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DATE: September 11, 2017

ALL PLAN LETTER 17-014
(SUPERSEDES ALL PLAN LETTER 16-018)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: QUALITY AND PERFORMANCE IMPROVEMENT REQUIREMENTS

PURPOSE:

The purpose of this All Plan Letter (APL) is to notify all Medi-Cal managed care health plans (MCPs) of changes to the Quality and Performance Improvement Program and requirements. The Department of Health Care Services (DHCS) requires MCPs to annually report performance measurement results, produce Plan-Do-Study-Act (PDSA) Cycle Worksheets for poor performance, conduct ongoing performance improvement projects (PIPs), and participate in the administration of consumer satisfaction surveys.

Specialty health plans (SHPs) serve a specialized population in the Medi-Cal managed care program. Some requirements presented below do not apply to SHPs and are noted when applicable. SHPs should refer to their contracts for further information.

This APL supersedes APL 16-018¹.

BACKGROUND:

MCPs with External Accountability Set (EAS) indicators below the Minimum Performance Levels (MPLs) in any given Reporting Year (RY) are required to complete and submit to DHCS written PDSA cycle improvement projects on approved PDSA Cycle Worksheets (see Attachment 3).

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Dual Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

¹ APL 16-018 can be accessed at the following link:
<http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

POLICY:

A. EAS Performance Measures

1. General Requirements

- a. Designated Contacts:** MCPs must provide DHCS with a primary contact for performance measurements (Healthcare Effectiveness Data Information Set [HEDIS^{®2}] lead) and at least one designated backup contact. The MCP's HEDIS[®] lead will act as a liaison between DHCS and the MCP to facilitate communication of DHCS's requirements including the coordination of satisfactory and timely completion of required quality improvement (QI) submissions. In the absence of the HEDIS[®] lead, the backup contact must be familiar enough with the performance measures to assume the duties of the HEDIS[®] lead.

Note: Only under certain circumstances will DHCS approve an MCP's request for an extension of time to submit performance measurement-related documentation (e.g., PDSA Cycle Worksheets or Corrective Actions Plans [CAPs]) due to staff absence.

- b. Technical Assistance:** DHCS or its External Quality Review Organization (EQRO) periodically convene technical assistance conference calls for all MCPs to: (1) present changes in performance measure methodology or processes; and (2) assist MCPs that are having difficulties with PDSA Cycle Worksheets or the PDSA process. DHCS requires MCPs to designate an appropriate lead and a backup to participate in technical assistance conference calls.
- c. EAS Selection, Collection, and Reporting:** DHCS selects a set of performance measures, referred to as EAS measures, to evaluate the quality of care delivered by an MCP to its beneficiaries. DHCS selects most EAS measures from HEDIS[®], which provides DHCS with a standardized method to objectively evaluate an MCP's delivery of services. MCPs must annually collect and report rates for EAS measures. When applicable, MCPs are also required to report rates for any statewide collaborative measure chosen by DHCS and the MCPs. Each SHP must report on two performance measures selected or developed specifically for that SHP.

² HEDIS[®] is a registered trademark of the National Committee for Quality Assurance.

d. New MCP or an Existing MCP Expanding into a New County/Region:

A new MCP, or an existing MCP expanding its operations into a new county/region, must begin to report its EAS performance measure rates during the first reporting cycle in which it is feasible to report them, as determined by DHCS, in consultation with its EQRO.

2. Selection Process

DHCS selects the final EAS measures after consulting with MCPs, the EQRO, and stakeholders. DHCS and each SHP agree on which measures are most appropriate to the membership of each SHP.

Prior to each RY, a complete list of all EAS measures is updated and released to all MCPs, including the performance measures that each SHP must report. Note that some measures have multiple indicators (e.g., more than one rate must be reported). See Attachment 1 for a complete list of the current EAS measures.

3. Audit Requirements

a. Annual Onsite EAS Compliance Audit: MCPs must participate in an annual onsite performance measure validation audit. The audit consists of an assessment of an MCP's (or its vendor's) information system capabilities, followed by an evaluation of an MCP's ability to comply with specifications outlined by DHCS for HEDIS® and non-HEDIS® measures. The EQRO follows the National Committee for Quality Assurance (NCQA) HEDIS® Compliance Audit™ methodology for HEDIS® measures to assure standardized reporting of quality performance measures throughout the health care industry.

b. Contracted EAS Auditor: MCPs must use DHCS's selected contractor for conducting the performance measure validation. The EQRO contractor will perform the EAS audits at DHCS's expense. The EQRO contractor may subcontract with one-or-more independent auditors licensed by the NCQA to conduct some of the EAS audits.

