Quality Improvement, Health Education, and Wellness 2024 Year-End Work Plan Evaluation

Purpose

The purpose of the CalViva Quality Improvement (QI), Health Education (HEd) and Wellness Program Work Plan is to integrate operational systems to both review clinical, service, access, and safety related outcomes against the priorities and objectives established by the Quality Improvement Program as well as provide a systematic plan of health education activities for the calendar year. It also documents the outcomes of proposed health education initiatives, programs and services. An assessment of critical barriers is made when objectives have not been met. The results of this Quality Improvement Program Evaluation provide evidence of the overall effectiveness of the QI Program and identify barriers and opportunities for improvement.

Mission

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.

Scope

The CalViva Health Quality Improvement Work Plan encompasses quality improvement and health education activities for 2024. The development of this document requires resources of multiple departments. Section I includes program objectives, monitoring and evaluation for the year. Section II includes ongoing monitoring of cross-functional activities across the organization. Section III lists Quality Improvement Tracking System activities that support meeting QI and HEd program objectives for the year.

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Glossary of Abbreviations/Acronyms

Acronym:	Description
A&G:	Appeals and Grievances
BH:	Behavioral Health
C&L:	Cultural and Linguistic
CA:	California region
CAHPS®:	Consumer Assessment of Healthcare Providers and Systems
CAIR:	California Immunization Registry
CAP:	Corrective Action Plan
CHW:	Community Health Worker
CS:	Community Supports
CDI:	California Department of Insurance
CM:	Case Management
DHCS:	Department of Health Care Services
DMHC:	Department of Managed Health Care
DN:	Direct Network
DM:	Disease Management
ECHO:	Experience of Care and Health Outcomes survey
FFS:	Fee-for-Service
HEDIS®:	Healthcare Effectiveness Data and Information Set
HPL:	High Performance Level
HRQ:	Health Risk Questionnaire
IHA:	Initial Health Appointments
IVR:	Interactive Voice Response
LTSS:	Long Term Services and Supports
MCAS:	Managed Care Accountability Set

Acronym:	Description
MCL:	Medi-Cal
MPL:	Minimum Performance Level
MSSP:	Multipurpose Senior Services Program
MY:	Measurement Year
N/A:	Not Available
N/R:	Not Reportable due to small denominator (<30)
NCQA:	National Committee for Quality Assurance
PAS:	Patient Assessment Survey
PCP:	Primary Care Physician
PEPM:	Provider Engagement Performance Management
PIP:	Performance Improvement Project
PDSA:	Plan, Do, Study, Act Project
PMPM:	Per Member Per Month
PMPY:	Per Member Per Year
POD:	Program Owners and Drivers
PNM:	Provider Network Management
PPG:	Participating Provider Group
PTMPY:	Per Thousand Members Per Year
QC:	Quality Compass
QI:	Quality Improvement
QIP:	Quality Improvement Project
RY:	Reporting Year
SPD:	Special Persons with Disabilities
UM:	Utilization Management

Glossary of Abbreviations/Acronyms (Measure Specific)

Acronym:	Description
AMR	Asthma Medication Ratio
BCS	Breast Cancer Screening
CBP	Controlling Blood Pressure
CCS	Cervical Cancer Screening
C.Diff	Clostridioides difficile
CAUTI	Catheter-associated Urinary Tract Infection
CHL	Chlamydia Screening in Women
CIS-10	Childhood Immunization Status - Combination 10
CLABSI	Central line-associated bloodstream infection
DEV	Developmental Screening in the First Three Years of Life
FUA	Follow-Up After ED Visit for Substance Abuse – 30 days
FUM	Follow-Up After ED Visit for Mental Illness – 30 days
FVA	Flu Vaccinations for Adults
GSD	Glycemic Status Assessment for Patients with Diabetes (>9%)
HBD	Diabetes Care -Blood Sugar Controlled (>9%)
IMA-2	Immunizations for Adolescents – Combo 2
LSC	Lead Screening in Children
MRSA	Methicillin-resistant Staphylococcus aureus
NTSV	Nulliparous, Term, Singleton, Vertex
PCR	Plan All Cause Readmission
POD	Pharmacotherapy for Opioid Use Disorder
PPC-Pst	Postpartum Care
PPC-Pre	Prenatal and Postpartum Care: Prenatal Care
PCR	Plan All Cause Readmission
POD	Pharmacotherapy for Opioid Use Disorder
SSI-Colon	Surgical site infection following colorectal surgery

Acronym:	Description
TFL-CH	Topical Fluoride for Children
SSI-Colon	surgery
TFL-CH	Topical Fluoride for Children
W30	Well-Child Visits in the First 30 Months of Life
W30-6+	visits
W30-2+	visits
WCC	Nutrition and Physical Activity for
WCV	Child & Adolescent Well-Care Visits

Section I: Work Plan Initiatives

Goal: Implement activities to improve performance measures.

Section I includes program objectives, monitoring and evaluation for the year.

Program Details	Responsible Party	Objectives	MY 2022 Objectives Met (%, ratio):	MY 2023 Objectives Met (%, ratio):	2024 Mid-Year Activities Completed (%, ratio):	2024 Year-End Activities Completed (%, ratio):	Projected Mid-Year Progress Towards MY 2024 Objectives (Glidepath) (>= 75% is on track)2	Projected Year-End Progress Towards MY 2024 Objectives (Glidepath) (>= 75% is on track)	Program Continuation (Populate at year-end)
1.Behavioral Health – Improving Behavioral Health (Mental Health and Substance Use) Outcomes Type of activity: •Ongoing activity – (monitoring of previously identified issue – under performing MCAS, DHCS priority area) Type of program: •Quality of Care •Safety	Kelli Lesser, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure (6 rates): FUA-30 (target 36.34), FUM-30 (target 54.87)	MY 2022: •FUA-30: (33%, 1/3) Fresno: 18.48% Kings: 31.79% Madera: 18.32% •FUM-30: (33%, 1/3) Fresno: 25.47% Kings: 70.07% Madera: 52%	MY 2023: •FUA-30: (0%, 0/3) Fresno: 15.01% Kings: 21.66% Madera: 16.84% •FUM-30: (0%, 0/3) Fresno: 14.17% Kings: 38.25% Madera: 22.47%	Mid-Year (Jan-Jun): 0%, (0/0) No activities were completed at mid-year. 3/3 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 83.33%, (5/6) of activities were completed at year-end.	Progress: On Track: 83.33% (5/6) of measures projected to meet objectives.	Progress: Off Track: 66.67% (4/6) of measures projected to meet objectives.	Continue Initiative with Modifications
2.A. Chronic Conditions – Diabetes (GSD >9) Type of activity: • Ongoing activity – (monitoring of previously identified issue – maintain achievement of DHCS MCAS MPL) Type of program: • Quality of Care • Quality of Service	Gigi Mathew, Program Manager III, QI Amy Schneider RN, Sr. Director Medical Management	•MCL: Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure: GSD (new 2024 measure replaces HBD) **(inverted rate)**	MY 2022: •CDC > 9: (100%, 3/3) Fresno: 37.47% Kings: 30.05% Madera: 35.93%	MY 2023: •GSD >9: (100%, 3/3) Fresno: 35.31% Kings: 25.42% Madera: 30.79%	Mid-Year (Jan-Jun): 75%, (6/8) of activities were completed at mid-year. 8/10 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 66.67% (10/15) of activities were completed at year-end.	Progress: Off track: 66.67% (2/3) of measures projected to meet objectives. CalViva to leverage targeted vendor campaigns to non-compliant members by utilizing multi-modal approaches and collaborating with providers to promote completion of in-home A1c kits.	Progress: Off Track: 66.67% (2/3) of measures projected to meet objectives. Leverage vendors to facilitate direct care gap closure in conjunction with enhanced collaboration with providers to improve completion of in-home A1c kits. Share root cause analysis of A1c measure to help providers prioritize outreach.	Continue Initiative with Modifications
2.B. Chronic Conditions – Heart Health/Blood Pressure (CBP) Type of activity: •Ongoing activity – (monitoring of previously identified issue – maintain achievement of DHCS MCAS MPL) Type of program: •Quality of Care •Quality of Service	Gigi Mathew, Program Manager III, QI Amy Schneider RN, Sr. Director Medical Management	MCL: Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure: CBP at 50th percentile 61.31%.	MY 2022: •CBP: (100%, 3/3) Fresno: 61.73% Kings: 71.81% Madera: 67.49%	MY 2023: •CBP: (100%, 3/3) Fresno: 64.29% Kings: 72.81% Madera: 71.04%	Mid-Year (Jan-Jun): 80%, (4/5) of activities were completed at mid-year. 8/8 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 93.33%, (14/15) of activities were completed at year-end.	Progress: On Track: 100% (3/3) of measures projected to meet objectives.	Progress: On Track: 100% (3/3) of measures projected to meet objectives.	Continue Initiative with Modifications
3. Hospital Quality/Patient Safety Type of activity: • Ongoing activity – (monitoring of previously identified issue – address quality/ safety of care priority) Type of program: • Quality of Care • Safety	Barbara Wentworth, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	• Hospitals with sufficient reportable data: Directional improvement, based on appropriate scores (SIR=<1.0) or outliers (SIR>2) for target hospital acquired infections (HAIs) (CAUTI, CLABSI, C.Diff, MRSA, and SSI-Colon), if baseline is <90% (appropriate) / >5% (outlier). Otherwise, maintain =>90%/<5% status. • Maternity hospitals with reportable data: Directional improvement for the proportion of hospitals meeting the national standard (=<23.6%) for all-payer NTSV C-section rates.	HAIs for Measurement period 10/1/2021 to 9/30/2022, C-section for MY 2022; All CVH network hospitals with sufficient data: •CAUTI: SIR=<1.0: 50%; SIR>2.0: 0% •CLABSI:SIR=<1.0: 25%; SIR>2: 25% •C.Diff: SIR=<1.0: 100%; SIR>2: 0% •MRSA: SIR=<1.0: 50%; SIR>2: 0% •SSI-Colon: SIR=<1.0: 50%; SIR>2: 0% •NTSV C-sections: Rate=<23.6%: 20%	Met 9/11 (82%) of objectives for HAI and NTSV C-section performance in network hospitals with reported data. Objective is to improve (or sustain high performance) on the % of network hospitals that meet targets on 5 HAI's and on NTSV C-section rates. Meets objective if the % of hospitals meeting the target improves upon (or sustains high performance) compared to the % of hospitals last year). • HAIs: 3 out of 5 of the HAIs improved (or achieved 100%) in the percentage of CVH hospitals that met the target (SIR<=1.0); and 5 out of 5 HAIs improved on (or achieved 0%) in the percentage of CVH hospitals avoiding outliers (SIR>2.0). (See current % of CVH hospitals meeting the target and avoiding outliers below, for recent period of 7/1/22 - 6/30/23. Compare to previous period.) • CAUTI: SIR=<1.0: 75%; SIR>2.0: 0% • CLABSI:SIR=<1.0: 0%; SIR>2: 0% • C.Diff: SIR=<1.0: 100%; SIR>2: 0% • MRSA: SIR=<1.0: 75%; SIR>2: 0% • SSI-Colon: SIR=<1.0: 25%; SIR>2: 0% • NTSV C-sections (MY 2023): Improved on the % of CVH hospitals meeting the NTSV C-section rate target of <=23.6% (3 of 5 hosps, or 60%) compared to the % in the previous period (1 of 5 hosps, or 20%).	Mid-Year (Jan-Jun): 0%, (0/0) of activities were completed at mid-year. 9/9 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 100% (9/9) of activities were completed at year-end.	N/A	N/A	Continue Initiative Unchanged
4. Member Engagement and Experience – Initial Health Appointment Type of activity: •Ongoing activity – (monitoring of previously identified issue – DHCS regulatory activity, audit non-compliance) Type of program: •Quality of Care	Miriam Rosales, Program Manager III, QI Sia Xiong Lopez CVH Health Equity Officer Amy Schneider RN, Sr. Director Medical Management	•MCL: Meet directional improvement of 1-5% from prior year. IHA does not have HEDIS benchmark but is a DHCS compliance measure.	MY 2022 • IHA: 59.82%	MY 2023 •IHA: 57.26%	Mid-Year (Jan-Jun): 0%, (0/0) of activities were completed at mid-year. 2/2 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): (100%, 2/2)	N/A	Progress: On Track: Preliminary Q4 2023 rate at 58.81%.	Continue Initiative Unchanged

Program Details	Responsible Party	Objectives	MY 2022 Objectives Met (%, ratio):	MY 2023 Objectives Met (%, ratio):	2024 Mid-Year Activities Completed (%, ratio):	2024 Year-End Activities Completed (%, ratio):	Projected Mid-Year Progress Towards MY 2024 Objectives (Glidepath) (>= 75% is on track)2	Projected Year-End Progress Towards MY 2024 Objectives (Glidepath) (>= 75% is on track)	Program Continuation (Populate at year-end)
5.A. Pediatric/Perinatal/Dental – Dental: TFL-CH Type of activity: • Ongoing activity - (monitoring of previously identified issue) Type of program: • Quality of Care • Quality of Service	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark for MCAS measure TFL-CH.	MY 2022 • TFL-CH: N/A – New Measure for MY 2023. But added due to DHCS MCAS priority measure.	MY 2023 • TFL-CH: (33%, 1/3) Fresno: 19.21% Kings: 9.63% Madera: 27.66%	Mid-Year (Jan-Jun): 0%, (0/0) of activities were completed at mid-year. 1/1 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 100% (1/1) of activities were completed at year-end.	Progress: Off Track: 0% (0/3) of measures projected to meet objectives. Measure is new for monitoring and further barrier analysis is needed. Planned activities will continue.	Progress: Off Track: 33.33% (1/3) of measures projected to meet objectives. Complete barrier analysis and modify activities as needed.	Continue with modifications. Complete barrier analysis and modify activities as needed.
5.B. Pediatric/Perinatal/Dental – Maternity/Perinatal Care: PPC-pre, PPC-pst Type of activity: •Ongoing activity – (monitoring of previously identified issue – maintain achievement of DHCS MPL, coordination of care priority) Type of program: •Quality of Care •Quality of Service	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark for MCAS measures: PPC-pre and PPC-pst.	MY 2022 • PPC-pre: (67%, 2/3) Fresno: 89.62% Kings: 87.76% Madera: 90.37% • PPC-pst: (100%, 3/3) Fresno: 84.23% Kings: 84.18% Madera: 87.04%	MY 2023 • PPC-pre: (100%, 3/3) Fresno: 90.39% Kings: 91.27% Madera: 90.82% • PPC-pst: (100%,3/3) Fresno: 82.1% Kings: 83.84% Madera: 80.1%	Mid-Year (Jan-Jun): 100%, (1/1) of activities were completed at mid-year. 3/5 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 83.33% (5/6) of activities were completed at year-end.	Progress: On Track: 100% (6/6) of measures projected to meet objectives at 50th percentile.	Progress: On Track: 100% (6/6) of measures projected to meet objectives at 50th percentile.	Continue Initiative Unchanged
5.C. Pediatric/Perinatal/Dental – Pediatric Measures for Children 3-21 of age: IMA-2, WCV Type of activity: •Ongoing activity – (monitoring of previously identified issue – under performing MCAS, DHCS priority area) Type of program: •Quality of Care •Quality of Service	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark for MCAS measures: IMA-2 and WCV.	MY 2022 • IMA-2: (67%, 2/3) Fresno: 39.17% Kings: 29.68% Madera: 53.86% • WCV: (33.33%, 1/3) Fresno: 48.14% Kings: 39.56% Madera: 57.71%	MY 2023 • IMA-2: (67%, 2/3) Fresno: 36.06% Kings: 31.39% Madera: 47.32% • WCV: (67%, 2/3) Fresno: 51.57% Kings: 41.79% Madera: 65.02%	Mid-Year (Jan-Jun): 100%, (1/1) of activities were completed at mid-year. 5/6 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 90% (9/10) of activities were completed at year-end.	Progress: Off Track: 50% (3/6) of measures projected to meet objectives. Barrier analysis is underway for these measures. The remaining activities will continue and contribute to improvements and will be modified as needed.	Progress: On Track: 83.33% (5/6) of measures projected to meet objectives.	Continue Initiative with Modifications
5.D. Pediatric/Perinatal/Dental – Pediatric Measures for Children under 3 years of age: CIS-10, LSC, DEV, W30-6+, W30-2+ Type of activity: •Ongoing activity – (monitoring of previously identified issue – under performing MCAS, DHCS priority) Type of program: •Quality of Care •Quality of Service	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark for MCAS measures: CIS-10, LSC, CDEV, W30-6+, W30-2+.	MY 2022 • CIS-10: (33.33%, 1/3) Fresno: 27.49%, Kings: 23.84%, Madera: 48.42% • LSC: (33.33%, 1/3) Fresno: 49.88%, Kings: 53.77%, Madera: 66.42% • CDEV: N/A no benchmark this year • W30-6+: (33.33%, 1/3) Fresno: 50.01%, Kings: 53.48%, Madera: 56.71%, • W30-2+: (33.33%, 1/3) Fresno: 62.69%, Kings: 55.59%, Madera: 75.65%	MY 2023 • CIS-10: (33%, 1/3) Fresno: 27.74%, Kings: 19.83%, Madera: 47.45% • LSC: (33%, 1/3) Fresno: 56.69%, Kings: 58.64%, Madera: 78.1% • CDEV: (33%, 1/3) Fresno: 28.04%, Kings: 3.36%, Madera: 57.47% • W30-6+: (33%, 1/3) Fresno: 56.55%, Kings: 57.44%, Madera: 63.7% • W30-2+:(33%, 1/3) Fresno: 65.01%, Kings: 53.74% Madera: 79.19%	Mid-Year (Jan-Jun): 100%, (3/3) of activities were completed at mid-year. 10/15 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 91.30% (21/23) of activities were completed at year-end.	Progress: Off Track: 46.67% (7/15) of measures projected to meet objectives. Barrier analysis is under way. Initiatives will continue and be modified as needed.	Progress: Off Track: 66.67% (10/15) of measures projected to meet objectives. Use Power Automate to educate and engage providers in utilizing Cozeva to identify and prioritize non-compliant members to target quarterly for all early childhood measures.	Continue Initiative with Modifications
6. Pharmacy and Related Measures – AMR Type of activity: •Ongoing activity – (monitoring of previously identified issue – maintain or address under performing MCAS) Type of program: •Quality of Care •Quality of Service	Alicia Bednar, Program Manager III, QI Amy Schneider RN, Sr. Director Medical Management	MCL: Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure: •AMR	MY 2022: •MCL: (66.67%, 2/3) Fresno: 62.15% Kings: 64.37% Madera: 72.93%	MY 2023: •MCL: (33.33%, 1/3) Fresno: 63.66% Kings: 59.29% Madera: 72.2%	Mid-Year (Jan-Jun): 100%, (1/1) activities were completed at mid-year. 1/4 ongoing or planned activities on track to be completed by year-end.	Year-End (Jan-Dec): 87.5% (7/8) of activities were completed at year-end.	Progress: Off Track: 66.67%, (2/3) of measures projected to meet objectives. Barrier analysis is under way. Interventions to continue as planned and will be modified as needed.	Progress: Off Track: 66.67% (2/3) of measures projected to meet objectives. Member calls to highlight Cal Aim remediation services available to members will be done thru CHW partnerships. Targeted provider education to emphasize use of ICS combos to control exacerbation.	Continue Initiative with Modifications. Member calls to highlight Cal Aim remediation services available to members will be done thru CHW partnerships. Targeted provider education to emphasize use of ICS combos to control exacerbation.

