Medi-Cal Managed Care Division

state of california

Medi-Cal Managed Care
External Quality Review Organization

Quality Improvement Projects Report
2nd Quarter 2006

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Delmarva Foundation
Improving Healthcare in the Communities We Serve.

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Quarterly Status Report
Validation of Quality Improvement Projects

Status of Quality Improvement Projects (QIPs)

Thirteen projects were submitted to Delmarva from Medi-Cal health plans in the second quarter, the period of April 1 – June 30, 2006. Validations were completed for each of these projects.

QIP Reporting

Of the 13 QIP projects submitted during the period, two of the projects were new proposals, nine projects (including the new proposals) were Individual Quality Improvement Projects (IQIPs) and four were Small Group Collaborative (SGC) QIPs. The topics for the 13 projects submitted are found in the table below.

Table I. QIP Topics for Submissions April – June 2006.

Project Name	Plan	Year	Status	Improvement Achieved
Improving Asthma Outcomes by Use of Asthma Tools (IQIP)	Alameda Alliance	Annual Submission Baseline (BL) 2005	Validation completed	NA – Baseline activity
Improving Asthma Care Through Community Collaboration (SGC)	Alameda Alliance	Annual Submission Baseline (BL) 2004 Remeasurement 2	Validation completed	Mixed*
Improving the Rates of Breast Cancer Screening (IQIP)	CalOptima	Annual Submission Baseline (BL) 2003 Remeasurement 1	Validation completed	Yes
Improving Health of Members with Asthma (SGC)	Central Coast Alliance	Annual Submission Baseline (BL) 2004	Validation completed	NA – Baseline activity
Emergency Department Frequent Use Management (IQIP)	Central Coast Alliance	Annual Submission Baseline (BL) 2004 Remeasurement 5	Validation completed	Yes
Childhood Immunization (SGC)	Community Health Group	Annual Submission Baseline (BL) 2004	Validation completed	NA – Baseline activity
Increasing Follow-up for a Positive Postpartum Depression Screen (IQIP)	Community Health Group	Annual Submission Baseline (BL) 2002 Remeasurement 2	Validation completed	Yes

Project Name	Plan	Year	Status	Improvement Achieved
Ambulatory Care Sensitive Conditions (IQIP)	HealthNet	Annual Submission Baseline (BL) 2003 Remeasurement 2	Validation completed	Mixed*
Health Education Behavioral Assessment (Staying Healthy) (IQIP)	Kern Family Health Care	Annual Assessment Baseline (BL) 2002 Remeasurement 3	Validation completed	Yes
Improving Well Child Visits 0 15 Months (IQIP)	LA Care	Annual Submission Baseline (BL) 2002 Remeasurement 1	Validation completed	Yes
Expanding and Improving the Scope of Services Provided to Pregnant Members (IQIP)	Molina Health Care of CA - Riverside	Annual Submission Proposal	Validation completed	NA - Proposal
Expanding and Improving the Scope of Services Provided to Pregnant Members (IQIP)	Molina Health Care of CA - Sacramento	Annual Submission Proposal	Validation completed	NA - Proposal
Improving Appropriate Use of Medications for People with Asthma (SGC)	Santa Barbara RHA	Annual Submission Baseline 2000 Remeasurement 4	Validation completed	Yes

* A determination of mixed means that the plan documented improvement on some indicators measured, but not for all. See Table II and the Appendix for additional information.

Overall Strengths and Opportunities - All Projects

The health plans submitting QIPs during this period demonstrated a range of proficiency and are performing activities targeted to improve health care quality, many of which include clinical HEDIS-related measures. In those QIPs with documented remeasurements, some plans have had success in improving the indicators under study. Table III below provides a summary of the level of improvement in the indicators documented

by all the plans for the QIPs performed and submitted this quarter. This level of improvement is grouped into three categories:

1. Substantial improvement: Indicators where improvement of 10 percent or above is documented,
2. Minimal improvement: Indicators where improvement of between one percent to nine percent is documented, and
3. No improvement: Indicators remaining the same or no documented increase or decrease based on a plan's goals.

Table II. QIP Improvements April – June 2006.