4. EAS Reporting Requirements

a. Calculating and Reporting Rates: Each MCP calculates its rates for the required performance measures and these rates will be audited by the EQRO or its subcontractor and reported to DHCS. Each MCP must report to the EQRO the results for each of the performance measures required of that MCP while adhering to HEDIS® or other specifications for the RY. MCPs must follow NCQA's timeline for collecting, calculating, and

reporting rates.

- b. Reporting Units:** MCPs must calculate and report performance measure rates at the county level, unless otherwise approved by DHCS for combined county-level reporting or regional-level reporting.
- c. Public Reporting of Performance Measurement Results:** DHCS publicly reports the audited results of HEDIS[®] and other performance measure rates for each MCP, along with the Medi-Cal managed care average and comparisons to national data, as applicable, for each DHCS-required performance measure.
- d. Managed Long-Term Services and Supports (MLTSS) Measures:** In order to comply with federal reporting requirements, DHCS requires those MCPs that provide MLTSS to report on a small set of measures selected by DHCS and the EQRO. For RY 2017, MCPs that provide MLTSS are required to report on the two MLTSS measures (that include three indicators) indicated in the attached EAS. Those MCPs that provide MLTSS must provide the necessary data specific to these measures to DHCS. The measures are reported in the same timeframe as the rest of the EAS. In future years, DHCS may choose different MLTSS measures and will advise MCPs as necessary.

5. EAS Performance Standards Established by DHCS

- a. MPLs:** MCPs must meet or exceed the DHCS established MPL for each required HEDIS[®] measure, except for those measures noted by DHCS on the most recent EAS. The MPL for each required measure is the 25th percentile of the national Medicaid results for that measure as reported in NCQA's Quality Compass. For measures where a lower rate is better, Quality Compass inverts the percentiles, so for each measure the MPL is the 25th percentile. In the event that the Quality Compass does not include a particular indicator, DHCS and its EQRO will determine an appropriate benchmark for that indicator.
- b. High Performance Levels (HPLs):** DHCS establishes an HPL for each required performance measure and publicly acknowledges MCPs that meet or exceed the HPLs. The HPL for each required measure is the 90th percentile of the national Medicaid results for that measure as reported in NCQA's Quality Compass. For measures where a lower rate is better, the Quality Compass inverts the percentiles, so for each measure the HPL is the 90th percentile. In the event that the Quality Compass does not

include a particular indicator, DHCS and its EQRO will determine an appropriate benchmark for that indicator.

6. MCP Performance Results and Compliance

a. PDSA Cycle Submission Requirements (for EAS indicators with rates below the MPLs): DHCS has adopted a focus on rapid-cycle improvement and implementation of PDSA cycles to increase the potential for improved outcomes in MCP performance. MCPs are required to submit a PDSA Cycle Worksheet for each indicator with a rate that does not meet the MPL, or is given an audit result of “Not Reportable.”

- i. Using the final, audited measurement year (MY) rates submitted to NCQA, DHCS and MCPs will identify indicators with rates below the MPLs.
- ii. MCPs are required to complete and submit a PDSA Cycle Worksheet for each indicator with a rate below the MPL in accordance with the PDSA instructions (see Attachment 3).
- iii. Prior to any RY, DHCS will notify MCPs on the specifics of the PDSA cycle submissions including, but not limited to, the required number of PDSA cycles and due date for submissions. All MCPs should conduct on-going evaluations of their rapid-cycle QI efforts. The DHCS nurse consultant (NC) liaison will work with the MCP to develop a schedule for submissions and provide any needed technical assistance to monitor PDSA cycle progress over the year.
- iv. DHCS encourages MCPs with an indicator with a rate below the MPL in more than one county/region to include all affected counties/regions in a single PDSA Cycle Worksheet implementing a common intervention. Note that MCPs should identify county/region-specific barriers and interventions/tests of change that will significantly impact the measurable objective. MCPs under a CAP should discuss PDSA cycle submission requirements with their DHCS NC liaison, as their submission requirements may vary.

b. Exceptions to PDSA Cycle Submissions

- i. **First-Year Measure Requirements:** DHCS does not hold MCPs to the MPL for the first year that rates are reported when it is the first year the indicator is required, when an MCP is reporting rates for the first time (e.g. in the case of a new MCP), or when an MCP is

reporting rates for the first time for a new county/region, as this is considered the baseline rate. Therefore, MCPs are not required to submit a PDSA Cycle Worksheet if a rate for a first-year indicator is below the MPL.

