Quality Improvement Program Evaluation

2022-2023

EVALUATION PERIOD

(JULY 1, 2022 – JUNE 30, 2023)

PARTNERSHIP HEALTHPLAN of CALIFORNIA

A Public Agency

Approval of Quality Improvement Program Evaluation

	**08/16/2023**

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Quality Improvement Overview and Program Oversight

QI TRILOGY

Scope of Data and Results Reported in the 2022-2023 Quality Improvement (QI) Program Evaluation

Partnership HealthPlan of California's (Partnership) Quality and Performance Improvement (QI/PI) program provides a systematic process to monitor the quality of clinical care and health care service delivery to all Partnership members. It includes an organized framework for ongoing review of activities to identify opportunities to improve the quality of health care services provided, promote efficient and effective use of health plan financial resources, and partner with internal and external stakeholders to support performance improvement and to improve health outcomes and advance health equity. The program promotes consistency in application of quality assessment and improvement functions for the full scope of health care services while providing a mechanism to:

- Ensure integration with current community health priorities, standards, and goals that impact the health of the Partnership member population
- Identify and act upon opportunities to improve care and service
- Identify overuse, misuse, and underuse of health care services
- Identify and act on opportunities to improve processes to ensure member safety
- Identify and act on opportunities to address disparities in health access and outcomes
- Address potential or tangible quality issues
- Review data for trends that suggest variations in health care service delivery processes or disparities in care

The QI/PI program adheres to the following goals to improve the quality and effectiveness of clinical care and service to Partnership members:

- Improve the health of the populations Partnership serves
- Enhance the patient care experience
- Support the delivery of high-quality clinical care
- Reduce disparities in health access and outcomes
- Ensure member safety
- Measure and encourage appropriate use of clinical resources
- Strengthen a culture of continuous quality improvement throughout the Partnership network

The QI/PI program accomplishes these goals by:

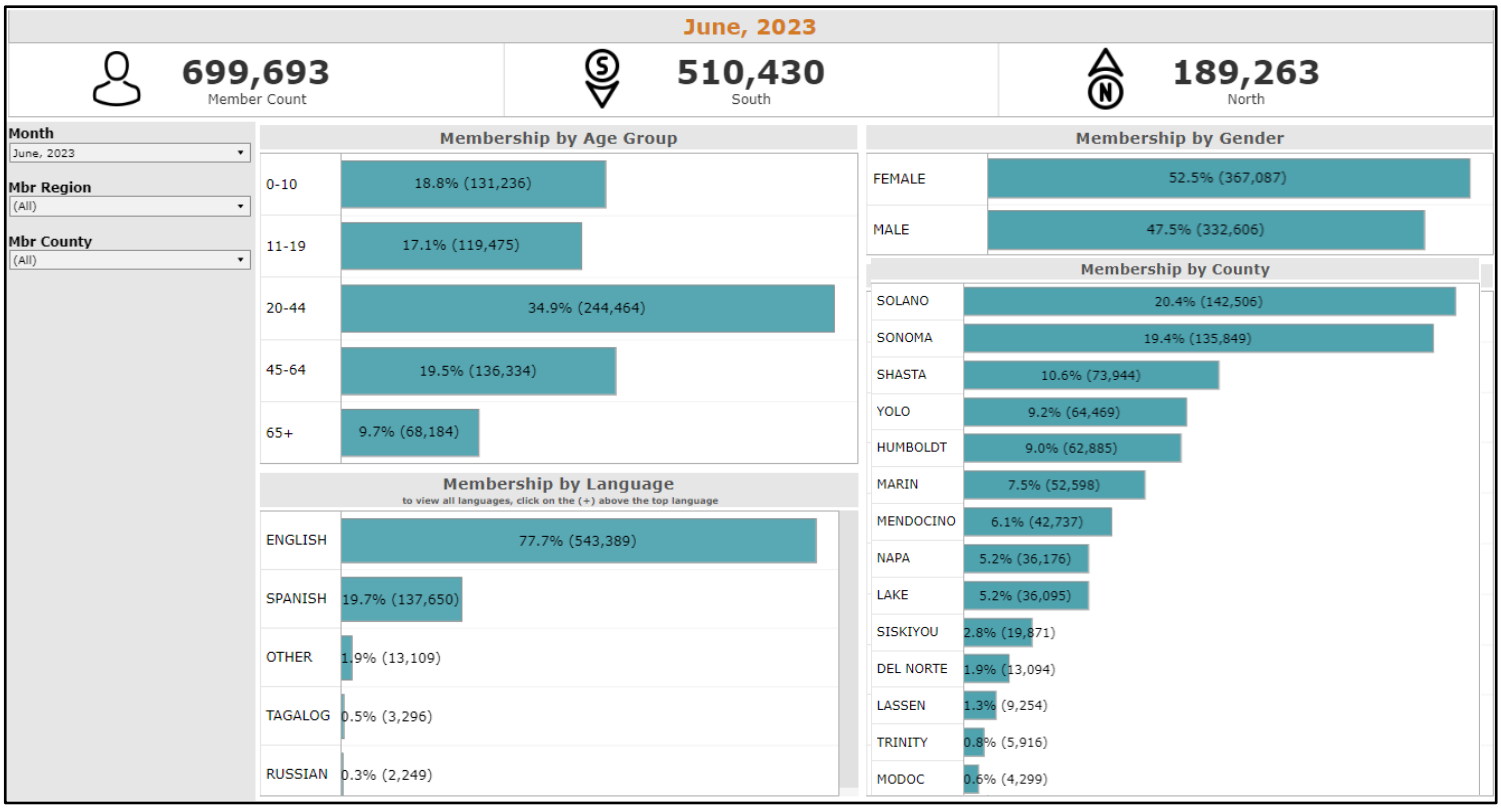
- Systematically monitoring and evaluating service and care provided
- Continuously improving data and analytics to validate care outcomes
- Actively pursuing opportunities for improvement in areas that are relevant and important to Partnership members' health
- Implementing strong interventions when opportunities for improvement are identified
- Addressing overall member experience by improving provider access and member awareness of the health plan's role and responsibilities

Detailed results of projects, programs, and quality assurance activities regulated by the Department of Health Care Services (DHCS) were presented to the various quality committees throughout the year. This evaluation provides highlights of activities led by or in partnership with the Quality and Performance Improvement department. The

evaluation does not include detailed results from the Grievance and Appeals department, Pharmacy department, Utilization Management, Care Coordination, or Population Health departments. Separate evaluations address these functional areas.

The 2022-2023 QI program covers Medi-Cal lines of business across 14 counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity and Yolo. Associated quality improvement initiatives and programs are designed to encourage appropriate care at the right time while being cognizant of resource utilization. Initiatives target areas of under-use, misuse, and overuse in addition to exploring different strategies and payment models for improving access to care and the care of medically complex patients.

The time period of this evaluation is July 1, 2022, to June 30, 2023. Since PHC's last evaluation (fiscal year 2021-2022), PHC's total membership has increased from 657,717 (as of July 1, 2022) to 699,693 (as of June 1, 2023). Across all 14 counties, 52.5% of PHC members are female and 47.5% are male. Caucasians represent (37.4%); Hispanic (31%); members who identify as "Other" (11%); Unknown (8.9%); Black (5.3%); Native American (2.2%); Filipino (1.8%); Asian/Pacific Islander (1%); Asian Indian (0.8%); and Vietnamese (0.6%). English speakers comprise 77.7%; followed by Spanish (19.7%); Tagalog (0.5%); and Russian (0.3%). Members ages 0-10 comprise 18.8%; members ages 11-19 comprise 17.1% of the population; followed by members ages 20-44 (34.95%); members ages 45-64 (19.5%); and 9.7% of PHC's membership is 65 or older. Below is a summary of membership by county.



Quality Improvement Program Structure

The QI/PI department directors execute program goals and objectives in collaboration with department managers leading teams focused on: Quality Assurance and Member Safety; Performance Improvement; Quality Improvement Programs; Quality Improvement Analysis; and Quality, Compliance, and Accreditation. Within these teams, there are efforts to support data quality and validation in collaboration with IT and Finance – Health Analytics. The department periodically utilizes external consultants to support QI training for provider organizations and internal staff and National Committee for Quality Assurance (NCQA) Accreditation and contract employees for Healthcare Effectiveness Data and Information Set (HEDIS®)-related data collection and reviews.

In fiscal year 2022-2023, QI resources continued supporting the development and testing related to the transition from Partnership's prior core claims processing system, Amisys, to the new core claims processing system, HealthRules Payor® (HRP). This new system is scheduled for implementation in August of 2023. In parallel, the expansion of reporting and accountability for HEDIS measures, defined under the DHCS Managed Care Accountability Set (MCAS) and required for NCQA health plan accreditation, increased the complexity and scope of work in not only quality measurement and reporting, but also in performance improvement activities. Improving quality measure scores across ever-expanding measure sets is essential to demonstrating Partnership's commitment to delivering the highest quality care possible to its members. Partnership's achievement of this aim will be evaluated on an ongoing basis by DHCS and in 2023 when PHC receives its first NCQA health plan rating. These complexities and aims led to the following program structure and resource changes in 2022-2023:

- The two regional QI/PI teams were re-structured and consolidated into one QI/PI team in May 2022. The Chief Medical Officer (CMO) maintains executive leadership with a Senior Director of QI/PI overseeing a fully integrated Quality department across all Partnership regions. To support this re-structuring, the designated QI director level roles were simultaneously recast. The director level roles are no longer regionally focused but instead functionally focused and include the Director of Quality Management and an expanded role for the Medical Director for Quality. This re-structuring was announced as effective as of May 2, 2022, and required ongoing activities over the course of 2022-2023 to align regional practices and adopt standard processes to gain operational efficiencies across the department. This re-structuring and consolidation is key to achieving the aim of Partnership's 5-Star Quality Strategy and the stated objectives of all focus areas in the corresponding QI Tactical Plan.
- Prior to the re-structuring of QI/PI, a new team within QI was formed, called the Quality Improvement Analyst (QIA) team. This team is devoted to fulfilling ongoing needs for advanced queries and visualization of health plan data essential to measurement and analysis across QI programs, as Partnership aims to become a 5-Star rated health plan. Additionally, the Supervisor of QIA was designated the primary point of contact to coordinate QI/PI deliverables in the ongoing data transformation and related validation efforts to implement PHC's new core claim system (HRP). This team has grown in 2022-2023 with the re-allocation of a regionally designated QI Analyst previously designated on the Northern Region (NR) Performance Improvement team.
- The CMO and Senior Director of QI/PI continue to work closely with Finance and IT leadership teams in developing a plan-wide analytics strategy. At the start of 2022-2023, this cross-functional leadership team committed itself to developing an enterprise-wide framework, over the next 5 years, to maximize use of data to generate information, knowledge and wisdom to improve health outcomes, enhance the member experience of care, and reduce or maintain the cost of care by optimizing utilization of resources, including data, technology and staff. At the closeout of year one, outcomes include achieving primary goals to establish a Partnership Analytics Strategic Plan, which is in active draft. Specific accomplishments include establishing a hybrid

analytics governance model, completing a plan wide data needs assessment, assessing data analyst roles and responsibilities that led to the adoption of a standardized Data Product Development Life Cycle. The newly defined governance model is in the process of being implemented operationally and will be utilized to facilitate prioritized analytics projects requiring cross-functional stakeholders with shared needs and dedicated to analytics and data governance. Simultaneously, the project interactions occurring within this model will further identify opportunities to optimize structures, expand access to self-service analytics tools, and integrate e advanced analytics. These plan-wide efforts will optimize and bolster the scope of work for QI Analysts and their roles within QI/PI programs relative to other analytics' resources across Partnership.