Program Details	Responsible Party	Objectives	MY 2022 Objectives Met (%, ratio):	MY 2023 Objectives Met (%, ratio):	2024 Mid-Year Activities Completed (%, ratio):	2024 Year-End Activities Completed (%, ratio):	Projected Mid-Year Progress Towards MY 2024 Objectives (Glidepath) (>= 75% is on track)2	Projected Year-End Progress Towards MY 2024 Objectives (Glidepath) (>= 75% is on track)	Program Continuation (Populate at year-end)
7.A. Preventive Health – Cancer Screenings Type of activity: •Ongoing activity – (monitoring of previously identified issue – maintain or address under performing MCAS) Type of program: •Quality of Care •Quality of Service	Ravneet Gill, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measures: BCS, CCS, and CHL.	MY 2022: •BCS: 100%, 3/3 Fresno: 51.99% Kings: 58.44% Madera: 60.87% •CCS: 66.67%, 2/3 Fresno: 57.08% Kings: 58.95% Madera: 61.58% •CHL: 100%, 3/3 Fresno: 58.86% Kings: 62.15% Madera: 59.38%	MY 2023: •BCS: (100%, 3/3) Fresno: 57.87% Kings: 61.9% Madera: 63.18% •CCS: (100%, 3/3) Fresno: 60.55% Kings: 61.1% Madera: 68.37% •CHL: (100%, 3/3) Fresno: 61.35% Kings: 64.11% Madera: 62.08%	Mid-Year (Jan-Jun): 0%, (0/0) activities were completed at mid-year. 5/5 ongoing or planned activities on track to be completed by year-end.	Year-End (Jan-Dec): 92.31% (12/13) of activities were completed at year-end.	Progress: On Track: 77.78%, (7/9) of measures projected to meet objectives.	Progress: On Track: 100%, (8/8) of measures projected to meet objectives.	Continue Initiative with Modifications
7.B. Preventive Health – Flu Campaign Type of activity: •New Activity – NCQA quality measure Type of program: •Quality of Care •Member Experience	Matt Anderson, Program Manager III, Quality Improvement CVH Health Equity Officer Amy Schneider RN, Sr. Director Medical Management	Meet directional improvement of 1-5% from prior year for the Flu Vaccine Adult Immunization Status.	MY 2022 AISE Flu: N/A	MY 2023 AISE Flu: 100% (3/3) Fresno: 21.45% Kings: 21.97% Madera: 23.92%	Mid-Year (Jan-Jun): 0%, (0/0) activities were completed at mid-year. 5/5 ongoing or planned activities on track to be completed by year-end.	Year-End (Jan-Dec): 66.67% (2/3) of activities were completed at year-end.	N/A	N/A	Continue Initiative with Modifications
8.A Provider Communication/ Engagement – Improving Member Experience (CAHPS) – Provider Focus Type of activity: •New Activity – improve performance NCQA quality measure. Type of program: •Quality of Care •Quality of Service •Member Experience	Guille Toland, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	Meet directional improvement of 1-5% from prior year on CAHPS Access measures including: Getting Needed Care, Getting Care Quickly and Care Coordination	MY 2022 CAHPS: Regulatory CAHPS survey was conducted for MY2022. Regulatory CAHPS: Getting Needed Care, (NA) Getting Care Quickly, (NA) Care Coordination, (NA) *No HSAG or Regulatory CAHPS survey was conducted for MY2021. There was a CVH Member Access Survey conducted during this period. Results don't align to measure directional improvement for MY2022. MY2022 will be use as baseline for MY2023.	MY 2023 CAHPS: N/A since there was no Regulatory CAHPS survey done in MY2023 HSAG CAHPS: Getting Needed Care, (0/3, 0%) Getting Care Quickly, (NR) Care Coordination, (NR) Non-reportable due to small sample size (n<100). None of the above CAHPS measures met the directional improvement of 1-5% from previous years. Getting Needed Care had a 73.5% rate compared to prior year of 76.7% and not meeting directional improvement. The other measures had no reportable rate.	Mid-Year (Jan-Jun): 100% (3/3) activities were completed at mid-year. 6/6 ongoing or planned activities on track to be completed by year-end.	Year-End (Jan-Dec): 71.43% (5/7) of activities were completed at year-end.	N/A	N/A	Continue Initiative with Modifications. Conduct quarterly root cause analysis that will drill down into the cause of these barriers. This will help identify any trends and points for improvement.
8.B Provider Communication/ Engagement - Improving Member Experience (CAHPS) – Plan Focus Type of activity: •Ongoing activity – (monitoring of previously identified issue – improve performance NCQA quality measure) Type of program: •Quality of Care •Quality of Service •Member Experience	Guille Toland, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	Meet directional improvement of 1-5% from prior year on the following CAHPS measures: Rating of Health Plan, Customer Service, Ease of Filling Out Forms	MY 2022 CAHPS: Regulatory CAHPS survey was conducted for MY2022. Regulatory CAHPS: Rating of Health Plan, (NA) Customer Service (NA) Ease of Filling out Forms (NA). *No HSAG or Regulatory CAHPS survey was conducted for MY2021. There was a CVH Member Access Survey conducted during this period. Results don't align to measure directional improvement for MY2022. MY2022 will be use as baseline for MY2023.	MY 2023 CAHPS: N/A since there was no Regulatory CAHPS survey done for MY2023 HSAG CAHPS: Rating of Health Plan (1/1, 100%) Customer Service, (NR) Ease of Filling out Forms (NR). Non-reportable due to small sample size (n<100). Rating of the Health Plan was the only measure that had a rate to compared from previous year. There was a 10.08% directional improvement.	MY 2023 CAHPS: N/A at mid-year (x/3, x%) HSAG CAHPS: Rating of Health Plan (1/1, 100%) Customer Service (N/A) Ease of Filling out Forms (N/A)	Year-End (Jan-Dec): 50% (2/4) of activities were completed at year-end.	N/A	N/A	Continue Initiative with Modifications
8.C Provider Communication/ Engagement - Improving Provider Survey Results Type of activity: •Ongoing activity – (monitoring of previously identified issue – compliance priority) Type of program: •Access and Availability	Paul Fuentes, Provider Relations Specialist II, Access and Availability Steven Si, Sr. Manager, Compliance and Privacy	To meet performance goal for Provider Appointment Access Survey (PAAS) at 70%. To meet performance goal for Provider After-Hours Access Survey (PAHAS) at 90%.	MY 2022 PAAS: 40% (2/5) •PCP Urgent: 49.0% •PCP Non-Urgent: 74.4% •Specialists (All) Urgent: 37.6% •Specialists (All) Non- Urgent: 56.1% •Ancillary Non-Urgent: 89.5% MY 2022 PAHAS: 100% (2/2) •Appropriate Emergency Instructions: 98.3% •Ability to Contact On-Call Physicians: 91.6%	MY 2023 PAAS: 60% (3/5) •PCP Urgent: 78.8% •PCP Non-Urgent: 85.3% •Specialists (All) Urgent: 56.8% •Specialists (All) Non- Urgent: 61.8% •Ancillary Non-Urgent: 89.4% MY 2023 PAHAS: 50% (1/2) •Appropriate Emergency Instructions: 98.4% •Ability to Contact On-Call Physicians: 85.9%	Mid-Year (Jan-Jun): 80% (4/5) activities were completed at mid-year. 2/2 ongoing or planned activities on track to be completed by year-end.	Year-End (Jan-Dec): 85.71% (6/7) of activities were completed at year-end.	N/A	N/A	Continue Initiative Unchanged

Section II: Ongoing Work Plan Activities

Section II includes ongoing monitoring of cross-functional activities across the organization.

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances review.	D. Saldarriaga; Manager, A&G S. Si, CVH Compliance Amy Schneider RN, Sr. Director Medical	12/31/24	Completed	12/31/2024	On track. Quarterly reports are provided to the CalViva Access workgroup where opportunities to improve member services and satisfaction are identified through the A&G system. We also provide monthly reports with the overall A+G universe including Access to care grievances, these reports are reviewed during the monthly MOM call and weekly QIUM workgroups.	Reports are provided to the CalViva Access workgroup which were reviewed during the monthly MOM calls. Feedback and education was done with multiple providers based on these reports around access issues, claims and balance billing related issues.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	ACCESS PROVIDER TRAINING: Conduct quarterly webinars.	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	5/1/24 - 12/31/24	Completed	12/18/2024	Training materials were produced are in review by the Marketing and Communications team. The first training will start 7/24/24 and continue through December 18th.	Access and Availability team conducted 10 timely Access provider training webinars with 744 attended and submitted webinar completion certificate.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	ACCESS SURVEY RESULTS: Monitor appropriate timely appointment and after-hours access and identify noncompliant PPGs and providers.	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	Q1-Q2 2024 validate and analyze survey results and identifies non-compliant PPGs and providers.	Completed	8/2/2024	Results for noncompliant PPGs and providers will be available in August 2024.	Survey completed. CAPs were sent out and closed 12/31/24.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s).	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	Q2 2024: Results for Q3-Q4 2023 PAAS PAHAS Telephone Access surveys conducted.	Completed	8/2/2024	Survey went out in July 2023. Results were expected in Q2 2024 but delayed to August 2024.	Telephone Access Survey Completed on 12/31/24.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Complete and submit DMHC Timely Access Reporting (TAR) by March 31 filing due date.	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	3/31/24	Completed	5/1/2024	DMHC extended due date to May 1, 2024. Submission was completed timely.	TAR filing submitted to the DMHC by filing due date.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Coordinate data and reporting for annual Provider Satisfaction Survey.	M. Miyashiro R. Davila S. Si, CVH Compliance	September 2024-November 2024	Completed	11/27/2024	Not started. On track.	Completed 11/27/24

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	DHCS MEDI-CAL MANAGED CARE TIMELY ACCESS REPORT SURVEY: Conduct quarterly education outreach to noncompliant providers identified by this survey.	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	Q1 2024	Off track/ Delayed	9/26/2024	Not started. Delayed to Q3 2024.	Provider outreached was completed on 9/26/24
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Engage with CalViva provider offices to complete MY 2024 MCAS training focused on best practices for closing care gaps.	A. Wittig, Director, Quality Improvement Erica Valdivia, Provider Engagement Amy Schneider RN, Sr. Director Medical Management	12/31/2024	Completed	12/31/2024	On track.	Our focus will be to engage and educate providers on MY2025 MCAS trainings. 2024 has been completed and closed out.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	GEO ACCESS: Assess and report on availability of network to identify opportunities for improvement. Analyze and inform Provider Network Management of areas needing increased contracting with a particular provider to improve availability.	D. Fang, Manager, Health Equity S. Si, CVH Compliance	Next report is due in Q3 2025.	Not started	Not started	Not started. Report will be complete in Q3 2025.	Not started. This report is not due until Q3 2025
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Health Equity Report: Analyze and report on Cultural and Linguistics.	D. Fang, Manager, Health Equity S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	Q2 and Q3	Completed	5/16/2024	2023 Health Equity Language Assistance Program End of Year report, 2024 Program Description, and 2024 Work Plan were completed and presented to CalViva Health QI/UM Committee on May 16, 2024. 2024 Work Plan and Language Assistance Program Mid-Year Evaluation reports will be completed in Q3.	2024 Work Plan and Language Assistance Program Mid-Year Evaluation reports were completed in Q3. 2024 Health Equity Language Assistance Program End of Year report, 2025 Program Description, and 2025 Work Plan will be completed in Q2 2025.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	In collaboration with Provider Engagement, engage with Quality EDGE priority provider offices to complete interventions addressing systemic barriers to HEDIS performance.	A. Wittig, Director, Quality Improvement Erica Valvidia, Director, Provider Engagement	12/31/2024	Completed	12/31/2024	On track.	Approved 116 EDGE requests to primarily address pediatric barriers for $660K in funds that sponsored initiatives such as point-of-care member incentive gift cards, mobile mammography events, one-stop clinic events, and equipment/supplies (lead screening machines and fluoride kits).

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Maintain and manage the CAHPS Action Plan: Collaborate with CAHPS measure owners to identify areas of opportunity and activities to improve CAHPS, identifying process improvement activities. This also includes working with the Provider Engagement and Medical Affairs teams to review provider CAHPS improvement plans, identifying best practices, and recommending changes when plans are insufficient to improve the member experience in a measurable and meaningful way.	T. Jaghasspanian M. Anderson G. Toland S. Si, CVH Compliance Amy Schneider RN, Sr. Director Medical Management	12/31/24	Completed	12/31/2024	On track.	Completed 12/31/24.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Maintain compliance with DHCS Initial Health Appointment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report.	A. Wittig, Director, Quality Improvement S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer Amy Schneider RN, Sr. Director Medical Management	11/21/24	Completed	11/21/2024	On track.	Completed 11/21/2024. MY 2024 final rates will be available in Q3 2025.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Monitor appropriate after-hours messaging and timely access to urgent/emergent care. Refer to Access and Availability Work Plan for additional details.	M. Miyashiro R. Davila S. Si, CVH Compliance	October 2024-January 2025	Completed	12/17/2024	Not started. On track.	Survey completed 12/17/24. Results are being analyzed.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Monitor Delegation Oversight activities through the PPG scorecards that captures PPGs' audit scores. The quarterly scorecard provides an opportunity to track/ trend low- high PPGs performers.	Manisha Makwana S. Si, CVH Compliance Amy Schneider RN, Sr. Director Medical Management	12/31/24	Completed	Jan, May, Aug, and Dec 2024	PPG Scorecards were produced for 5 CalViva service area PPGs for Q1 and Q2 2024.	Q4 2023 report produced in January 2024; Q1 2024 produced in May 2024; Q2 2024 produced in August 2024; Q3 2024 produced in December 2024.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Write integrated member satisfaction reports, in partnership with the QIRA Team, to satisfy NCQA Accreditation ME.7 Standard. This report captures appeals, grievances, CAHPS results, and identifies barriers, areas of opportunity, and ongoing initiatives.	T. Jaghasspanian G. Toland S. Si, CVH Compliance Amy Schneider RN, Sr. Director Medical Management	Q4 2024	Completed	11/6/2024	On track.	NCQA Accreditation ME.7 report was completed and sent to CVH Compliance team and QIUM workgroup on 11/06/24.

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
BEHAVIORAL HEALTH	Conduct oversight of Behavioral Health (BH) through delegated reports on BH (may include member satisfaction surveys, etc.)	G. Gomez, Director, QI Amy Schneider RN, Sr. Director Medical Management	12/31/24	In progress	3/21/24 7/18/24 10/17/24	ECHO survey fielding starting in September with results report will be received in November. The CAHPS team to complete report. Remaining BH performance reports were delivered for Q1 (complete) and Q2 due in September. After that, fully transitioned to other units.	The ECHO Survey was fielded between July 21, 2024 and September 21, 2024. MHN reporting, Access 24/QIUM 40 Behavioral Health Performance Indicator Report for Q4 2023-Q3 2024 were reported by QI Team (Maya Cashman); MHN staff are fully transitioned to other units and under the responsibility of other departments. Due to MHN transition, Q3 2024 and current reports were reported by Behavioral Health Utilization Management, Clinical Ops (Jessie Blake's team). The completed Q3 2024 report will reviewed by QIUM Committee on 2/20/2025. The NCQA ME.7 QIUM 89 Behavioral Health report was reported in Q1 2024 and approved at 3/21 QIUM Committtee.
CONTINUITY AND COORDINATION OF CARE	Educate providers on importance of well-child visits. Well-child visits include developmental screenings.	J. Coulthurst, PMIII, QI Amy Schneider RN, Sr. Director Medical Management	12/31/2024	Completed	12/31/2024	Provider Facing Teams trained on all pediatric measures and importance of well-child visits and all services to be completed during well-child visits. All Provider Tip Sheets are up-to-date.	HEDIS team identified developmental screening coding issues. HEDIS team educated Provider facing teams and providers on correct coding and modifiers for developmental screenings. Provider facing teams continued provider education on importance of well-child visits.
CONTINUITY AND COORDINATION OF CARE	Monitor opportunities and interventions for NCQA Standards QI.3 & QI.4 Coordination of Care (COC) requirements (non-BH and BH reports).	K. Lesser/ M. Rosales Program Manager III, Quality Improvement	QI 3 & QI 4: 5/31/24 & 12/31/24	In progress	Q13: MY2022/ Year 1 was approved before 05/31/24. QI4: The 2024 QI4 Plan was reviewed/approved before 5/31/24	QI3- 1st year report (2023)was approved. QI4: Approved 2024 Plan identifies timeliness of exchange (measured by provider satisfaction) and often seen in PCP setting (measured by FUM and FUA) as selected opportunities (measurments) to improve COC between Medical and BH providers.	Approval of updated QIUM 65 and 67 reports by internal collaboration team members anticipated in January 2025. Once approved, Q1 & QI4 document will be presented for Plan approval at Q2 2025 Quarterly Quality Committee meeting.

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
CREDENTIALING / RECREDENTIALING	Credentialing/Recredentialing Practitioners/Providers: Achieve and maintain a 100% timely compliance and 100% accuracy score.	M. Catello, Sr. Manager	12/31/24	Completed	12/19/2024	Not started. On track.	Completed.
CREDENTIALING / RECREDENTIALING	PPG Delegates Credentialing/Recredentialing oversight achieve and maintain audit scores between 90 -100% compliance for annual review.	K. Bowling, Sr. Manager	12/31/24	Completed	11/1/2024	On track. Compliant.	Completed and compliant.
DISEASE/CHRONIC CONDITIONS MANAGEMENT	Monitor Chronic Conditions (Disease) Management Program for appropriate member outreach quarterly.	Denise Miller, Program Manager III Customer Experience	12/31/24	Completed	12/19/2024	Submitting new program updates for regulatory approval. On track.	Waiting for ETA on when CalViva will submit program revisions to DHCS.
QUALITY AND SAFETY OF CARE AND SERVICE	Complete all potential quality issues (PQIs) received within 90 day TAT to maintain internal compliance.	P. Carpenter, Director, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	12/31/24	Completed	12/31/2024	On track.	Completed and compliant.
QUALITY AND SAFETY OF CARE AND SERVICE	Delegation Oversight -- Monitor PPG-level delegated activities and issues, including CAPs, and report findings to CalViva Credentialling Sub Committee and QIUM Committee at least annually. Activities include Utilization Management, including CCM; credentialing; and claims payments.	K. Bowling A. Tonkogolosuk	12/31/24	Completed	12/17/24	On track.	All annual audits for delegates have been completed for 2024. Performance results including CAPs have been shared at least annually with the required committees and groups. Majority of the delegates were overall complaint. Needed CAPs were issued and addressed with delegates. On-going monitoring was conducted regularly and continues for 2025.
QUALITY AND SAFETY OF CARE AND SERVICE	Handling of Member Grievances and Appeals: Ongoing monitoring and assessment of compliance with the handling of member grievances and appeals; ensure compliance with regulatory requirements for TAT and process.	L. Carrera Amy Schneider RN, Sr. Director Medical Management	12/31/24	Completed	12/31/2024	On track. Quality controls are in place to ensure every task with in the A+G process follows contractual and regulatory compliance standards.(FL, BKB, team and management Calibration calls, day 18 audits).	All TAT metrics met 95% or above across all categories.
QUALITY AND SAFETY OF CARE AND SERVICE	Integrated Care Management (ICM) • Implement PHM pyramid as the predictive modeling tool to identify high-risk members for referral to ICM. • Evaluate the ICM Program based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	C. Patnaude, Director, Care Management	Ongoing by 12/31/24	Completed	12/31/24 - continue in 2025	On track.	Through Q2 outcomes readmision rate decreased by 4.3% (above 3% goal). ED claims down 21% (above 3% goal). CM had a significant reduction in IP and OP claims with slight increase in Rx claims. Member satisfaction is within 90% goal.

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
QUALITY AND SAFETY OF CARE AND SERVICE	Monitor credentialing findings and report to CalViva Credentialing Sub Committee quarterly.	P. Carpenter, Director, Quality Improvement	12/31/24	Completed	4/9/2024, 7/11/2024, 10/07, 1/8/2025	On track.	Completed with no findings.
QUALITY AND SAFETY OF CARE AND SERVICE	Monitor peer review determinations and report to CalViva Credentialing Sub Committee quarterly.	P. Carpenter, Director, Quality Improvement	12/31/24	Completed	4/9/2024, 7/11/2024, 10/07, 1/8/2025	On track.	Completed with no findings.
QUALITY AND SAFETY OF CARE AND SERVICE	Monitor potential quality incidents and quality of care findings and report to CalViva quarterly.	P. Carpenter, Director, Quality Improvement	12/31/24	Completed	12/31/2024	On track.	Completed with no findings.
QUALITY AND SAFETY OF CARE AND SERVICE	Update Clinical A&G Quality of Care Concerns Policy & Procedure and Peer Review Committee Policy & Procedure.	P. Carpenter, Director, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	12/31/24	Completed	12/19/2024 Peer Review	On track.	Completed policy review.
QUALITY IMPROVEMENT AND COMPLIANCE	Evaluate written plan for safety and quality data collection: To improve patient safety by collecting and providing information on provider and practitioner safety and quality (at least annually).	L. Aaronson A. Wittig Pamela Carpenter Barbara Wentworth	February 2024	Completed	2/15/2024	2023 Evaluation was submitted to committee in February 2024 and presented to committee February 15, 2024. Refer to the 2023 Year End QI Executive Summary section on safety monitoring of potential quality issues.	Completed in Q1.
QUALITY IMPROVEMENT AND COMPLIANCE	Evaluation of the QIHEd program of the previous year (Q1). Complete QIHEd Work Plan evaluation semi-annually.	L. Aaronson M. Gumatay A. Wittig S. Luce T. Jaghasspanian L. Pak A. Schneider	February 2024 September 2024	Completed	3/18/2024 09/12/2024	Year end evaluation completed. Mid-year evaluation in progress.	Mid-year evaluation completed on 09/12/2024.
QUALITY IMPROVEMENT AND COMPLIANCE	Maintain Facility Site Review (FSR) and Medical Record (MRR) Compliance: To ensure provider offices and medical records comply with DHCS contracted requirements per APL 22-107 and Physical Accessibility Review Survey per MMCD Policy Letter 12-006 and 15-023. Report FSR/MRR data to DHCS twice per year (1/31 and 7/31), including all sites with failed scores.	P. Carpenter, Director, Quality Improvement	12/31/24	Completed	12/31/2024	On track. DHCS implementing a new portal called MSRP to upload bi-annual FSR/MRR data, however it is not in production yet. We have submitted data for 7/1/23-12/31/23 to DHCS on 4/26/24 using their existing process and 1/1/24-6-30/24 is due 8/16/24.	Completed and compliant.
QUALITY IMPROVEMENT INFASTRUCTURE	Care gap reports produced by the HEDIS Team monthly, by contract level and participating provider group (PPG) level to identify non-compliant members.	HEDIS D. Mehlhouse	Monthly by 12/31/24	Completed	Jan-December 2024	In progress and on track.	Completed monthly.

