	CVH/HN
Implement Provider Incentives to close the Care Gaps and Improve HEDIS rates for Childhood Immunizations.	P	Q1,-Q2,Q3	CVH/HN
Provider Tip Sheets will be developed and made available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended immunization guidelines.	P	Q2,Q3	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 led a Childhood Immunization (CIS-3), Performance Improvement Team in collaboration with one high volume, low compliance clinic in Fresno County. • 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 the needed immunizations and a Well-child Exam. The clinic also initiated “Nurse Only Visit” scheduling on designated days. These visits offered very flexible scheduling because the patient saw only the Medical Assistant in order to receive their immunization. Additionally, the clinic accommodated walk-in patients at their designated “Walk-in Only Clinics” on Saturdays. • It was determined that “Nurse Visit” was the preferred option for members. The final compliance rate is 68.7%.	

• The second intervention was a $25 per member/per visit gift card incentive at point of service. • The member newsletter will be distributed to members in the Fall of 2019 to educate them on the importance of childhood immunizations. • Providers were offered an incentive to encourage outreach to members and completion of their immunizations. • The Childhood Immunizations billing and coding sheet was provided to Providers. The development of a Provider Tip Sheet is pending revisions and future launch date.	

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 RY2019	Rate RY2019	Baseline Source	Baseline Value
Childhood Immunization Combo 3	Meet or Exceed SMART Aim Goal of 60.0%	Fresno: 51.12%	49.02%	RY 2018 CVH results	Fresno: 51.12%

Analysis: Intervention Effectiveness w Barrier Analysis	**Successes** • Engaged with high volume Fresno County clinic sites to address childhood immunization gaps, and exceeded performance improvement project goal (60%) by reaching 68.7% compliance, despite project challenges. **Barriers** • Initially, we began the project with two clinic sites and after one year of the project CIS-3, the stronger of the two clinics had to drop out. • This was followed by all new staff at the clinic and on our team, as the clinic was restructured after a change in ownership. • The clinic went through a change in scheduling and clinical software at all clinic sites. • These factors impacted the team's ability to initiate change, maintain support of leadership and team membership and our ability to sustain change after testing. • We clearly saw improvement after implementation of the first intervention, but we were unable to sustain additional improvement beyond that
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 2019 DHCS Strategy for Quality Improvement in Health Care in the delivery of effective, efficient and affordable care under Medi-Cal Managed Care (Priority 2). DHCS has also adopted the strategy of eliminating health disparities in the Medi-Cal population (Priority 7).[1] The PIP proposed by CalViva Health addresses both priorities by aiming to develop interventions specifically for disparities within a population receiving postpartum care. Closing gaps in care due to disparity is also a priority for CalViva Health, which has developed a strategy to address disparities using the Robert Wood Johnson Foundation's definition of health equity:

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

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

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

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

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

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 continue to monitor postpartum care rates and disparity activity (Modules 4 and 5).	P	Q1,Q2,Q3	CVH/HN
Implement and monitor EMR OB Alert	M	Q1,-Q2,Q3	CVH/HN
Monitor the use of the revised ACOG OB History Form to address cultural issues	M	Q1,-Q2,Q3	CVH/HN
Provider Tip Sheet on Postpartum Care will be developed and made available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended postpartum care guidelines.	P	Q2,Q3	CVH/HN
Provider level incentive for PCPs to close Care Gaps and improve HEDIS scores	P	Q1, Q2,Q3	CVH/HN
Implement Postpartum Member Incentive by sending a $25 gift card to members for whom we receive a correctly completed and timely Postpartum Care Notification Form from their provider in all CVH Counties	M	Q1, Q2,Q3	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 2019, Medical Management continued its partnership with a high volume, low compliance clinic with an identified disparity in Fresno County. The project team was focused on a clinic site located in Mendota, in a rural area of Fresno County. • The team's initial intervention focused on scheduling the postpartum visit within the correct timeframe after delivery (21-56 days) and involved the creation of an "OB Alert" in the clinic's electronic medical record (EMR). Barrier analysis revealed that clinic staff were unsure of the appropriate timing for the postpartum visit and historical data revealed visits occurring outside the recommended timeframe were common. This intervention required revision during the first six month of 2019 after the clinic went live with a new electronic medical record. The team approved a new workflow for staff where a postpartum	

visit would be scheduled for all pregnant women with an estimated delivery date (EDD) in the EMR. • The second intervention implemented was designed to facilitate integration of the mother's cultural preferences regarding the postpartum period into the plan of care. The intervention was developed after a barrier analysis was performed during several meetings with Mendota clinic patients, staff, and providers. It was determined that a cultural disparity existed for a sub-population of women from El Salvador which impacted compliance with the postpartum appointment. At the start of the PIP: Kerman Clinic rate: 73%; Mendota Clinic rate: 50%. • A revised OB History (ACOG) form was developed to prompt staff and providers to inquire about cultural preferences early in the pregnancy that may impact care and scheduling of the postpartum visit and document responses on the OB History form which follows the mother from diagnosis to delivery. From these meetings, it was determined that there was minimal cultural awareness related to postpartum practices among clinic staff and providers. • A Provider Tip Sheet was uploaded to the Provider Portal as a quick reference for providers. • Providers were offered an incentive to encourage outreach to members and completion of their postpartum visit. • Members were offered a $25 incentive to encourage the completion of their postpartum visit. • At the conclusion of this project, the timely Postpartum Visit compliance rate is 82%. The rate is calculated by: # Postpartum visits completed per month divided by # of deliveries per month on a rolling 12 month basis.	