- ii. Newly Created Regions:** For MCPs with newly created regions comprised mostly or entirely of counties that have not previously reported HEDIS® measures, the region will be considered a new reporting unit and the MCP will not be required to submit a PDSA Cycle Worksheet for indicators with rates below the MPLs in the region for its first RY. Note that in the first RY of an MCP's region comprised mostly or entirely of counties that have previously reported HEDIS® measures, the region will not be considered a new reporting unit. The region will be required to submit a PDSA Cycle Worksheet for each indicator with a rate below the MPL.
- iii. Significant Changes to Technical Specifications:** DHCS does not require MCPs to submit PDSA Cycle Worksheets for measures with significant changes to the technical specifications. DHCS will communicate this information to the MCPs if and when DHCS is notified of significant changes.
- iv. Additional Exceptions:** DHCS may also determine that PDSA cycle submissions are not required for reasons in addition to those listed above. DHCS will notify MCPs in instances where it has made such a determination.

c. MCPs with No Indicators with Rates below the MPLs

If an MCP's rates for all indicators meet or exceed the MPLs, the MCP is not required to submit a PDSA Cycle Worksheet for any indicator. MCPs should continue to evaluate ongoing QI efforts on a quarterly basis. MCPs may use the PDSA Cycle Worksheet to help guide ongoing, rapid-cycle improvement processes, in addition to other QI tools and strategies.

For MCPs that have indicators with rates that are declining or showing worsening trends, DHCS recommends that these MCPs utilize PDSA cycles or other QI tools and strategies to proactively address these indicators, as well as share these QI activities and the results of their ongoing evaluation with DHCS.

d. Development of PDSA Cycle

MCPs must follow the DHCS instructions on PDSA cycle development, attached to the PDSA Cycle Worksheet (Attachment 3). MCPs are encouraged to contact their assigned DHCS NC liaison for specific questions on the required components of a PDSA cycle. The PDSA methodology is a rapid-cycle/continuous QI process designed to perform small tests of change, which allows more flexibility to make adjustments throughout the improvement process. As part of this approach, MCPs should perform real-time tracking and evaluation of their interventions.

e. Reporting Requirements

i. Medical Director Identified: PDSA Cycle Worksheets must identify the MCP medical director who approved the PDSA cycle prior to it being submitted to DHCS.

ii. Timeline: DHCS will notify MCPs of submission due dates.

iii. Submission: MCPs must submit PDSA Cycle Worksheets to DHCS's quality mailbox at: dhcsquality@dhcs.ca.gov.

f. DHCS's Advance Warning Letter

As part of DHCS's efforts to provide MCPs with as much notice as possible regarding possible future CAPs, an MCP will receive a warning letter if it is at risk of triggering a CAP in the following year based on the following criteria: (1) MCP has three indicators with rates below the MPLs for two consecutive years in the same reporting unit; (2) MCP has 40 percent or more of all EAS indicators for which MCPs are held to the MPLs below the MPLs for the most recent MY; or, if (3) DHCS identifies a concerning quality improvement trend or issue that needs to be addressed with the MCP.

g. CAPs

DHCS may require a CAP for MCPs that have numerous indicators with rates below the MPLs, indicators with rates below the MPLs for multiple years, or when DHCS determines that a CAP is necessary, as outlined in the DHCS Quality of Care CAP Process. CAP requirements may include, but are not limited to:

i. Quarterly reporting of HEDIS® PDSA Cycle Worksheets with corresponding continuous rapid-cycle improvement activities.

ii. Additional PIPs.

- iii. Additional technical assistance calls.

B. Consumer Satisfaction Surveys

Full scope MCPs are required to participate in EQRO-conducted member satisfaction surveys at intervals determined by DHCS, as per the contract.