- Together, the Northern and Southern Region Performance Improvement Managers established five (5) measure focused improvement workgroups under the Quality Measure Score Improvement Initiative (QMSI). Each workgroup is responsible for a specified measure domain and has 1-2 designated leaders to facilitate cross-departmental review of quality measure performance and collaboration in improvement activities and interventions. This represents a shift in PI strategy to affect quality measure score improvement in more impactful and lasting ways. Past quality measure score improvement pursuits were typically focused on regional or departmental interventions, risking provider and community partner confusion, competing priorities, and limited scaling opportunities. Additionally, in the past year PI leadership further designated project and program management resources dedicated to transitioning small tests of change from the QMSI workgroups into expanded pilots and/or sustainable programs for plan-wide scaling. Examples of these transitions in the past year include Mobile Mammography and integrating the Well Child Birthday Club pilot into Partnership's Growing Together program, administered by the Population Health team.
- In 2022-2023, Partnership launched the Enhanced Provider Engagement (EPE) strategy, which represents an expanded approach to coaching providers around quality improvement. The EPE stratifies PCP provider organizations by performance in priority quality measures, with its initial focus on provider organizations who have historically been low performers on the PCP QIP and disproportionately serve communities who have historically experienced healthcare inequities. (see pg.61 for additional information on the EPE)
- In the first half of 2022-2023, Partnership transitioned leadership and administration of its CAHPS Program, including scoring improvement activities, from Member Services to QI. Multi-disciplinary workgroups focused on driving member experience and access improvements remain in place, which include representation from QI, Member Services, Communications, Population Health Management, Provider Relations, Regional Offices, Regional Medical Directors, Health Analytics, and Grievances & Appeals. This transfer of CAHPS to the QI Program structure reflects an approach common to many health plans across California and it creates stronger linkage to Partnership's 5-Star Strategy and the stated objectives of the Engaging Members focus area in the corresponding QI Tactical Plan.
- In 2022-2023, Partnership's NCQA Accreditation Program expanded in scope to include NCQA Health Equity Accreditation. In addition to leading organization-wide preparations for Partnership's NCQA Health Plan Accreditation Renewal Survey in fall 2023, the program team prepared business owners across the organization for a Health Equity Accreditation focused gap assessment in January 2023. The results of the gap assessment led to assignment of business owners and work planning with a target mock survey planned for 3Q 2024 and initial survey in June 2025. Partnership also named a Health Equity Officer in January 2023, who serves within the Health Services department organizational structure, but is recognized as the plan-wide leader in advancing health equity strategies.

Quality Improvement Governance

The organization is satisfied with the number and types of specialties represented in the following committees:

Board of Commissioners

The core purpose of the Board of Commissioners on Medical Care ("the Commission") is to negotiate exclusive contracts with DHCS and to arrange for the provision of health care services to qualifying individuals, as well as other purposes set forth in the enabling ordinances established by the respective counties.
The Commission promotes, supports, and has ultimate accountability, authority, and responsibility for a comprehensive and integrated QI/PI program. The Commission is ultimately accountable for the quality of care and services provided to members. The Commission has delegated direct supervision, coordination, and oversight of the QI/PI program to the Physician Advisory Committee (PAC), which serves as the main Quality Improvement committee. PAC is supported by two other quality committees – the Quality and Utilization Advisory Committee (Q/UAC) and the Internal Quality Improvement (IQI) Committee, which are described in more detail below. The county Boards of Supervisors for each geographic area appoints members of the Commission, which include representation from the community, consumers, business, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health departments. The Commission meets six times per year.

Internal Quality Improvement Committee

The Internal Quality Improvement (IQI) Committee is comprised of appropriate Partnership department directors and staff that track progress towards successful completion of quality initiatives, surveys, audits, and accreditation. The IQI Committee meets ten times per year, with the option to add additional meetings if needed, and reviews new or revised policies, delegation reports, activities, and other reports specific to quality improvement and utilization management initiatives. Multidisciplinary improvement teams may be designated to complete analysis and intervention recommendations for quality improvement issues and activities. The IQI Committee serves to integrate quality activities organization-wide. Activities and progress are reported to the Quality and Utilization Advisory Committee (Q/UAC) and then the Physician Advisory Committee (PAC).

The IQI Committee met 11 times during fiscal year 2022-2023. Partnership's IQI Committee agenda remained heavy throughout the year, due to the volume of policy changes related to NCQA Accreditation and DHCS requirements. To date, Partnership addressed all agenda items timely. The IQI Committee membership remained stable, consisting of a multi-departmental team that included the necessary level of leadership across departments impacted by policies and procedures moving through the IQI Committee. The meeting structure included a policy pre-review process and dedicated policy review time during the meeting, both of which ensure there is adequate time for policy discussion. Discussion topics were presented to the committee, and Partnership leveraged these presentations and reports for IQI Committee members to provide input and qualitative feedback. Overall, the IQI Committee structure has been sufficient to provide adequate oversight and support in tracking quality initiatives and providing health plan and/or clinical expertise into policy and procedure review.

Quality and Utilization Advisory Committee

The Quality and Utilization Advisory Committee's (Q/UAC) role is to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. This responsibility includes providing significant input on the QI Program Description, Annual Evaluation, and Work Plan. The committee is required to meet at least ten times per year, with the option to add meetings if needed. Q/UAC voting membership includes consumer representative(s) and external providers whose specialties are internal medicine, family medicine, pediatrics, OB/GYN, neonatology, and behavioral health, among others. The Partnership CMO (chair of the committee), Clinical Director of Behavioral Health, Medical Director for Quality, and leadership from the QI/PI, Provider Relations, Utilization Management, Care Coordination, Pharmacy, Population Health and Grievance and Appeals departments regularly attend Q/UAC meetings. Q/UAC activities and recommendations are reported to PAC and to the Commission at least quarterly.

Q/UAC met 11 times during fiscal year 2022-2023. PHC's Q/UAC agenda remained heavy due to the volume of policy changes related to maintaining NCQA Accreditation and new DHCS requirements largely associated with California Advancing & Innovating Medi-Cal (Cal-AIM) and other All Plan Letters. PHC was able to address all agenda items timely. Membership remained steady and quorum was met each meeting. Overall, the Q/UAC committee structure was sufficient and provided adequate oversight and support to the Quality Improvement program and sufficient clinical expertise to support informing policy and procedure.

The Q/UAC agenda is expected to remain heavy for the foreseeable future as Partnership prepares for new State-mandated programs expected in 2023-2024, including further provisions defined under Cal-AIM and demonstrating compliance to DHCS 2024 Contract deliverables. Furthermore, Partnership's consideration of adding ten new counties to its service area, effective in January 2024, could also impact the QI Program at large.

Physician Advisory Committee (PAC) Oversight Program

Physician Advisory Committee (PAC) and voting membership included external PCPs, board certified high-volume specialists, and advanced practice clinicians such as certified nurse midwives, nurse practitioners, or physician assistants. A voting provider member of the committee chaired PAC. Per Partnership policy, the committee met monthly, at least ten times during fiscal year 2022-2023. PAC monitored and evaluated all Health Services activities and was directly accountable to the Commission for the oversight of the QI/PI program. The parameters for membership and meeting frequency were met for the fiscal year 2022-2023, and activities including review and approval of policies and procedures, QI activities, and evaluations of projects and programs were addressed by an appropriate mix of Primary Care and Specialty physician members who attended. Quorum requirements were met for nine of the ten convened meetings. The Partnership CMO, Medical Director for Quality, Clinical Director of Behavioral Health, and leadership from QI/PI, Provider Relations, Utilization Management, Care Coordination, and Pharmacy departments attended PAC meetings regularly.

Quality Improvement Program Advisory Groups

As detailed later, Partnership has several incentive programs called Quality Improvement Programs (QIPs). QIP Advisory Groups are made up of appropriate Partnership staff and representative providers to assure ongoing collaboration in Partnership's value-based program offerings. Each year they review and recommend measures for the QIP programs in which they participate, with each member of the QIP Advisory Group serving for a two-year time period. The QIP team manages the Advisory Group member list and is responsible for inviting new participants at the conclusion of the two-year service period. Advisory Group meetings are held once per quarter throughout a

measurement year for most QIPs and less frequently but no less than twice per measurement year for smaller programs.

PAC oversees the QIP Advisory Groups and the QIP team is responsible for creating the Advisory Group meeting agenda in collaboration with the Partnership Chief Medical Officer. Each QIP Advisory Group formulates recommendations generated by internal QIP Technical Working Groups, in the form of draft measures which are released to their respective provider networks during a "public comment period." Feedback from the public comment period is shared with the QIP Advisory Groups, who assimilate them into a set of measure recommendations that are forwarded to PAC for review and approval. The current committee structure supports the QIPs and allows for valuable feedback from appropriate stakeholders, in a fashion that helps Partnership meet its goals. The Quality department restructured in 2022, transitioning from a split-region model into a consolidated QI/PI model. The QIP Advisory Group includes representation from both PHC regions, including invitees from smaller organizations in order to diversify feedback and increase stakeholder buy-in.

Quality Improvement Leadership Engagement & Commitment

Chief Executive Officer

The Partnership Chief Executive Officer's (CEO) primary roles in quality management and improvement were four fold:

- Maintained a working knowledge of clinical and service issues targeted for improvement
- Provided organizational leadership and direction
- Participated in prioritization and organizational oversight of quality improvement activities
- Ensured availability of resources necessary to implement the approved QI/PI program

The CEO is a member of the IQI Committee and is a standing attendee at PAC. Along with other members of the Executive Team, the CEO further supports the QI/PI program through participation in the NCQA Steering Committee and Executive Quality Measure Score Improvement meetings. The Executive Team provides oversight, accountability and support for NCQA, HEDIS, and related quality improvement initiatives.