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 RY2018	Rate RY2019	Baseline Source	Baseline Value

HEDIS® Postpartum Care Visits	Meet or Exceed SMART Aim Goal of 64.0%	Fresno: 50.0%	82.0%	RY 2018 CVH results	Fresno: 50.0%

Analysis: Intervention Effectiveness w Barrier Analysis	**Successes** • Engaged with high volume, rural clinic to exceed performance improvement project goal of 64.0%. • In-depth analysis of cultural barriers led to a new prenatal form, which was completed at 100% of the appointments as of the final data collection in July 2019. • Motivational interviewing and staff training to improve cultural competency engaged providers and staff at all levels. **Barriers** • Clinic changed electronic medical records (EMR) during the project, and had IT staff turnover delaying the implementation of the first intervention (flagging in EMR). The medical management team worked with the new IT staff to implement the EMR alert in the system. • Staff needed continued education on flagging and alert system, which delayed the progress of the intervention. • Staff turnover required re-education of data collection to ensure consistent data monitoring • Providers needed re-education and encouragement to complete cultural section of the prenatal intake form, which resulted in slow progress of second intervention.
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?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
WELLNESS/ PREVENTIVE HEALTH					
1. Distribute Preventive Screening Guidelines (PSG) to Members	CVH/HN	Distributing in the new member packet	☐		
2. Adopt, Disseminate Medical Clinical Practice Guidelines (CPG)	CVH/HN	CPGs are available on the provider library. Last sent out July 19, 2019.	☐		
3. Implement CalViva Pregnancy Program and identify high risk members by Case Management	CVH/HN	Through Q2 221 members managed in PCM program, exceeding number managed in 2018. Quarterly average engagement rate remained constant at 25% across Q1 and Q2.	☐		
4. Promote CA Smokers' Helpline to smokers	CVH/HN	Conducted one mailing promoting the Helpline to identified CalViva Health's smokers.	☐		
5. Launch a Diabetes Prevention Program	CVH/HN	Pending approval of promotional materials before it can be launched.	☐		
CHRONIC CARE/ DISEASE MANAGEMENT					
1. Monitor Disease Management program for appropriate member outreach	CVH/HN	Program transitioned fully to Envolve People Care (a Centene corporation) at the end of March 2019. Program ongoing.			
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 2019 on the following reports: 2018 End of Year Language Assistant Program and 2018 End of Year Work Plan, 2019	☐		

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
		Program Description and 2019 Work Plan. For details on the 2018 outcomes and 2019 activities, please refer to C&L reports accordingly. Also completed / submitted the Language Assistance Program Assessment Report for the DMHC Timely Access Reporting.			
2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s) and/or CCHRI	CVH/HN	Surveys for MY2019 will begin in September 2019.	☐		
3. Complete and submit DMHC Timely Access Reporting (TAR) by April 30 filing due date	CVH/HN	TAR filing submitted timely.	☒	4/30/19	TAR filing submitted timely
4. ACCESS SURVEY RESULTS: Monitor appropriate timely appointment and after-hours access and identify noncompliant PPGs and providers.	CVH/HN	Surveys were completed 12/31/2018. After receiving information from vendor, data will be analyzed, and CAP packets for noncompliant PPGs and providers will be sent out.	☐		
5. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances	CVH/HN	A&G will continue to assist members with obtaining timely access appointments and facilitate referrals as needed.	☐		
6. 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 and Quality Improvement (QI) programs.	CVH/HN	C&L continues to utilize GNA findings to develop and implement C&L priorities to ensure members, providers and staff have access to culturally and linguistically appropriate services,	☐		

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
		trainings and resources inclusive of language services. Next GNA report is scheduled for 2021.			
7. 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. (Quarterly: next report 2020)	CVH/HN	C&L Geo Access report in progress and scheduled to be completed during Q3 2019.	☐		
8. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report	CVH/HN	IHA was submitted for review and accepted at QIUM May and July 2019. Ongoing IHA 3 pronged outreach is reported on a quarterly basis.	☐		
QUALITY AND SAFETY OF CARE					
Integrated Case Management • Implement use of ImpactPro as the predictive modeling tool to identify high risk members for referral to ICM. • Evaluate the ICM Program based on the following measures: o Readmission rates o ED utilization o Overall health care costs Member Satisfaction	CVH/HN	Reports using Impact Pro stratification are used to identify high risk members for CM. Q1 program outcomes include PH, BH, & TCM cases. 134 members met outcome inclusion criteria. Results of members managed: • Number of admissions and readmissions was lower; 27% difference • Volume of ED claims/1000/year decreased by 328	☐		

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
		• Total health care costs reduction related to reduction in inpatient costs, slight increase in outpatient services and pharmacy costs Member Satisfaction Survey - respondents reported 72.7% improvement in ability to care for self/family post CM (46.3%) vs pre CM (26.8%); 97.5% (39/40) 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 and Recredentialing reports received timely to QI Workgroup during Q1 and Q2. On target for credentialing and recredentialing goals.	☐		
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	MHN QI created a practitioner newsletter specifically for CalViva Health practitioners (Jan.-June 2019), which highlighted the 2018 member satisfaction survey results. MHN QI continues to meet and collaborate with HN's Culture and Linguistics and Appeals and Grievances	☐		