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
QUALITY IMPROVEMENT INFASTRUCTURE	Encourage further Cozeva adoption/usage among PCPs and provider groups in program's 5th year; Expand Cozeva-EHR integrations and bidirectional data-sharing with priority PCP/clinics; Enhance Cozeva platform to support regulatory requirements and key opportunities / initiatives.	S. Pao S. Myers	12/31/2024	Completed	7/12/2024	Published first 2024 Cozeva adoption/engagement dashboard on 7/12/24; outreach to adopt new targeted providers and reengage existing users to begin in July 2024 and continue through December 2024; 4 of 20 Cozeva enhancement items completed, remaining 16 of 20 are in progress (ETC: 12/31/24).	Year-end 2024 Cozeva adoption for CalViva PCPs/clinics stands at 96% (equates to >99% of membership), and priority PCP/clinic platform “engagement” stands at 59% (vs. 30% annual goal).
QUALITY IMPROVEMENT INFASTRUCTURE	QI improves communication with stakeholder departments and identifies interventions to improve CAHPS through monthly Quality Focus Touchbase meetings and Quality Governance Committee meetings.	T. Jaghasspanian G. Toland M. Anderson	Monthly by 12/31/24	Completed	Q1 08/05/24 Q2 10/08/24 Q3 11/04/24 Q4 01/31/25	Off track for Q2 A&G Root Cause Analysis report. Q1 report was submitted on 09/05/2024.	Q3 A&G Root Cause Analysis report report was on track and submitted on 11/04/24. Q4 A&G Root Cause Analysis report will be submitted on 2/21/25.
QUALITY IMPROVEMENT INFASTRUCTURE	Quality Improvement team will work with Provider Engagement and Medical Affairs to review quality improvement action plans for best practices and recommend changes when existing action plans are ineffective in producing the needed change.	QI PMIII team members M. Najarro	12/31/2024	Completed	12/13/2024	As of June, 403 action plans have been submitted. Meetings are held monthly based on measure of focus calendar.	445 action plans were submitted in 2024. Fresno = 325 Kings = 40 Madera = 80
QUALITY IMPROVEMENT INFASTRUCTURE	Support development of HEDIS best practice tools.	S. Wright (lead)	12/31/2024	Completed	2/7/2024	Completed. QI Best Practices Slide deck given to the PE team 02/2024.	Completed activity on 02/2024.
WELLNESS/ PREVENTIVE HEALTH	Adopt and disseminate Medical Clinical Practice Guidelines (CPG).	CalViva Health/HN K. Macsicza Director, Clinical Programs A. Schneider, RN, Sr. Director Med Management	May 2024	Completed	05/13/2024. 06/20/2024.	HN Medical Advisory Council approved the CPG on May 13, 2024. Provider communication distributed on June 20th.	HN Medical Advisory Council approved the CPG on May 13, 2024. Provider communication distributed on June 20th.
WELLNESS/ PREVENTIVE HEALTH	Collaborate with Marketing team to distribute member educational emails on various topics via internal and external resources: Topics TBD.	Health Ed	Q4: 12/31/2024	Cancelled	12/31/2024	On track.	Intervention was discontinued due to limited impact.
WELLNESS/ PREVENTIVE HEALTH	Distribute Preventive Screening Guidelines (PSG) to Members and Providers.	B. Head, Sr. Health Education Specialist A. Jayme A. Wittig S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer J. Felix	Sept/Oct 2024- via Member Newsletter	Completed	9/23/2024	Activity is on track. Article refers members on how to obtain access to PSGs in "Catch Problems Early with the Proper Health Screenings" article.	The Member Newsletter was distributted on 9/23/2024.

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
WELLNESS/ PREVENTIVE HEALTH	Distribute the Health Education Programs and Services Flyer to members via the Medi-Cal member welcome packet.	M. Lin S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	12/31/24	Completed	12/31/2024	The Health Education Programs and Services flyer is being sent to members via the Medi-Cal member welcome packet. The 2025 version of the Health Education Programs and Services flyer is in the process of being updated.	The Health Ed Services flyer is being sent to members via the Welcome Packet monthly.
WELLNESS/ PREVENTIVE HEALTH	Health education material management	L. Aaronson, Director of Quality Improvement and Health Education A. Wittig, Director of Quality Improvement and Health Education A. Jayme, Program Manager II	12/31/24	Completed	12/31/2024	As of mid-year there have been nine calls to the CCC regarding health education and 6,620 pieces of printed health education material have been ordered.	At year end there were ten calls to the CCC regarding health education and 12,610 pieces of printed health education material were ordered.
WELLNESS/ PREVENTIVE HEALTH	Health Education System P&Ps, monitoring of initiatives, maintenance of printed materials, digital programs and requirements, health promotion to providers.	A. Wittig S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	12/31/24	Completed	12/31/2024	On track.	At year end all CVH P&Ps were renewed on their assigned renewal date.
WELLNESS/ PREVENTIVE HEALTH	Maintain compliance with childhood blood lead level screening requirements in accordance with DHCS APL 18-017 and APL 20-016. Baseline: Quarterly monitoring of HEDIS Lead Screening for Children (LSC) RY 2020 administrative rate; Member education materials include lead screening flyer and preventive service guidelines (PSGs); Provider training and education include the Medi-Cal provider operations manual and HEDIS provider tools on Lead Screening for Children (LSC). Medical Record Reviews for lead screening conducted during Facility Site Reviews submitted to DHCS twice a year.	A. Wittig P. Carpenter S. Wright J. Coulthurst A. Schneider L.Armbruster	12/31/24	COMPLETED	12/31/2024	On track. Please see below for MY 2023 LSC Rates: MPL: 62.79% Fresno: 56.69% Kings: 58.64% Madera: 78.10%	Results are provided: MPL: 33.33% Fresno: 63.90% Kings: 52.94% Madera: 56.66%

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
WELLNESS/ PREVENTIVE HEALTH	Member newsletter	B. Head (Medi-Cal) S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	10/1/2024	Completed	10/1/2024	In February, the content development stage was completed with the weight management article added as a small blurb. CVH approved the content. In March, the project design phase was completed and moved into the regulatory review phase. In April, all internal reviews were completed, and the content was sent to CVH compliance for review, which would then send it to DHCS for approval. In May, the initial DHCS review was completed and sent back with minor edits. The edits were redlined and the updated version was sent to CVH for resubmission to DHCS. In June, the DHCS review was sent back with additional edits. The edits were redlined, and the updated final version was sent to CVH for the second AIR submission to DHCS.	English, Hmong & Spanish newsletter versions were posted to CVH website 9/9/24. Mailing distribution completed on 9/30 - reached 162,337 unique households.
WELLNESS/ PREVENTIVE HEALTH	Monitor CalViva Health Pregnancy Program and identify high risk members via Care Management.	C. Patnaude, Director, Care Management S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	Ongoing by 12/31/24	Completed	12/31/24 - continue in 2025	On track.	Successful program with above 60% engagement rate with members. Program successful in increasing prenatal appointment attendance by 7%, postpartum appts by 9.1% (above 5% goals), and reduced preterm deliveries by 1.5% (just below 2% goal).
WELLNESS/ PREVENTIVE HEALTH	New vendor onboarding and ongoing management to provide Diabetes Prevention Program (DPP) services to our eligible Medi-Cal population.	A. Mojadedi S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	6/30/25	Off track/ Delayed	Continue in 2025	CVH on track to go to DHCS for review mid-September.	CVH was provided with all approved member materials and contracting documents on 11/1/24. CVH has submitted for DHCS approval.

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
WELLNESS/ PREVENTIVE HEALTH	QR Code Material promotion	L. Aaronson, Director of Quality Improvement and Health Education A. Wittig, Director of Quality Improvement and Health Education A. Jayme, Program Manager II B. Head Sr. Health Education Specialist A. Schneider. Sr. Director, Medical Management	12/31/24	Completed	12/31/2024	Currently promoting digitial health education materials and resources. Working on a survey to assess the effectiveness of resources.	The survey, distributed to 1,134 providers, assessed relevance, clarity, usability, and satisfaction through closed- and open-ended questions. As of December 19, 28 providers responded. 3 of the 4 areas exceeded the 70% KPI benchmark for feedback scores. Key findings include: Relevance: 89% found the topics highly or moderately relevant. Usability: 97% reported navigating and sharing the presentation as easy. Satisfaction: 89% were satisfied with the quality and usefulness. Resource Sharing: 57% shared resources with patients via QR codes, printed materials, or direct discussions. This survey was also used to support the PEDS QMIP PDSA intervention.

Section III: Quality Improvement Tracking System Activities Log

Section III lists Quality Improvement Tracking System activities that support meeting program objectives for the year (listed in Section I).

Work Plan ID	Work Plan Section	Intervention Name	Intervention Description	Measures	Counties/ Regions	Planned Start Date	End Date	Status	Department Owner	Mid-Year and Year-End Updates	Activity Barriers	Activity Changes
10072	N/A	IHQC - Project Management Training	QUALITY EDGE/TRAINING/PROVIDER COMMUNICATION - IHQC will host the Project Management (PM) training for a cohort of providers in April. The training includes content and incidental coaching to build skills to manage small scale projects and large initiatives. An additional PM training will be provided to internal staff (PE/QI) in May.	HPQI - Health Plan Quality Improvement	CVH-ALL	5/1/2024	5/31/2024	DELAYED	Gladys Lazaro, Lora Maloof-Miller	Lora Maloof-Miller - 7/1/2024: 7.1.24 No feedback from PE. We will hold this in 2025. -----Lora Maloof-Miller - 6/3/2024: Due to low enrollment, this training will be rescheduled. Potential dates: Late July/Aug. or November. Feedback from PE (Robin MacBride) is pending. Shekinah Wright is okay with offering it in 2025, if needed. -----Lora Maloof-Miller - 4/2/2024: 4.2.24 Dates selected: May 16th and 23rd. Flyer completed and sent to PE for distribution. -----Lora Maloof-Miller - 2/1/2024: Training in May 2024. Date: TBD.-----Lora Maloof-Miller - 11/13/2024: This training will be rescheduled to 2025. -----Gladys Lazaro - 1/18/2024:	None at this time.	Discontinue
10627	Section 1	HNBH/Participating Provider Group (PPG) Webinar	BEHAVIORAL HEALTH: Provider webinar-Topic TBD	FUA - F/U ED Substance Abuse - 30,FUA - F/U ED Substance Abuse - 7,FUM - F/U ED Mental Illness - 30,FUM - F/U ED Mental Illness - 7	CVH Fresno, CVH Madera, CVH Kings	1/1/2024	12/31/2024	DELAYED	Kelli Lesser	Kelli A. Lesser - 8/26/2024: 8/26/24-Deleted MCD LOB to allow for separate MCK entries-----Kelli A. Lesser - 4/11/2024: 2024 webinar topic still TBD; FUM/FUA measures are tentative-----Kelli A. Lesser - 12/20/2024: Intervention delayed until 2025 due to ongoing BH staffing changes	Ensuring provider attendance	Continue
9871	Section 2.A	Diabetes Prevention Program (DPP) Vendor Onboarding	CHRONIC CONDITIONAS - Diabetes Preventative Program for members with Pre-Diabetes.	CDC - Diabetes HbA1c poor control > 9	CVH-All	04/01/2024	12/31/2024	DELAYED	Arzoo Mojadedi	2.1.24 (AM)- SOW finalized and sent to procurement team. MSA signed. DHCS required member materials are ready. Once SOW is signed then all DHCS required documents will be sent to compliance. 10.14.24 (AM)- CVH on track to go to DHCS for review in early November. There has been a delay in timeline. 11.14.24 (AM)- Submitted branded materials and all DPP member materials to Hannah Kim for CVH compliance review on 11.1.24.	DPP contract will need approval from CA DHCS compliance.	Continue
10157	Section 2.A	Direct Mail Kits for Blood Glucose (HbAc/A1c) - CVH All	Chronic Conditions - A direct to member mail campaign to support members that may be due for an A1c (A1c kit). Quality Improvement (QI) is partnering with the vendor, to directly mail A1c Kits (to support an A1c home test).	CDC - Diabetes HbA1c < 8	CVH-All	1/1/2024	12/31/2024	DELAYED	Martha Zuniga	Martha A. Zuniga - 7/2/2024: Decision was made to contract with the Corporate vendor Everlywell for in-home kits. Everlywell contracting is in progress. -----Martha A. Zuniga - 12/20/2024: Did not have vendor stood up in 2024 for in-home A1c kit mailings to Medi-Cal members due to shifting contractual timelines and requirements. DHCS approval received in early December - moving forward with collateral submission and PPA execution.	Member may have moved; member does not return test kit.	Continue
10507	Section 2.A	In Home Test Kits -A1c	CHRONIC CONDITIONS - Non-compliant members receive in-home A1c kits from vendor; collaborate with PPGs/PCPs to encourage members to return completed kits	CDC - Diabetes HbA1c poor control > 9	CVH-ALL	01/01/2024	12/31/2024	DELAYED	Paul Nigels	Gigi A. Mathew - 6/15/2024: Everly Health member collateral undergoing approvals. C&L approved between 4/4/24 -4/11/24; submitted to Workfront. Privacy approved. SMS messaging privacy approval pending.-----Gigi A. Mathew - 12/20/2024: Did not have vendor stood up in 2024 for in-home A1c kit mailings to Medi-Cal members due to shifting contractual timelines and requirements. DHCS approval received early December - moving forward with collateral submission and PPA execution.	N/A	Continue
10400	Section 2.A	Sprinter Health Medi-Cal Member Outreach	Chronic Conditions: In-home Diabetic Retinal Exams (DRE) for eligible members. Results will be sent to member's PCP.	CDC - Diabetes HbA1c poor control > 9	CVH-ALL	08/01/2024	12/31/2024	DELAYED	Arzoo Mojadedi	Arzoo Mojadedi - 9/16/2024: 9.16.24 (AM)- CVH to seek DHCS approval after HN submits and receives DHCS approval. -----Arzoo Mojadedi - 8/14/2024: 8.14.24 (AM)- CVH to seek DHCS approval after HN submits and receives DHCS approval. -----Arzoo Mojadedi - 7/15/2024: 7.15.24 (AM)- For HN- received guidance from compliance to include NDN and NOLA links in the character count and to spell out the name of the Health Plan at least in the initial texting campaign. Abbreviations can be used for subsequent texting campaigns.Arzoo Mojadedi - 6/24/2024: 6.24.24 (AM)- For HN- All member materials approved by C&L and Privacy except the SMS campaign. Instructions sent to Sprinter via corporate liaison Eleni so Sprinter can update their SMS campaign with CA Privacy regulations. Arzoo Mojadedi - 5/14/2024: 5.14.24 (AM)- Meeting with corporate tomorrow to gain clarification on Sprinter's member incentive reward strategy. We will also be discussing the flexibility of modifying member materials if needed for HN internal processes and CA DHCS requirements. -----Arzoo Mojadedi - 11/14/2024: 11.14.24 (AM)- CVH to seek DHCS approval after HN submits and receives DHCS approval. -----Arzoo Mojadedi - 10/14/2024: 10.14.24 (AM)- CVH to seek DHCS approval after HN submits and receives DHCS approval.	Ensuring that the Medi-Cal member documents meets the CA DHCS requirements.	Continue
10280	Section 2.A	Update Diabetes Resources Webpage	CHRONIC CONDITIONS: Project to update Diabetes Resources Webpage	CDC - Comprehensive Diabetes Care	CVH-All	02/01/2024	6/28/2024	DELAYED	Arzoo Mojadedi	Arzoo Mojadedi - 9/16/2024: 9.16.24 (AM)- CVH to receive mock-up of website once it's developed. Workfront request in progress. -----Arzoo Mojadedi - 8/14/2024: 8.14.24 (AM)- CVH to receive mock-up of website once it's developed. Workfront request will be submitted by Stacey this week. -----Arzoo Mojadedi - 7/15/2024: 7.15.24 (AM)- For HN-the document did not pass field testing layout review. Stacey will contact field testing team for suggestions on what to modify. -----Arzoo Mojadedi - 6/24/2024: 6.24.24 (AM)- The webpage prototype has been submitted for Health Educator review.-----Arzoo Mojadedi - 5/14/2024: 5.14.24 (AM)- This document has been sent to Traci in Legal for final approval. -----Arzoo Mojadedi - 4/15/2024: 4.15.24 (AM)- Readability is set at 6th grade level for this resource page so it can be utilized for all LOB's. Currently, it's being reviewed by Legal. -----Arzoo Mojadedi - 3/15/2024: 3.15.24 (AM)- Gigi, Stacey, and I are working on updating the Diabetes Resources webpage, to add more member focused content and resources. We're working on a similar Diabetes Resources Webpage across all LOB's. Currently, we have a layout complete and are verifying readability. -----Arzoo Mojadedi - 11/14/2024: 11.14.24 (AM)- Hannah Kim to connect with CVH to see if there is interest in posting the diabetes resources webpage to CVH's website. -----Arzoo Mojadedi - 10/14/2024: 10.14.24 (AM)- CVH to receive mock-up of website once it's developed. Workfront request in progress.	Some Krames materials does not meet readability per our Readability Studio.	Continue
10654	Section 2.B	BP Reach Initiative	CHRONIC CONDITIONS - Blood Pressure Disparities Reduction, Equity, and Access among safety net patients with Cardiovascular Health Risk is a NIH-fund initiative led by Dr. Amy Towfighi, Director of Neurology for LA County DHS and Associate Medical Director for Research at LA General Hospital, and Dr. Alejandra Casillas, Internal Medicine Faculty and RWJ Scholar from UCLA. The initaitive will focus on Medi-Cal members, starting with LA County and expanding to others, including CVH	CBP - Controlling Blood Pressure	CVH-ALL	04/01/2024	12/31/2024	CANCELLED	LA County DHS/UCLA - external study	Gigi A. Mathew - 9/9/2024: Met with BP researchers on 7/1 outlining next steps regarding plan's involvement. Identified potentially 850 members for study. Several requests made to researchers for BP flyer or any other detailed information to draft member letter. Researchers have been non-responsive. Tarjani sent email request on 9/6 asking for additional details.-----Gigi A. Mathew - 5/24/2024: The focus of the study is blood pressure (BP) control of patients with stroke or MI, who are enrolled into the randomized controlled trail for one year - currently recruiting members from health plans and FQHCs serving LA County. There is no cost for Health Net to participate --we need to provide a MOU and list of eligible participants meeting study criteria. Met with Legal on 5/6 and told member lists can not be shared directly with researchers, and suggested mailing a letter to eligible members informing of them of the study. On 5/24 reviewed the eligible member list -- identified missing systolic BP and PCP info; meeting with Dr. Towfighi team pending.-----Gigi A. Mathew - 12/20/2024: CANCELLED - Decision made not to proceed forward due to researchers' non-responsiveness to multiple outreaches by QI and Population Health team.12/31/24 This has been discontinued.	N/A	Discontinue
10126	Section 5.B, 5.C, 5.D	Peds+ POD Action Plan Reviews	PEDIATRIC/PERINATAL/DENTAL - Review all Pediatric/Perinatal/Dental Action Plans in the Provider Engagement Database and provide feedback to improve action plans	CIS - Childhood Immunization Combo 10,IMA - IMA - Adolescent Immunizations Combo 2,LSC - Lead Screening in Children,PPC - PPC - Postpartum Visit,PPC - PPC - Prenatal Visit (Timeliness),W30 - Well Child Visits in the First 30 Months of Life (previously W15),WCV - Child and Adolescent Well-Care Visits (previously W34 and AWC)	CVH-ALL	01/08/2024	12/31/2024	DELAYED	Juli Coulthurst	Juli B. Coulthurst - 6/17/2024: Action Planning on Hold	N/A	Discontinue