In recognition of the need to better engage executive leadership at provider sites primarily responsible for driving quality measure performance, the CEO and CMO meet with the executive and senior leadership of ten of our largest primary care provider sites. One to three meetings were held with each of the participating provider organizations in 2022-2023. The CEO was also a member of the Board Quality Advisory Group, and partnered with the CMO in the consideration of topic and areas to gain further insights and recommendations from Board members who are also leaders at some of our largest participating network provider sites. The CEO's level of involvement in quality improvement activities was appropriate to ensure executive level accountability in support of the department and organization wide goals and responsibilities.

Chief Operating Officer

The Chief Operating Officer (COO) worked closely with leaders in Utilization Management to provide accountability for delegates to meet necessary NCQA accreditation requirements and provided strategic leadership and guidance in the review and revision of provider contracts to ensure QI reporting requirements and value based program contingencies were met. As a member of the IQI Committee, ad hoc PHC member of PAC and participant

in several IT workgroups and subcommittees, the COO continued to advocate for data quality improvements to support measure reporting for HEDIS. The COO also had purview over the Population Health, Provider Relations, Member Services, Claims, and Care Coordination departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The COO's level of involvement fulfilled the need for executive support and accountability for improvements with data quality, as well as coordination of activities between QI and other departments including; Member Services, Population Health, Communications, and Provider Relations.

Chief Medical Officer

The Chief Medical Officer (CMO), with the assistance of the members of the PAC, Q/UAC, and IQI Committees, is responsible for providing professional judgment regarding matters of quality of care, peer review, clinical services, and medical procedures. The CMO is the chair of the IQI Committee and Q/UAC and has significant involvement in all QI/PI, Pharmacy and Health Services activities. The CMO facilitates the Board Quality Advisory Group and presents a report on quality at each Board of Commissioners meeting.

The CMO and the QI Program senior leadership team provides oversight for QI programs on a day-to-day basis. The team is comprised of:

- Associate Medical Directors - Assists CMO with utilization management review, review of appeal decisions, and review of Potential Quality Issues (PQI). The level of involvement of the associate medical directors was sufficient for reconciliation of PQIs via the peer review process.
- Medical Director for Quality - Assists CMO by providing physician support for varying activities within the Quality department, including Performance Improvement, Member Safety, Peer Review, and the Quality Improvement Programs, as well as assisted with utilization management review activities. Late in the 2021-2022 year, this role was expanded to include management oversight of the Member Safety and HEDIS teams to support a re-structuring of the Quality department. The time allocated and scope of responsibilities of the Medical Director for Quality was set appropriately to meet the needs of the QI/PI department.
- Regional Medical Directors - Works closely with respective counties on quality improvement activities including: liaison to physician leaders, serve as medical leadership at community meetings, support process improvement activities, author/ edit provider and member QI newsletter articles, drive improvements on adult and child measures and foster further collaboration and engagement with providers through regional meetings.
- Health Services Senior Director - Reports to the CEO but works in close collaboration with the CMO and QI Program senior leadership. Responsible for the day-to-day implementation of Partnership's Utilization Management, Care Coordination and Population Health Management and Health Equity Programs. This position has the authority to make decisions on coverage not relating to medical necessity. This role serves as a standing Member of PAC, Q/UAC and the Peer Review Committee and provides oversight, guidance, and evaluations of ongoing UM activities and programs under her oversight.
- Quality and Performance Improvement Senior Director - Works collaboratively with the CMO to define strategy, develop programs and services, and to evaluate the effectiveness of the QI/PI program. Together with the QI management team, including the Medical Director for Quality, provides oversight of Facility Site Reviews, investigation of potential quality issues, compliance with NCQA standards, HEDIS and other performance measure data collection and performance reporting, value based payment programs (QIPs), external and internal QI training, provider education on the QIPs and HEDIS, grant application and grant management. This role works to foster greater cross collaboration of QI staff and strategic involvement of other

departments to support the execution of tactics defined and maintained under Partnership's 5-Star Quality Strategy.

The number of associated Health Services staff and level of involvement of the CMO was appropriate for meeting the objectives of the Quality Improvement Program.

Northern Region Executive Director

The Northern Region Executive Director supports QI/PI work in the PHC Northern Region (NR) by leading operational staff based in Eureka and Redding. Following the re-structuring and consolidation of the NR and SR QI teams into one QI team in May 2022, the Northern Region Executive Director continued working collaboratively with the CEO, Chief Medical Officer (CMO), and Senior Director of QI/PI to assure the objectives of the QI/PI program are fulfilled in the northern region. The Northern Region Executive Director is also essential in fostering relationships with community based organizations and providers while supporting regionally based quality leadership in executing the QI/PI strategy. The Executive Director provided more than adequate levels of support for garnering resources for member and provider facing performance improvement activities while encouraging interdepartmental support for quality improvement initiatives.

Quality Improvement Departmental Changes

The structure of the QI/PI department, including committee structure (inclusive of leadership and practitioner participation), position changes, staff and team roles and responsibilities, are periodically assessed. The results of these assessments can lead to major operational and structural changes to the department or related QI functions. Consideration is given to new state directives, local and national events, general business needs, staff growth and development and fiscal responsibility when making a determination on whether to make structural or operational changes.

Based on the considerations noted above and the evaluation and assessment of the 2021-2022 QI Program, the following changes were made during fiscal year 2022-2023:

Changes within QI Department

Key personnel changes and Program restructuring in fiscal year 2022-2023:

- Member Safety
  - As Partnership works with "members" not "patients", the department is shifting away from the use of "Patient Safety" to "Member Safety" when referring to work QI does in this area. This terminology change reflects that distinction.
  - In 2022, DHCS implemented the use of significantly expanded site and medical records review tools. These tools incorporate >35 new required review elements, resulting in more sites requiring corrective action plans (CAPS) and additional follow-up by the Facility Site/Medical Records Review (FSR/MRR) team nurses. To assist with the tracking, documentation and scheduling of follow-up reviews related to the increase in CAPs, a "Clinical Site Review Coordinator" joined the team in July 2022. This new position frees up nurses' time to complete their reviews and has been particularly welcomed with the return to in-person site reviews (post-COVID restrictions) and increased travel. This position will be very helpful with the increased demand for scheduling site reviews related to Partnership's anticipated expansion into 10 additional counties in CY

2024, particularly since these reviews and the site certification must occur before members can be assigned to the sites.
    - To more accurately describe the scope of work performed by the FSR/MRR team (and to differentiate from the team performing quality of care investigations), job description changes were implemented in May 2023. The "Manager of Clinical Compliance and Patient Safety" became the "Manager of Clinical Compliance"; the "Supervisor of Patient Safety" became the "Supervisor of Clinical Compliance"; and, the "Performance Improvement Clinical Specialists" (nurses) became "Clinical Compliance Inspectors".
    - Early in 2022-2023, the manager of the Quality of Assurance and Patient Safety team requested to step down into a lower role, prior to her pending retirement. She requested this in order to train the then Supervisor of Patient Safety as her replacement; the then Supervisor was interested and felt to be an excellent internal candidate. This worked out very well, as it allowed for 6 months of side-by-side training. The two leaders swapped positions effective January 1, 2023, creating an essentially seamless transition and obviating the need for recruitment and additional on-boarding of a new team member.
- Performance Improvement
    - In the first half of 2022-2023, Partnership transitioned leadership and administration of its CAHPS Program, including scoring improvement activities, from Member Services to QI. This led to a new program manager role being developed and filled. This program manager oversees the contracted vendor's administration and reporting of CAHPS surveys and the multi-disciplinary member experience and access focused improvement workgroups.
- NCQA Accreditation
    - With the advent of the DHCS requirement to achieve NCQA Health Equity Accreditation (HEA) by January 2026, a new program manager position focused on HEA was added to the NCQA Accreditation Program team. Given the importance of getting an early start on this new NCQA requirement, and the pending departure of the manager of the NCQA team in June 2023, the new position was filled before the end of the 2022/23 fiscal year, allowing for overlap and knowledge transfer with the departing NCQA manager. The vacated manager position was successfully filled with an internal candidate prior to the end of 2022-2023.
- HEDIS
    - After a two year reduced scope, due to the global pandemic, the HEDIS team resumed its full-scope medical record review for the Annual HEDIS Project devoted to Measurement Year (MY) 2022. The HEDIS team continued to balance the demands of a growing measure set defined under the DHCS Managed Care Accountability Set (MCAS) along with the parallel Annual HEDIS Project specific to NCQA Health Plan Accreditation (HPA) reporting. MY2022 represents the first year NCQA will evaluate and publically report Partnership's NCQA Health Plan Rating (HPR). Due to the growing complexity and need, a new program manager position was added to the HEDIS team and filled in February 2023 with an internal candidate possessing HEDIS experience.

Re-Structuring of QI Department

Simultaneous to the re-structuring of QI into a consolidated department in May 2022, two director level vacancies remained. At the start of 2022-2023, these vacancies were addressed with the creation of two new roles, the Associate Director of Quality Measurement and the Director of Quality Management. The Associate Director of Quality Measurement was intended to provide primary strategic and management oversight for the HEDIS and NCQA Accreditation teams and positioned as a key collaborator with the CMO and Senior Director on the strategic direction of the HEDIS projects and related improvement initiatives. The Director of Quality Management was developed as the role directing plan-wide and regional performance improvement initiatives, quality improvement

programs, and quality improvement data visualization tools and analyses. This includes, but is not limited to strategic goal setting, program planning, budget/account management, and supervision of teams. The Director of Quality Management was also framed as essential in fostering strong partnerships between QI, Health Analytics, IT, and Population Health to fulfill data collection, reporting, and dashboard needs in achieving QI/PI deliverables and related organizational goals, while addressing competing priorities and assuring good stewardship of technical resources.

The Associate Director of Quality Measurement and Director of Quality Management were posted in June 2022 and were in active recruitment at the close of 2021-2022 fiscal year. At that time, the Senior Director of QI/PI and the Medical Director for Quality shared director level oversight roles and responsibilities across the QI/PI team.

After extensive recruiting in 2022-2023, the Director of Quality Management role was filled in January 2023. The Associate Director of Quality Measurement recruitment was postponed after several months of searching. At the time of this decision, the role to be assumed by that Associate Director position was divided between the Senior Director of QI/PI and the Medical Director for Quality. As further time has allowed for adjustment and assimilation of this additional oversight by these two directors, the perceived need for the Associate Director position has diminished and has been eliminated.