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
		Departments to track, trend and investigate member grievances. MHN QI added appointment wait time reminders to MY 2019 Provider Appointment Availability Survey outreach letter and May Newsletter. Professional Relations is tracking and focusing on provider recruitment efforts using a new quarterly report of provider network changes and updated and corrected provider directory information based on outcome data from the MY2018 Provider Appointment Availability Survey			
QUALITY IMPROVEMENT					
1. Maintain Facility Site Review (FSR) and Medical Record (MRR) Compliance: To ensure practitioner offices and medical records comply with DHCS contracted requirements per MMCD Policy Letter 14-004 and Physical Accessibility Review Survey per MMCD Policy Letter 12-006 and 15-023	CVH/HN	Q3 and Q4 2018 monitoring and reporting completed. Q1 and Q2 2019 reports are in progress. Promoting and training on changing FSR/MRR requirements is underway. Q3-Q4 planned work is on track.	☐		
2. Evaluation of the QI program: Complete QI Work Plan evaluation annually.	CVH/HN	Ongoing monitoring in progress.	☐		
CLINICAL DEPRESSION FOLLOW-UP					
1. Continue development and distribution of provider educational resources on	CVH/HN	On track. In May, completed an online provider webinar on			

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
screening for clinical depression and follow up (12 years and older)		motivational interviewing for behavioral health screenings and referrals, including the Patient Health Questionnaire (PHQ) for depression.			

Item #8

Attachment 8.B

2019 UM Work Plan Mid-Year Evaluation
Work Plan Evaluation

CalViva Health
2019
Utilization Management (UM)/ Case Management (CM)
Work Plan
Mid-Year Evaluation

Created: January 25, 2019
Last updated: August 28, 2019

TABLE OF CONTENTS

1. Compliance with Regulatory & Accreditation Requirements

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.	☒ Medi-Cal	Qualified licensed and trained professionals make UM decisions.	Health Net (HN) has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions. Nurse, physician and pharmacy (for pharmacists and technicians) licensure status is maintained in Workday (HN software). Credentialing maintains records of physicians' credentialing. 100% compliance with maintaining records of professional licenses and credentialing for health professionals.	Provide continuing education opportunities to staff. Conduct Medical Management Staff new hire orientation training. Review and revise staff orientation materials, manuals and processes. Verification of Continuing Medical Education (CME) standing, verification of certification, participation in InterQual training and IRR testing. Conduct training for nurses.	Monthly As needed Ongoing Ongoing Ongoing

Created: January 25, 2019
Last updated: August 28, 2019

Health Net

CalViva HEALTH

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The following monthly clinical education (CE) and Quality Improvement (QI) in-services were offered to all nurse and MD reviewers in the first half of 2019 • Pathways to Safer Pain Management • Work up and Management of COPD • End of Life • Updates on Evidence-based Statin Re-challenge Guidelines • HIV Part II Prevention and Management • Clinical Effectiveness & Scalability of the Diabetes Prevention Program • Motivational Interviewing New hire overview training is offered monthly for all new hires. Medical management onboarding classes are offered and completion is monitored through our online learning management system. Ongoing process of verification of CME standing and certification is in place.	None identified	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Created: January 25, 2019
Last updated: August 28, 2019

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.2 Review and coordinate UMCM compliance with California legislative and regulatory requirements.	☒ Medi-Cal	Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations. This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance.	Review and report on legislation signed into law and regulations with potential impact on medical management. Appropriate and timely changes are made to Medical Management processes to accommodate new legislation as appropriate. 100% compliance of UMCM staff and processes with all legislation and regulations.	Review new legislation and regulations, either through e-mail or department presentation. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	Ongoing

CalViva Health
2019 UM/CM Plan

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

Created: January 25, 2019
Last updated: August 28, 2019

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.3 Separation of Medical Decisions from Fiscal Considerations	☒ Medi-Cal	DHCS, DMHC, and CMS, at a minimum, require that Medical Decisions made by Medical Directors (MDs) and Nurse reviewers are free from fiscal influence.	Affirmative statement about incentives is distributed to employees and communicated to members in member mailings and to practitioners/providers in Provider Updates. 100% compliance with acknowledgement of affirmative statement about financial incentives to practitioners, providers and employees.	All individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in underutilization or adversely affects subsequent claim activity. UM staff review and acknowledge this statement upon hire and annually thereafter through Cornerstone (online learning platform). Management Incentive Plan (MIP) Goals will not be created that benefit MDs or Nurse reviewers based on any potential to deny care.	Ongoing

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' upon hire and annually thereafter through Cornerstone. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	None identified	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Created: January 25, 2019
Last updated: August 28, 2019

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.4 Periodic audits for Compliance with regulatory standards	☒ Medi-Cal	Ensure compliance with regulatory standards.	Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turnaround time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision.	Conduct File Reviews for compliance with regulatory standards. Provide ongoing education and/or UM process improvement with staff on issues revealed during the file review process. File Audits completed the month following each quarter.	Ongoing Ongoing April 2019, July 2019, October 2019, January 2020

CalViva Health
2019 UM/CM Plan

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

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS)	☒ Medi-Cal	Health Net (HN) Medical Directors (MDs) interact with the Medi-Cal Managed Care Division (MMCD) of DHCS: ▪ MMCD Medical Directors Meetings ▪ MMCD workgroups ▪ Quality Improvement workgroup ▪ Health Education Taskforce There are benefits to HN MD participation: ▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program. ▪ Provides HN with in-depth information regarding contractual programs. ▪ Provides HN with the opportunity to participate in policy determination by DHCS.	HN Medical Directors and CalViva Health Chief Medical Officer participate on DHCS workgroups, task forces and meetings. Ensures participation by MDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each MD. HN and CalViva remain a strong voice in this body with participation on key workgroups.	The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2019. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