10086	Section 5.D	Pfizer Missed Dose IVR	PEDIATRIC/PERINATAL/DENTAL - Missed Dose Program - sends IVR phone messages to parents of children at ages 6 months, 8 months, and 16 months to remind them they may have missed a vaccine shot.	CIS - Childhood Immunization Combo 10	CVH-All	02/01/2024	12/31/2024	DELAYED	Guille Toland	Guille V. Toland - 9/22/2024: Compliance Vendor intake pending approval.-----Guille V. Toland - 7/12/2024: Need HN approval before moving forwrd with CVH reviews. Vendor deploying campaigns contract ended 6/30. New contract has not been executed yet! All final approvals for HN are on hold due to this new encounter.-----Guille V. Toland - 6/10/2024: Waiting for Corporate to complete the new HN Compliance intake to be able to move the final review process forward.-----Guille V. Toland - 5/15/2024: Need HN approvals before moving forward with CVH.-----Meena Dhonchak - 2/21/2024: Will not be submitting Pfizer Missed Dose IVR Checklist for Missed Dose Program to corporate. -----Guille V. Toland - 12/19/2023: Working with Corporate to bring these programs to the CA Market-----Guille V. Toland - 12/12/2024: Corporate approved the new contract with Pfizer. DHCS already approved these campaigns for HNCS and CHPIV. Campaigns for COMM/MKT were also approved. Next steps are to get the Compliance Intake approved by Jamie Babby's team and check with Corp (Kelly Burton) that they can pull the CA data on their own.	Not getting the approvals needed to launch programs in a reasonable timeframe.	Continue
10174	Section 6	PPG/PCP Community Supports Asthma Remediation Campaign	PHARMACY & RELATED MEASURES - Increase awareness of the Asthma Remediation Services Program to Medi-Cal members with a focus on asthma denominator. Create email draft for PPG, PCP, and/or Community Supports Provider to use for outreach to members to inform them of the Asthma Remediation Project.	AMR - Asthma Med Ratio Total 5 to 64	CVH-All	1/1/2024	12/31/2024	DELAYED	Justina Felix, Alicia Bednar	Created email content to increase awareness of the Asthma Remediation Services Program to Medi-Cal members. The email content is intended for PPG, PCP, and/or Community Supports Provider to use for outreach to members to inform them of Asthma Remediation Services. Content was submitted for internal approval and received approval from C&L. We were informed by CalViva Health Compliance that the email address domain cannot have mention of clinic or PPG name and the goal of this activity was for the provider to send the email to the member. This activity is on pause until we explore other options/opportunities.	None at the moment.	Continue
9892	Section 7.B, 8.A, 8.B	CalViva Provider Communication CAHPS Article	CAHPS - CAHPS article and measure rates	CAHPS - Access to Care,CAHPS - Care Coordination,CAHPS - Annual Flu Vaccine,CAHPS - Rating of All Health Care,CAHPS - Rating of Health Plan,CAHPS - Rating of Specialist,CAHPS - Rating of Personal Doctor	CVH - ALL	1/1/2024	12/31/2024	DELAYED	Guille Toland	Guille Toland - 12/31/24: A new lead person was assigned to collect information for this provider communication. Work has not started yet.	Staffing change	Continue
9861	Section 8.A, 8.B	CAHPS Playbook (One Time)	CAHPS - best practices captured in one resource (internal use)	CAHPS - Access to Care,CAHPS - Rating of Personal Doctor,RHP - Rating of Health Plan,RDP - Rating of Drug Plan,CS - Customer Service,CAHPS - Care Coordination	CVH-All	1/15/2024	12/31/2024	DELAYED	Taline Jaghasspanian	CAHPS Best Practices captured in this provider CAHPS playbook resource. The CAHPS provider playbook hasn't been updated since 2023 so it's delayed to 2025 and the CAHPS team will work on refreshing it in Q1 2025.	None	Continue

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Fresno-Kings-Madera Regional Health Authority Approval

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

David S. Hodge

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

February 20, 2025

Date

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

February 20, 2025

Date

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO: CalViva Health QI/UM Committee
Fresno-Kings-Madera Regional Health Authority Commissioners

FROM: Patrick Marabella, MD, Chief Medical Officer
Amy Schneider, RN, Senior Director Medical Management

COMMITTEE DATE: February 20, 2025

SUBJECT: CalViva Quality Improvement (QI) and Health Education Program Evaluation Executive Summary 2024 – Year-End

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Summary:

CalViva Health (CalViva) annually assesses the overall effectiveness of its Quality Improvement (QI) and Health Education (QIHEd) Program at improving network-wide clinical and service practices. CalViva has an Administrative Services Agreement with Health Net to provide capitated provider, network, and administrative services. Health Net is a National Committee for Quality Assurance (NCQA) accredited health plan for its Medi-Cal product line for both Health Plan (HPA) Health Equity (HEA) and Health Equity Plus Accreditation. As part of the CalAIM strategy to be "NCQA accredited" by January 1, 2026, CalViva obtained HP Accreditation in July 2024 and plans to obtain HEA in Q2 2025. The Quality Management (QM) Department is a centralized team with specialized knowledge of each population and collaborates with a dedicated analytics team.

The Quality Improvement (QI) and Health Education Program Evaluation Executive Summary 2024 Year-End includes:

- Summary of Overall effectiveness of QIHEd Program
- Goals and Quality Indicators
- Overall Effectiveness of QIHEd Work Plan Initiatives
- QIHEd Reporting
- Summary of Key Accomplishments
- Annual QIHEd Program Changes

Quality Improvement (QI) and Health Education Program Evaluation Executive Summary 2024 – Year-End

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Section 1: Summary of Overall Effectiveness of QIHEd Program

CalViva Health ("CalViva") is a National Committee for Quality Assurance (NCQA) accredited health plan and plans to obtain Health Equity Accreditation in Q2 2025. Annually CalViva assesses the overall effectiveness of its Quality Improvement (QI) and Health Education Program at improving network-wide clinical and service practices to improve health outcomes and reduce disparities. CalViva has an Administrative Services Agreement with Health Net Community Solutions to provide provider, network, and administrative services Health Net is a National Committee for Quality Assurance (NCQA) accredited health plan for its Medi-Cal product line for Health Plan (HPA), Health Equity (HEA) and Health Equity Plus Accreditation.

Health Net and CalViva collaboratively and continually strive to incorporate a culture of quality across their organizations, conduct operations to improve service and satisfaction for CalViva members as well as support and oversee the provider network to improve provider quality outcomes using measurement systems including Healthcare Effectiveness Data and Information Set (HEDIS®), provider access, availability, and satisfaction surveys, the Experience of Care and Health Outcomes (ECHO) Survey and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) rates. The Quality Management (QM) Department is a centralized team with specialized knowledge of each population and collaborates with a dedicated analytics team.

Health Equity Accreditation (HEA) recognizes organizations that lead the market in providing culturally and linguistically responsive services, and work to reduce health care disparities. The NCQA HEA Plus Standards, are an additional add-on option to HEA, and help provide a roadmap to improve and refine initiatives focused on providing high quality health care and connecting social and community support services to the communities we serve. Health Net was awarded HEA and HEA Plus status in September 2022 and both renewed in September 2024. As part of the CalAIM strategy to be "NCQA accredited" by January 1, 2026, CalViva plans to obtain HEA in Q2 2025, with the HEA Plus option.

QI Committee Structure

CalViva's QIHEd Program was successfully supported by the CalViva QI/UM Committee which met seven times in 2024. The committee oversaw the QIHEd Program, provided feedback, decision support, and recommendations for the QIHEd Program throughout the year. The QI/UM Committee reported to the CalViva Regional Health Authority (RHA) Commission six times in 2024.

CalViva's Credentialing and Peer-Review Subcommittees also successfully supported CalViva's QI Program, as demonstrated in the organizational chart below. These subcommittees met four times each in 2024. Additionally, QI/UM Workgroup, Appeals and Grievance Workgroup, and Access Workgroup meetings were held in 2024 to develop, monitor, and evaluate activities supporting the QI Program.

The QI/UM Workgroup supported the efforts of the QI/UM Committee by scheduling, receiving, reviewing, editing, and approving reports for presentation at the QI/UM Committee. QI Workgroup aided in the identification and pursuit of opportunities to improve health outcomes, safety, access and member and provider satisfaction.

The QI/UM Workgroup met thirty-one times in 2024 and was chaired by CalViva's Chief Medical Officer. Members of the Workgroup consisted of CalViva staff including Senior Director of

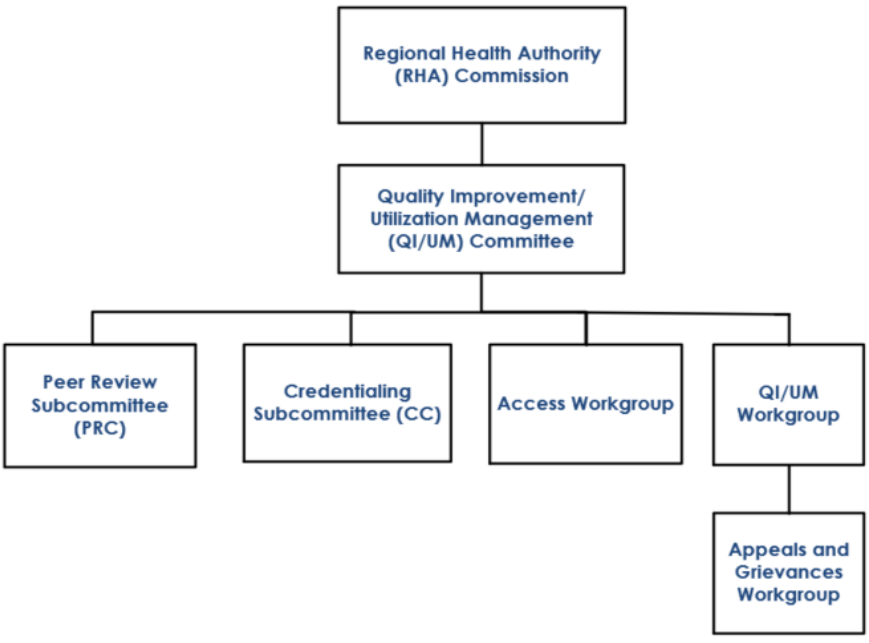
Medical Management (Registered Nurse) and a Manager of Medical Management Services (also a Registered Nurse); and Health Net staff from Quality Improvement/Health Education/Wellness, Appeals and Grievances, Health Equity, Pharmacy, Credentialing, Customer Contact Center, Population Health Management, Provider Network Management, and Provider Relations. The Workgroup conducted performance improvement reviews and discussions of monitoring of QI/UM activities, findings, barriers, and interventions to develop and implement actions. Significant findings and follow-up were reported to the QIUM Committee and RHA Commission.

CalViva's Access Workgroup met seven times in 2024. The CalViva Health Access Workgroup included representatives from CalViva Health and Health Net departments with access and network adequacy related functions. The Workgroup reviewed findings from ongoing monitoring of access to plan services, identified gaps, and developed and evaluated activities that addressed those gaps in access to care. The Workgroup submitted issues that required escalation to the Management Oversight Meeting ("MOM"), QI/UM Committee and/or RHA Commission for final decision and approval of recommended actions.

The Appeal and Grievance Workgroup reported to the QI/UM Workgroup and supported the QI Program through the review and analysis of appeal and grievance data. The Appeals and Grievances Workgroup met seven times in 2024. The workgroup processed, tracked, and trended member grievances and appeals at the provider and plan level. The Workgroup submitted reports to the Peer Review Subcommittee to review, act on and follow-up on identified significant events or trends.

Please refer to the 2024 Quality Improvement and Health Education Program Description for more information on the sub-committees.

CalViva's Quality Improvement Committee Organizational Chart



Practitioner Participation and Leadership Involvement in the QIHEd Program
The committee structures for CalViva ensured that external and internal physicians with various specialties participated in the planning, design, implementation, and review of the QIHEd Program. Six external providers were participants in the QIUM Committee and both the Credentialing and Peer Review Sub-Committees with specialties in Pediatrics, Behavioral Health, Internal Medicine, Family Medicine, Obstetrics and Gynecology, and General Surgery. CalViva's Chief Medical Officer chaired the committees and invited external practitioners to participate.

Practitioner involvement in 2024 included: reviewing and approving the 2023 QI Work Plan Year-End Evaluation, and the 2024 QIHEd Program Description and Work Plan. Practitioners discussed opportunities for improvement based on Reporting Year (RY) 2024 HEDIS© results and performance. Practitioners were also involved in performance improvement projects to address underperforming measures. In 2024, CalViva worked with high volume, low performing providers, and clinics in Fresno County. CalViva and Health Net established multidisciplinary improvement teams, including local providers and practitioners, that worked collaboratively to determine the current processes, identify potential barriers, and establish plans for improvement to address potential barriers with work plan projects and outcomes. This included projects on Well-child Visits and Behavioral Health.

In 2024 CalViva Medical Management Team reinstituted Annual Clinic Visits focused on high volume FQHC's/Clinics throughout Fresno, Kings, and Madera counties. During these 90-minute clinic site visits, the Medical Management Team presents provider specific HEDIS® results, discusses barriers to meeting the measures, and shares successful strategies and lessons learned from current and previous quality improvement projects. In Q4 two Annual Clinic Visits were conducted, one at United Health Centers in Fresno County and one at Adventist Health in Kings County. Both visits were very successful, engaging clinic leadership and quality improvement staff in productive dialogue regarding future activities and collaborative efforts.

Adequacy of QIHEd Program Resources
In 2024, CalViva's QI Team included a Chief Medical Officer, a Senior Director of Medical Management, a Manager, a Nurse Analyst, and an Administrative Coordinator. The Chief Medical Officer (CMO), who oversaw the QIHEd Program, chaired all QI/UM Committee meetings in 2024. Along with the Senior Director of Medical Management, he reviewed and approved all QI policies and procedures during the annual policy review and when updates/edits were made throughout the year. The CMO reported at least quarterly to the RHA Commission on the status and activities of the QIHEd program. The CMO and Senior Director of Medical Management co-chaired bi-weekly multi-disciplinary team meetings for all PIP, Quality Management Improvement Projects (QMIP)and regulatory projects in 2024. These teams were the focal point for evaluating current results and processes, identifying and testing potential interventions, monitoring and evaluating results, and modifying interventions or spreading lessons learned and best practices to other providers and counties. Finally, reports were shared with appropriate regulatory agencies.

The CalViva QIHEd Program was led by the Senior Director of Medical Management who worked in collaboration with the Health Net Quality Management Departments and teams to implement QIHEd programs and activities to address and improve quality of care and service, patient safety, and member and provider satisfaction. Monthly QI Leadership Meetings occurred between the CalViva QI Team and the Health Net departments to provide high level updates from Quality Improvement, Provider Engagement, and Medical Affairs teams and discuss any issues that may require follow up.

In 2024, the delegated Quality Management Department at Health Net led by the Vice President of Quality Management, remained a centralized, interdisciplinary team working to support members in a coordinated manner, resulting in focused efforts to improve HEDIS and CAHPS performance. Participating provider groups (PPGs) could access HEDIS report cards, highlighting their performance on key measures compared to national benchmarks, as well as care gap reports including member and practitioner-level information for PPGs to determine actionable approaches to close care gaps. Five departments comprised Quality Management, each with a separate leadership structure: 1) Quality Improvement and Health Education, 2) Credentialing/Clinical Quality of Care/Potential Quality Issues/Facility Site Review, 3) Program Accreditation and CAHPS, 4) Health Equity, and 5) HEDIS and Quality Analytics. The Quality Improvement Analytics team supported data needs across all Quality Management teams and departments. Based upon the results of the 2024 monitoring activities noted below and within the attached full Work Plan, CalViva has determined that program resources met the needs of CalViva membership and providers. Planned activities were consistently completed (110/129 overall) and within expected timeframes. HEDIS® measures demonstrated compliance in fifty-eight percent of objectives met.

Quality Improvement Department and Health Education System
Under the direction of the Medi-Cal QI Director, and in collaboration with the Senior QI Manager, the Program Owners and Drivers (PODs) lead each program/measure strategy. Program Managers lead the Measure Specific PODs and drove strategy by measure/area of focus as well as drove long-term strategy for their geographic or topical areas to address health education and quality outcomes improvement. The PODs generally consisted of Program Manager IIIs, Senior QI Specialists, QI Specialists, Health Educators, and Project Managers who ensured compliance and implementation for all required activities. The Health Education POD was led by two Directors that managed a team implementing health education programs, compliance activities and comprised of Senior Health Education Specialists, Health Education Specialists, and Program Manager IIs. As needed, external providers, clinics and clinic staff were brought in as guest partners on formal QI projects.

Credentialing/Clinical Quality of Care/Potential Quality Issues/Facility Site Review Department

Credentialing/Clinical Quality of Care/Potential Quality Issues/Facility Site review was led by a QI Director of Clinical Services and included two Senior Managers of Provider Data Management and Credentialing, and a QI Manager of Clinical Grievance for PCPs for Medi-Cal.

The Facility Site Review (FSR) team collaborated with other Medi-Cal Managed Care plans throughout the state to maintain and refine a standardized system-wide process for conducting reviews of primary care physician facility sites, along with Medical Record Review (MRR) and Physical Accessibility Review Surveys (PARS). This process minimized duplication and supported consolidation of FSR surveys. The process incorporated evaluation criteria and standards in compliance with DHCS contractual requirements and was applicable to all Medi-Cal Managed Care plans. The FSR department also conducted provider education, provider outreach, and other QI activities. The FSR QI Director provided regular updates of FSR, MRR, and PARS activity via reports to the Quality Improvement Committee. These evaluation reports identified overarching areas of noncompliance by sections and selected elements, reported at the regional level with year-over-year (YOY) comparison. This detailed analysis allowed for monitoring and identification of improvement opportunities. The FSR team collaborated with the Regional Medical Directors and Credentialing, Provider Network, Clinical Grievances, Health Education, Health Equity, and Provider Relations departments to implement process improvements.

Program Accreditation Team
The QI Senior Director led the Program Accreditation team. The Program Accreditation team included a Manager of Accreditation, two Compliance Specialists, and a Compliance Analyst. This team led activities to ensure ongoing organization-wide compliance with requirements of accrediting bodies for Health Plan Accreditation (HPA), Health Equity Accreditation (HEA), and external and internal audit readiness; including completion of HPA for CalViva in Q2 2024. At year end, in review of staff resources and support, the Quality department transitioned Quality EDGE to the Program Accreditation team. As a result, a Compliance Analyst and Compliance Specialist were promoted to Project Manager II positions, a Quality Improvement Specialist I was added to the team, and a Quality Program Specialist transferred from the Quality Medi-Cal team.

CAHPS Team
The QI Sr. Director also led the CAHPS team that included two Program Manager IIIs focused on implementing the CAHPS member experience survey. The team also led improvement strategies including root cause analysis of member pain points, CAHPS exposure and training, mock CAHPS implementation, and improvement initiatives in partnership with operations and provider-facing teams.

Health Equity Team
The Health Equity team was unique in its cross-functional support structure. The Health Equity team had representation throughout the State and was staffed by a Vice President of Quality Management, a Manager of Health Equity, one Program Manager III, five Senior Health Equity Specialists, two Health Equity Specialists, and one supplemental staff position. There was a strong governance structure to oversee and provide support to cultural and linguistic/health equity services. The Health Equity team had a breadth of knowledge as it related to the integration of cultural and linguistic services within the health plan and across operational areas of cultural competency, health literacy, language assistance services, addressing health disparities and compliance. The Health Equity team analyzed, designed, and implemented strategies to support the reduction of health disparities and facilitate the Health Equity

workgroups, which were responsible for developing and implementing an action plan to reduce health disparities in targeted HEDIS measures.

CalViva adopted the Culturally and Linguistically Appropriate Services (CLAS) Standards. The CLAS standards represented 15 different standards that served as the foundation for the development of the Health Equity Department strategic plans. To ensure that the plan was continually striving to be responsive to the membership, the Health Equity Team conducted data analysis and designed and implemented services to meet the needs of CalViva members. Internally, the Health Equity Team surveyed new employees to determine staff diversity and cultural and linguistic, and supported and trained bilingual associates. In 2024, there were 202 certified bilingual staff members who supported the CalViva service area. Externally, the Health Equity team conducted a biennial Geo Access report, which used member zip code data and correlated it with member language preference. These data were further overloaded with provider network language capabilities and a gap analysis was conducted to target network expansion. The Human Resources Department and Diversity and Inclusion team were responsible for the overall coordination to ensure a diverse leadership and workforce.

HEDIS Department

A Senior Director of HEDIS Reporting and Business Analytics led the HEDIS Department. There were one Director, two Senior Managers, two Managers, three Supervisors, and four HEDIS Program Managers, along with Medical Record Abstractors, Analysts and Customer Service Advocates that comprised the team. The HEDIS team was responsible for HEDIS measurement and reporting annual rates, creating provider report cards/care gaps, provider incentive programs and outward-facing provider and member outreach to support data and care gap closure.

The HEDIS team also had a QI Director of Data Analysis who oversaw the QI Research and Analysis (QIRA) team within the department and was responsible for ensuring the production of detailed reporting and analytics. The QIRA team reported directly to the QI Director of Data Analysis and was responsible for providing data and analytical support for QI projects and is comprised of seven analysts (six Biostatistician I and one Biostatistician II) and three Quality Analytics Program Managers (QAPMs) who supported CalViva.

Section 2: Goals and Quality Indicators

The Quality Improvement 2024 Work Plan included eight categories. To determine CalViva's success in achieving specified goals, the plan calculated the number and percentage of activities completed and objectives met per category (**Tables 2.1 and 2.2**) and outlined RY 2024 performance against the goals in the Appendix.