1. **Survey Instrument:** DHCS uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS^{®3}) surveys to assess member satisfaction with MCPs. DHCS may develop additional customized survey questions, in compliance with NCQA standards, to assess specific problems and/or special populations.
2. **CAHPS[®] Survey Administration:** The EQRO administers the CAHPS[®] survey for the adult and child Medicaid population every three years and for the Children's Health Insurance Program Medicaid population, which includes children with chronic conditions, annually.
3. **Reporting of Survey Results:** In years when DHCS's EQRO administers the adult and child Medicaid CAHPS[®] surveys, the EQRO will provide a reporting unit-level analysis for each MCP, when applicable, in the CAHPS[®] Summary Report. Reporting unit-level analysis allows DHCS, MCPs, and other stakeholders to better understand how member satisfaction and MCP services vary among counties/regions.
4. **Member Surveys for SHPs:** Although SHPs are not required to participate in the EQRO-conducted CAHPS[®] survey, each SHP must conduct a member satisfaction survey annually and provide DHCS with results specific to the SHP's Medi-Cal members. Each SHP must provide DHCS a copy of its survey instrument and survey calculation/administration methodology, so that the EQRO can evaluate them for compliance with state and federal requirements.

C. PIPs

1. **Number of Required PIPs:** MCPs and SHPs are required to conduct or participate in a minimum of two PIPs per year. DHCS will provide guidance to each MCP and SHP on topic selection and may require MCPs and SHPs to participate in collaborative discussions.
2. **PIP Topic Selection:** MCPs and SHPs choose PIP topics in consultation with DHCS. DHCS strongly recommends that PIP topics align with demonstrated areas of poor performance, such as low HEDIS[®] or CAHPS[®] scores, and/or DHCS/EQRO recommendations.

³ CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- a. **Topic Proposal Timelines and Format:** DHCS will notify MCPs and SHPs of the due date for PIP topic selection and the format to use for selection proposal.
- b. **Topic Proposal Submission:** Each MCP must submit its completed PIP topic proposal form to DHCS's quality mailbox at dhcsquality@dhcs.ca.gov.
- c. **DHCS's Approval of PIP Topic:** After receiving an MCP's or SHP's proposed PIP topic, DHCS will send the MCP a notice of approval, a request for additional information, or suggest that the MCP participate in a technical assistance call with the EQRO.

3. PIP Module Submissions

The rapid-cycle PIP process requires the submission of five modules. MCPs and SHPs must submit and pass Module 1 (PIP Initiation) and Module 2 (SMART Aim Data Collection) prior to submitting Module 3 (Intervention Determination). DHCS's EQRO will conduct technical assistance calls as needed to assist MCPs and SHPs through the process. The EQRO will review module submissions and provide feedback to the MCPs and SHPs, which will have multiple opportunities to fine-tune Modules 1 through 3. Module 4 is Intervention Testing, utilizing PDSA cycles. This is the longest phase of the five modules. Module 5 concludes the PIP process by summarizing the project. MCPs and SHPs will have opportunities for technical assistance with both DHCS and the EQRO throughout the entire PIP process.

- a. **PIP Duration:** DHCS will notify MCPs and SHPs regarding the length of the PIP cycle. PIPs typically will last approximately 12–18 months, employing a rapid-cycle improvement process to pilot small changes. MCPs and SHPs that would like to conduct longer PIPs must seek DHCS approval.
- b. **Assessment of Results:** Upon completion of each PIP, the EQRO provides a confidence level on the validity and reliability of the results.
- c. **Special Considerations**
 - i. **New MCPs and Existing MCPs Expanding into a New County/Region:** DHCS requires new MCPs and existing MCPs with new county/regional start-ups to participate on a technical assistance conference call with DHCS and the EQRO to discuss the appropriateness of PIP topics and the timeline for their initial PIP submissions. DHCS and its EQRO may adjust reporting requirements for new MCPs and existing MCPs with new county start-ups to accommodate the particular circumstances of the

MCP's date of start-up in relation to the reporting cycle. MCPs should contact the EQRO or their DHCS NC for step-by-step instructions about the initial PIP process.