CalViva Health
2019 UM/CM Plan

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

Created: January 25, 2019
Last updated: August 28, 2019

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.6 Review, revision, and updates of CalViva UM /CM Program Description, UMCM Work plan, and associated policies and procedures at least annually.	☒ Medi-Cal	Reviews/ revises Medi-Cal UM/CM Program Description and UMCM Policies and Procedures to be in compliance with regulatory and legislative requirements.	Core group comprised of State Health Programs Chief Medical Director (CMD), Regional Medical Directors, Director of Medical Management and Medical Management Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2019 UMCM Program Description. Write and receive CalViva approval of 2018 UMCM Work Plan Year-End Evaluation. Write and receive CalViva approval of 2019 UMCM Work Plan. Write and receive CalViva approval of 2019 UMCM Work Plan Mid-Year Evaluation. Prepare and Submit UMCM Program Description and Work plan to CalViva QIUM Committee and CalViva RHA Commission annually, providing mid-year updates and any ad hoc queries from CalViva Health leadership. Continue to monitor and revise policies and procedures based on DHCS and DMHC requirements.	Q 1 2019 Q 1 2019 Q 1 2019 Q 3 2019 Ongoing Ongoing

Created: January 25, 2019
Last updated: August 28, 2019

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The 2018 Year End UM/CM Work Plan Evaluation, 2019 UMCM Work Plan, 2019 UM Program Description and the 2019 CM Program Description were submitted and approved in Q1 2019. Continued assessment of needs to review and revise the program materials or policies and procedures based on DHCS, DMHC and other regulatory requirements is ongoing.	None identified	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

2. Monitoring the UM Process

CalViva Health
2019 UM/CM Plan

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

CalViva Health
2019 UM/CM Plan

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

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td><td>The leadership team meets daily to review reports to track turn-around times (TAT), current inventory and staffing resources. Daily goals, action plans, barriers are discussed and staffing adjustments are made in order to meet TAT goals.

Monthly Key Indicator (KIR) and Staffing reports are reviewed to track trends, results, opportunities and are discussed in the Medical Management Leadership Meetings. Action plans are developed/implemented as needed based on results/trends to mitigate risks with meeting requirements.

Authorization Volume
<table><tr><th>Months</th><th>Approved</th><th>Modified</th><th>Denied</th></tr><tr><td>January</td><td>6,120</td><td>34</td><td>1,191</td></tr><tr><td>February</td><td>5,936</td><td>34</td><td>1,220</td></tr><tr><td>March</td><td>6,223</td><td>34</td><td>1,362</td></tr><tr><td>April</td><td>5,793</td><td>37</td><td>1,327</td></tr><tr><td>May</td><td>6,795</td><td>45</td><td>1,578</td></tr><tr><td>June</td><td>5,926</td><td>51</td><td>1,331</td></tr><tr><td>Totals</td><td>36,793</td><td>235</td><td>8,009</td></tr></table></td><td>None identified</td><td>None</td><td>Ongoing</td></tr>
<tr><td>Annual Evaluation

☐ MET OBJECTIVES

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

Created: January 25, 2019
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CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request (Turnaround Time =TAT)	☒ Medi-Cal	TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications). Provide oversight, tracking, and monitoring of turnaround times for authorization requests.	Track and trend authorization requests month to month in all categories and report monthly in the Key Indicator Report.	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of TATs. Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining.	Ongoing UM TAT summaries due monthly

Health Net

CalViva HEALTH

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	Activities were on target in Q1 of 2019, however barriers listed have adversely impacted TAT. TAT: Q1-2019: 98.9% Q2-2019: 65.6%	1. New hiring process rolled out in Q1 resulted in delays in onboarding staff. This contributed to a backlog in May and June and missed TAT 2. Central Valley provider inundated authorization request volumes, sending 100-600 requests daily in May, June. This caused a backlog throughout May and June.	1. Weekly meetings being held with Human Resources and Recruiting for status on open positions and ensure a timely candidate pool. Job Fairs being held in July to fill remaining vacancies. 2. Involved Medical Directors and Provider Relations to educate provider on appropriate level of services being requested. Authorization requests continue to be received from this provider in July, however volumes have greatly reduced.	9/15/19
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Created: January 25, 2019
Last updated: August 28, 2019

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making	☒ Medi-Cal	Consistency with which criteria are applied in UM decision-making is evaluated annually. Opportunities to improve consistency are acted upon.	Health Net administers McKesson InterQual® IRR Tool to physician and non-physician UM reviewers annually Physician and non-physician UM reviewers achieving ≥ 90% passing score on InterQual® IRR Tool	<u>Physician IRR</u> Administer Physician IRR test using case review method and McKesson InterQual® IRR tool in Q3-4 2019. <u>Non-Physician IRR</u> Administer annual non-physician IRR test using McKesson InterQual® IRR tool in Q3-4 2019.	Q3-4 2019 Q3-4 2019