Table 2.1 Activities Completed by Category

Work Plan Programs	Year-End Activities Completed	Rate (%)
1. BEHAVIORAL HEALTH	5/6	83.33%
2. CHRONIC CONDITIONS	24/30	80%
3. HOSPITAL QUALITY/ PATIENT SAFETY	9/9	100%
4. MEMBER ENGAGEMENT AND EXPERIENCE	2/2	100%
5. PEDIATRIC/PERINATAL/DENTAL	36/40	90%
6. PHARMACY	7/8	87.5%
7. PREVENTIVE HEALTH	14/16	87.5%
8. PROVIDER COMMUNICATION/ ENGAGEMENT	13/18	72.22%
Total	**110/129**	**85.27%**

Table 2.2 Objectives Met

Category	2024 Objectives Met	Rate (%)
1. BEHAVIORAL HEALTH	0/6	0%
2. CHRONIC CONDITIONS	6/6	100%
3. HOSPITAL QUALITY/ PATIENT SAFETY	9/11	81.82%
4. MEMBER ENGAGEMENT AND EXPERIENCE	0/1	0%
5. PEDIATRIC/PERINATAL/DENTAL	15/30	50%
6. PHARMACY	1/3	33.33%
7. PREVENTIVE HEALTH	12/12	100%
8. PROVIDER COMMUNICATION/ ENGAGEMENT	5/9	55.56%
Total Rate	**49/78**	**62.82%**

As shown in **Table 2.1**, 85.27% of the total 2024 work plan activities were completed as planned. Overall, CalViva met 62.82% of the total year work plan objectives **(Table 2.2)**.

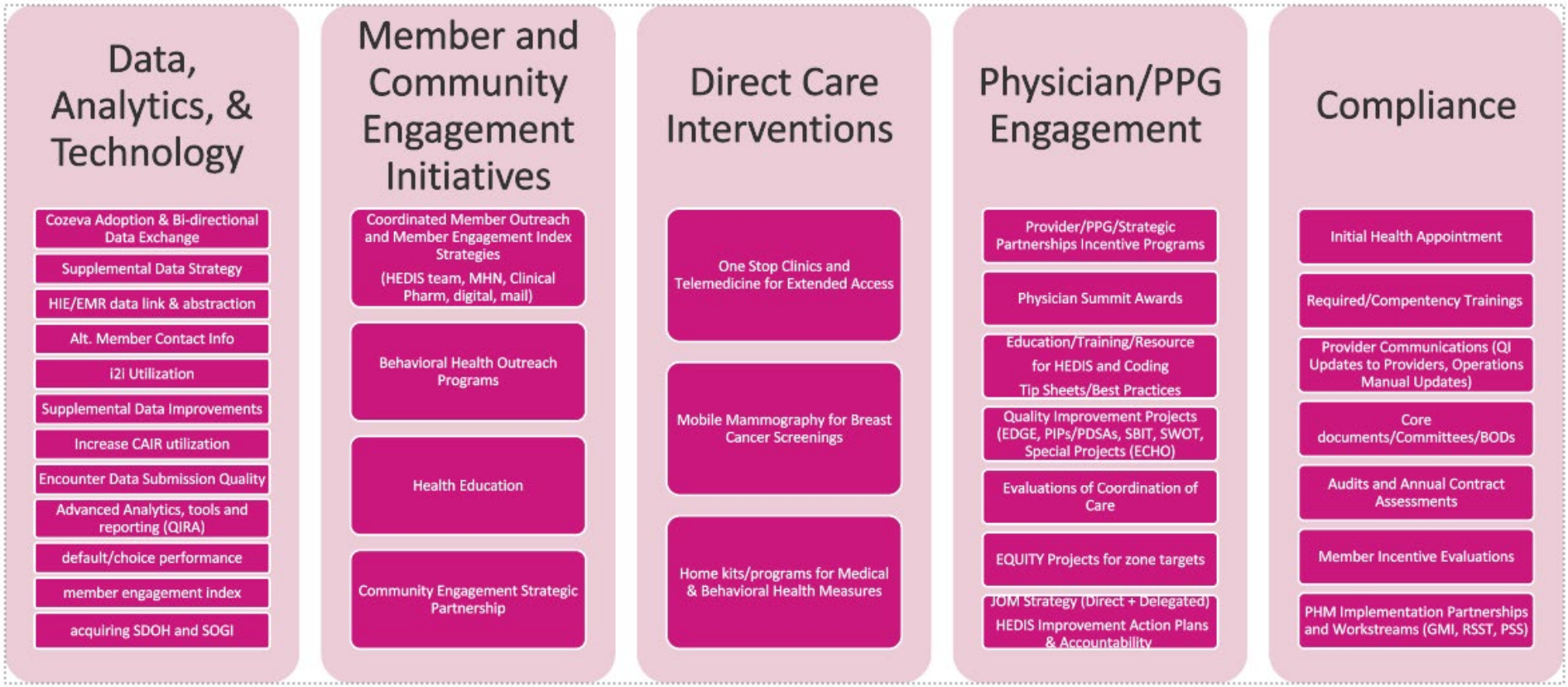
Quality goals follow regulatory and accreditation standards, which can change annually. **Appendix Table A-1** provides the performance goals of the plan. These goals were the overall percentiles that CalViva seeks to achieve. Additionally, the objectives were tied to how much of the goals were accomplished within the year, which can include meeting directional improvement (e.g., improved performance year-over-year, **Appendix Table A-5 to Table A-19**).

As set by DHCS, all MCAS measure rates must exceed the minimum performance level (MPL) of 50th percentile. CalViva's performance goal for CAHPS was to meet the NCQA 25th percentile national benchmark. The goal for provider surveys was to meet the 70% or 90% performance rate for provider access or satisfaction survey measures. The outcomes tables in the Appendix provide detailed measure-level progress toward goals.

To meet or exceed the MPL, CalViva carried out numerous targeted programs and performance improvement projects to close care gaps. The team continued to prioritize interventions along

the strategic tracks noted in **Chart 1**. Critical interventions that address data and targeted analysis, member supportive and direct care services, provider engagement and compliance, all worked cohesively to support goal achievement.

Chart 1 Quality Improvement Strategic Tracks



In addition, the QI Team collaborated with the Provider Engagement Team to continue implementation of Quality EDGE (Evaluating Data to Generate Excellence). Quality EDGE is a systematic five step change management cycle that integrates quality improvement tools, focused measure sets and provider engagement strategic assessments to drive providers to rapid improvements in HEDIS outcomes. The mission of Quality EDGE is to outperform all market competitors on quality metrics by providing unparalleled consultative services, innovative programs and actionable reports while improving health equity. The Vision: We are the partner of choice, collaborating internally and with our providers to deliver the highest quality of care to the most vulnerable population. The team collaborated to identify the following goals for 2024:

1. Complete and deploy action plans for priority providers (specific targets in development).
2. Continually measure, evaluate, and improve processes to ensure efficacy of Quality EDGE and full engagement among the staff.
3. Improve results for "voice of the provider" (specific target in development).

Goals Met:

Quality of Care: MCAS

Overall, CalViva achieved 59% of MCAS measures above the MPL for Measurement Year (MY) 2023. **Appendix Table A-2** provides a breakdown of the percent of required MCAS measures above MPL for each of the three CalViva Medi-Cal counties. Fresno County met 50% of its objectives. Kings County met 39% of its objectives. Madera County met 89% of its objectives. Refer to **Section 5** for a summary of key accomplishments by county and measure category.

Hospital Quality/Patient Safety

Hospital quality performance was measured across CalViva's network based on facilities with sufficient publicly available data across priority metrics (5 facilities total). CalViva hospitals largely showed either appropriate performance or improvement, and continued avoidance of outlier performance for hospital-acquired infection metrics. The network showed directional improvement for hospitals meeting the standardized infection ratio of 1.0 or lower for *catheter-associated urinary tract infections* (CAUTI) and *Methicillin-resistant Staphylococcus aureus* (MRSA), while all hospitals continued to meet the goal for *Clostridioides difficile* (C.Diff). The proportion of hospitals meeting the goal for *central line-associated bloodstream infection* (CLABSI) and *Surgical site infection following colorectal surgery* (SSI-Colon) declined from last year's performance due to one fewer hospital meeting the goal for each infection. The network successfully avoided outliers for all five infections. Hospitals meeting the NTSV C-section rate standard of 23.6% or lower showed directional improvement, with three out of five facilities (60%) meeting the goal compared to just one hospital (20%) the previous year.

Behavioral Health

For 2024, the focus was on improving timely follow up care after an emergency department (ED) visit for either a principle mental health or substance use diagnosis, or the FUM and FUA HEDIS® metrics, for CalViva members. For all three CalViva counties, the National 50th percentile Quality Compass goal was not achieved and all metrics showed decreases from the prior measurement year. There is an ongoing focus on improving both the FUM and FUA metrics moving forward, including an ongoing regulatory Performance Improvement Project and a Lean process improvement project. (**Appendix Table A-6)**.

Health Services Advisory Group (HSAG) CAHPS Survey

In 2024, the annual CAHPS survey was conducted for CalViva by the state (HSAG). Results showed 3/8 measures met the Outcome Quality Compass (QC) 25th percentile goal: Rating of

All Health Care, Rating Personal Doctor, and Rating of Health Plan. Three out of the eight measures had non-reportable data due to small sample size (N<100). (**Appendix Table A-7)**.

Provider Access, Availability, Satisfaction Survey Measures

Results from provider surveys showed directional YOY improvement achievement or met the 70 (PAAS) or 90% (PSS, PAHAS) rate objectives in 69.08% (105/152) of total measures. CalViva met the following goals:

- 50.82% (68/88) of PAAS measures (**Appendix Tables A-8 to A-12**).
- 66.67% (4/6) of the Telephone Access Survey measures (**Appendix Table A-13**).
- 64% (22/32) of Provider Satisfaction Survey (PSS) measures and 50% of BH PSS measures (**Appendix Tables A-14, A-15, and A-16**).
- 66.67% (4/6) of Provider After-Hours Survey measures (**Appendix Table A-17**).
- 27.78% (5/18) of ECHO survey measures (**Appendix Table A-18**).
- 100% (2/2) of Behavioral Health PAAS by Risk Rating measures (**Appendix Tables A-19**).

*Refer to the **Appendix Tables A-3 and A-5** for the summary of goal attainment by program category for RY 2024.*

As the tables demonstrate, there is still progress needed to reach the goals set for each county/category, for example Kings County is at 39% where Fresno and Madera Counties are at 50 and 89%,respectively. Despite meeting a majority of the MCAS objectives, meeting directional improvement on CAHPS measures, and reaching the 70 or 90% performance goal rate for provider survey measures. There also remains an opportunity to reach the goals set for CalViva. Opportunities by category are found in **Appendix Table A-4:** Summary of Barriers and Opportunities.

Barriers to Achieving Goals and Objectives:

MCAS

- Initial outreach calls to members resulted in a low reach rate. A portion of members who were contacted were not successfully reached after three (3) phone attempts and thus remained noncompliant for their chronic illness.
- A portion of members who were reached lacked the understanding/desire to learn about how to manage their chronic illness through basic education, lifestyle changes, medication management, etc.
- Members reported transportation issues, such as only having one car to transport all family members to their activities, broken down vehicles and/or unexpected family emergencies.
- Members stated they could not commit to attending the classes because they work long varied hours, needed more advance notice, have to arrange for childcare, and encountered family emergencies.
- Many of these members reported that a standard classroom setting during regular business hours may not be feasible and expressed interest through a virtual or hybrid class model.

Measure Barriers.

- *Breast Cancer Screening* (BCS):
    - Disparities in BCS in the Hmong population.

- Language barriers and low health literacy may take several attempts to explain a mammogram. The Healthy Equity Team, Health Education and Provider Engagement must work together for successful outreach, education, and events with on-site mammograms.
- Unable to reach members due to disconnected phone numbers, no voice mail set-up, and wrong numbers.
- Members often do not arrive at their scheduled time and adjustments may be required to fit them in the schedule.
- Inadequate access to screening mammography and there is a limited volume of mobile mammography vendors. Further, regulatory requirements for DHCS provider contracting has delayed implementation with available vendors.
- Variable provider referral and follow-up practices.
- Appointment availability at high traffic radiology facilities.

- *Childhood Immunization Status – Combination 10* (CIS-10) :
  - Lack of member understanding of the importance of immunizations.
  - The complicated and time-bound immunization schedule – immunizations completed out of timeframe.
  - Parent refusals for vaccines during office visits.
  - Lack of strong recommendations from providers for immunizations.
  - Missing one or both flu vaccines. Parent's viewing the flu vaccine as optional.
  - Missing Hep B vaccines from hospitals.
  - Members not completing the vaccine series after turning one year.
  - Language barriers.

- *Developmental Screening in the First Three Years of Life* (DEV)
  - Incorrect modifiers used by providers billing for developmental screenings.

- *Immunizations for Adolescents – Combination 2* (IMA-2)
  - Missing HPV vaccines.
  - Member vaccine hesitancy for the HPV vaccine.
  - Providers not starting HPV vaccine series at age 9.

- *Well-Child Visits in the First 30 Months of Life - 0 to 15 Months* (W30-15)
  - Members did not understand the importance of infant well-care checkups, the periodicity schedule and what to expect in infant well-care checkups.
  - Lack of connection of pregnant members to pediatricians to get the parent established with the pediatrician so the parent knows when to bring in the newborn after discharge from the hospital.
  - Data gap of W30-6+ visits. Completed W30-6+ visits are not getting to the health plan primarily due to the lack of a link between the birthing parent and the newborn.
  - Lack of access to infant well-care visits. It could take weeks or months to get well-care appointments, putting the infant behind on visits according to periodicity schedule. Lack of dedicated provider time to well-care visits.

- *Well-Child Visits in the First 30 Months of Life - 15 to 30 Months* (W30-30)
  - Members did not complete infant well-care after babies turn one year.
  - Parents were not able to bring children to well-care appointments during regular business hours.

- Lack of access to well-care visits. It could take weeks or months to get well-care appointments. Lack of dedicated provider time to well-care visits.

- *Child and Adolescent Well-Care Visits* (WCV):
  - Lack of provider outreach to members to complete WCV.
  - Lack of member engagement with child and adolescent well-care.
  - Parents were unable to bring children to well-care appointments during regular business hours.
  - Lack of access to well-care visits. It could take weeks or months to get well-care appointments. Lack of dedicated provider time to well-care visits.

- *Cervical Cancer Screening* (CCS):
  - Members could not be reached by phone.
  - Members refused the CCS screening.
  - Lack of knowledge regarding the test.
  - Members are not yet educated on the self-test.
  - Providers are not aware of the self tests as it is a new update.
  - Fears related to the service.
  - Staff turnover.
  - Stigma around the topic within certain populations.

- *Controlling Blood Pressure* (CBP)
  - Lack of champion at the PPG/Provider level to promote the measure; increased workload and limited provider time impact availability.
  - Home digital blood pressure cuffs are a covered Medi-Cal benefit; lack of awareness around the benefit impacts access to the BP monitoring devices..
  - Poor medication adherence.
  - Lack of follow-up.
  - Fear of side effects.
  - Knowledge gap on self-measured blood pressure monitoring (SMBP); lack of awareness about the benefits of SMBP monitoring.
  - Inaccurate home BP monitoring.
  - Unable to reach members due to outdated or inaccurate contact information.

- *Hemoglobin A1c Control for Patients with Diabetes* (HBD)
  - Poor medication adherence.
  - Lack of follow-up or clear communication regarding treatment goals, medication use/adjustments, and lifestyle modifications.
  - Knowledge gap: some providers may not be updated on the latest diabetes management guidelines.
  - Unable to reach members due to outdated or inaccurate contact information.
  - Lack of regular monitoring of A1c levels to achieve optimal glycemic control.
  - Medi-Cal regulatory approval timelines impact availability of mass A1c kit mailing to targeted population.

- *Asthma Medication Ratio* (AMR)
  - Poor medication adherence.
  - Unable to reach members due to outdated or inaccurate contact information.
  - Low awareness of CalAIM Asthma Remediation Services by providers.

Hospital Quality/ Patient Safety

- Hospital leadership may not assign quality performance sufficient importance among other institutional priorities.
- Hospital Acquired Infections and C-section rates reflect all-payer data. Limited influence as a single plan on all-payer scores.

Behavioral Health

- Difficulty reaching Medi-Cal population by phone because of unreliable and highly variable contact information.
- Lack of education about behavioral health treatment & address the stigma of diagnosis.
- Timely access to Admit, Discharge, and Transfer (ADT) data.
- ADT data may not include 100% of the eligible populations because of internal facility limitations on data sharing.
- Timeliness of referrals and follow-ups.
- Plan limitations and restrictions on data sharing with providers for substance use disorders impacts timeliness of follow up.
- Not all providers leverage Cozeva platform on a daily basis to prioritize behavioral health outreach and gap closures.
- Members in ADT reports may not ultimately end up in the eligible population because of the lack of a principle mental health or substance use diagnosis.

Member Experience/CAHPS

- All patient interaction has the potential to impact CAHPS scores.
- CAHPS results were often based on patient perception and patient recall.
- Any negative experience will stay with members regardless of the look-back period.
- Staff shortages and turnover due to minimum wage increases.
- Operational issues that impact member experience/CAHPS:
    - Prior authorization delays for care.
    - PCP and specialist referral delays.
    - Attitude and service issues related to customer service.

Provider Access and Availability Surveys

- Providers not complying with timely appointments standard.
- Provider offices were having difficulty responding accurately to the survey calls due to the volume of providers requiring appointment availability responses, busy with patients during normal office hours.
- Health Plan to understand barriers that practices have in meeting timely access to better assist providers.
- Members did not have access to or information for urgent care services.
- Specialty access issues in certain geographies.
- Provider practices may be closed to new patients, leading to access issues.
- Ineligibility rates from PAAS.
- PAAS non-responders.
- Providers non-compliance with access standards year-over-year.

Provider Engagement Oversight

- Plan encounters challenges in navigating relationships between Provider Group and when ownership of provider group changes are frequent.
- Insufficient Plan program or processes to assist clinics with physician shortages.

- Plan provider incentives are not adequate alone to improve provider performance and PPGs prioritize other plan's programs.
- Lack of consistent payment or oversight models in place that incentivize providers to accommodate member's needs (after work/school hours, multi appointment family member scheduling, one-stop visits, etc.).
- Lack of consistent and effective engagement with providers and clear method of accountability of internal teams.

Section 3: Overall Effectiveness of QIHEd Work Plan Initiatives

3.1. Behavioral Health

Improve Behavioral Health Measures

Health Net continued providing behavioral health (BH) oversight through attendance and participation in QI/UM and Access Workgroup Meetings and submitting BH Performance Indicator Reports timely. There were no corrective actions required.

Follow Up After Emergency Department (ED) Visits for Mental Illness or Substance Use (FUM/FUA)

The Behavioral Health Population Health Clinical Operations continued live outreach to CalViva members in Fresno and Madera counties for follow-up after mental health or substance use disorder emergency department visits, or FUM and FUA. Kings County was excluded from this live phone intervention outreach because it had already achieved the minimum performance level the prior measurement year.

Results: The final FUA-30-day follow-up rate for MY 2023 was 15.66%. The final FUM-30-day follow up rate for MY 2023 was 17.55%. These rates reflect Fresno, Kings, and Madera county performance combined (Accreditation Rate) does not meet benchmarks.

Improving rates for FUM and FUA will continue in MY 2025. CalViva saw rate increases over time during MY 2024, primarily due to the Legacy MHN phone outreach calls that were taking place. As part of the Non-Clinical PIP and a Lean Project for Madera County, CalViva is implementing a Coding Education training and a Cultural Competency training for hospital staff.
.

For both FUM and FUA measures across all three CalViva Health Counties, rates showed a downward trend from the prior measurement year and therefore didn't achieve the National 50th Percentile benchmark goal for any metric component. Some of the significant decreases were seen in the FUM30 metric. Fresno County decreased from 25.47% to 14.17%, Kings County decreased from 70.07% to 38.25%, and Madera County decreased from 52% to 22.47%. Rate decreases were also seen for FUA30, but to a lesser degree; dropping from 18.48% to 15.01% in Fresno County, 31.79% to 21.66% in Kings County, and 18.32% to 16.84% in Madera County.

Non-Clinical Performance Improvement Project (PIP) Behavioral Health

Target Population: Individuals who have had an ED Visit for Substance Use (FUA) or Mental Health (FUM) and received follow-up care within 7 days of an ED visit in Fresno and Madera Counties.

The California Department of Health Care Services (DHCS) updated the required PIP process in 2023. Each health plan is required to initiate one Clinical PIP and one Non-Clinical PIP to run from 2023 through December 31st, 2026. The initial submission of Steps 1-8 of the PIP process and two Intervention Worksheets were submitted to HSAG/DHCS in September and December 2024 and CalViva Health received 100% validation in January 2025 for the Non-Clinical PIP.

The PIP had two Aim Statements:

- During the measurement period, CalViva Health will carry out targeted interventions*that will result in improvement in the percentage of provider notifications for CalViva Health members with substance use disorder (SUD)/ mental health (MH) diagnoses following or within 7 days of an emergency department visit in Fresno and Madera Counties.