Quality Improvement Executive Summary

QI TRILOGY

Executive Summary

Partnership has identified four strategic priorities in its 2021-2024 Strategic Plan – 1) high-quality health care, 2) leveraging community partnerships, 3) operational excellence, and 4) financial stewardship to deliver on its mission to help its members, and the communities we serve, be healthy.

Partnership's Quality Improvement (QI) Program was successful over the course of fiscal year 2022-2023 in achieving its quality improvement goals and commitments. The structure of the QI Program and its associated work planning process included ongoing monitoring of planned objectives and activities dedicated to improving quality of clinical care, safety of clinical care, quality of service and members' experience.

Key accomplishments and highlighted learnings, further detailed in this annual QI Evaluation, include:

- The NCQA Program Management Team worked with business owners across Partnership to maintain compliance with all assigned NCQA Health Plan Accreditation (HPA) Standards and Guidelines. Assurance of ongoing compliance to the latest standards and guidelines was assessed formally through a mock survey completed in October 2022, with subsequent monitoring of actions from resulting findings. Partnership is prepared for its Renewal HPA Survey, scheduled for October 2023. At the completion of the Renewal HPA Survey, Partnership anticipates its first NCQA Health Plan Rating (HPR) as an accredited health plan.
- The HPR methodology used by NCQA represents a composite metric of health plan performance under HPA HEDIS measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures. As such, Partnership's QI Program has adapted in recent years to incorporate greater focus on improving both the quality measures defined by the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS), NCQA HPA, and CAHPS surveys, as each are used to assess the quality of healthcare provided to our members. Partnership continues to evaluate its QI Program under its 5-Star Quality Strategy (last updated in February 2020) and corresponding tactical plan, which is updated quarterly. This framework is reflected in detailed goals and deliverables within Partnership's annual QI Work Plan. This approach has aided Partnership in demonstrating an increased organizational focus on improving HEDIS and CAHPS scores over 2022-2023, which will continue as a multi-year effort and focus across the health plan.
- The updated 2024 contract between DHCS and Partnership share a mutually stated goal of advancing health equity and reducing health disparities. By January 2026, all managed care plans must achieve NCQA Health Equity Accreditation (HEA). NCQA HEA is a new standards program focused on advancing the delivery of more equitable and culturally and linguistically appropriate services across member populations. The NCQA Program Management team has worked closely with Partnership's NCQA consultant, and key stakeholders across the organization to estimate current performance and develop a readiness timeline to achieve the new NCQA HEA.
- With the effects of COVID-19 finally subsiding in 2022-2023, portions of Partnership's provider network have begun to emerge from associated financial, labor, and quality performance challenges, while others have been slower to reengage in QI activities. Quality Improvement staff dedicated to performance improvement and value based programs continued successful improvement interventions and programs from 2021-2022 through 2022-2023, with enhancements to further impact outcomes. In some cases, these enhancements reflected resuming pre-COVID-19 practices like in-person collaboratives and joint leadership initiative meetings, hands-on improvement trainings, and other ad hoc in-person coaching support. At the same time, the return to a more normal state permitted the launching of new strategies including enhanced provider engagement and provider coaching of Partnership's lowest performing provider organizations in its PCP QIP clinical measure set. Preparations also began in QI for provider onboarding in Partnership's geographic 10-county expansion targeted for January 2024.

- A new strategy was launched within the PI/QIP and QI Analysis teams to better identify and address health disparities in quality performance. Opportunities for increased dissection of disparate conditions for targeted populations through enhanced data visualization have resulted in greater collaboration with internal and external stakeholders. This collaboration will be used to leverage quality improvement practices in collecting and assessing more data and optimizing community based contacts and resources necessary to achieve Partnership's health equity aims.
- Internally, Quality Measure Score Improvement focused measure workgroups expanded and were optimized to meet the evolving and expanding DHCS MCAS and NCQA HPA measure sets in the areas of Pediatrics, Chronic Diseases, Medication Management, Behavioral Health, Women's Health and Perinatal Care. This approach ensures monitoring and review of all measure performance by workgroup teams as data becomes available, as well as assessment of gaps and execution of new performance improvement interventions and activities. The QMSI workgroups include representation from Care Coordination, Claims, Health Education, the Office of the CMO, Pharmacy, Behavioral Health, Population Health, Provider Relations, QI, Health Analytics, and other regional leadership.
- For the most recent reporting year, representing 2021-2022, CAHPS Composite Scores reflected drops in scores for adult CAHPS respondents while child CAHPS respondents scored more favorably. The results across both surveys warrant focused and expanding improvement efforts both on behalf of the health plan and within the provider network. Short and long term interventions were launched over the course of 2022-2023 to affect member experience as measured by CAHPS. This included identifying additional data sources that provide more real-time member satisfaction indicators. The impact of these interventions will be closely evaluated versus the anticipated 2022-2023 results, but Partnership already recognizes investments in larger scale interventions to enhance member experience and access to care must continue with focus in 2023-2024 and beyond to impact CAHPS results.
- The Member Safety team devoted to potential quality of care issue investigations cited lower case referrals versus prior years, attributing it to several factors including actions taken to improve the PQI referral system and Medical Director review of Grievance cases. These actions have helped eliminate inappropriate referrals. The Member Safety team devoted to site reviews observed high Facility Site Review and Medical Record Review scores but noted areas of improvement are actively cited on an individual provider basis and addressed as part of the site review process, including just-in-time education.
- The structure and function of the quality committees remained stable. Overall, the quality committee structure was sufficient and provided adequate oversight and support to the QI Program and provided sufficient health plan and/or clinical expertise to inform and maintain policies and procedures. In 2022-2023, particular focus to policy and procedure updates was given to policy changes related to maintaining NCQA Accreditation and new DHCS requirements largely associated with Cal-AIM and other mandates. In addition to reporting HEDIS and CAHPS annual results, the quality committee structure also received and provided feedback on results from provider access studies, monitoring of grievances and appeals, Initial Health Assessment trends and actions, monitoring of site review results and corrective actions trends, monitoring of potential quality of care issues, evaluations of performance improvement interventions and pilots, and outcomes of the Partnership Improvement Academy activities.
- There were sufficient resources to support the QI Program overall. Given the growing complexity and scope of requirements between DHCS MCAS and NCQA accreditation, the HEDIS, NCQA Accreditation Program, and Performance Improvement teams grew in staff allocated to program and project management roles. The newly released DHCS Facility Site Review and Medical Record Review tools also required new Member Safety staffing to fulfill all reporting and timeliness requirements.

2022-2023 QI Work Plan Summary

Background

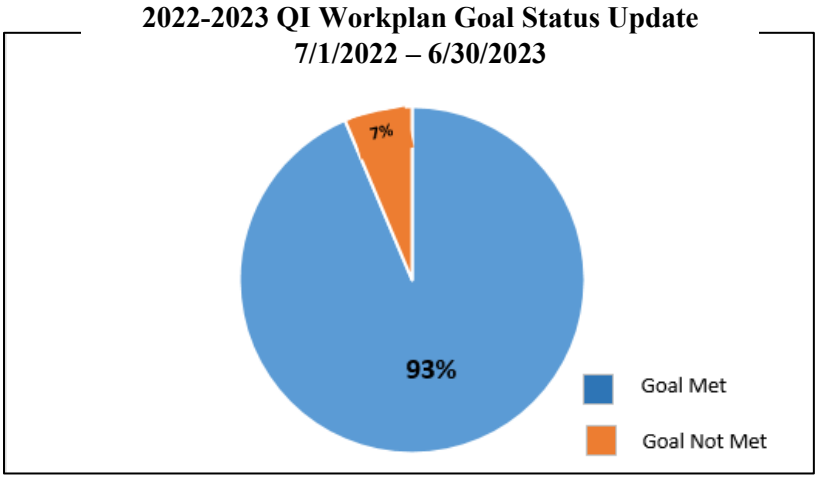
Background: The QI Work Plan is designed to track progress on key QI activities and initiatives throughout the year. Approved by our Board of Commissioners and quality committees, it includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service and members' experience. This update includes progress on activities from July 1, 2022 through June 30, 2023.

Results: Goals were assessed for level of completion based on the status of supporting deliverables. Of the 59 goals outlined in the work plan, 55 are "Goal Met" and 4 are "Goal Not Met".

Table 1
2022-2023 QI Workplan Goal Status

7/1/2022 – 6/30/2023

Status	n	%
Goal Met	55	93%
Goal Not Met	4	7%



2022-2023 QI Major Milestones and Activities

- The HEDIS® Monthly Project, reporting HEDIS® monthly rates as required by NCQA® Health Plan Accreditation and the Department of HealthCare Services (DHCS) Managed Care Accountability Set (MCAS), for Measurement Year (MY) 2023 was implemented in June 2023.
- The Consumer Assessment of Healthcare Providers & Systems (CAHPS®) program oversight transitioned from Member Services to Quality Improvement and restructured the organizational/department goal process. These combined changes paved the way for additional cross-department resource dedication and collaboration. During this measurement period, several workgroups focused on known barriers derived from the CAHPS® MY2021/Report Year (RY) 2022 survey results, coupled with identifying additional data sources that provided more real-time members satisfaction or dissatisfaction indicators.
- The 2023 eReports kick-off webinar was held on 05/03/2023 and provided an overview of eReports and the Preventive Care Dashboard, which is a source of supplemental data. Well-child visits are visible on the Preventative Care Dashboard, which helps providers track member's well-care visits and be proactive with office visits.
- The Partnership Quality Dashboard (PQD) Primary Care Provider Quality Improvement Program (PCP QIP) internal and provider view dashboards were evaluated for updated user needs during the fiscal year. Communication with network stakeholders informed updated requirements that were published in the dashboard, including the addition of two new dashboards displaying measurement year 2022 QIP data.
- The disparity analysis dashboard was a significant organizational focus this fiscal year. Analysis and identification of health disparities across key health indicators is a primary focus for intervention. This

dashboard was developed to meet updated internal reporting needs in order to better align summarized data with state directives, allowing the evaluation of member data by key demographic indicators including race and ethnicity.