Created: January 25, 2019
Last updated: August 28, 2019

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	IRR training and retesting courses were offered in May/June 2019 for those who did not pass the 2018 test. Trainers we will be attending train the trainer in July/August for IRR updates. Updates will be trained and retested Oct-Dec 2019.	None identified	None	12/31/2019
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
2.4 UM Process Improvement Initiative	☒ Medi-Cal	Increase Medical Director collaboration with the UM teams to ensure members are receiving appropriate services timely	5% Increase in number of inpatient and preservice referrals for Medical Director review	Managers will huddle with clinical staff daily to review cases. Medical Directors will be attending daily huddles/rounds to identify cases for further consultation and direction. Institute nurse cross training and training regarding appropriate use of policies related to MD referrals, Monitoring productivity report and quality audits by volume and by staff member to ensure referrals are appropriate. MD referral rates will be incorporated into existing reports.	Ongoing Ongoing Jan 2019 and Ongoing Ongoing Q1 2019 and Ongoing

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Last updated: August 28, 2019

Health Net

CalViva HEALTH

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	We are continuing to work with the MD's and the nursing teams. We have implemented different processes to ensure reviews/referrals are being sent appropriately. We are working with an outside consultant to ensure correct referrals and education is department wide and consistent. We are still in process of adding additional measures to the teams.	Inconsistent review process and workflows in the teams. End to End processes were formalized and trained to each department/team.	Working with outside consultant to ensure reviews are consistent and appropriate.	12/31/2019
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
2.5 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals.	☒ Medi-Cal	Track the number of clinical appeals received for authorization decisions and also the number upheld and overturned to determine where modifications in authorization process are appropriate.	Measure UM Appeals volume as a percentage of the total authorization requests. Measure the number upheld and overturned, as well as Turnaround Times.	Appeals data, the numbers received, timeliness of completion of appeals reported to HNCS UM/QI Committee bimonthly Collaborate with QI Department for review of Appeals at least annually, including an analysis of trends. Identify opportunities for removing or adjusting prior authorization requirements or criteria based on appeals that are regularly overturned Bring this analysis to UM/QI committee for discussion and input from community practitioner committee members. Ensure appeals are processed by specialty matched physicians, which at a minimum requires pediatricians or family practitioners to evaluate all medical necessity appeals for members under age 21, and family practitioners or internists to evaluate all medical necessity appeals for members over age 21.	Ongoing

CalViva Health
2019 UM/CM Plan

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

☒ ACTIVITY ON TARGET

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

Turnaround Time Compliance for resolved expedited and standard appeals = 99.71% or 341 out of 342.

<table>
<tr><th colspan="3">2019 Semi-Anneal Appeals January -June 2019</th></tr>
<tr><th>Appeal Type</th><th>Case Count</th><th>Percentage</th></tr>
<tr><td>Overturn</td><td>153</td><td>44.74%</td></tr>
<tr><td>Partial Uphold</td><td>6</td><td>1.75%</td></tr>
<tr><td>Uphold</td><td>180</td><td>52.63%</td></tr>
<tr><td>Withdrawal</td><td>3</td><td>0.88%</td></tr>
<tr><td>Total Cases</td><td>342</td><td></td></tr>
</table>
</td><td>None identified</td><td>None</td><td>Ongoing</td></tr>
<tr><td>Annual Evaluation

☐ MET OBJECTIVES

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

Created: January 25, 2019
Last updated: August 28, 2019

3. Monitoring Utilization Metrics

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance	☒ Medi-Cal	Health Net Central Medical Directors and Medical Management manage the non-delegated shared risk PPGs and a sizable FFS membership.	Health Net manages shared risk non-delegated PPGs and FFS inpatient UM. Data reported quarterly at State Health Programs UM/QI Committee meeting ▪▪▪▪▪▪▪▪▪▪▪▪▪▪▪ Key Metrics (SPD, Non-SPD, MCE) Bed days/k ALOS Admit /K All cause readmits within 30 days 2019 Goals: • 10% reduction in admissions over prior year • 5% increase in discharge to recuperative and alternative care	Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services. Use data to identify high cost/high utilizing members to target for care management. The UM team will continue transition care management collaboration and enhanced discharge planning to increase discharges to alternative and recuperative care settings. Focus on the top 10 admitting diagnosis, and long length of stay admissions will also continue in 2019; adding a focus on 0-2 day stay admissions for appropriateness of admission. The effectiveness of the utilization management program will be tracked using key indicator performance reports for review and improvement.	Ongoing