- ii. **Multiple Counties:** MCPs and SHPs that serve multiple counties under a single contract may submit a PIP that addresses the same improvement topic in more than one county, provided the targeted improvement is relevant in more than one county covered by that contract. However, the PIP proposal and subsequent PIP submissions must specifically address the targeted population in each county included in the PIP by submitting county-specific data and results.

d. **Communication and Meetings with DHCS and Among MCPs**

- i. **Designated Contacts:** MCPs and SHPs must provide DHCS with one primary contact (PIP lead) and at least one backup contact for each PIP who is familiar enough with the PIP to step in during the PIP lead's absence. Only under certain circumstances will DHCS approve an MCP's or SHP's request for an extension of time to submit PIP-related documentation due to staff absence.
- ii. **Technical Assistance:** To ensure that PIPs are valid and result in real improvements in the care and services provided to beneficiaries, DHCS periodically holds technical assistance conference calls for all MCPs and SHPs to: (1) present changes in methodologies or processes; and, (2) assist MCPs that are having difficulties with a PIP. MCPs and SHPs are required to participate in these technical assistance calls. The EQRO and DHCS also conduct quarterly collaborative conference call discussions that are PIP topic related that give additional opportunity for MCPs and SHPs to share their PIP interventions and experiences.

D. **Focus Studies**

DHCS may require MCPs to participate in focus studies of specific quality priority areas by submitting data or participating in surveys.

E. **Patient-Level Reporting**

MCPs are required to submit patient-level data as specified by the EQRO as part of the HEDIS® audit process.

1. **Reporting Requirements Impacting Alternative Health Care Services Plans (AHCSPs):** All full scope MCPs will be required to include an AHCSP identifier as part of their patient-level reporting. AHCSP is defined in California Code of Regulations, Title 22, Section 53810.

ADDRESSES FOR ELECTRONIC SUBMISSIONS:

A. EQRO's File Transfer Protocol (FTP) Website

DHCS's EQRO, Health Services Advisory Group (HSAG) Inc., uses an FTP website, which is to be used when MCPs and SHPs are sending communications containing patient-level data. All current MCPs and SHPs have identified FTP users who have been assigned user names and passwords by HSAG to access each MCP's or SHP's specific folder. To establish additional user profiles or remove previous users, MCPs and SHPs should contact the EQRO or their DHCS NC. For communications that do not contain patient-level data, the EQRO's email address is sufficient.

B. DHCS's Submission E-Address

DHCS's quality mailbox: dhcsquality@dhcs.ca.gov.

CONTACTS

If you have questions or concerns about the information in this APL, please contact your DHCS NC. The NC may direct questions to the EQRO as appropriate.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

Attachment 1.

**External Accountability Set – Full-Scope Plans
Measurement Year (MY) 2017 (to be reported in 2018)**

#	Measure Acronym	Measure	Measure Type Methodology	SPD** Stratification Required	Auto Assignment Algorithm****
1.	ACR*	All-Cause Readmissions	Administrative (non-NCQA), defined by ACR collaborative	Yes	No
2.	AMB-OP* AMB-ED*	Ambulatory Care: <ul style="list-style-type: none"> • Outpatient visits • Emergency Department visits (Children)*** • Emergency Department visits (Adults) • Emergency Department visits (Total) 	Administrative	Yes	No
3.	MPM-ACE MPM-DIU	Annual Monitoring for Patients on Persistent Medications (2 indicators): <ul style="list-style-type: none"> • ACE inhibitors or ARBs • Diuretics 	Administrative	Yes	No
4.	AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Administrative	No	No
5.	BCS	Breast Cancer Screening	Administrative	No	No
6.	CCS	Cervical Cancer Screening	Hybrid	No	Yes
7.	CIS-3	Childhood Immunization Status – Combo 3	Hybrid	No	Yes
8.	CAP-1224* CAP-256* CAP-711* CAP-1219*	Children & Adolescents' Access to Primary Care Practitioners (4 indicators): <ul style="list-style-type: none"> • 12-24 Months • 25 Months – 6 Years • 7-11 Years • 12-19 Years 	Administrative	Yes	No
9.	CDC-E CDC-HT CDC-H9 CDC-H8 CDC-N CDC-BP	Comprehensive Diabetes Care (6 indicators): <ul style="list-style-type: none"> • Eye Exam (Retinal) Performed • HbA1c Testing • HbA1c Poor Control (>9.0%) • HbA1c Control (<8.0%) • Medical Attention for Nephropathy Blood pressure control (<140/90 mm Hg)	Hybrid	No	Yes, for <i>HbA1c Testing only</i>
10.	CBP	Controlling High Blood Pressure < 140/90 mm Hg (except < 150/90 mm Hg for ages 60-85 without diabetes)	Hybrid	No	Yes
11.	IMA-2^	Immunizations for Adolescents (meningococcal, Tdap, HPV)	Hybrid	No	No