- Data from the new claims system, HealthRules Payor (HRP), has been programmed to integrate with all QI processes. This includes HEDIS®, PQD, and EDW DataMart's, which are provided to end users for reporting and analyzing data. The EDW team integrated the HRP data to HEDIS application and performed two rounds of testing. The development work was completed along with the testing efforts. Testing and integration for the Perinatal QIP was completed as well. For PQD the HRP data for clinical and non-clinical to EDW environment was integrated, however the development & testing work has not started. This is due to delays in receiving necessary data from other teams. All QI processes mentioned above are in non-production environments, as HRP has not yet gone live
- The Data Quality Dashboard was updated to retire old data sources and adding new data sources. The dashboard was enhanced to include sources that PHC is receiving through the Clinical Analytics Gateway into the Clinical Data Repository. The sources that were added included NCHIIN, Quest, LabCorp, SVMS, NorthBay, Pharmacy data from Magellan, and DHCS All Plan Data.
- Successfully launched the 2023 PCP QIP Kick-off webinar, reviewing the structure of the program, Measurement Year (MY) 2023 timeline, payment methodology, data collection, ongoing collaboration with providers, in addition to a detailed overview of the different measure sets and the changes made from last MY to current MY.
- Perinatal Quality Improvement Program (PQIP) evaluation was completed in December of 2022. This evaluation addressed the history and background of the PQIP, programmatic design, provider participation, and overall annual performance of participants.
- HEDIS® Electronic Clinical Data Systems (ECDS) Depression Measures as a gateway measure was launched successfully for the Perinatal QIP 2022-2023 MY, as planned. Education and technical support was provided to participants as needed, including template distribution and troubleshooting, login credential updates, and data review for accuracy and acceptance.
- The Long Term Care Quality Improvement Program measure set for MY 2023 was approved and included California Immunization Registry (CAIR) enrollment as a gateway measure, as well as a new measure focusing on health equity.
- The Quality Measure Score Improvement group successfully engaged five measure-focused workgroups (Pediatrics, Chronic Diseases, Medication Management, Behavioral Health and Women's Health and Perinatal Care). Each workgroup had specific deliverables. A few notated accomplishments include an Adolescent Immunization Poster Contest; Healthy Kids Growing Together Program expansion across PHC; a mobile mammography intervention and with best practices/recommendations captured for implementation of future mobile mammography events; and medication-focused Academic Detailing sessions with providers.
    - Provider in-service sessions related to Potential Quality Issue (PQI) case investigation/resolution and Provider Preventable Conditions (PPC) were conducted. The intent of the sessions was to educate providers and staff on PQI/PPC and promote high-quality medical care by identifying areas of non-compliance to reduce risks of adverse events to our members in the community settings and facilities.
    - The Patient Safety Site Review Team assisted primary care provider sites in transitioning to the newest version of the DHCS mandated 2022 Site Review Tools by successfully conducting 15 provider educational trainings.
    - PHC continued collaboration with Northern Region consortia, represented by the Health Alliance of Northern California and North Coast Clinics Network. Leveraging the existing peer network and rural round table events were great ways to share key information with the network. When evaluating quality scores, consortia member practices performed higher than non-member practices. The consortia offer a unique perspective from their discussions that PHC does not always see from the payer perspective.
    - The Accelerated Learning Series occurred between January and April 2023 and included six (6) virtual training sessions covering content on priority Managed Care Accountability Sets (MCAS) measures (Cervical, Breast, and Colorectal Cancer Screening; Asthma Medication Ratio; Comprehensive Diabetes

Care; Controlling High Blood Pressure; Pediatric Health for 0-2 Year Olds; and Pediatric Care for 3-17 Year Olds). Attendance ranged from 49 to 77 attendees, with each session representing 25 to 33 unique organizations, and 100% of attendees rating the topics covered in these sessions as relevant and useful. One of the Accelerated Learning sessions, Diabetes Management – HbA1c Good Control, was re-purposed to an on-demand self-study webinar where viewers can earn CME/CE credit.

- Partnership completed all Joint Leadership Initiative (JLI) meetings on schedule during the fiscal year. Seven (7) of the nine (9) provider organizations (PO) participating in JLIs in 2022-2023 improved their PCP QIP performance between 2021 and 2022. The addition of "measures within striking distance" content was particularly impactful for focusing PO executive teams on their 2022 QIP performance in the fall JLI series; one PO ranked in the bottom 20 PO's on the 2022 QIP at the time of their fall JLI was able to improve their performance to rank as one of the top 20 PO's by December 2022.
- The first in-person ABCs of QI training since the pandemic was held on 11/08/22 in Fairfield. There were 47 attendees at this training, representing 13 unique organizations; 95% of attendees rated they were extremely satisfied/satisfied with the course. A second in-person ABCs of QI training was held in Redding on 04/27/23. There were 52 attendees, representing 15 unique organizations; 100% of attendees rated they were extremely satisfied/satisfied with the course.
- Existing framework of regional provider meetings in place in the Southeast and Southwest regions were used to build a plan for Northern region expansion. These meetings provide a regional forum to problem-solve issues relevant to quality improvement.
- Quality Improvement (QI) demonstrated strong delegation oversight in support of delegation standards/ delegated entities (Carelon/Beacon and Kaiser) and PHC policies and procedures. QI also worked closely with the Regulatory Affairs and Compliance department in the annual delegation audits and also in pre-delegation activities.
- The National Committee for Quality Assurance (NCQA) Program Management Team maintained compliance of all assigned NCQA Health Plan Accreditation (HPA) Standards and Guidelines.

FY 22/23 Work Plan Final Goal Status

Goal Status: Not Met

Project or Program	Goal	Status Details	Next Steps
2d. Primary Care QIP Provider Experience Data	Improve provider survey participation by 10% from prior year survey.	A slide about the survey was included in both kick-off webinars to explain the intent and importance of the survey. Despite a good attendance rate for webinars, only seven (7) surveys were completed. With this low survey participation rate, the goal of increasing participation by 10% from prior year survey rate was not met.	The PCP QIP Team has been strategizing ways to make the survey more accessible to providers during the next measurement year, such as including survey link in the quarterly newsletters, Operations Meetings, etc. With this action plan, we anticipate a higher response rate during the next survey cycle.

Project or Program	Goal	Status Details	Next Steps
4f. Well-Woman Birthday Club, Screening Mammography	By June 30, 2023, there will be 20% activity from PHC members, who are in the Breast Cancer Screening (BCS) measure gap list for Lake County, who have scheduled and completed their screening mammography exam and secured the gift card incentive as part of the Well-Woman Birthday Club Pilot.	The 2022 Well Woman Birthday Club Phase 2 pilot focused on women in the Breast Cancer Screening (BCS) cohort assigned to provider organizations (POs) in Lake County, who were due or overdue for a mammogram. All women identified were sent an outreach mailer during the month of their birthday between June – December 2022, offering a gift card incentive of $30 for completion of a mammogram by 12/31/2023. The SMART Aim for the pilot, to increase Lake County's BCS completion rate to 53.93% by 12/31/2022, was not achieved; Lake County's BCS completion rate was 48.64% as of 12/31/2022. As a whole, the member incentive outreach campaign did have an overall completion rate of 18.23% (97 of 532) that were close to SMART Goal 1 for the pilot's Work Plan, to achieve 20% completion rate for women receiving outreach and an incentive offer as part of the Well Woman Birthday Club.	The pilot was assessed as very labor-intensive by the pilot team, with coordination efforts between PCP's, imaging centers, and Partnership adding the largest amount of effort to the process. For this reason, the pilot team concluded that the $30 gift card offer paired with coordination with PCP's and imaging centers was not successful in increasing BCS completion rates and recommends abandoning the Well Woman Birthday Club intervention. Future work will include continuing more successful interventions such as mobile mammography events, and exploring alternate opportunities to continue the engagement with Lake County providers and increase utilization of imaging centers for mammograms. If future pilots propose testing the use of member incentives for Breast Cancer Screening completions, the recommendation is to consider a more streamlined approach to the program, possibly including member attestation for mammogram completion or piloting workflows that use a gift card management tool.

Project or Program	Goal	Status Details	Next Steps
8d. Practice Facilitation and Provider Coaching	The Practice Facilitation program provides provider coaching framework to key SR provider organizations that builds organizational capacity for quality improvement work. In 2022-23, the program's impact and structure will be evaluated and lessons learned will be integrated into the ongoing Practice Facilitation program going forward.	The following deliverable was delayed: From the 2022 evaluation, integrate at least one "lessons learned" into Practice Facilitation program design. In January 2023, there were several changes in the provider organizations participating in Practice Facilitation: One provider organization re-started Practice Facilitation in 2023; another provider organization decided not to continue Practice Facilitation in 2023, due to team formation needs on their QI team. Staff transitions on the Partnership Performance Improvement team led to two provider organization transitioning to a new Practice Facilitation coach in April – May 2023. Changes to the Practice Facilitation format gleaned from the 2022 evaluation have been postponed during the coaching transition process until Fall 2023.	There is a desire to develop new activities in Fall 2023. There is also potential to leverage best practices from the Enhanced Provider Engagement program that launched in Spring 2023 with Practice Facilitation providers, such as completion of a Needs Assessment survey by each PO's leadership, or training Practice Facilitation teams on the Building Blocks frameworks, especially around Team Based Care and Population Health Management. As Enhanced Provider Engagement continues and is evaluated in early 2024, there will be a need to further define how this second form of provider coaching will align with Practice Facilitation, and whether there is the potential to merge or better align the two programs.
10b. Delegation Oversight	• Obtain complete picture of current and prospective delegation oversight	The following deliverable was delayed: If there are significant changes	The milestone requirement to plan for both NCQA and DHCS 2024 requirement pre-delegations was

Project or Program	Goal	Status Details	Next Steps
	requirements for both NCQA and DHCS. • By January 1, 2023 assess prospective DHCS and NCQA delegation oversight requirements – identify misalignment between the two and understanding of new requirements. • By February 1, 2023 develop a timeline and work plan for compliance with new requirements. • Communicate timeline and plan with impacted/responsible operational departments. • Maintain compliance of all current requirements from July 1, 2022 – June 30, 2023.	identified, plan for and begin conducting pre-delegation evaluations and make updates to applicable delegation agreements with new 2023 NCQA Standards and prospective 2024 DHCS standards.	completed; however, there will be a delay in completing delegation evaluations and updates to applicable agreements. The team will plan to update delegation agreements and conduct pre-delegations for both DHCS and NCQA (in one audit) during the '23/24 QI work plan year. As such, this particular milestone will be carried into the next year's goal cycle.

Please see Appendix (G) for approved 2022-2023 QI Work Plan Summary.

National Committee for Quality Assurance (NCQA) Accreditation

NCQA Overview
(National Committee for Quality Assurance)

Partnership strives to improve the health status of members and their care experience to become one of the highest quality health plans in California. The NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA) support Partnership's vision, mission, and strategic goals and fulfill Partnership's contractual obligations with the Department of Health Care Services (DHCS).