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Completed end to end processes and continue to work towards consistent processes. Working with an outside consultant for LOC, review consistency and training to ensure consistent and accurate reviews are completed within regulated TAT.	None identified	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
3.2 Over/under utilization	☒ Medi-Cal	Health Net ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non-SPD members. Fraud, Waste and Abuse of medical services is monitored and reported. PPG Reports are used internally and externally with medical groups to develop member and population level interventions. Quarterly reports are made available for PPGs with member Non-SPD >1000 and SPD greater than 500 members. And MCE members >1000.	The UM metrics will be reported quarterly and the procedure metrics will be reported annually for PPGs with greater than 1,000 non-SPD, greater than 1,000 MCE or 500 SPD Medi-Cal Members. Metrics for the PPGs and CCR will be for the SPD, MCE and TANF populations and will include: 1. Admissions/K 2. Bed days/K 3. Acute care average length of stay 4. ER admits/K 5. All case readmits 6. % 0-2 day admits In addition PPG metrics will include: 7. Specialty referrals for target specialties 8. C-section rates. PPG profile reports are made available quarterly and specialty referrals are assessed on a biannual basis.	Continue to enhance provider profile. Identify PPG PIP, outcome results and barriers on a biannual basis and present aggregated results to CalViva. (Over and Under Utilization reports) Identify possible fraud, waste and abuse issues. Report any issues to the SIU and Compliance Department Thresholds for 2019 are under evaluation. <u>Referral Rates: Specialist</u> PM/PY referral rates are calculated from claims and set as internal thresholds by PPG. Referral rates to be determined and compared with PPG peers including Health Net Region 3 (Central Valley) and Health Net Medi-Cal State wide. PPG's with significant deviation from the peer comparison will be identified as potential outliers and engaged to determine the drivers of variation. Specialties and PPG's identified as potential outliers for the metrics measured undergo further analysis by the MD to determine if a Quality Improvement Plan is indicated. The Quality Improvement Plans, if applicable are reviewed at the regional team meetings lead by the Medical Directors.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The CVH PPG specific data Dashboard Reports are produced quarterly. A narrative summary portion has been added to the reports. The data is presented at the CalViva Management Oversight meeting. The reports are derived from claims data and have a time lag of approximately four to five months.	None identified	Access: Updated UM metrics reported are Bed Days/K, Admits/K, ALOS, ER Visits/K, and 30-day all-cause readmission rates. Reports are presented by aid type (SPD, Non-SPD, and MCE) and compared to established benchmarks. The analysis of the data includes: 1) Current status compared with benchmarks; 2) Changes and trends with causal analysis; and 3) Action plan including performance improvement plans o CVH and HN working together on Report. HN working with PPG to improve identified areas of concern (i.e. AHP, First Choice) and will provide quarterly updates	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
3.3 PPG Profile	☒ Medi-Cal	PPG Profiles provide performance metrics for delegated PPGs. The data is collected from the PPGs for CalViva members and compiled in a dashboard. Variances of 15% or more from previous quarter are researched and reported quarterly during the CalViva MOM.	Medi-Cal PPGs with delegated CalViva members provide quarterly reporting to Health Net Delegation Oversight (DO). Delegation oversight compiles the data, seeks root causes for any variances of 15% or greater and normalizes the data to PMPY. The following metrics are tracked by Delegation oversight: 1. Claims timeliness 2. Provider dispute volume & timeliness 3. Prior authorization volume & timeliness 4. Specialty referral volume for in network/out of network 5. Specialty referral access timeliness 6. Credentialing volume The DO Dashboard also includes additional data provided on the dashboard where the RMD and the Finance department track and report on i.e. Utilization rate, Financial, HEDIS score etc.	CalViva PPG profile dashboard includes metrics for claims, utilization management processing and timeliness and credentialing for delegated providers CalViva delegated PPGs reports are evaluated on a quarterly basis for variance and compliance rates Variance rate is calculated from previous quarter and all Variances >+- 15% are researched Compliance rate is calculated as identified by DHCS for: • Claims timeliness • Provider dispute timeliness • Prior authorization timeliness CalViva delegated PPGs identified as non- compliant are requested to complete a root cause analysis and submit a corrective action plan to HN Delegation Oversight. CAPs identified during an annual audit by the HN delegation Oversight is monitored and followed-up by HN Delegation Oversight.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Q1 2019 PPG Profile and Narrative was provided 5/31/2019 and was reviewed at MOM at 6/11. CalViva PPG profile reports are made available quarterly. CAPS are monitored by the Delegation Oversight team to insure actions are implemented and documentation and follow up are completed.	None identified	Enhancements to PPG profile dashboard data sources and ownership were completed in the first half of 2019.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

4. Monitoring Coordination with Other Programs and Vendor Oversight

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
4.1 Case Management (CM) Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing physical and emotional health and well-being and improving quality of life. Assisting members with complex and serious medical conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of RNs, LCSWs, Program Specialists, Program and Care Coordinators to perform physical health and integrated CM activities. Continue use of ImpactPro as the predictive modeling tool to identify high risk members for referral to CM. Review outcome measures quarterly.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Number of HIFs completed in January -June by member and returned or EPC outreach was 2,429. 180 members subsequently referred to CM through June. Total members managed through Q2 across physical, behavioral health and TCM programs was 421. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in PH, BH, & TCM & 90 days after enrollment. Q1 results include members with active or closed case on or between 1/1/2019 & 3/31/2019 & remained eligible 90 days after case open date. 134 members met criteria. Results of members managed: • Number of admissions and readmissions was lower; 27% difference • Volume of ED claims/1000/year decreased by 328 • Total health care costs reduction related to reduction in inpatient costs, slight increase in outpatient services and pharmacy costs • Member Satisfaction Survey comprised of two sections; Care Team Satisfaction and Quality of Life 42 members were successfully contacted through Q2 • Care Team Satisfaction - overall members were satisfied with the help they received from the CM and reported the goals they worked on improved understanding of their health • Quality of Life Section 72.7% improvement in ability to care for self/family post CM (46.3%) vs pre CM (26.8%); 97.5% (39/40) of respondents reported CM exceed their expectations	None	Continue existing interventions. Behavioral health cases included in CM utilization outcome measures. Evaluating opportunity to utilize member contact data from Health Information Exchange to increase successful outreach.	Ongoing Ongoing Q3

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Case Management	☒ Medi-Cal	Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes.	Notify PCP's or PPG's of patients identified for program. Measure program effectiveness based on the following measures: o Member compliance with completing • 1st prenatal visit within the 1st trimester and • post-partum visit between 21 and 56 days after delivery compared to pregnant members who were not enrolled in the program	PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms. Dedicated staff of RNs, Program Specialists, and Program Coordinators to perform perinatal CM activities. Implement use of Pregnancy Program materials to increase outreach to moderate and high risk member through education packets, text reminders, etc. Use of NOP reports to identify members with moderate and high risk pregnancy for referral to the pregnancy program. Review outcome measures quarterly.	Ongoing Ongoing Q1 Ongoing Quarterly

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Referrals increased from 135 in Q1 to 514 in Q2. Through Q2 221 members managed in PCM program, exceeding number managed in 2018. Quarterly average engagement rate remained constant at 25% across Q1 and Q2.			Ongoing
	Distribution of materials began late Q4. Texting portion of program on hold while texting policy under review by DHCS.	Issue identified with pregnancy and post-delivery mailings for CalViva Pregnancy Program	Continue collaboration with Corporate team to address issue impacting mailings for pregnancy program	Q3

	Outcome measures based on member's compliance with completing 1st prenatal visit within 1st trimester & post-partum visit between 21 & 56 days after delivery compared to pregnant members who were not enrolled in the program. Q1 results demonstrated greater compliance in managed members for both measures.
	