Attachment 1. (continued)

**External Accountability Set –Full-Scope Plans
Measurement Year (MY) 2017 (to be reported in 2018)**

#	Measure Acronym	Measure	Measure Type Methodology	SPD** Stratification Required	Auto Assignment Algorithm****
12.	AMR	Asthma Medication Ratio	Administrative	No	No
13.	PPC-Pre PPC-Pst	Prenatal & Postpartum Care (2 indicators): <ul style="list-style-type: none"> • Timeliness of Prenatal Care • Postpartum Care 	Hybrid	No	Yes, for <i>Prenatal only</i>
14.	DSF*	<ul style="list-style-type: none"> • Depression Screening and Follow-Up for Adolescents and Adults 	Electronic Clinical Data Systems (ECDS)	No	No
15.	LBP	Use of Imaging Studies for Low Back Pain	Administrative	No	No
16.	WCC-N WCC-PA	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents <ul style="list-style-type: none"> • Counseling for nutrition • Counseling for physical activity 	Hybrid	No	No
17.	W-34	Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life	Hybrid	No	Yes

Total Number of Measures = 1 ECDS + 8 Hybrid + 8 Admin measures (29 indicators total)

^ MCPs will be held to a benchmark for HEDIS 2018 pending the availability of the benchmark from the National Committee on Quality Assurance'^'. * MCPs will not be held to an MPL for measures marked with '^*'

** Seniors and Persons with Disabilities (SPD)

*** Same age bands that Plans already report to NCQA

**** Data from MY 2016 will be used in 2017 auto assignment algorithm. Subsequent years to be determined.

Attachment 1. (continued)

Performance Measures for Specialty Plans Measurement Year (MY) 2017 (to be reported in 2018)

AIDS Healthcare Foundation Healthcare Centers

- Colorectal Cancer Screening (COL)
- Controlling High Blood Pressure (CBP)

Family Mosaic Project

- Promotion of Positive Pro-Social Activity: Measure specifics to be determined with the EQRO.
- School Attendance: The number of capitated Medi-Cal managed care members enrolled in Family Mosaic with a 2 or 3 in school attendance on both the initial and most recent Child and Adolescent Needs and Strengths (CANS) outcomes/assessment tool during the measurement period.

SCAN

- Colorectal Cancer Screening (COL)
- Osteoporosis Management in Women Who Had a Fracture (OMW)

Performance Measures for Managed Long-Term Services and Supports Plans (MLTSSP) MY 2017 (to be reported in 2018)

- Ambulatory Care (AMB-OP and AMB-ED)
- Medication Reconciliation Post-Discharge (MRP)

Attachment 2.

Abbreviations

Abbreviation	Full Name
AAB	Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
ACR	All-Cause Readmissions
AMB - OP	Ambulatory Care - Outpatient Visits
AMB - ED	Ambulatory Care - Emergency Department Visits
AMR	Asthma Medication Ratio
BCS	Breast Cancer Screening
CAP - 1224	Children & Adolescents' Access to Primary Care Practitioners - 12 - 24 Months
CAP - 256	Children & Adolescents' Access to Primary Care Practitioners - 25 Months - 6 Years
CAP - 711	Children & Adolescents' Access to Primary Care Practitioners - 7 - 11 Years
CAP - 1219	Children & Adolescents' Access to Primary Care Practitioners - 12 - 19 Years
CBP	Controlling High Blood Pressure
CCS	Cervical Cancer Screening
CDC-BP	Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)
CDC-E	Comprehensive Diabetes Care - Eye Exam (Retinal) Performed
CDC-H8	Comprehensive Diabetes Care - Hemoglobin A1c (<8.0%)
CDC-H9	Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)
CDC-HT	Comprehensive Diabetes Care - HbA1c Testing
CDC-N	Comprehensive Diabetes Care - Medical Attention for Nephropathy
CDF	Screening for Clinical Depression and Follow Up Plan
CIS-3	Childhood Immunizations Status - Combination 3
IMA-2	Immunizations for Adolescents
LBP	Use of Imaging Studies for Low Back Pain
MMA-50	Medication Management for People with Asthma - Medication Compliance 50% Total
MMA-75	Medication Management for People with Asthma - Medication Compliance 75% Total
MPM - ACE	Annual Monitoring for Patients on Persistent Medications - Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARB)
MPM - DIU	Annual Monitoring for Patients on Persistent Medications - Diuretics
PPC-Pre	Prenatal and Postpartum Care - Timeliness of Prenatal Care
PPC-Pst	Prenatal and Postpartum Care - Postpartum Care
W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
WCC-N	Weight Assessment and Counseling for Nutrition & Physical Activity for Children & Adolescents - Counseling for Nutrition Total
WCC-PA	Weight Assessment and Counseling for Nutrition & Physical Activity for Children & Adolescents - Counseling Physical Activity Total