Substantial Improvement	Minimal Improvement	No Improvement
Community Health Group's postpartum depression screening rate increased from 8.51% to 43.19% and the postpartum visit rate increased from 23.16% to 41.72%.	Alameda Alliance's hospitalization rate among members with asthma decreased from 11.6% to 9%.	Alameda Alliance's ER visit rate for members with asthma increased from 28.7% to 29.4%.
Kern Health Systems rate of completed Staying Healthy Assessment questionnaires present in member medical records increased from 14% to 75.79%.	CalOptima's breast cancer screening rate improved from 49.5% to 52.20%.	HealthNet's average rate of annual PCP visits for members with the four Ambulatory Care Sensitive Conditions (ACSCs) decreased from 277.92 visits to 261.20 visits.
LA Care's well child visit rate for children 0 – 15 months of age increased from 33.17% to 43.96%.	Central Coast Alliance's rate of ED visits among frequent users decreased from 7.57 visits to 6.89 visits and the rate of members with pain contracts and medication lists available to the EDs increased from 3% to 5%.	
Santa Barbara Regional Health Authority's combined rate in the use of long-term controller medications for all age bands increased from 58.02% to 71.45%.	HealthNet's ER visit rate for four Ambulatory Care Sensitive Conditions (ACSCs), i.e. asthma, ear, nose and throat (EENT) infections, gastroenteritis, and urinary track/kidney infections decreased from 69.94 visits to 61.78 visits. The plan's average rate of annual calls to its HealthLine for the four ACSCs increased from 2.21 calls to 4.19 calls.	

Recommendations

As demonstrated in the above table, the Medi-Cal Managed Care plans submitting QIPs vary in the level of improvement achieved. Delmarva recommends the following strategies as potential adjunctive efforts that may be useful in achieving and sustaining improvement.

1. Health Net may benefit from disaggregating and reporting their data by each individual ACSC to identify how the rate of overall improvement is impacted by each condition. Data reporting in this manner helps target interventions and promotes more cost-effective use of resources for improvement.
2. Health plans participating in collaboratives, e.g. asthma, that identify the same or similar barriers to improvement may benefit from coordinating interventions, e.g. joint plan and provider staff trainings, distribution of educational materials, when feasible.
3. Health plans indicate barriers to achievement in the QIP documentation. However, addressing how they will overcome the barriers may be a more effective means in helping the health plans develop strategies and will allow the reviewer to track the decrease in barriers over time.
4. Maintaining gains in improvement is an opportunity. Health plans may benefit by documenting their "plan for sustainability of improvement" in the QIP report.
5. To promote the spread of successful interventions, when sustainability of improvement has been attained, CDHS should consider promoting a "Best Practice" forum to enhance plans' knowledge of effective interventions and methodology for sustaining improvement.

Please refer to the following Appendix that contains a summary of each QIP reviewed and validated during the second quarter.

Appendix

Alameda Alliance: Improving Asthma Outcomes by Use of Asthma Tools

- Relevance: The plan reports that its evaluation of clinics has shown that not all staff are comfortable or aware of various methods of using medication delivery devices, which results in patients' lack of knowledge of medication usage. The plan also reports that practice sites have expressed the need for additional information and training to increase their ability to improve patient education and care for asthma.

- Goals: To increase patients' knowledge of asthma medication usage and increase their usage of asthma management plans; to reduce the number of patients who miss school or day care because of asthma.

- Best Interventions:
  - Training of clinic staff in the usage of asthma medication devices
  - Collaboration with practices to develop asthma action plans
  - Provided written asthma materials to clinics for patients to take home

- Outcomes: N/A – This is a baseline activity.

- Attributes/Barriers to Outcomes:
  - Lack of staff knowledge regarding asthma medication devices
  - Information regarding proper medication use and ways to avoid asthma triggers not distributed to patients
  - Irregular development of asthma action plans by practices

Alameda Alliance: Improving Asthma Care Through Community Collaboration

- Relevance: The plan reported that seven percent of emergency room (ER) visits and 17 percent of hospitalizations among its members are for asthma. The plan conducted a survey in June 2005 which showed that 40 percent of its members with asthma experienced nighttime symptoms and 75 percent of children missed some school due to asthma.

- Goals: To reduce ER use and inpatient hospitalizations for asthma by 50 percent over 36 months.

- Best Interventions:
  - Provided asthma patient registry to practice sites
  - Communicated guidelines for severity classification of asthma according to the chronic care model

- Outcomes: The plan's ER visit rate increased slightly between the baseline measurement (28.7 percent) and remeasurement 2 (29.4 percent). The plan's hospitalization rate decreased between the baseline measurement (11.6 percent) and remeasurement 2 (nine percent).