For the non-clinical PIP, CalViva leveraged dedicated hospital staff to notify providers of eligible members visiting the emergency department for SUD/MH diagnoses. Timely provider notifications could support follow-up care for members who had an ED visit for mental illness or substance use. Two interventions are currently being implemented:

1. Educate the Substance Use Professionals and MH Liaisons/Social Workers regarding the use of codes to accurately and completely document services and referrals provided.
2. Culturally Appropriate Education Strategies for Mental Health/Substance Use Disorder to Increase Follow-up Care.

CalViva completed a Lean Quality Improvement & Health Equity Project for Madera County. CalViva submitted a completed A3 QI tool for the Coding and Cultural Competency training. Too few CalViva members in Madera were having follow-up care after a mental health or substance use disorder emergency department event. CalViva' s Madera rates did not meet minimum performance levels for FUA or FUM. The completion rate for FUA and FUM was 9.84% combined, when the MPL for FUA and FUM were 24.51% and 40.59%, respectively. The majority of Madera members in the FUA/FUM population were Hispanic (at 62%) so there may have been cultural drivers negatively impacting follow-up care rates. The FUA & FUM member outreach was conducted in 2024 and resulted in an engagement rate of 17% due to lack of accurate member contact information (e.g., phone numbers) and member reluctance. Outreach was also impacted by privacy issues in sharing admission, discharge and transfer (ADT) data, and only identified approximately 35% of BH ED Visits.

CalViva will continue to monitor the effectiveness of the interventions in 2025, and with timelier follow up by PCPs for FUA should positively contribute to better rates for 2025.

3.2. Chronic Conditions/Chronic Disease

Improve Chronic Conditions

Chronic diseases are complex and influenced by multiple risk factors such as genetics or age which cannot be changed, and by modifiable risk factors like diet, physical activity and tobacco use that can be changed. Individuals with diabetes face an increased risk of developing serious health complications and co-morbidities. Hypertension or high blood pressure increases the

risk of heart disease and stroke. Individuals with asthma experience frequent disease state symptoms, hospitalizations, and emergency room visits related to uncontrolled asthma which can then lead to miss work and school. The burden of chronic disease can be reduced by focusing on strategies in primary prevention, early detection and interventions, and disease management. Implementing evidence-based approaches to prevent chronic disease can improve the quality of care.

2024 improvement activities included:

- The multi-gap HEDIS calls identified 70,932 CalViva members for the outreach, with 49,394 total attempts made and 11,763 CalViva members reached. Live outreach to close multiple gaps in care including those with controlling blood pressure and diabetes care gap yielded a reach rate of 23.8%. The reach rate exceeded goal rate of 20%.
- Outcomes Medication Therapy Management (MTM) is a pharmacist-based intervention launched in late Q2 to close A1c and CBP care gaps for Medi-Cal members, YTD results show 78 members compliant for CBP, and 28 members compliant for HBD.
- Community Health Worker (CHW) interventions targeting 397 CalViva members, around CBP and A1c control yielded to date 21 self-reported BP readings, of which 13 were compliant and 20 members identified for chart chase for recent A1c screening.
- Direct, bulk mailing of in-home A1c kits to CalViva members was delayed in 2024 due to shifting timelines for vendor regulatory review process. However, vendor received DHCS approval early December 2024, allowing for with member collateral submission and contract execution to impact direct gap closure of HBD measure for MY 2025.
- Provider targeted interventions for Medi-Cal members included live calls (53% reach rate), digital service alert and targeted e-mail blasts to encourage providers to get members screened for BP prior to year end, and to aim for compliant reading of < 139/89.
- Members who had an Asthma Medication Ratio (AMR) gap were outreached to by a pharmacist to address barriers to asthma medication adherence using motivational interviewing techniques and encouraged to discuss action plans with their providers. Fresno and Madera counties improved rates YOY and Madera exceeded the MPL.
- The plan partnered with Central California Asthma Collaborative (CCAC), a Community Support Provider, to provide Asthma Remediation and Education Services to qualifying members with asthma in Fresno County. Members enrolled in the program learned how to reduce asthma triggers in their home and received resources to help remove allergens and other indoor triggers. CCAC outreached to a total of 200 members, of which 44 agreed to a home assessment, making this a 22% enrollment rate.
- CalViva will continue to promote CalAIM Asthma Remediation services by partnering with providers and making the program available to qualifying members with asthma.

The multigap HEDIS calls to CalViva members, targeted provider calls and e-mail blasts, and direct bulk mailing of A1c Kits to members will continue in MY 2025 to impact care gap closure. CalViva to explore opportunities in MY 2025 to collaborate between CHWs and provider groups targeting CalViva members to enhance engagement, promote care coordination and address social needs by connecting members to appropriate resources. Due to the low yield of compliant Medi-Cal members for Outcomes MTM, this intervention will not continue in MY 2025.

3.3. Hospital Quality/Patient Safety

Improve Hospital Quality/Patient Safety

CalViva's hospital quality initiatives focused on raising awareness among hospitals about performance expectations for specific metrics and connecting facilities with the organizations and QI resources that they may need to drive improvements.

These programs include collaboration with external organizations that report outcomes and/or provide the technical quality improvement guidance that hospitals may need, such as: Cal Hospital Compare and its sister organization Convergence Health, and the Health Services Advisory Group (HSAG) (both participants in the CMS-funded Hospital Quality Improvement Contract (HQIC) program); The Leapfrog Group, including as co-chair of Leapfrog Partners Advisory Committee; the California Health Care Foundation; the California Maternal Quality Care Collaborative (CMQCC); and other health plans.

Three of CalViva's hospitals identified as poor performers (Clovis Community Hospital, Community Regional Medical Center, and Saint Agnes Medical Center), received enhanced outreach to the hospital's Quality leadership to convey our concerns about the status of low performing priority metrics and to obtain information about their efforts to improve.

While CalViva hospitals showed good performance and continued avoidance of outlier performance for 3 hospital-acquired infection metrics (CAUTI, MRSA, and C.Diff), 2 infections warrant more attention. CLABSI and SSI-Colon declined in the number of hospitals meeting the target of an SIR <= 1.0. Focus on these metrics is needed to reduce the risk to patients of preventable complications. C-section performance improved, with 3 in 5 hospitals meeting the target of an NTSV C-section rate of 23.6% or below, compared to just 1 hospital previously. Continued engagement to drive excellence and to raise performance among network facilities is called for, as well as collaboration across stakeholders to support those goals.

CalViva's subcontractor, Health Net, collaborated with other key stakeholders in order to amplify our messaging and facilitate hospital access to QI tools and resources.

3.4. Member Engagement and Experience

Improve Satisfaction with Quality of Care/Service

<u>Member CAHPS Survey</u>
CalViva participated in the HSAG CAHPS survey, and it launched successfully in Q1 2024. The year over year rate increased for the following rating measures: Rating of Health Plan and Rating of All Health Care. Other findings were shared in the MY2023 ME7 report. Root cause analysis on appeals and grievances data was conducted on a quarterly basis to identify quarter over quarter and year over year trends in member pain points and areas for improvement. Findings were shared with appropriate internal stakeholders and teams. The CAHPS Team continues to meet regularly with departments to track progress of the various activities around CAHPS performance and general member experience. These meeting spaces were also a platform to brainstorm any new ideas or projects to address any member issues that come up during the year.

A few CAHPS related improvement activities in 2024 included:

- CAHPS Provider Webinar Training Series via Sullivan Group. The 3 topics included were:
    - Improving Service Excellence Through Successful Telephone Communication.

    - A Better Care Experience with A.I.M. (Assess, Improve, Manage) and
    - Managing Challenging Situations with Patients.
- CAHPS Best Practice Core Measure:
    - Provider Communication/Engagement – Provider Outreach: CAHPS. Created a one-page Best Practice Core Measure for Provider Engagement facing teams.
- CAHPS Playbook:
    - Provider Communication/Engagement – Provider Outreach: highlighted the importance of CAHPS and best practices around CAHPS provider influenced key measures.
- Provider Communication Update:
    - CAHPS article and measure rates.

Opportunities for 2025 include:

The CAHPS Team will attend the A&G Workgroups to discuss and plan efforts that may impact CAHPS and member experience at least quarterly and report to the QI/UM Committee.

- CAHPS and member experience awareness and education continue to be a focus since there are multiple stakeholder teams that are member-facing and have the potential to impact CAHPS scores.
- The CAHPS Team will continue to educate and collaborate with multiple stakeholder teams to promote CAHPS.
    - All patient interaction has the potential to impact CAHPS scores.
    - CAHPS results are often based on patient perception and patient recall.
    - Any negative experience will stay with the member regardless of a look-back period.

3.5. Pediatric/Children's Health Program

Improve Pediatric/Children's Health

Clinical PIP: Well-Child Visits in the First 30 Months of Life – 0 – 15 months – Six or More Well-Child Visits (W30-6+)

Target Population: Black or African American members in Fresno County.

The California Department of Health Care Services (DHCS) implemented a new PIP process in 2023. The initial submission of Steps 1-6 of the PIP process were submitted to HSAG/DHCS in September and November 2023 and CalViva received 100% validation in January 2024.

CalViva submitted Steps 1-8 and an intervention worksheet to HSAG/DHCS in September 2024 and resubmitted minor revisions to HSAG in early December 2024. Validation results may not be available until end of January 2025.

The PIP has two AIM statements:

- Do targeted interventions lead to statistically significant improvement in the percentage of Black or African American children 15 months of age in Fresno County that had six or more well-child visits during the remeasurement year. The baseline rate is 31.3%.
- Do targeted interventions lead to statistically significant improvement in the percentage of Black or African American children who complete three or more infant well-care visits within 120 days of life in Fresno County during the remeasurement year. The baseline rate is 41.5%.

CalViva partnered with Black Infant Health (BIH) in Fresno County and began referring identified Black or African American pregnant members and infants up to three months of age to BIH for the first intervention. In 2024, CalViva referred two lists of members and infants to BIH who outreached to members to enroll them into BIH. BIH reached 39.86% of members referred. Of the members reached, 20.34% enrolled in BIH. The referral lists continue to be sent to BIH approximately every two months.

CalViva also started planning additional interventions to implement in 2025, including incentivizing participants enrolled in BIH to complete the prenatal and postpartum classes and incentivizing participants to complete the 2-month infant well-child visit. Furthermore, CalViva will be promoting CDC's Milestone Tracker for the members enrolled in BIH by providing flyers, brochures, and posters with a QR code to encourage members to download the app on their phones. . A PowerPoint slide on CDC's Milestone Tracker will also be included in BIH's curriculum at members postpartum group session (week 2) that speaks on infant development and members will be guided to utilize the app for tracking doctor's appointments. Moreover, the CDC Milestone Tracker will be promoted at the Provider Webinar and a provider update or provider communication flyer will be launched in Q1.

Quality Monitoring Improvement Program

CalViva completed a Comprehensive Quality Improvement & Health Equity Process for the childhood domain in Fresno County in 2024. CalViva completed a fishbone diagram for the childhood domain in Fresno County and implemented two strategies to improve childhood domain measure rates. The first strategy targeted member engagement in increasing member access to evidence-based health educational resources through provider offices. CalViva distributed an email to providers containing a slide deck with QR codes and links to nationally recognized web-based resources. The slide deck was sent to 10 high volume pediatric providers and a total of 70 providers, including adult providers in Fresno County. Eighty-nine percent (89%) or more of the providers who completed a survey about the materials found the materials were relevant and easy to use and shared the resources with patients.

The second strategy addressed the data gap in W30-6+, W30-2+ and WCV. CalViva QI partnered with the HEDIS team and Provider Engagement to develop a desktop procedure for data reconciliation in order to standardize the data reconciliation process. CalViva created a desktop procedure and tested the data reconciliation process using Power Automate targeting 144 providers for W30 and 220 providers for WCV. For W30-6+, W30-2+ and WCV, 72% of providers targeted engaged in data reconciliation for W30 and 65% of providers engaged for WCV. Comparing rates to the same time last year, 71% of the engaged providers for W30-6+, 62% of the engaged providers for W30-2+ and 69% of the engaged providers for WCV showed improvements in their rates.

CalViva completed a Lean Quality Improvement & Health Equity Process for Kings County. CalViva submitted a completed A3 QI tool for the data reconciliation process in Kings County. The desktop procedure was created and the process tested in Kings County for W30-6+, W30-2+ and WCV. Sixty-five percent (65%) of the providers who engaged in the data reconciliation process for W30-6+ showed year over year improvements in their rates. Fifty-seven percent (57%) of the engaged providers for W30-2+ showed year over year improvements in their rates. Sixty-five percent (65%) of the engaged providers for WCV show improvements in their year over year rates.

Child Health Equity W30-6+ Collaborative Sprint (CHEC Sprint)

CalViva participated in the CHEC Sprint led by the Institute for Healthcare Improvement (IHI) and the California Department of Health Care Services (DHCS) since April 2024. While working with IHI and DHCS, CalViva engaged with a high volume low performing provider in Fresno County, Clinica Sierra Vista. CalViva and Clinica Sierra Vista- Elm Clinics implemented designed/suggested strategies throughout the CHEC Sprint to reduce equity gaps, improve access and build capacity in Fresno County. CalViva has been partnering and working closely with the CSV- Elm sites to implement best practices in children's preventive services to provide effective whole-person pediatric care. Some of the critical elements to achieve the project's aim included effective team-based care, automation, and effective use of technology, including electronic health records, population health management, and addressing social drivers of health. As of December 2024, CalViva and the pilot sites have completed three interventions designed by IHI and submitted all related deliverables to IHI and DHCS. Interventions 4 and 5 are expected to be completed by March 2025.

3.6. Perinatal Health/Reproductive Health

Improve Perinatal Health/ Reproductive Health

CalViva performed well in perinatal and reproductive health measures. All CalViva counties exceeded the 50th percentile for timely prenatal care (PPC-pre), postpartum care (PPC-post) and chlamydia screening (CHL). Kings County exceeded the 90th percentile and Fresno and Madera counties exceeded the 75th percentile for PPC-pre. Fresno and Kings counties exceeded the 75th percentile for PPC-post. Kings County also exceeded the 75th percentile for CHL. Despite the overall good performance for PPC, a disparity exists for Black or African American pregnant and postpartum members. CalViva is partnering with Black Infant Health (BIH) for the clinical W30-6+ PIP by directly referring pregnant and postpartum members to BIH. BIH reached 39.86% of the members referred and 20.34% of members reached enrolled into BIH, which has reported higher rates of prenatal and postpartum visits.

The Population Health Management team continued postpartum outreach calls to assist members in scheduling a postpartum visit and the first infant well care visit. The team reached an average of 85% of members. Of those reached, 35% self-report to have scheduled a postpartum visit and 46% self-report to have scheduled an infant well-care visit.

3.8. Preventive Health/Cancer Prevention

Improving Preventive Health/Cancer Screenings

Cancer screening programs aimed to improve the quality and accessibility of preventive health services, leading to an increased member participation in screenings. These programs were designed to raise awareness among both members and providers, address structural barriers, and offer training and process assessments to optimize clinic workflows. In 2024, efforts to improve preventive health screening performance included multi-gap member outreach, mobile mammography services with associated incentives, and comprehensive provider education paired with action planning.

CalViva members who had multiple gaps were outreached to schedule their appointments and address other barriers related to closing both breast and cervical cancer screening care gaps.

To complement these efforts, educational resources such as tip sheets for breast cancer, cervical cancer, and chlamydia screenings were made available through the Provider Library. Health Net partnered with the mobile mammography vendor, Alinea, to address access challenges for CalViva members. This partnership enabled the successful completion of 16 mobile mammography events, with two held in Kings County and 14 in Fresno County. These events resulted in 292 care gaps closed, 69 in Kings County and 223 in Fresno County. Furthermore, the multi-gap HEDIS calls identified 70,932 CalViva members, resulting in 29,392 contact attempts and successful engagement with 11,763 members.

Building on these initiatives, opportunities for 2025 include forming direct partnership with radiology facilities to address resource limitations and enhance service capacity. Another key area for growth involves collaborating with community-based organizations to deliver equitable and culturally sensitive care, ensuring that preventive health services are accessible and relevant to all members. These strategies reflect a commitment to addressing systemic challenges and fostering inclusive, effective preventive health care.

3.9. Provider Engagement

Quality EDGE

Quality EDGE continued to focus on the 18 Medi-Cal Accountability Set (MCAS) measures held to the minimum performance level (MPL). There was a special focus to align with DHCSs' bold goal of achieving the 50th percentile for all pediatric MCAS measures by 2025. Provider Engagement developed action plans to improve the MCAS measure rates for priority providers in Fresno, Kings, and Madera Counties. As of December 20, 2024, 112 Quality EDGE requests were approved. CalViva supported providers and members with over $660K in funds to sponsor initiatives such as point-of-care member incentive gift cards, mobile mammography events, one-stop clinic events, and equipment/supplies (lead screening machines and fluoride kits).

CalViva also implemented member outreach through the Family Unit HEDIS outreach calls. The team prioritized interventions along the strategic tracks of Data Analytics & Technology, Member and Community Engagement, Direct Care Interventions, Physician/PPG Engagement and Compliance and Operations to support goal achievement.

Provider Engagement increased operational oversight to allow the implementation of corrective action plans for non-compliant providers as appropriate. Some providers were encouraged to engage in the DHCS Equity and Practice Transformation Payments Program to provide additional practice transformation resources.

A standardized data reconciliation process was implemented, kicked off, and piloted in 2024 to help address the significant challenges that data workflow, provider use of codes, and other systems issues can impact the receipt of evidence of member care. Full implementation will be deployed in 2025.

3.10. Continuity/Coordination of Care (Behavioral and Nonbehavioral)

Improving continuity and coordination of care

Continuity and coordination of care between medical care and behavioral health care is an important aspect of care requiring focused and proactive assessment. A patient with a medical or surgical condition may have a behavioral complication or comorbidity. Similarly, a patient with

a behavioral disorder may have a medical comorbidity, or there may be a medical implication. The delivery system may or may not have a mechanism to ensure the seamless transfer of information between medical and behavioral care. This lack of structure, commonly found in the current industry, can cause members to experience discontinuity. The goals of the monitoring and evaluation process are to promote seamless, continuous, and appropriate care to members.

The CalViva Quality Improvement/Utilization Management (QI/UM) Committee provided oversight and guidance for CalViva's QI, Utilization Management (UM), and Credentialing Programs. The QI/UM Committee monitored the quality and safety of care and services rendered to members, identified clinical and administrative opportunities for improvement, recommended policy decisions, evaluated the results of QI and UM activities, and instituted needed actions.

Coordination of Care (Non-Medical):

CalViva used information at its disposal to facilitate continuity and coordination of medical care across its delivery system. CalViva utilized NCQA as a roadmap for improvement on how an organization can deliver high-quality care. Organizations use NCQA standards to perform a care gap analysis and align improvement activities with areas that are most important to the State and employers. It provides a framework for implementing best practices to apply a QI process to improve key operational areas and is reported every two years for accreditation.

Opportunities for improvement identified included providing enhanced member and provider education, engaging both, and utilizing available resources. During RY 2024, CalViva Health monitored the following aspects of continuity and coordination of medical care:

- Timeliness of Perinatal Care – Postpartum Care (PPC)
- Eye Exam for Patients with Diabetes (EED)
- Pharmacotherapy for Opioid Use Disorder (POD)
- Plan All-Cause Readmissions (PCR).

CalViva Health consistently achieved the NCQA 50th percentile across all measures, with the exception of the Pharmacotherapy for Opioid Use Disorder POD measure. This presents an opportunity to reassess and refine our strategies to drive improvement in this area.

Coordination of Care (Behavioral):

In an effort to improve care coordination and exchange of information between and amongst medical and behavioral providers, especially as it related to members visiting the ED for a mental health or substance use issue, an article was published in the September 2024 issue of CalViva's Provider Update. The article emphasized the importance of care coordination, its impact on member satisfaction, tips for improving care coordination, and when timely exchange of information is crucial for quality care. This information was also posted in the online Provider Library for on-demand access.

3.11. Access, Availability, and Service and Satisfaction

Improve Provider Access, Availability, Satisfaction and Service

CalViva is required to follow and monitor timely access standards set by regulators. The DMHC developed the Provider Appointment Availability Survey (PAAS) Methodology and survey tools

set for each measurement year. For MY 2023, CalViva administered the DMHC PAAS to randomly selected sample of in-network PCPs, specialists, and ancillary providers. CalViva adopted DMHC's regulatory compliance goals for Urgent and Non-Urgent Appointment Availability at 70% to align with health care industry standard performance goals for Provider Appointment Availability Survey (PAAS) goals for all appointment measures. For MY 2023, the new survey vendor QMetrics conducted the DMHC PAAS surveys between August through December for CalViva.