NCQA Health Plan Accreditation (HPA) Goals

During fiscal year 2022-2023, Partnership achieved the following goals relative to NCQA Accreditation:

1) Maintain compliance of all NCQA HPA requirements following the most up-to-date Standards and Guidelines
2) Report HEDIS and CAHPS results to NCQA for NCQA HPA by June of 2023

NCQA Accreditation Compliance and Preparation for HPA Renewal Survey

The plan-wide NCQA-related goal was approved by the NCQA Steering Committee for fiscal year 2022-2023. The goal included five milestones aimed at ensuring continuous compliance of requirements in preparation for Partnership's next survey, scheduled on October 17, 2023. The goal was met and all milestones were completed on time. A summary of the goal and outcomes towards obtaining NCQA Renewal Survey HPA are presented below.

Goal: Departments will maintain compliance of all assigned HPA Standards and Guidelines and prepare for Renewal Survey, as measured by five milestones:

Milestone 1: Milestone 1 was achieved by obtaining a "MET" score on all assigned elements during the mock survey. For the gaps identified on Year 1 evidence, business owners:

- Submitted a Corrective Action Plan (CAP) to address any applicable recommendations by September 19, 2022
- Corrected evidence by the applicable look-back period according to the CAP. The new or updated evidence was submitted to Partnership's NCQA consultant for review and approval by October 14, 2022
- Shared any modifications to approved evidence which affect NCQA requirements with the NCQA Program Management Team for review and further assessment prior to the effective/production date

Milestone 2: By December 16, 2022, the following deliverables were met by updating the annual Health Plan Accreditation (HPA) Workbook (Work Plan and Evidence Submission Library):

- Reviewed and confirmed or updated the work plan information; collected attestations from newly identified key stakeholders and contributors
- Reviewed and updated the department's evidence submission library based on HPA 2023 Standards and Guidelines and subsequent tri-annual changes and mock survey findings

Milestone 3: Departments maintained compliance of all assigned requirements from July 1, 2022 – June 30, 2023 by completing the following deliverables:

- Completed the annual grand analysis and other NCQA-related reports based on the production date indicated in the Annual Reporting Schedule. Submitted all reports to our NCQA consultant for feedback, and incorporated all edits by June 30, 2023
- Addressed any modifications to evidence, if applicable, as a result of HPA 2023 Standards and Guidelines / Tri-annual Policy Update / Monthly FAQs, to meet the standard in accordance to NCQA's look-back period, timelines and/or expectations. Submitted all edits to the NCQA Program Management Team and obtained approval by our NCQA consultant
- Produced all evidence based on the date(s) listed under the Evidence Submission Library. Reviewed any date changes or document revisions with the NCQA Program Management Team in collaboration with our NCQA consultant

Milestone 4: Departments maintained strict oversight of Partnership and non-NCQA Accredited delegates' files from July 1, 2022 – June 30, 2023 by completing the following:
For PHC Files:

- Addressed all mock survey findings related to the file review requirements by October 14, 2022.
- Continued ongoing monitoring of files and shared results with the NCQA Program Management Team for regular updates at the NCQA Steering Committee

For non-NCQA Accredited delegates:

- Implemented a corrective action plan for any findings from annual delegation audits, mock file review with our NCQA consultant, or ongoing monitoring
- Continued ongoing monitoring of files to ensure compliance throughout the look-back period. Provided regular updates based on the risk assessed to the NCQA Steering Committee for feedback and decision

Milestone 5: By June 30, 2023, business owners submitted all annotated evidence for Renewal Survey, based on the evidence dates listed in the Evidence Submission Library, and the submission guidelines provided by the NCQA Program Management Team.

Overall, the activities outlined above along with staff that serve as the NCQA Program Management Team were sufficient and provided strong oversight to achieve the fiscal year 2022-2023 goals and objectives for NCQA HP Accreditation included in the QI Work Plan.

CAHPS and HEDIS Reporting for Health Plan Accreditation

Partnership was required to formally report HEDIS and CAHPS for HPA for the first time by June 2022. HEDIS and CAHPS reporting is a requirement that must be fulfilled annually by accredited health plans in order to maintain their accredited status. A health plan may choose the version of the CAHPS survey to be reported: Adult CAHPS or Child CAHPS. For RY 2022, Partnership chose to submit the Adult CAHPS rates. The Adult CAHPS results were submitted to NCQA by the CAHPS vendor by the deadline of May 25, 2022. PHC also successfully reported HEDIS HPA rates by the June 15, 2022, mandated deadline.

NCQA uses the annual HEDIS/CAHPS reporting to calculate the Health Plan Rating (HPR) that is released on NCQA's website every September. The HPR is the weighted average of a plan's HEDIS and CAHPS measure ratings, plus bonus points for plans with current Accreditation status.

Of note, PHC was only required to report HEDIS/CAHPS results for MY 2021, and no HPR score was calculated in September 2022, as Partnership chose not to publicly report the data for HPA. Partnership will be scored for the first time in September 2023, based upon the performance of MY 2022 HEDIS and Child CAHPS results. The MY2022 HEDIS and CAHPS results were successfully reported to NCQA for NCQA HPA in June 2023.

During the next fiscal year, Partnership will continue to work on sustaining compliance of all Renewal Survey requirements through key defined activities, as well as its NCQA Program Management and NCQA Steering Committee structure to assure our readiness for Renewal Survey Accreditation in October 2023.

Compliance with NCQA Survey Standards

In the new 2024 contract, DHCS's stated goal is to increase health equity and reduce health disparities. By January 1, 2026, all Managed Care Plans (MCPs), including Partnership, will be mandated to achieve both NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation (HEA).

Partnership successfully achieved NCQA HPA on January 25, 2021 and our reaccreditation survey is scheduled on October 17, 2023. NCQA HEA is a new standards program focused on advancing the delivery of more equitable and culturally and linguistically appropriate services across member populations. The NCQA Program Management team worked closely with Partnership's NCQA consultant, and key stakeholders across the organization to estimate Partnership's current performance and develop a readiness timeline to achieve the new NCQA HEA by the mandated deadline of January 1, 2026.

In August 2022, a selected group of PHC's staff attended NCQA's training on Health Equity Accreditation. In January 2023, Partnership hosted a 3-day gap analysis based on the newly released HEA 2023 Standards and Guidelines.

The gap analysis summarized the organization's gaps in performance, system infrastructure, data needs and recommendations to create or enhance evidence to meet the new NCQA HEA requirements. This analysis formed the basis for the launch of a new Organization Goal on Health Equity Accreditation in FY 23-24. PHC will work toward readiness for all NCQA Health Equity Accreditation Standards and Guidelines for initial survey, targeted for June 2025, as part of PHC's overall health equity strategy.

NCQA Health Equity Accreditation Gap Assessment & Planning

In January 2023, Partnership's NCQA consultant, led a virtual HEA gap analysis. The goal of the gap analysis was to establish a baseline performance against the 2023 HEA Standards and Guidelines. As part of the gap analysis, the identified business owners and key stakeholders were requested to:

- Review the subset of HE Standards and Guidelines based on the organization's functional area(s)
- Attend meetings or respond to questions to further clarify and discuss potential ownership and documentation, as needed
- Provide documentation that will support the gap analysis
- Attend the gap analysis sessions, ask clarifying questions about the standards, and leverage the gap analysis as an educational opportunity for future plans

Subsequently, a comprehensive analysis report was distributed to the executive team and the key stakeholders; the report outlined the strengths, key gaps and recommendations to achieve HEA.

Based on the analysis results, the NCQA Program Management Team developed a compliance dashboard to calculate Partnership's baseline score against the 2023 HEA standards. As of January 2023, Partnership obtained 1 point out of the 27 total points available, with a 3.7% compliance score. Partnership must obtain a minimum of 22 points (80% of available points) to be HE accredited. The results of the gap analysis underscore that the organization needs to significantly improve performance of the standards to undergo a survey successfully.

An executive summary was presented to the NCQA Steering Committee in March 2023, highlighting potential survey date options, resources needed and other competing priorities that departments and stakeholders would face in 2023 and 2024. A final decision was reached, that Partnership is targeting an Initial HEA Survey in June 2025.

Throughout March to June 2023, the NCQA Program Management team continued to work on building the new program structure, including but not limited to hosting check-ins with business owners, distributing work plans and action items trackers to business owners, identifying the planned activities after the Gap Analysis, and addressing issues that require further investigation and long-term planning. The NCQA Program Management Team developed a plan-wide HEA-related department goal for FY 23-24, which will ensure a standardized approach across the organization to achieve HEA. In addition, the NCQA Program Management team continued to engage key stakeholders in clarifying scope of work in order to define ownership as well as the contributors for HEA requirements, and to build readiness for Initial HEA Survey, targeting in June 2025.

Partners in Quality

As of November 2021, Partnership is an NCQA Recognition Program Partner in Quality (PIQ) and has been awarded the PIQ stamp by NCQA. The PIQ program recognizes organizations that provide financial incentives or support services to practices seeking recognition through a subset of NCQA programs, including Patient-Centered Medical Home (PCMH) Recognition. This distinction was awarded to Partnership based upon the incentive payment offered to practices who are PCMH providers as well as technical assistance provided for gap analysis or assessment to assist practices with identifying areas to focus transformation. As of November 2021, Partnership is also listed on NCQA's website as a PIQ organization. NCQA will reassess our PIQ status on a yearly basis via survey shared with our organization.

As a result of this recognition, provider practices that are first time applicants and are supported by Partnership will also be eligible for a 20% discount for NCQA Recognition programs. This discount opportunity was shared with the Provider network through articles included in Partnership newsletters throughout FY 2022 – 2023.

Key benefits of being a Partners in Quality (PIQ) recognized organization:

- NCQA will grant auto-credit on a small subset of Health Plan Accreditation (HPA) Standards and Guidelines
- NCQA offers provider quality data at a discounted rate to organizations seeking to integrate validated quality ratings into their information tools.
- Provider Practices supported by Partnership that are first time applicants will be eligible for a 20% discount for NCQA Recognition programs.