Attachment 3.



PDSA CYCLE WORKSHEET

- A. Managed Care Plan:
 - B. Topic/Performance Measure:
 - C. County(ies):
 - D. Time frame of PDSA cycle:
 - E. Person Responsible for Implementing PDSA:
 - F. Medical Director Responsible for Approving PDSA:
 - G. Submission Date:
-

1. What is the **Global Aim** of this project?
2. Based on the *Pre-Planning Phase*, what is the **Identified Barrier** that this PDSA cycle will address?
3. For **NEW** interventions – submit the data analysis and evidence validating why you chose this intervention to test:
 - Data and/or supporting documentation submitted as attachment
 - Data and/or supporting documentation imbedded in Plan portion of PDSA Worksheet
 - N/A
4. What is the **SMART Objective** for this PDSA cycle?

Reminder: The SMART objective should lead to the Global Aim and it must include these elements:

- Time frame: *by when?*
- Change: *an increase or decrease?*
- From baseline to goal: *baseline rate/value to goal rate/value?*
- Target population: *who/what subgroup will be the target of your intervention?*
- Where: *county(ies)?*

Attachment 3. (continued)

Plan	<ul style="list-style-type: none">• What is the intervention for this PDSA cycle? (Only <u>ONE</u> intervention per PDSA cycle)• What is the desired outcome of the intervention?
	<ul style="list-style-type: none">• Develop a plan to test the intervention.• Who will conduct the intervention?• How will they conduct the intervention?• When will they conduct the intervention?• Where will they conduct the intervention?
	<ul style="list-style-type: none">• Predict what will happen, and why.• How will you measure that the change is an improvement?
	<ul style="list-style-type: none">• Plan for the collection of data.• What data needs to be collected? Include data elements and data sources.• Who is responsible for collecting the data?• When and how often will the data be collected?
Do	<ul style="list-style-type: none">• Conduct the intervention.• Collect and record data, and begin your analysis of the data.• Describe what you and/or your external partner(s) did.• What did you observe? Include unexpected barriers.

Attachment 3. (continued)

Study

- Complete the data analysis (quantitative and qualitative).
- Compare the data to your predictions.
- Discuss findings and summarize what was learned (e.g., barriers, successes).

Act

- Based on what was learned from the intervention, are you going to (*choose one of the following*):

ADOPT (keep/expand the intervention)

- Are you going to expand and further test the intervention?
- Is there a plan to test the sustainability of the intervention?

ADAPT (modify the intervention)

- What are the modifications to the intervention?
- What are the lessons learned?
- What changes to the SMART objective will you make in the next PDSA cycle?

ABANDON (end the intervention)

- What are the lessons learned?

- Answer all corresponding question(s).
- Provide the rationale for your choice.

- What will you do for the next PDSA cycle?

Note: Once an intervention has resulted in improvement with the narrowed focus, the MCP should develop a plan to further test the intervention in additional settings. As additional improvement is achieved, the intervention should be considered for MCP-wide implementation.

Attachment 3. (continued)

Information and Instructions for the Plan-Do-Study-Act (PDSA) Cycle Worksheet

SMART Objective for a PDSA cycle

Rules for writing your SMART objective:

- **DO NOT** use an overall HEDIS measure rate for the PDSA cycle.
- **DO NOT** use data based on claims when there is a delay of claims.