After-hours access is evaluated annually through telephonic Provider After-Hours Access Surveys (PAHAS) with performance goals of 90%. Results indicated a need for improvement in several areas. The DMHC PAAS was also administered to Health Net Behavioral Health (HNBH) psychiatrists and non-physician mental health providers who provided behavioral health services to CalViva members. The surveys were conducted via fax, telephone, and/or email between August through December 2023. Additionally, CalViva administered a separate Provider Appointment Availability Survey to capture appointment access among a wider group of PCPs and specialists, to monitor appointment access standards and fulfill reporting requirements (NCQA).

Corrective Action Plans (CAP)

For MY 2023 deficiencies were identified through analysis of the survey results and Corrective Action Plans (CAP) and educational packets were issued to PPGs and providers who failed in one or more of the timely access or after-hours measures. PPGs that received a CAP are required to complete an Improvement Plan (IP), submit a signed non-compliant providers notification attestation, and attend a Timely Access webinar. There were five PPGs and six Direct network providers who received CAP packets. Nine PPGs and four direct network providers received educational packets. PPGs that received a CAP have submitted Improvement Plans and supporting documentation and signed attestations. CAP Improvement Plan (IP) reviews were completed and closed. Two direct network providers who were unresponsive were issued 30-day termination letters, and have since been terminated.

- For 2024, the Access & Availability team have conducted ten provider training webinars from July to December. A total of 744 participants attended. The team continued to enhance training materials and provided some clarification on survey guidelines based on DMHC survey methodology. The team continued to recommend PPGs and provider offices to encourage their staff and coworkers to attend the training. A self-paced provider training is also available on Health Net's portal. Over 100 questions were answered during the webinar and copies of the presentation and Q&As were shared with all attendees.

Opportunities for 2025 include:

- Incentivize providers to improve and maintain access standards.

3.12. Health Education

Member Incentives

A total of 6,073 CalViva members participated in six-member incentive programs during 2024. These programs were aimed at increasing participation in Well Care Visit, Breast Cancer Screening, Cervical Cancer Screening, Childhood Immunization, and Well Child Visits. In total, $151,825 worth of gift cards were distributed to the members as awards. Of the recipients, 62%

were from Fresno County, 28% were from Madera, and 8% were from Kings.

Member Materials Management
A total of 12,780 pieces of member materials have been ordered for CalViva members. The pieces of member materials with the most orders were lead poisoning, diabetes, nutrition, and weight management/exercise. Providers were able to order materials using the online Health Education Material Order Form, while members can request for materials to be ordered from their provider or by calling Member Services.

Health Education Information Line
A total of ten calls have been made to the Health Education Information Line in the CalViva service area. One call inquired about the weight loss program for families and kids. Two calls inquired about diabetic services, one call inquired about provider information and six calls inquired about the health risk assessment form.

Section 4: QI Reporting

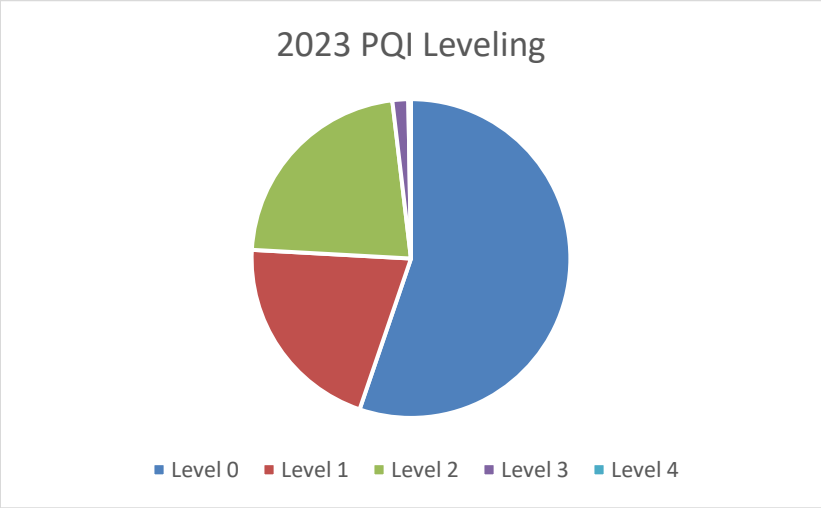
4.1 Safety Monitoring of Potential Quality Issues (PQIs) (Work Plan Section IV Crosswalk -QI Activity)

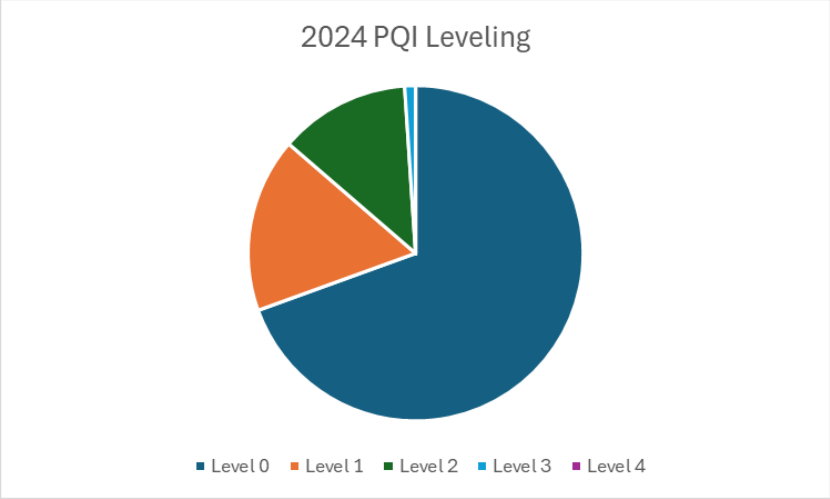
In 2024, CalViva received and closed 285 PQIs. All cases were completed within the regulatory turnaround time to maintain compliance with regulatory requirements. The following table shows the breakdown of leveling for cases. The plan used four severity levels for all PQIs:

- Level 0 – Investigation indicates no quality-of-care issue has occurred.
- Level 1 – Investigation indicates that a particular case demonstrated no potential for serious adverse effects.
- Level 2 – Investigation indicates that a particular case demonstrated a minimal potential for serious adverse effects.
- Level 3 – Investigation indicates that a particular case has demonstrated a moderate potential for serious adverse effects.
- Level 4 – Investigation indicates that a particular case has demonstrated a significant potential for serious adverse effects.

Table 4.1 2023-2024 PQI Cases

PQI Level	2023	2024
Level 0	206	198
Level 1	77	48
Level 2	83	36
Level 3	5	3
Level 4	1	0
Total Cases	**372**	**285**





4.2 Vendor Oversight

The Vendor Oversight team ensured delegated vendors supporting the plan were compliant with contractual and regulatory requirements. This was accomplished via ongoing monitoring and auditing.

2024 Delegated Vendor Auditing and Monitoring Activities
Delegated Utilization Management (UM) – American Specialty Health (ASH), TurningPoint and Evolent were delegated for UM.

- The Evolent audit resulted in UM findings for not consistently providing denial rationale written in layman terms. The ASH and TurningPoint annual audits have not been finalized.
- Transportation Program – The semi-annual scorecard evaluations of ModivCare resulted in non-compliance with the Physician Certification Statement (PCS) form process. ModivCare has an existing corrective action for this requirement and an active remediation plan. The annual audit has not been finalized. The health plan will be bringing the PCS form process in-house in 2025.

Delegated Vendor Auditing and Monitoring Summary

- Delegated Credentialing – American Specialty Health (ASH) and Centene Vision were delegated for Credentialing.
    - The Centene Vision audit demonstrated compliance with no findings. The ASH audit has not been finalized.
- Delegated Utilization Management (UM) – American Specialty Health (ASH), TurningPoint and Evolent were delegated for UM.
    - The Evolent audit resulted in UM findings for not consistently providing denial rationale written in layman terms. The ASH and TurningPoint annual audits have not been finalized.
    - Transportation Program – The semi-annual scorecard evaluations of ModivCare resulted in non-compliance with the PCS form process. ModivCare has an existing corrective action for this requirement and an active remediation plan. The annual audit has not been finalized. The health plan will be bringing the PCS form process in-house in 2025.

<u>2025 Delegated Vendor Auditing and Monitoring Plan</u>
For 2025, the plan will continue to perform transportation monitoring via scorecard evaluations, quarterly JOCs, monthly ModivCare VOCs and perform annual audits of delegated services.

Delegated Vendor	Description of Services	Proposed Audit & Monitoring Schedule
Evolent Specialty Services	Advanced Radiology Services	Annual Audit: June
American Specialty Health (ASH)	Acupuncture Network	Annual Audit: June
ModivCare	Transportation Services: Non-Medical & Non-Emergency (NMT & NEMT)	Annual Audit: June Scorecard reviews, March and October
TurningPoint Healthcare Solutions	Musculoskeletal Surgical, Cardiac Procedures	Annual Audit: May
Centene Management Company	Utilization Management, Claims, Member Services	Annual Audit: December
Centene Vision Services (Envolve Vision)	Vision Benefits Manager (Optometry & Ophthalmology)	Annual Audit: May

Section 5: Summary of Key Accomplishments

The 2024 reporting year was a productive year for CalViva's Quality Improvement Program. The following is a summary of some of the key QI interventions and accomplishments for this period.

Health Education:

- The Plan promoted a newly developed digital resource which included QR codes and links to health education resources for members.

- The Plan worked with Member Services to inform members of available health education materials and programs available to CalViva members.
- The Plan reviewed and updated health education materials as needed, following DHCS guidelines, and promoted digital ordering and print distribution of required and high-volume topic articles.
- Completed the emergency room (ER) visit analysis in September 2024 for the Central California Asthma Collaborative (CCAC) asthma project. There were 59 ER visits (59/134) among program participants who completed the program compared to 73 ER visits (73/141) among program participants before the program began. In addition, among members who completed the program, the AMR gap closure rate was 16%, which was slightly higher than members who did not complete the program.
- Continue partnership and promotion of BCS and CCS screenings via partnerships with community based organizations such as Every Woman Counts.,
- Promoted Kick It California tobacco cessation program in the member newsletter and at various meetings.
- Awaiting DHCS approval of new Diabetes Prevention Program (DPP) with new DPP provider.
- Developed 2-member outreach campaigns to promote new DPP once approved by DHCS.
- Developed 1-provider outreach campaign to promote new DPP once approved by DHCS.
- Weight Management Fit Families For Life (FFFL): 1 request received and fulfilled for this resource in 2024.
- Received DHCS and DMHC approval for the myStrength Program transition to Teladoc Mental Health (Digital Program).
- Completed a member material assessment and converted the material to Krames content and the Staywell Library.

Quality Indicators and Ratings for MY 2023

- Fresno, Kings, and Madera counties all met 100% of the Chronic Conditions measures MPL – 50th percentile (CBP and Diabetes Poor Control).
- Fresno, Kings and Madera Counties met 100% of the Adult Preventive Care/Cancer Prevention Measures MPL - 50th percentile (CHL, BCS, and CCS, and AISE Flu).
- Madera County met 100% of the Children's Health and Pharmacy Measures MPL – 50th percentile as well as met all measures (16) except two (2) behavioral health measures
- Fresno, Kings, and Madera counties all met 100% of the Perinatal/Reproductive Care measures MPL – 50th percentile (PPC).
- CalViva scored 100% for BH PAAS by Risk Rating measures.

Regulatory Requirements and Submissions

- High Volume Physical Accessibility Review Survey (PARS) report was submitted to DHCS in January 2024.
- The Clinical Improving Infant Well-Child Visits (W30-6+) Among Black or African American Infants in Fresno County PIP Steps 1-8 were submitted to HSAG in Q3 2024 with an Intervention Worksheet. Minor revisions were submitted in early December 2024. Awaiting validation from HSAG.
- The Kings County Lean Quality Improvement & Health Equity Process A3 initial plan was submitted to DHCS in May 2024 and the Progress report submitted in September2024.

- The Madera County Lean Quality Improvement & Health Equity Process A-3 Initial plan was submitted to DHCS in May 2024 and the Progress report was submitted in September 2024.
- The Fresno County Comprehensive Quality Improvement & Health Equity Process Fishbone Diagram was submitted to DHCS in May 2024. The two strategies and action items were submitted to DHCS in June 2024 and the Progress Report was submitted to DHCS in October 2024.
- The Child Health Equity Collaborative Sprint deliverables (3 storyboards and 3 post-intervention reports) were submitted to the Institute for Healthcare Improvement (IHI) in June, August, and November 2024.
- The Non-Clinical Behavioral Health PIP SUD/SMH Steps 1-8 were submitted to HSAG in Q4 2024; currently awaiting final validation.

Quality Improvement Initiatives

- Continued pilot of tracking high volume, low performing providers for Initial Health Appointments (IHA) with Provider Engagement team on a quarterly cadence. The performance overall YTD for High Volume low performing providers increased by 2.86%.
-
- Provided 27 POC lead analyzers with one year supply of test strips to provider offices in the CalViva Health service area.
- Completed 21 PARS in Fresno, Kings, and Madera counties.
- Results from annual HSAG CAHPS Survey (2023 results): YOY rate increased for the following rating measures: Rating of Health Plan and Rating of All Health Care.
- Successfully prepared and coordinated all needed requirements for CalViva to launch regulatory CAHPS in Q1 2024. 2025 will be the last year that HSAG will be conducting adult and child CAHPS surveys. Starting in 2026, the health plan will be responsible for conducting its own adult and child CAHPS survey.
- Conducted a total of 10 provider Timely Access webinars sessions in 2024 statewide, with a total of 744 attendees participated.
- For Pediatric/Children's Health, CVH developed a partnership with Black Infant Health (BIH). CVH referred a total of 208 members during the initial intervention cycles combined (76 prenatal and 132 postpartum members) to BIH Fresno and 15 CVH members total were enrolled in the BIH program from the June, July and August CVH list of referrals. The total reach rates for the prenatal members were 46.05% and the total reach rates for the postpartum members was 36.13%.
- CalViva is currently engaged in a plan wide Provider Training on IHA Best Practices that includes IHA visit compliance requirements. Year to Date (YTD), 557 provider trainings have been completed, resulting in a 14% increase YTD for IHA visit compliance completion rates within 120 days of enrollment.
- In Quarter 1, the Plan trained Provider Engagement on LSC requirements including anticipatory guidance documentation and provided California Department of Public Health resources and materials to be shared with providers and members. In Quarter 2 the Anticipatory Guidance Compliance Rates increased by 1.06%.
- DHCS approval of vendor to administer in-home A1c kits to Medi-Cal members allows for targeted outreaches in 2025 for direct care gap close; all Medi-Cal collateral have been approved prior to contract execution.

Quality Improvement Department and Program

- Implemented Quality EDGE through Provider Engagement and Medical Affairs targeting priority providers and PPGs in Fresno, Kings, and Madera Counties.

- Quality EDGE funding supported 117 activities to close care gaps in CalViva counties in 2024. Activities include community events, equipment for providers, blood pressure and lead screening resources, technology support, direct care services (one-stops and mobile mammography), and member and provider staff incentives.

Section 6: Annual QIHEd Program Changes

Based on this evaluation, the QIHEd Program effectively meets safe clinical practice goals, has adequate resources, and a strong QI Committee structure, which includes productive practitioner participation and effective leadership. Program and Drivers (PODs) continue to gain efficiency across various teams, streamline operations, and reduce duplication within and across teams and programs. The purpose of the team PODs is to improve the design and group of programs to achieve strategic outcomes and goals, foster collaboration and align teams, and create more opportunities for innovation and growth. Quality Management will continue to leverage health plan materials, activities, and reporting along with its internal processes to improve care and services for CalViva members..

Appendix

Table A-1. Performance Goals

Standard	Goal
DHCS Managed Care Accountability Set (MCAS) HEDIS Measures	NCQA QC National 50th Percentile
Behavioral Health MCAS HEDIS Measures	NCQA QC National 50th Percentile
Hospital Care/Patient Safety	YOY Directional improvement for % network hospitals meeting Hospital-Acquired Infections and Nulliparous, Term, Singleton, Vertex C-section rate targets
CAHPS	YOY Improvement and/or NCQA QC National 25th Percentile (stretch goal)
Provider Access and Availability and Satisfaction Surveys	70 or 90 Percentage Rate (%) or directional YOY improvement.

Table A-2. MY 2023 MCAS Measures Above 50th Percentile by County

CalViva Counties	Fresno	50%	**Overall 59%**
	Kings	39%	
	Madera	89%	

Table A-3. Summary of RY 2024 Outcomes by Category

Category	Medi-Cal	
	N	Rate %
Adult Chronic Care	6/6	100%
Adult Preventive Care/Cancer Prevention	6/6	100%
Adult Survey (CAHPS)^	3/5	50%
Behavioral Health	0/12	0%
Children's Health	7/18	38.89%
Hospital Care/Patient Safety	9/9	100%
Pharmacy*	7/8	87.5%
Provider Access and Availability and Satisfaction Surveys	105/152	69.08%
Reproductive Health	9/9	100%
Total	**152/225**	**67.56%**

^ In 2024, HSAG conducted the annual CAHPS survey for CalViva Health.

Table A-4. Summary of Opportunities

Based on results, the following performance measures are areas of focus for improvement for CalViva.

Adult Health Opportunities	Reproductive Health Opportunities
Chronic Care: • Controlling High Blood Pressure • Hemoglobin A1c Control for Patients With Diabetes - HbA1c Poor Control **Pharmacy:** • Asthma Medication Ratio **Preventive Health/Cancer Prevention:** • Cervical Cancer Screening	• N/A
	Children's Health Opportunities
	• Childhood Immunization Status - Combo 10 • Immunizations for Adolescents - Combo 2 • Well-Child Visits in the First 30 Months of Life - 0 to 15 Months • Well-Child Visits in the First 30 Months of Life - 15 to 30 Months • Child and Adolescent Well-Care Visits • Lead Screening in Children • Developmental Screenings in the First 3 Years of Life
Behavioral Health Opportunities	

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)

New opportunities identified by DHCS (currently not being held to the MPL):
- Depression Remission or Response for Adolescents and Adults (DRR-E)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Hospital Care/Patient Safety Opportunities

- Hospital performance on HAIs: Central Line Associated Bloodstream Infection and Surgical Site Infection – Colon

Member Experience – CAHPS Opportunities

CAHPS Measures:
- Customer Service Composite
- Getting Needed Care Composite
- Getting Care Quickly Composite
- How Well Doctors Communicate Composite
- Coordination of Care
- Overall Rating Measures (Personal Doctor, Specialist)

Provider Survey Opportunities

PAAS Survey Measures:
- Access to PCPs,
- Access to Specialists
- Access to Ancillaries
- Access to Psychiatry and Non-Physician Mental Health
- Telephone Access: Provider call-back for non-urgent issues during normal business hours

PAHAS Survey Measures:
- Appropriate After-Hours Emergency Instructions
- Ability to Contact On-Call Physicians After-Hours

Provider Satisfaction Survey:
- All Provider Satisfaction Survey Access Measures
- Behavioral Health Practitioners Survey Access Measures: Routine Care, Urgent Care, Non-Life-Threatening Emergent Care, and Coordination of appointments with an interpreter Standards.
- All BH Experience of Care and Health Outcomes (ECHO) measures

Table A-5. County Level MCAS HEDIS Outcomes for MY 2022 – MY 2023

Fresno	HEDIS Measure	MY 2022 (%)	MY 2023 (%)	^ Rate Trend	*QC MY 2023 Nat'l 50th Percentile	Outcome Met (Y/N)
Adult Chronic Care						
CBP	Controlling High Blood Pressure	61.73%	64.29%	↑	61.31%	Y

CDC/ HBD	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Poor Control (<8%) **(inverted)**	37.47%	35.31 %	↑	37.96%	Y
Adult Preventive Care/Cancer Prevention						
BCS	Breast Cancer Screening	52.14%	57.87 %	↑	52.20%	Y
BCS-E	Breast Cancer Screening-E	N/R	N/R	-	52.60%	N/R
CCS	Cervical Cancer Screening	57.08%	60.55 %	↑	57.11%	Y
Children's Health						
CIS-10	Childhood Immunization Status - Combo 10	27.49%	27.74%	↑	30.90%	N
IMA-2	Immunizations for Adolescents - Combo 2	37.23%	36.06 %	↓	34.31%	Y
LSC	Lead Screening in Children	49.88%	56.69%	↑	62.79%	N
W30-6+	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	50.01%	56.65%	↑	58.38%	N
W30-2+	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	62.69%	65.01%	↑	66.76%	N
WCV	Child and Adolescent Well-Care Visits	48.14%	51.57 %	↑	48.07%	Y
Pharmacy						
AMR*	Asthma Medication Ratio	62.15%	63.66 %	↑	65.61%	N
Reproductive Health						
CHL	Chlamydia Screening in Women	58.86%	61.35%	↑	56.04%	Y
PPC	Prenatal and Postpartum Care – Postpartum Care	84.23%	82.10%	↓	78.10%	Y
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	89.62%	90.39%	↑	84.23%	Y
Kings	**HEDIS Measure**	**MY 2022 (%)**	**MY 2023 (%)**	**^ Rate Trend**	***QC 2023 Nat'l 50th Percentile**	**Outcome Met (Y/N)**
Adult Chronic Care						
CBP	Controlling High Blood Pressure	71.81%	72.81%	↑	61.31%	Y
CDC/ HBD	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (<8%) **(inverted)**	30.05%	25.42%	↑	37.96%	Y
Adult Preventive Care/Cancer Prevention						