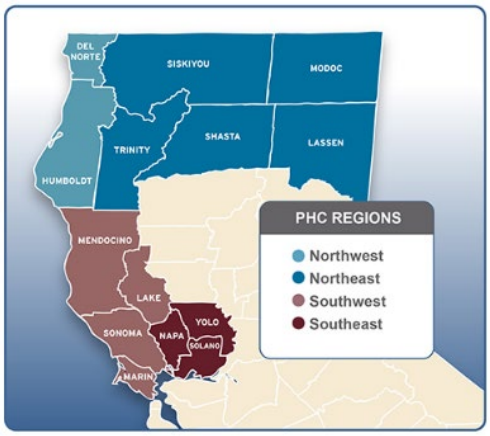
HealthPlan Quality Performance

QI TRILOGY

Overall Summary

In addition to HEDIS reporting, updates on the following activities were presented to the IQI and physician committees annually: CAHPS, summary results from specific access studies, Grievances & Appeals, Initial Health Assessments, facility site and medical record reviews, potential quality issues, targeted improvement projects, and the Partnership Improvement Academy. Project measures were reviewed during improvement team meetings. Partnership completed a robust, comprehensive evaluation annually for major programs and quality improvement projects and initiatives.

NCQA Reporting – DHCS Populations	
Northwest	Humboldt, Del Norte
Northeast	Lassen, Modoc, Siskiyou, Trinity, Shasta
Southwest	Sonoma, Marin, Mendocino, Lake
Southeast	Solano, Yolo, Napa
NCQA Reporting – HPA Population	
PHC Total	All 14 counties – Plan-wide reported rates



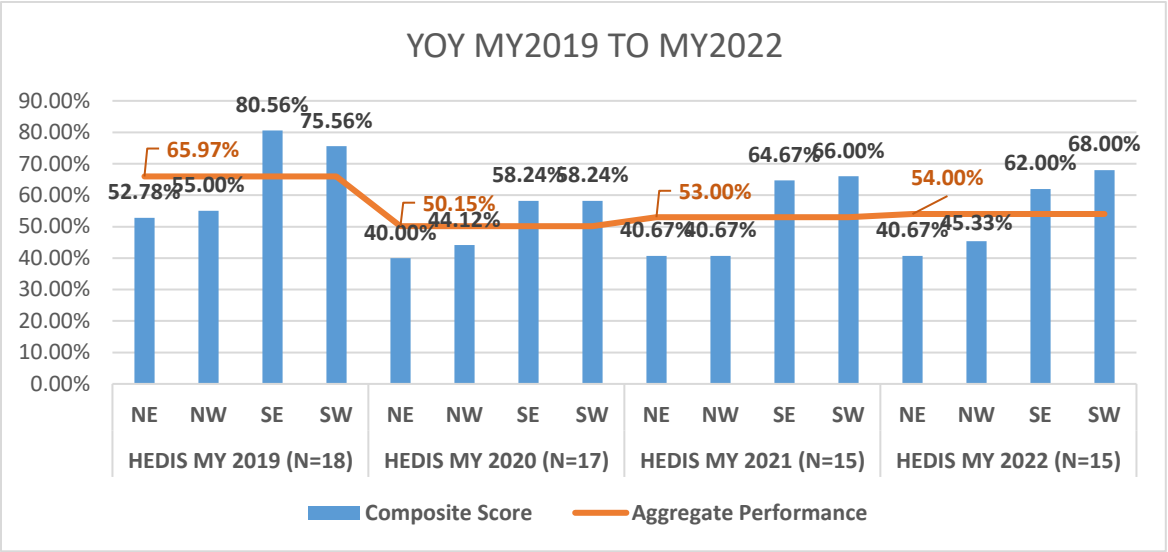
Overall Health Plan Ranking: DHCS Managed Care Accountability Set (MCAS)

DHCS uses a scoring methodology to determine an aggregated Quality Factor Score (QFS) which ranks health plan performance relative to California Medicaid reporting health plans. Partnership adopts DHCS's scoring methodology to determine Partnership's regional and plan-wide composite scores year over year. Each measure in each reporting region is given a score from one to ten (1-10) based on performance relative to national benchmarks. A regional composite score is then calculated by dividing total earned points by total possible points. Annually, in mid to late September. DHCS releases a dashboard indicating the plan's regional Quality Factor Scores and associated rankings to other health plans. The results of this ranking will be published upon the release of this information.

Partnership calculates its plan-wide aggregate score across all four DHCS MCAS reporting regions by factoring in eligible populations by region, given membership is significantly greater in the southern region reporting units than northern. This creates a weighted aggregate score more representative of plan-wide performance.

MY2022 HEDIS Composite Performance Year Over Year Comparison: DHCS Managed Care Accountability Set (MCAS)

Note: MY2022/RY2023: Total Points Earned: 274 Points out of 480 Total Points (12 measures included)



- **Reported Measures included due to being held accountable to MPL for HEDIS MY2019:** ABA, AWC, CBP, CCS, CDC-H9, CDC-HT, CIS-10, IMA-2, PPC-Pre, PPC-Post, W15, W34, WCC-BMI, AMM-Acute, AMM-Cont, AMR. BCS, CHL
- **Reported Measures included due to being held accountable to MPL for HEDIS MY 2020:** AMM-Acute, AMM-Cont, AMR, BCS, CCS, CIS-10, CHL, CDC-H9, CBP, SSD, IMA-2, APM, PPC, PPC, WCC-BMI, WCC-PA, WCC-Nut
- **Reported Measures included due to being held accountable to MPL for HEDIS MY 2021:** BCS, CCS, CIS-10, CHL, CDC-H9, CBP, IMA-2, PPC-Pre, PPC-Post, WCC-BMI, WCC-PA, WCC-Nut, W30-0-15, W30-15-30, WCV
- **Reported Measures included due to being held accountable to MPL for HEDIS MY 2022:** BCS, CCS, CIS-10, CHL, HBD-H9, CBP, IMA-2,FUM-30, FUA-30, PPC-Pre, PPC-Post, W30-0-15, W30-15-30, WCV

In MY2022, Partnership observed an increase in overall membership, which increased the eligible population across a subset of measures. This is largely attributed to the state's continuation to place a hold on all Medi-Cal eligibility re-determinations and adverse benefit determinations (less disenrollment from Medi-Cal than usual). This latter decision (holding redeterminations for two to three years) continued to have a steady negative impact on measures whose denominator includes all members in a particular age range, such as breast cancer screening or well-child visits. With the state discontinuing the hold on Medi-Cal eligibility redeterminations and adverse actions in April 2023, membership is anticipated to become more aligned to the pre-pandemic years over the next 1-2 years.

With the national COVID-19 pandemic slowly winding down over the course of MY2022, and the county restrictions being lifted, primary care sites resumed more in-person visits and many primary care practices devoted more leadership attention to quality improvement activities. This was a contributing factor to a number of performance measures showing an improvement relative to the prior year. This is attributed to the increased utilization of medical services and in-person office visits during 2022. Partnership also observed an increase in prescription claims impacting multiple measures. The integration of new data sources also contributed to an overall improvement in a subset of clinical measures.

Nonetheless, the COVID-19 pandemic continues to have a significant residual impact on primary care capacity and access, with an average current vacancy rate for primary care physicians and non-physician providers of 24%. May factors have contributed to this severe deficit in primary care capacity internationally, nationally and locally. Primary care access challenges are a primary driver of suboptimal member experience and clinical measures.

In July of 2021, NCQA released a number of changes to HEDIS measurement specifications that applied to MY2022 including the following:

- Clarification change for all measures: Members in hospice or using hospice services anytime during the measurement year are required exclusions.
- Palliative Care: As applicable, members receiving palliative care during the measurement year are a required exclusion.
- Race and Ethnicity (RE) Stratification: Select measures require race and ethnicity stratification per DHCS and/or NCQA. Race is a social construct, not biological. Stratifying measures by race and ethnicity is intended to be used to further understanding of racial and ethnic disparities in care and to hold health plans accountable to address such disparities, with the goal of achieving equitable health care and outcomes.
- Pharmacy Benefit Transition (Medi-Cal Rx): Beginning January 1, 2022, Partnership's pharmacy services were transitioned to the Medi-Cal Fee-For-Service delivery system. Partnership members now receive pharmacy benefit/services via Magellan Medicaid Administration, Inc. (Magellan). Although no longer administering a pharmacy benefit, Partnership receives pharmacy claims data from Magellan. Measures that are affected by Medi-Cal Rx require pharmacy data with or without a pharmacy benefit.
- The former Comprehensive Diabetes Care (CDC) measure has been separated into three standalone measures:
    - Hemoglobin A1c Control for Patients with Diabetes (HBD).
    - Blood Pressure Control for Patients with Diabetes (BPD).
    - Eye Exam for Patients with Diabetes (EED).

Partnership successfully launched our HEDIS MY2022/RY2023 data collection and reporting audits incorporating all changes as noted above.

DHCS MCAS Regional HEDIS Performance

In MY2022/ RY2023 HEDIS Annual Final Reporting, DHCS is holding managed care plans (MCPs) accountable and imposing sanctions on selected Hybrid and Administrative measures performing below the minimum performance level (MPL) (50th national Medicaid percentile) by reporting region.

As noted earlier, with the winding down of the national COVID-19 pandemic and provider sites returning to normal operations, this resulted in a number of performance measures showing slow improvement relative to prior year due to the gradual increase in utilization of medical services and in person office visits in 2022.

The table below indicates measures that fell below the MPL in MY2022:

Note: *This table provides the final rankings on rates in which Partnership performed below the 50th MPL percentile rankings provided by DHCS.*

Measures	NORTHEAST	NORTHWEST	SOUTHEAST	SOUTHWEST
Breast Cancer Screening (BCS)*	●	●		
Cervical Cancer Screening (CCS)	●	●		
Childhood Immunization Status (CIS) - Combo 10	●	●		
Chlamydia Screening in Women (CHL) - Total*	●	●		
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	●	●	●	●
Immunizations for Adolescents (IMA) - Combo 2	●	●		
Lead Screening in Children (LSC)	●	●	●	●
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care			●	
Well Care Visits (WCV) - Total*	●	●	●	●
Well Child 30 (W30) - Well child visits for age15-30 months*	●	●	●	●
Well Child 30 (W30) - Well child visits in the first 15 months*	●	●	●	●

Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).* ***NOTE**: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

Where measures remained in the MCAS in MY 2022, the next table shows that Partnership observed a number of measures within our four reporting regions that declined or improved in percentile ranking relative to prior years. Improvement observed resulted from a number of performance improvement activities led and/or supported by Partnership and our contracted provider network, which is outlined in more detail within subsequent sections of the Quality Improvement Evaluation.