- Attributes/Barriers to Outcomes:
  - Lack of asthma registries or databases at practice sites
  - Project participation difficult due to staffing and time constraints at practice sites
  - Lack of updated information on asthma patients at practice sites

CalOptima: Improving the Rates of Breast Cancer Screening

- Relevance: Although CalOptima's breast cancer screening rate reported for HEDIS 2005 exceeded its HEDIS 2004 rate, the plan did not meet its HEDIS 2005 goal.

- Goal: To increase the breast cancer screening rate to 55 percent.

- Best Interventions:
  - Initiation of breast cancer screening campaign with member and provider incentives
  - Promoted the need for breast cancer screening at community-based events and through the media
  - Designed a telephone outreach survey to identify barriers to screening
  - Distributed monthly women's wellness birthday reminders

- Outcomes: The plan's breast cancer screening rate improved between the baseline measurement (49.5 percent) and remeasurement 1 (52.20 percent).

- Attributes/Barriers to Outcomes:
  - Lack of member and provider education
  - Members' refusal to be screened due to cultural beliefs
  - Members lack of transportation

Central Coast Alliance: Improving Health of Members with Asthma

- Relevance: Members with asthma comprise 4.6 percent of the plan's membership. The plan reports that 30 percent of visits to the ER and 2 percent of hospital admissions for these members are due to their asthma.

- Goal: To improve the HEDIS rate for the Use of Appropriate Medications for Asthma measure to 71 percent in 2006, 73.5 percent in 2007, and 76 percent in 2008.

- Best Interventions:
  - Telephone and mail contact with members with ER visits for asthma to promote PCP follow-up
  - Identified members in need of services and forwarded information to providers
  - Developed incentives for providers based on their members' receipt of asthma care
  - Collaborated with area clinics to implement chronic disease registry
  - Changed policy to no longer require paper referrals to receive services

- Outcomes: N/A – This is a baseline activity.

- Attributes/Barriers to Outcomes:
  - Lack of member awareness regarding seriousness of asthma
  - Lack of member awareness of the resources available to treat asthma
  - Lack of resources in rural areas
  - No integrated patient information related to member visits, lab results, pharmacy and medications

Central Coast Alliance: Emergency Room (ER) Frequent Use Management/Chronic Pain

- Relevance: In 2004, Central Coast Alliance's ER visit rate for Medi-Cal members was 40.98 visits/1,000 member months. Frequent users, which the plan defines as members seen in the ED five or more times per quarter, represented 13.5 percent of ER visits and 27.9 percent of visits by frequent users was due to chronic pain (back pain, neck pain, headaches, and abdominal pain).

- Goals: To decrease the number of ER visits by frequent users by five percent per quarter in the first year. For 10 percent of members establish chronic pain contracts and medication lists available to ERs via secure web portal in the first year. (This indicator is measured every six months.)

- Best Interventions:
  - Identification and stratification of members with five or more ER visits by primary diagnosis
  - Informing members by mail regarding their primary care provider (PCP) contact information, how to make appointments, and appropriate use of the ER
  - Informing PCPs of frequent ER users
  - Referring frequent ER users with asthma and diabetes to chronic care case management
  - Referring frequent ER users with chronic pain to pain program for care coordination
  - Contacting PCPs to request that pain contracts be instituted for members with chronic pain with frequent ER use
  - Initiating a pay for performance system whereby providers receive compensation for low non-emergent ER visit rates among their assigned members

- Outcomes: The plan documented a decrease in the quarterly rate of ER visits among frequent users between the baseline measurement (7.57 visits) and remeasurement 5 (6.89 visits). The rate of members with posted pain contracts and medication lists available to the ERs increased from three percent to five percent between the baseline measurement and remeasurement 2.

- Attributes/Barriers to Outcomes:
  - Members lack awareness of alternatives to ER use
  - Complexity in coordinating care between PCPs and ER staff
  - Members' language and cultural issues impact compliance with pain contract
  - Providers lack secure web portal

Community Health Group: Childhood Immunization

- Relevance: Community Health Group's review of data from the California State Immunization System Project indicated that only 25.7 percent of the plan's PCPs participated in the San Diego Immunization Registry (SDIR).

- Goals: To increase the percentage of PCPs who access and use the SDIR. To increase the HEDIS rates on the Childhood Immunization Combo 1 and 2 measures to 80 percent.