	• 30 members met the outcome inclusion criteria
	• Members enrolled in the High Risk Pregnancy Program demonstrated:
	  ○ 7.6% greater compliance in completing the first prenatal visit within their first trimester
	  ○ 12.5% greater compliance in completing their post-partum visit
		Texting portion of program delayed due to new DHCS texting requirements,	Upon approval of DHCS texting policy collaborate with Health Education and Corporate team to implement program.	Q3

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
4.3 Behavioral Health (BH) Case Management Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing emotional health and well-being and improving quality of life. Assisting members with behavioral health conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of LCSWs, LMFT, and Care Coordinators to perform BH CM activities. Use of ImpactPro as the predictive modeling tool to identify high risk members for referral to CM. Review outcome measures quarterly.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Referrals to behavioral health program through Q2 was 183. Total members managed through Q2 was 84. CY engagement rate 42%. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in BH & 90 days after enrollment. Q1 results include members with active or closed case on or between 1/1/2019 & 3/31/2019 & remained eligible. Outcome results are consolidated across PH, BH, & TCM programs and are reported in 4.1.	None identified	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
4.4 Disease Management (DM)	☒ Medi-Cal **Diabetes Age Groups** 0-21 CCS Referral (100%) >21 Enrolled in program	The Managed Care Plan is responsible for initiating and maintaining a Disease Management program for high volume, common conditions, where guidelines and proven timely intervention have been shown to improve outcomes.	Eligibility data from sources such as: pharmacy/ encounter claims, health appraisal results, data collected through the UM or case management process, and member or provider referrals. Evaluation of outcome data from HEDIS®-like measures. Review/analyze DM partner annual report	Continue transition to insourced disease management programs for: asthma, diabetes, and heart failure. Transition process began Q4 2018. Ongoing program monitoring to assure that reporting needs are met including enrollment statistics.	April 2019 Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Complete: Successful transition to insource disease management programs for asthma, diabetes, and heart failure to Envolve People Care (EPC). Transition process began Q4 2018 and concluded end of March 2019. Ongoing: Insourced DM program will continue to send educational materials and information about the program to enrolled CVH members. Additionally, insourced program will continue to conduct outbound telephonic interventions and make referrals to case management for CVH members identified as being at high risk for hospitalizations or poor outcomes, or in need of assistance with behavioral health issues. Ongoing program monitoring is taking place to assure that reporting needs are met including enrollment statistics.	None identified	None	Complete Ongoing Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2019 Planned Interventions	Target Completion Date
4.5 MD interactions with Pharmacy	☒ Medi-Cal	Medi-Cal formulary is a closed formulary consisting of primarily generic medications. State Health Program (SHP) MDs and the CalViva Health Chief Medical Officer work with Pharmacy to refine the formulary and injectable guidelines to facilitate member and provider efficiencies; to ensure adequate and current medications are included, and to ensure appropriate utilization. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to remove unnecessary PA obstacles for practitioners and pharmacists. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to improve CCS ID using pharmacy data. SHP MD's and Pharmacy continue to mirror the DHCS narcotic prescribing quantity limits. This is to prevent fraud and abuse, and prevent adverse selection to the CalViva Medi-Cal plan.	Monthly report of PA requests.	Continued active engagement with pharmacy. Continue narcotic prior authorization requirements. Consider implementation of opioid edits based on updated CDC guidelines for prescribing opioids.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Monthly PA statistics are tracked and reported quarterly in the UM/QI meeting. Active engagement with Pharmacy and existing narcotic prior authorization requirements continue as planned. New opioid edits on track for September/October implementation pending Provider Notification 30-45 days prior to go live and regulatory approval of Formulary Front Matter.	None	Removed "Monthly check write review." from Methodology.	Ongoing Ongoing 10/1/2019 (pending approval/ notification)
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2019 Planned Interventions	Target Completion Date
4.6 Manage care of CalViva members for Behavioral Health (BH)	☒ Medi-Cal	CalViva collaborates with BH practitioners to improve coordination between medical and behavioral health care members.	Total number of registrations and referrals.	Review data that indicates when a member was referred to the County for services to ensure that MHN staff are facilitating coordination of care. Each month is compared to data from previous months to ensure the number of referrals to County follows an acceptable trend. For example, a consistent drop in referrals may indicate the need for additional staff training. Review data that indicates when a PCP has referred a member to a BH provider. Each month's data is compared to those from previous months to ensure that coordination of care between medical and behavioral health is occurring. For example, a drop in these referrals may indicate a need for enhanced medical provider training on the services that MHN provides.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	MHN continues the bidirectional referral process with Fresno, Kings and Madera counties. Referrals were based on acuity of clinical presentation and member need for particular behavioral health services. MHN Care and Case Managers continue weekly rounds with HN medical case management staff and Medical Directors with the purpose of integrating medical and behavioral health services and ensuring that members receive optimal care. PCPs are also offered opportunities to collaborate with MHN MDs for guidance on treating routine psychiatric conditions. During the period January through June, 2019, MHN received 308 referrals from Fresno, Kings and Madera counties. MHN referred 2 members to the county for Specialty Mental Health Services.	None Identified	Continue monitoring, tracking, and revising metrics. as needed, to ensure coordination, continuity and integration of care Continue Behavioral health complex case management through the HN CM department.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2019 Planned Interventions	Target Completion Date
4.7 Behavioral Health Performance Measures	☒ Medi-Cal	CalViva collaborates with Behavioral Health practitioners to improve performance measures for the CalViva behavioral health care members.	Performance Measures to be monitored: Appointment Accessibility by Risk Rating Authorization Decision Timelines Potential Quality Issues Provider Disputes Network Availability Network Adequacy: Member Ratios Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder.	Participate in cross functional team to improve quality of behavioral health care.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	Performance measures monitored. Participated in cross functional team to improve the quality of behavioral health care. • **Provider Appointment Availability Survey (PAAS):** For MY 2018 all reporting populations and Psychiatrist & NPMH provider types fell below the 90% target for access to urgent appointments, measuring against both the DMHC 96-hour standard and the CDI 48-hour standard. For non-urgent appointments (for either new or existing patients-the DMHC metric), Medi-Cal NPMH providers met the 90% standard but all other results are below standard. However, routine appointment access results came in at or above 80 % for both provider types and all reporting populations. MY 2018 showed excellent results among autism providers across all applicable reporting populations. Compliance results for routine appointment availability ranged between 90% and 100%. The DHMC tool does not adequately apply to autism providers and the autism model of care. DMHC has instructed plans to exclude autism providers from PAAS in measurement year 2019	• Provider data accuracy and response rate to the survey continue to be a challenge.		
	• **Timeliness:** Performance was below target for Q1 2019 Authorization Decisions Timeliness. The overall rate for MHN is 93%, which is 2% below the target. In Q2 the Authorization Decisions Timeliness was 100% for non-ABA requests and 96% for ABA requests.	• Timeliness numbers were artificially low because MHN's medical management system has historically been incapable of capturing when an extension is applied to a particular case. Therefore, many cases with extensions were reported as not having met timeliness when they actually did.	• Developed method to record a request for extension in UNITY case management system as well as enhanced reporting capabilities. • Provider communication regarding PA requirements. • Claims staffing changes and changes to process for requesting clinical information when claim is received.	8/1/19 4/1/19 9/1/19