BCS	Breast Cancer Screening	58.61%	61.90	↑	52.20%	Y
BCS-E	Breast Cancer Screening	N/R	N/R	-	52.60%	N/R
CCS	Cervical Cancer Screening	58.95%	61.10	↑	57.11%	Y
Children's Health						
CIS-10	Childhood Immunizations Status – Combo 10	23.84%	19.83%	↓	30.90%	N
IMA-2	Immunizations for Adolescents - Combo 2	29.68%	31.39 %	↑	34.41%	N
LSC	Lead Screening in Children	53.77%	58.64%	↑	62.79%	N
W30-6+	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	53.48%	57.44%	↑	66.76%	N
W30-2+	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	55.59%	53.74 %	↓	66.76%	N
WCV	Child and Adolescent Well-Care Visits	39.56%	41.79 %	↑	48.07%	N
Pharmacy						
AMR*	Asthma Medication Ratio	64.37%	59.29 %	↓	65.61%	N
Reproductive Health						
CHL	Chlamydia Screening in Women	62.15%	64.11 %	↑	56.04%	Y
PPC	Prenatal and Postpartum Care - Postpartum Care	84.18%	83.84%	↓	78.10%	Y
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	87.76%	91.27 %	↑	84.23%	Y
Madera	**HEDIS Measure**	**MY 2022 (%)**	**MY 2023 (%)**	**^ Rate Trend**	***QC 2023 Nat'l 50th Percentile**	**Outcome Met (Y/N)**
CBP	Controlling High Blood Pressure	67.49%	71.04%	↑	61.31%	Y
CDC/ HBD	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Poor Control (<8%) **(inverted)**	35.93%	30.79 %	↑	37.96%	Y
Adult Preventive Care/Cancer Prevention						
BCS	Breast Cancer Screening	61.03%	63.15%	↑	52.20%	Y
BCS-E	Breast Cancer Screening-E	N/R	N/R	-	52.60%	N/R
CCS	Cervical Cancer Screening	61.58%	68.37%	↑	57.11%	Y
Children's Health						
CIS-10	Childhood Immunization Status - Combo 10	48.42%	47.45%	↓	30.90%	Y

IMA-2	Immunizations for Adolescents - Combo 2	53.53%	47.32%	↓	34.41%	Y
LSC	Lead Screening in Children	66.42%	78.10%	↑	62.79%	Y
W30-6+	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	56.71%	63.70%	↑	66.76%	N
W30-2+	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	75.65%	79.19%	↑	66.76%	Y
WCV	Child and Adolescent Well-Care Visits	57.71%	65.02%	↑	48.07%	Y
Pharmacy						
AMR*	Asthma Medication Ratio	72.93%	72.20%	↓	65.61%	Y
Reproductive Health						
CHL	Chlamydia Screening in Women	59.38%	62.08%	↑	56.04%	Y
PPC	Prenatal and Postpartum Care - Postpartum Care	87.04%	80.10 %	↓	78.10%	Y
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	90.37%	90.82 %	↑	84.23%	Y

*Percentile based on Quality Compass (QC) 2023 National HMO benchmarks for MY 2023 MCAS. Outcomes met for regional performance are based on the DHCS MPL at the 50th percentile.
^ rate trend based on directional changes to rates year over year.
NT Not trendable year over year due to significant differences in NCQA technical specifications.
N/R Not reported.
^Administrative rate only
*These measures are not current MY 2024 MCAS measures but are upcoming MY 2024 MCAS measures.

Table A-6. Progress to MY 2023 Goals – Behavioral Health Outcomes (HEDIS)

Fresno	HEDIS Measure	MY 2022 (%)	MY 2023 (%)	^ Rate Trend	*QC 2023 Nat'l 50 Percentile Rate	Outcome Met (Y/N)
~FUM7	Follow-Up Within 7 Days After Emergency Department Visit for Mental Illness	14.98%	6.65%	↓	40.59%	N
~FUM30	Follow-Up Within 30 Days After Emergency Department Visit for Mental Illness	25.47%	14.17%	↓	54.87%	N
~FUA7	Follow-Up Within 7 Days After Emergency Department Visit for Substance Use	10.84%	8.52%	↓	24.51%	N
~FUA30	Follow-Up Within 30 Days After Emergency Department Visit for Substance Use	18.48%	15.01%	↓	36.34%	N

Kings	HEDIS Measure	MY 2022 (%)	MY 2023 (%)	^ Rate Trend	*QC 2023 Nat'l 50 Percentile Rate	Outcome Met (Y/N)
~FUM7	Follow-Up Within 7 Days After Emergency Department Visit for Mental Illness	58.50%	26.78%	↓	40.59%	N
~FUM30	Follow-Up Within 30 Days After Emergency Department Visit for Mental Illness	70.07%	38.25%	↓	54.87%	N
~FUA7	Follow-Up Within 7 Days After Emergency Department Visit for Substance Use	21.85%	16.56%	↓	24.51%	N
~FUA30	Follow-Up Within 30 Days After Emergency Department Visit for Substance Use	31.79%	21.66%	↓	36.34%	N
Madera	**HEDIS Measure**	**MY 2022 (%)**	**MY 2023 (%)**	**^ Rate Trend**	***QC 2023 Nat'l 50 Percentile Rate**	**Outcome Met (Y/N)**
~FUM7	Follow-Up Within 7 Days After Emergency Department Visit for Mental Illness	36.80%	10.11%	↓	40.59%	N
~FUM30	Follow-Up Within 30 Days After Emergency Department Visit for Mental Illness	52.00%	22.47%	↓	54.87%	N
~FUA7	Follow-Up Within 7 Days After Emergency Department Visit for Substance Use	11.45%	9.47%	↓	24.51%	N
~FUA30	Follow-Up Within 30 Days After Emergency Department Visit for Substance Use	18.32%	16.84%	↓	36.34%	N

*Percentile based on Quality Compass (QC) 2023 National HMO benchmarks for MY 2023 MCAS. Outcomes met for regional performance are based on the DHCS MPL at the 50th percentile.
^ rate trend based on directional changes to rates year over year.
[NT]Not trendable year over year due to significant differences in NCQA technical specifications.
[N/R] Not reported.
^Administrative rate only
~ MY23 rates reflect work that took place starting in Q4 2023

Table A-7. Regulatory CAHPS Survey administered by HSAG

CAHPS Measures	MY 2022 (%)	MY 2023 (%)	^ Rate Trend	Baseline Source (Source: For 2023 - Quality Compass MY 2023 25th Percentile)	**Outcomes Met (Y/N)
Getting Needed Care	76.7%	73.50	↓	77.83%	N
Getting Care Quickly	81.8%	N/R	-	76.01%	N/R
How Well Doctors Communicate	93.5%	90.2%	↓	91.44%	N
Customer Service	86.3%	N/R	-	88.1%	N/R
Coordination of Care	81.8%	N/R	-	82.18%	N/R
Rating of All Health Care	74.7%	76.87%	↑	72.32%	Y
Rating of Personal Doctor	85.7%	81.38%	↓	80.4%	Y
Rating of Health Plan	71.9%	81.98%	↑	74.71%	Y
Rating of Specialist	80.4%	N/R	-	78.63%	N/R

^ In 2024, HSAG conducted the annual CAHPS survey for CalViva Health, with final results available in May 2024.
N/R Non-reportable data due to small sample size (n<100).
** Outcome met Y/N based on Quality Compass MY 2023 25th Percentile.

Provider Appointment Availability Survey (PAAS)

Table A-8. PAAS (DMHC PAAS + Non-DMHC Medi-Cal Questions) – Access to PCPs

PAAS (DMHC + Non-DMHC Medi-Cal)										
Access Measure and Standard (Performance Goal = 70%)										
County	Urgent Care Appointment within 48 hours of request (PCP)		Non-Urgent Appointment within 10 business days of request (PCP)		Access to Preventive Health Check-Up/Well-Child Appointment within 10 business days of request (PCP)		Access to Physical Exams and Wellness Checks within 30 calendar days of request (PCP)		Access to First Prenatal Appointment within 2 weeks of request (PCP)	
	(Rate %)									
	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023
Fresno	50.2	79.7↑	76.8	89.5↑	62.9	87.5	81.7	92.3	71.9	80.5
Kings	62.7	80.0 ↑	77.2	87.0↑	69.8	70.6	84.6	85.3	82.1	75.01
Madera	60.0	80.0 ↑	73.2	78.7 ↑	68.6	91.4	84.8	94.1↑	90.0	100.0
Telehealth	42.2	N/A	70.3	N/A	56.7/A	N/A	76.0	N/A	66.7	N/A
Kern	N/A	75.6	N/A	80.2	N/A	77.2	N/A	92.3	N/A	91.3

PAAS (DMHC + Non-DMHC Medi-Cal)										
Access Measure and Standard (Performance Goal = 70%)										
	Urgent Care Appointment within 48 hours of request (PCP)		Non-Urgent Appointment within 10 business days of request (PCP)		Access to Preventive Health Check-Up/Well-Child Appointment within 10 business days of request (PCP)		Access to Physical Exams and Wellness Checks within 30 calendar days of request (PCP)		Access to First Prenatal Appointment within 2 weeks of request (PCP)	
	(Rate %)									
County	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023
Mariposa	N/A	100.0*	N/A	100.0*	N/A	100.0*	N/A	100.0	N/A	100.0
Merced	N/A	66.7*	N/A	10.0	N/A	20.0*	N/A	20.0	N/A	75.0
Overall	**49.0%**	**78.8 %↓**	**74.4%**	**85.3%**	**61.8%**	**83,9%**	**86.7%**	**91.1%**	**72.6%**	**83.1%**

Rate - Percent of total number of respondents surveyed who met the access standard.
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2022 PAAS (p<0.05).
* - Denominator less than 10,
^ Low response rates compared to MY 2021 and
therefore comparisons should be made with caution

Table A-9. PAAS (DMHC + CalViva) – Access to Specialists (All)

PAAS (DMHC + CALVIVA PAAS)						
Access Measure and Standard (Performance Goal = 70%)						
	Urgent Care Appointment within 96 hours of request (Specialists)		Non-Urgent Appointment within 15 business days of request (Specialists)		Access to First Prenatal Appointment within 2 weeks of request (Specialists)	
	(Rate %)					
County	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023
Fresno	39.3	55.3	60.1	64.8	63.9	83.3
Kings	47.1	41.2	82.4	52.6↓	100.0*	66.7*
Madera	32.3	61.1	48.6	62.5	0.0	100.0”
Telehealth	34.6	N/A	42.9	N/A	N/A	N/A
Kern	N/A	61.1	N/A	57.1	N/A	N/A
Merced	N/A	75.0*	N/A	75.0*	N/A	N/A
Monterey	N/A	33.3*	N/A	0.0*	N/A	N/A
San Luis Obispo	N/A	100.0*	N/A	100.0*	N/A	N/A
Overall	**37.6%**	**56.8%**	**56.1%**	**61.8%↓**	**67.4%**	**85.0%**
County	Urgent Care Appointment within 96 hours of request		Non-Urgent Appointment within 15 business days of request			

	(Specialists - Oncology)		(Specialists - Oncology)	
	(Rate%)			
	MY 2022	MY 2023	MY 2022	MY 2023
Fresno	25	78.6	86	78.6
Kings	33*	33.3*	67*	100.0*
Madera	50*	100.0*	75*	100.0*
Kern	N/A	50.0*	N/A	50.0*
Merced	N/A	100.0*	N/A	100.0*
Overall	**35.8%**	**75.0%**	**81.5%**	**83.382**

Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2022 PAAS (p<0.05)
N/A – No available responses
* - Denominator less than 10

Table A-10 PAAS (DMHC ONLY)–SCPs (Cardiologists, Gastroenterologists, Endocrinologists)

PAAS (DMHC)				
Access Measure and Standard (Performance Goal = 90%)				
County	Urgent Care Appointment within 96 hours of request (Specialists)		Non-Urgent Appointment within 15 business days of request (Specialists)	
	(Rate %)			
	MY 2022	MY 2023	MY 2022	MY 2023
Fresno	40.9	54.0	50.0	59.8
Kings	50.0	55.6	100.0	63.6
Madera	26.3	63.4	42.2	64.0
Telehealth	34.6	N/A	42.9	N/A
Kern	N/A	61.1	N/A	57.1
Merced	N/A	75.0*	N/A	75.0*
Monterey	N/A	33.3*	N/A	0.0*
San Luis Obispo	N/A	100.0*	N/A	100.0*
Overall	**35.4%**	**57.6%**	**46.3%**	**59.9%**

Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant
difference between MY 2021 PAAS vs MY 2022 PAAS (p<0.05)
N/A – No available responses
* - Denominator less than 10

Table A-11. PAAS (DMHC) – Access to Ancillary

PAAS (DMHC)			
Access Measure and Standard		Non-Urgent Services within 15 business days of request (Ancillary)	
County	Performance Goal	MY 2022 (%)	MY 2023 (%)
Fresno	70%	92.3	85.7
Kings	70%	100.0*	66.7*
Madera	70%	75.0*	100.0*
Kern	70%	N/A	94.7
Merced	70%	N/A	N/A
Monterey	70%	N/A	N/A
San Luis Obispo	70%	N/A	100.0*
Overall	**70%**	**89.5%**	**89.4%**

Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2022 PAAS (p<0.05)
N/A – No available responses
* - Denominator less than 10

Table A-12. PAAS (DMHC) – Access to Psychiatry and Non-Physician Mental Health

PAAS (DMHC)								
Access Measure and Standard (Performance Goal = 70%)								
	Urgent Care services within 96 hours of request (Psychiatrist)		Non-Urgent Appointment within 15 business days of request (Psychiatrist)		Urgent Care services within 96 hours of request (NPMH)		Non-Urgent Appointment within 10 business days of request (NPMH)	
	(Rate %)							
County	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023
Fresno	38.5	57.1*	50.0	50.0*	50.0	78.7	77.1	81.1
Kings	0.0	N/A	0.0*	N/A	33.3*	87.53*	66.7	77.8*
Madera	N/A	N/A	N/A	N/A	75.0*	83.3	100.0*	92.3
Telehealth	25.0*	66.7*	50.0*	66.7*	37.8	87.5	60.5	94.4
Overall	**33.3%**	**60.0%**	**47.4%**	**54.5%**	**47.4%**	**80.6%**	**73.4**	**83.3%**

Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2022 PAAS vs MY 2023 PAAS (p<0.05)
N/A – No available responses
* - Denominator less than 10

CalViva Telephone Access Survey

Table A-13. CalViva Telephone Access Survey

Access Measure	Standard	Goal	County	MY 2022 (%)	MY 2023 (%)
Telephone Answer Time	Within 60 seconds	90%	Fresno	100	99.5
			Kings	100	100.0
			Madera	92.0	100.0

			Total	**99.0**	**99.6**
Provider Call-back for non-urgent issues during normal business hours	Within one business day	90%	Fresno	86.0	58.8
			Kings	87.0	64.7
			Madera	88.0	100.0
			Total	**87.0**	**63.6**

N - Total number of respondents to the survey question

Provider Satisfaction Survey - Satisfaction with Timely Access Regulations

Medical/Non-Behavioral Health

Table A-14. CalViva Provider Satisfaction Survey (PSS) Survey (% Satisfied/Very Satisfied) – Overall Results

Metric	MY 2022 (%)	MY 2023 (%)
Access and Availability (Composite)	69.7	78.1
Referral and/or prior authorization process necessary for your patients to access covered services	65.5	80.5
Access to Urgent Care	71.7	74.6
Access to non-urgent primary care	73.9	82.6
Access to non-urgent specialty services	68.0	73.6
Access to non-urgent ancillary diagnostic and treatment services	70.0	78.6
Access to current and accurate provider directory data	68.8	78.9

Table A-15. CalViva PSS Survey Results (% Satisfied/Very Satisfied) – by County

Access Measure	Source	Fresno		Kings		Madera	
		MY 2022 (%)	MY 2023 (%)	MY 2022 (%)	MY 2023 (%)	MY 2022 (%)	MY 2023 (%)
Referral and/or prior authorization process	CalViva Provider Satisfaction Survey	61	86	50*	40*	90	64
Access to urgent care		73	79	50*	50*	75	67
Access to non-urgent primary care		72	87	100*	50*	80	75
Access to non-urgent specialty services		68	76	50*	50*	71	75
Access to non-urgent ancillary diagnostic & treatment services		71	76	50*	50*	71	78
Access to current and accurate provider directory data		67	76	100*	60*	71	88

* Rates calculated with small denominator size (≤30), and therefore comparisons and conclusions should be made with caution.
N/A – Not Applicable for measurement year

Table A-16. CalViva PSS for Behavioral Health Practitioners Survey Results

Access Measure	Source	MY 2022 N (%)	MY 2023 N (%)
Perspective on or concerns with compliance with the Routine Care standard (*% usually/always able to meet standard)*	Behavioral Health Provider Satisfaction Survey (PSS)	29 (58.6)	36 (86.1)
Perspective on or concern with the time standard for routine follow up appointments with a non-physician behavioral health provider? *(% usually/always able to meet standard)*		No data	32 (90.6)
Perspective on or concerns with compliance with the Urgent Care standard *(% usually/always able to meet standard)*		28 (60.7)	30 (76.7)
Perspective on or concerns with compliance with the Non-Life-Threatening Emergent Care standard *(% usually/always able to meet standard)*		27 (70.4)	31 (51.6)
Perspective on or concerns with the coordination of appointments with an interpreter? *(% not used/no concern)*		25 (84.0)	40 (92.5)
Perspective on or concerns with the availability of an appropriate range of interpreters? *(% not used/no concern)*		24 (95.8)	40 (92.5)
Perspective on or concerns with compliance with the training and competency of available interpreters? *(% not used/no concern)*		24 (91.7)	40 (90.0)

CalViva Provider After-Hours Availability Survey (PAHAS)

Table A-17. Provider After-Hours Survey Results

		Appropriate After-Hours Emergency Instructions		Ability to contact on-call physician after-hours within 30 minutes	
County	Performance Goal	MY 2022 (%)	MY 2023 (%)	MY 2022 (%)	MY 2023 (%)
Fresno	90%	97.8	98.2	90.1	84.5↓
Kings	90%	100	98.5	94.3	83.1↓
Madera	90%	100	100	100	100
Overall	**90%**	**98.3%**	**98.4%**	**91.6%**	**85.9%**

N – Total number respondents to the question
Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2022 PAAS vs MY 2023 PAAS (p<0.05)

Table A-18. CalViva Health Experience of Care and Health Outcomes (ECHO)

Access Measure	Performance Goal	Source	FRESNO		KINGS		MADERA	
			MY 2022 N (%)	MY 2023 N (%)	MY 2022 (%)	MY 2022 N (%)	MY 2022 N (%)	MY 2023 N (%)
Non-urgent initial appointment with a psychiatrist within 15 days of request	90%	Experience of Care and Health Outcomes (ECHO)	61 (59.0)	55 (50.9)	7 (42.9)	3 (0.0)*	6 (66.7)	4 (50.0)*
Non-urgent initial appointment with psychiatrist within 10 days of request	90%		61 (37.7	55 (32.7)	7 (42.9)	3 (0.0)*	6 (33.3)*	4 (25.0)*
Non-urgent follow-up appointment with psychiatrist within 30 days of request	90%		89 (79.8)	76 (76.3)	7 (71.4)	4 (75.0)*	5 (80.0)*	5 (60.0)*
Non-urgent initial appointment with a non- physician within 10 days of request	90%		75 (45.3)	76 (46.1	8 (25.0)	4 (0.0)*	11 (36.4)	7 (42.9)*
Non-urgent follow-up appointment with non-physician behavioral health care provider within 10 days of request	90%		94 (51.1)	94 (44.7)	11 (27.3)	5 (20.0)*	9 (44.4)*	8 (37.5)*
Non-urgent follow-up appointment with non-physician behavioral health care provider within 30 days of request	90%		94 (84.0)	94 (84.0)	11 (45.5)	5 (20.0)*	9 (100)*	8 (87.5)*

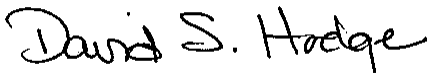
* Rates calculated with small denominator size (≤30), and therefore comparisons and conclusions should be made with caution.
N - Represents the number of respondents who populated a response to that particular Access Measure

Table A-19. MHN BH Appointment Availability Results by Risk Rating

Access Measure	Performance Goal	Source	MY 2022 (%)	MY 2023 (%)
Access to Urgent care within 48 hours	90%	Behavioral Health Case Management System	100	100
Access to NLTE care within 6 hours			100	100

Fresno-Kings-Madera Regional Health Authority Approval

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



February 20, 2025

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

Date

February 20, 2025

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

Date