Objectives **Must**:

- Be well defined and clear.
- Specify a “change” in the target population as an “increase” or “decrease”.
- Consist of a narrowed focus and contribute towards the Global Aim.
- Include the baseline (rate or value) and the goal (rate or value).
- Include the relevant time period (no longer than 4 months).
- Include a small “sub-group” as the target population (e.g., one to three providers; one to three providers from a provider group; a specific sub-population of members; a specific geographic area; etc.).

Objectives must be **SMART**:

- **Specific**:
 - *What*: What is your goal? What do you want to accomplish?
 - *Target population*: Who is your target population?
 - *Where*: Where will this intervention be implemented?
- **Measurable**:
 - *Change*: How much change is expected, and in what direction (increase or decrease) will the change be?
 - Include baseline rate/value, if known, and goal rate/value. If the baseline rate is not known, the MCP should provide an explanation and collect a baseline rate over a three-month or longer time period.
 - Do you have data to measure and prove the desired change has occurred?
- **Achievable**:
 - Can you achieve this objective within the selected time frame?
 - Have you identified any limitations or constraints/challenges you may encounter?
 - Can you meet the objective with the resources/support available?

Attachment 3. (continued)

- **Relevant:**
 - Will this objective have an effect on the global aim?
 - Does it seem reasonable and worthwhile to measure this objective?
- **Time-Bound:**
 - *Time Frame:* When will the objective be completed (data: mm/dd/yyyy)? Each PDSA cycle should be ≤ 4 months.
 - Is the specific time frame realistic? Will you be able to test the intervention in this time frame?

Filling out the PDSA Cycle Worksheet

Answer all questions in the space provided on the PDSA Cycle Worksheet.

Global Aim: What is the Global Aim of the project? (e.g., Improve HEDIS rate to above the Medi-Cal state average, Improve HEDIS rate to above the MPL, etc.)

Example: *To improve CIS-3 HEDIS rate above the MPL.*

Identified Barrier: Based on the Pre-Planning Phase, what is the barrier that this PDSA cycle will address?

Example: *Providers and office staff lack knowledge about how to log on and enter vaccines into CAIR.*

New Interventions: Why did you choose this intervention to test?

- Justify your choice of intervention with a description of the planning process (e.g., key driver diagram, fishbone, work flow process maps, literature review, etc.).
- Submit the data analysis and evidence supporting your choice of intervention (e.g., quantitative or qualitative data).

SMART Objective: What is the SMART objective for this PDSA cycle?

The SMART objective should lead to the Global Aim, and it must include these elements:

- Time frame: *by when?*
- Change: *an increase or decrease?*
- From baseline to goal: *baseline rate/value to goal rate/value?*
- Target population: *who/what subgroup will be the target of your intervention?*
- Where: *county(ies)?*

Attachment 3. (continued)

The SMART objective must include all the elements, but it does not need to be in the exact order as shown in the template below.

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Example: *By 12/31/2015, increase the percent of Plan's pediatric providers who use the California Immunization Registry (CAIR) in one high volume/low performing provider group in X County, from 50% as of 9/2015, to 70%.*

Filling out the P-D-S-A Section on the Worksheet

PLAN: Answer all questions in the space provided on the Worksheet.

- **Intervention:** The intervention must answer the following questions:
 - What are you going to test?
 - Be specific – you can only test ONE intervention per PDSA cycle.
 - Who is involved with testing the intervention?

Example: *QI staff will develop a 'CAIR Checklist' to be tested by the provider office staff as part of their regular workflow. QI staff will provide a 30-60 minute training on how to use the Checklist.*

DO: Answer all questions in the space provided on the Worksheet. You may submit data documentation, but it is not required.

STUDY: Answer all questions in the space provided on the Worksheet.

ACT: What was learned from testing the intervention? What are you going to do next?

- Choose whether you will:
 - **Adopt** (keep/expand the intervention)
 - **Adapt** (modify the intervention)
 - **Abandon** (end the intervention)

Mark your choice by checking one of the boxes on the Worksheet. Answer the corresponding questions and provide the rationale for your choice.

Read the note at the end of the Worksheet and answer the final question.

If you have questions related to PDSA cycles or filling out the Worksheet, please contact your DHCS Nurse Consultant Liaison.