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	• **PQI:** There were 3 cases submitted in Q1 • **Provider disputes**: In Q1 26 provider disputes were received and all were upheld. In Q2, 3 provider disputes were received and one resolved in favor of the provider. • **Network Availability and Adequacy:** All availability and adequacy metrics met standard in Q1. • **Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder.** For MY 2018, 83% compliance with 10 day first appointment standard was achieved.	• Post Service Review received a high volume of Medi-Cal ABA cases due to poor provider compliance with prior authorization requirements, resulting in slower turnaround times for case review • Some PSR cases were late as a result of claims backlogs-cases received through Claims Dept. Some cases were not received by PSR until close to or after the due date for decision. • N/A • For MY 2019, DMHC has instructed the industry to exclude autism providers from PAAS. MHN will be developing and administering its own survey. It will be called the ABA Provider Accessibility Survey.	Development of the new ABA Provider Accessibility Survey.	Q4-2019
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

5. Monitoring Activities for Special Populations

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
5.1 Monitor of California Children's Services (CCS) identification rate.	☒ Medi-Cal	Health Net State Health Programs (HN SHP) will monitor Medi-Cal CCS identification rate YTD.	All HN SHP staff will work with Public Programs Coordinators and UM staff to identify potential CCS cases and refer to county for approval. Based on the standardized formula, monthly report indicates CCS %. Goal: Health Net identifies 5% of total population for likely CCS eligibility.	CCS identification and reporting continues to be a major area of focus for SHP. Work in CY 2018 to further develop internal systems and handoffs are expected to yield improvements in 2019. Continue current CCS policies and procedures. Continue to refine CCS member identification and referral through concurrent review, prior authorization, case management, pharmacy, claims review and member services (welcome calls and Child and Adolescent Health Measurement Initiative (CAMHI) screening tool). Continue to improve and refine coordination with CCS between specialists and primary care services. Continue to distribute quarterly provider letters based upon DHCS Corrective Action Plans.	Ongoing

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Health Net

CalViva HEALTH

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	End to end process completed. This team is in process of cross training to ensure all staff are able to cross cover. Continue current process and poly. Continue to identify CCS members and eligibility. <u>Q1-2019 % identified as CCS eligible:</u> Fresno 8.36% Kings 6.73% Madera 6.79% <u>Q2-2019 % identified as CCS eligible:</u> Fresno 8.39% Kings 7.02% Madera 6.87%	None identified	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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

Health Net

CalViva HEALTH

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Member stratification being conducted monthly using Impact Pro/related report to identify members for ICM as noted under 4.1. 199 SPD members have been managed 2019 through Q2. This includes PH CM, BH CM, & OB CM, as well as, both Care Coordination & Complex CM. Timely HRA outreach reported for CalViva SPD members as of June 2019: 100%	None identified	Continue monthly stratification/referrals to ICM.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

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