- Best Interventions:
  - Sent letters to high volume providers to encourage participation in the SDIR
  - Provided education about the SDIR to providers
  - Conducted on-site visits to providers who did not respond to initial letter

- Outcomes: N/A – This is a baseline activity.

- Attributes/Barriers to Outcomes:
  - A decrease in the processing of encounter data to calculate immunization rates
  - Fewer medical records available at primary care sites
  - Lack of provider awareness and education about immunization registries
  - Cost and/or time to train provider staff to participate in the registry
  - Providers question value of registry participation to their practice

Community Health Group: Postpartum Depression

- Relevance: In June 2003, the MCO reported a low rate (30.9 percent) of documented postpartum depression screenings and no documentation of follow-up or treatment in a review of a sample of obstetrical medical records.

- Goals: To increase the postpartum depression screening and postpartum visit rate.

- Best Interventions:
  - Distribution of Postpartum Depression Program description with screening and treatment guidelines to PCPs and OB/GYNs
  - Postpartum depression educational material targeted to mothers of newborns and their families added to post-delivery letter sent to new mothers

- Outcomes: The plan documented improvement in the postpartum depression screening (8.51 percent to 19.74 percent) and postpartum visit rates (23.16 percent to 34.39 percent) between the baseline measurement and remeasurement 1. Although the increase has face validity, the rates were not entirely comparable, e.g. baseline = 12 months, remeasurement = four months. The rates for postpartum depression screening (43.19 percent) and postpartum visits (41.72 percent) increased further for remeasurement 2, which encompassed 12 months.

- Attributes/Barriers to Outcomes:
  - Physicians not familiar with postpartum mood disorders
  - Physicians do not have time during post-delivery visits to screen for depression
  - OB/GYNs not comfortable treating depression and are unaware of community resources
  - New mothers reluctant to seek help
  - New mothers feel guilty about being depressed
  - New mothers take their babies to well-child visits but skip their own postpartum visits

HealthNet: Ambulatory Care Sensitive Conditions (ACSC)

- Relevance: In 2003, four ACSCs (Asthma, Ear, Nose and Throat infections, Gastroenteritis, and Urinary tract/kidney infections) represented approximately 23 percent of the MCO's total ER visits.

- Goals: 1) To decrease the annual rate of ER visits for each of the ACSCs, 2) to increase annual call volume for the plan's HealthLine, 3) to increase HealthLine calls for the four ACSCs, and 4) to increase the rate of PCP visits for the four ACSCs

- Best Interventions:
  - Developed and distributed postcards to all members with an ACSC in English and Spanish
  - Published articles in the member newsletter on the four ACSCs

- Outcomes: The plan reported that its rate of ER visits for the four ACSCs decreased statewide between the baseline measurement (69.94 visits) and remeasurement 1 (58.51 visits). For remeasurement 2 the rate of ER visits increased slightly (61.78 visits), but remained below the baseline rate. The plan also documented improvement in the overall statewide rate of annual calls to the HealthLine (8.44 calls to 8.73 calls to 29.64 calls) and for the four ACSCs (2.21 to 1.72 to 4.19) between the baseline measurement, remeasurement 1, and remeasurement 2. The statewide rate of PCP visits for the four ACSCs has decreased from the baseline measurement (277.92 visits), remeasurement 1 (262.14 visits), and remeasurement 2 (261.20 visits).

- Attributes/Barriers to Outcomes:
  - Postcard mailings delayed
  - Difficulty accessing HealthLine data
  - Lack of interrater reliability of HealthLine data. ("Interrater" refers to multiple staff that compiled and reviewed the data.)
  - Delays in receipt of claims data from ER may cause delays in postcard mailings
  - Lack of member knowledge about managing an ACSC and the availability of after-hours care
  - Lack of provider knowledge about treating ACSCs

Kern Health Systems: Health Education Behavioral Assessment (Staying Healthy)

- Relevance: Kern Health Systems identified that Staying Healthy Assessment questionnaires, which are a component of initial health assessments, were not present in member medical records. In May 2001, the plan documented that the assessment was present in only 14 percent of medical records across the entire provider network.

- Goals: To increase the compliance rate for Staying Healthy Assessment questionnaires present in medical records to 90 percent by remeasurement 3.

- Best Interventions*:*
  - Reminder letters sent to all providers regarding the Staying Healthy Assessment questionnaire
  - Annual evaluation sent to providers regarding their performance in complying with the Staying Healthy program
  - Education update on Staying Healthy program presented to all PCPs
  - Incentive risk pool instituted to include completion of Staying Healthy Assessment questionnaire in the criteria for distribution of funds

- Outcomes: The plan documented increases in the rate of Staying Healthy Assessment questionnaires being present in member medical records between the baseline measurement (14 percent), remeasurement 1 (45.72 percent), remeasurement 2 (67.68 percent), and remeasurement 3 (75.79 percent).

- Attributes/Barriers to Outcomes:
  - Providers felt completion of the questionnaire was additional paperwork and repetitive
  - New staff members in provider offices not trained regarding Staying Healthy program and completion of the questionnaire

LA Care: Improving Well Child Visits 0 – 15 Months – LA Care

- Relevance: Following an analysis of its HEDIS rates, LA Care identified an opportunity to improve the well child visit rate for its Medi-Cal members.

- Goals: To increase the well child visit rate by 10 percent per year.

- Best Interventions:
  - Initiated an educational campaign targeted to pediatricians, family practitioners, and general practitioners regarding the components of well child visits, coding, and reporting of visits
  - Initiated an incentive program to reward providers whose members receive their required well child visits
  - Initiated an incentive program to reward parents who take their children to well child visits
  - Postcards sent to parents reminding them of required well child visits

- Outcomes: The plan documented an increase in its well child visit rate between the baseline measurement (33.17 percent) and remeasurement 1 (43.96 percent).

- Attributes/Barriers to Outcomes:
  - LA Care has difficulty identifying newborns until they are two to three months old
  - Commonly missed newborn and first month visits
  - Incomplete well child exams performed by physicians
  - Inaccurate coding of preventive health visits by providers

Molina Riverside/San Bernardino and Sacramento: Expanding and Improving the Scope of Services Provided to Pregnant Members

- Relevance: Molina reported low rates of participation in the plan's Motherhood Matters program and low HEDIS scores for postpartum check-ups. In addition, participants in the Motherhood Matters program are not referred for perinatal case management as appropriate.

- Goals: To increase the rate of participation by pregnant members in the Motherhood Matters program by 10 percent, to increase the HEDIS postpartum visit score to 55.58 percent, and to increase by five percent the number of Motherhood Matters participants who are referred for perinatal case management.

- Best Interventions:
  - Enrolled new members into the Pfizer Health Solutions InformaCare disease management platform to improve communication between departments and capture PCP collaboration efforts

- Outcomes: N/A – This is a baseline activity.

- Attributes/Barriers to Outcomes:
  - Physicians did not refer members to the Motherhood Matters program or referred them late in their pregnancies
  - Cultural attitudes affect members perception of the importance of prenatal and postpartum care
  - Members lack transportation to appointments
  - Members receive inadequate discharge instructions after delivery

Santa Barbara Regional Health Authority (SBRHA): Improving Appropriate Use of Medications for Peoples with Asthma

- Relevance: In 2001, SBRHA's rates of anti-inflammatory medication use by members with persistent asthma in all age bands (5 – 9; 10 – 17; 18 – 56) were lower than the 90th percentile, and 30 percent of members with persistent asthma did not receive an inhaled corticosteroid.

- Goals: To increase the rate of long-term controller medication use by members with persistent asthma in all age bands to reach the 90th percentile for Medicaid plans.

- Best Interventions:
  - Generated provider reports identifying members with persistent asthma who were not prescribed an acceptable medication
  - Published asthma educational materials in provider newsletter and other provider publications
  - Provided education to practitioners regarding the Asthma Medication Management Program
  - Published educational materials regarding controlling asthma in member newsletters
  - Developed bilingual educational materials on multiple asthma topics
  - Conducted on-site consultations with providers to review asthma reports and discuss medication use

- Outcomes: The plan documented increases in the use of long-term controller medications in all age bands between the baseline measurement and remeasurement 4. The combined rate increased from 58.02 percent for the baseline measurement to 71.45 percent for remeasurement 4, which was just short of the 90th percentile rate (73.10 percent).

- Attributes/Barriers to Outcomes:
  - Providers lack of knowledge of current asthma management strategies and guidelines for the use long-term controller medications
  - Members lack of understanding on how to control their asthma
  - Community resources not used by providers/members