● Measure percentile ranking improved from Prior Year
● Measure percentile ranking decreased from Prior Year ● Rates unavailable for that MY

Regional Performance Rates MY 2022/RY 2023:

Regional Distribution of Measures by Percentile Ranking

	NORTHEAST	NORTHWEST	SOUTHEAST	SOUTHWEST
90th (HPL)	1	1	3	4
75th	2	2	3	3
50th (MPL)	2	2	3	3
25th	3	4	3	2
<25th	7	6	3	3

MCAS Performance Relative to Quality Compass® Medicaid Benchmarks

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

Note: *This table provides the final rankings on rates in which PHC performed at the 50th MPL and the 90th percentile rankings provided by DHCS.*

	Regional Performance				National Medicaid Benchmarks			
Measures	NORTHEAST	NORTHWEST	SOUTHEAST	SOUTHWEST	25TH	50TH	75TH	90TH
Breast Cancer Screening (BCS)*	45.63%	41.44%	58.18%	56.40%	45.23%	50.95%	56.52%	61.27%
Cervical Cancer Screening (CCS)	54.01%	55.04%	65.82%	67.25%	52.39%	57.64%	62.53%	66.88%
Childhood Immunization Status (CIS) - Combo 10	18.49%	23.84%	46.47%	41.61%	28.95%	34.79%	42.09%	49.76%
Chlamydia Screening in Women (CHL) - Total*	49.13%	52.38%	61.27%	58.49%	48.67%	55.32%	62.65%	67.84%
Controlling High Blood Pressure (CBP)	62.89%	62.77%	61.73%	67.27%	54.50%	59.85%	65.10%	69.19%
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	26.85%	16.34%	22.43%	28.59%	44.82%	54.51%	63.44%	72.01%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total*	42.86%	32.16%	34.08%	31.24%	10.72%	21.24%	25.81%	32.38%
Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)	33.75%	33.42%	35.94%	31.19%	46.96%	39.90%	35.52%	30.90%
Immunizations for Adolescents (IMA) - Combo 2	18.73%	24.82%	51.34%	49.64%	30.41%	35.04%	41.12%	48.42%
Lead Screening in Children (LSC)	29.68%	45.74%	50.61%	44.28%	53.28%	63.99%	72.67%	79.57%
Prenatal and Postpartum Care (PPC) - Postpartum care	79.02%	85.67%	88.41%	90.48%	72.87%	77.37%	81.27%	84.18%
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care	90.49%	86.27%	83.09%	94.56%	81.27%	85.40%	88.86%	91.89%
Well Care Visits (WCV) - Total*	40.73%	43.98%	45.67%	46.99%	43.50%	48.93%	57.44%	62.70%
Well Child 30 (W30) - Well child visits for age15-30 months*	53.22%	61.15%	62.39%	65.71%	60.53%	65.83%	72.24%	78.07%
Well Child 30 (W30) - Well child visits in the first 15 months*	36.18%	43.52%	37.65%	42.96%	49.88%	55.72%	61.19%	67.56%

NCQA Health Plan Accreditation (HPA) – Health Plan Rating (HPR) Methodology

As an NCQA-Accredited Health Plan, Partnership is required to report HEDIS and CAHPS annually. This reporting started in June 2022 for MY 2021. Reporting in June 2023 for MY 2022 will be formally assessed by NCQA for Partnership's first publically reporting Health Plan Rating (HPR).

- Health Plans are given the option to choose to report the Adult CAHPS survey results or Child CAHPS survey results.
- Partnership chose to report the Child CAHPS survey results for MY2022.
- There were 52 HEDIS measures requiring plan-wide level reporting for the HPA Annual Project.
- At the close of 2022-2023, Partnership awaits NCQA's formal assessment and final HPR for MY2022. Partnership has utilized NCQA scoring methodology and anticipates achieving a 3.5 Star Rating.

In July 2021, NCQA released the current Health Plan Rating Methodology: (Plan-wide)

- NCQA ratings are based on three (3) types of quality measures:
  - Measures of clinical quality from NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®); and
  - Health Outcomes Survey (HOS); measures of patient experience using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®); and
  - Results from NCQA's review of a health plan's health quality processes (NCQA Accreditation). NCQA rates health plans that choose to report measures publicly.
- The overall rating is the weighted average of a plan's HEDIS, HOS, and CAHPS measure ratings added to any Accreditation bonus points (if the plan is accredited by NCQA), which is then rounded to the nearest half point and displayed as stars.
- The overall rating is based on performance tied to dozens of measures of care. The rating is calculated on a 0–5 scale including half points with 5 being the highest. Performance includes three subcategories (also scored 0–5 in half points):
  1. Patient Experience
  2. Rates for Clinical Measures
  3. NCQA Health Plan Accreditation

MY2022 HPA Star Rating Results (Estimated, pending NCQA notification):

Estimated Star Rating with Child CAHPS Survey Results:

HEDIS HealthPlan Accreditation Star Rating Scoring MY2022 With Child CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2021	TOTAL ACCRD Score MY2022	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	65	135	154	195.5	3.007692308	3.5
Child CAHPS Rating	10.5	18	12	18		
Patient Experience	10.5	14	12	18	1.714	1.5
Prevention and Equity	16.5	34	39	52.5	3.182	3
Treatment	38	83	103	125	3.289	3.5

Estimated Star Rating with Adult CAHPS Survey Results:

HEDIS HealthPlan Accreditation Star Rating Scoring MY2022 With Adult CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2021	TOTAL ACCRD Score MY2022	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	65	132	159	203	3.123076923	3.5
Adult CAHPS Rating	10.5	15	17	25.5		
Patient Experience	10.5	11	17	25.5	2.429	2.5
Prevention and Equity	16.5	34	39	52.5	3.182	3
Treatment	38	83	103	125	3.289	3.5

For PHC's full HPA performance, refer to Star Rating Score Dashboard, Appendix (F)

Summary of Measures in the Primary Care Provider Quality Improvement Program (PCP QIP)

The table below provides a summary of Primary Care Provider Quality Improvement Program measures included in the Measures Managed Care Accountability Sets (MCAS) for Medi-Cal Managed Care Plans Measurement Year 2022 | Reporting Year 2023.

MCAS-HEDIS Measures (Partnership held to MPL)	MY 2021 PCP QIP Measures	MY 2022 PCP QIP Measures	Alternate Measure in PCP QIP Measures
Adult Body Mass Index (BMI) Assessment (ABA)			

Antidepressant Medication Management: Acute Phase Treatment (AMM-Acute)*			
Antidepressant Medication Management: Continuation PhaseTreatment (AMM-Cont)*			
Asthma Medication Ration (AMR)*	X	X	
Breast Cancer Screening (BCS)*	X	X	
Cervical Cancer Screening (CCS)	X	X	
Childhood Immunization Status (CIS) – Combo 10	X	X	
Chlamydia Screening in Women (CHL)*			
Comprehensive Diabetes Care (CDC-H9) – HbA1c PoorControl (>9.0%)*			For the PCP QIP, the inverse of this measure: HbA1c Good Control (<9.0%) is used.
Comprehensive Diabetes Care (CDC-HT) – HbA1c Testing			
Controlling High Blood Pressure (CBP)	X	X	
Immunizations for Adolescents (IMA) – Combo 2	X	X	
Prenatal and Postpartum Care (PPC) – Postpartum Care			
Prenatal and Postpartum Care (PPC) – Timeliness of PrenatalCare			
Weight Assessment and Counseling for Children/Adolescents(WCC) – BMI Assessment			
Well-Child Visits in the first 15 months (W30+6)	X	X	
Blood Lead Screening in Children			A Measure with different specs is included in the Unit of Service Measure set. The MCAS measure will likely be added to PCP QIP in 2023.
Child and Adolescent Well Care Visits (WCV)	X	X	
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
Follow-Up After Emergency Department Visit for Substance Use (FUA)			

**-Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).*
PCP QIP Measurement Set: http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx

For PHC's full summary of HEDIS MY2022 performance, please refer to Appendix (F).

Quality in Data Governance

Data Governance

The QI and IT departments play a key role in supporting the Data Governance framework throughout the organization. Data Governance is the planning, oversight, and control over the management of data and the use of data related resources.

The main goal of Data Governance is to make data available, more reliable, better understood, and easy to use. There is an important emphasis on partnering with each department to solve data related problems.

The Enterprise Data Warehouse (EDW) team, within IT, built a new data warehouse system with the data from Health Rules Payor (HRP) (the new claims system) and integrated member, claims, and provider data to Data Warehouse and DataMarts. This data is utilized by QI teams for some of their critical applications and processes.

Data Stewardship

The Data Stewardship program is one key process under the Data Governance framework. In preparation for the introduction of HRP, the team partnered with several departments to identify the data stewards for some of the data domains and established roles and responsibilities.

The goals and deliverables set for FY 2022-2023 included the following:

- Integrate the data from the new claims systems (HRP) into all QI processes. This would include both HEDIS and Partnership Quality Dashboard (PQD).
- Integrate membership, claims, and provider data from the HRP claims system into the EDW DataMart.

The EDW team was able to successfully integrate data from the new claims system, HRP, into all QI processes. This included the HEDIS project, the Provider Quality Dashboard, and EDW DataMart's which are provided to end users to use for reporting and analyzing data. By doing this it will allow for the QI processes to seamlessly switch sources of data for their projects, dashboards, and reporting when the new claims system goes live. Multiple iterations of testing have been performed to ensure the data from the new system will meet quality standards and the EDW team will continue to oversee this as the go live date approaches.

Partnership Quality Dashboard

The Partnership Quality Dashboard (PQD) is one of many dashboard projects that can be accessed on PHC's Tableau server landing page. This page houses multiple healthcare quality measure data dashboards and supports PHC's data and analytics objectives. Dashboards visualize key performance indicators for multiple PHC department stakeholders, including behavioral health, population health, care coordination, data quality, cost avoidance, member access and utilization projects. The PQD dashboards focus their scope on visualization of source data maintained by the QI department, HEDIS, and QIP. These dashboards enable providers and PHC staff to prioritize, inform, and evaluate quality improvement efforts. PQD supports year-over-year performance trending and enables analysis across geographic regions and demographic aggregates.

The PQD is maintained by staff in PHC's Quality Improvement, IT, and Finance departments. Annual dashboard development involves evaluation of project data needs, documentation of business requirements, data and dashboard

development, and user acceptance testing. Ongoing maintenance of dashboards throughout the year involves monthly warehousing of both HEDIS and QIP source data and issue resolution. PQD training is a key project activity conducted throughout the year.

All PQD project goals and deliverables outlined under the 2022-2023 QI Department Work Plan were successfully accomplished during the fiscal year. The continued PQD goal to reconcile changes to impacted PQD data under HRP integration was successfully completed. Business rules for mapping primary care provider identification numbers under the new HRP provider data structure were identified and shared with stakeholders. Other business rules defining data linkages were identified for source data projects (eReports, Inovalon), to help minimize delays during mid-2023 implementation. Source data validation and user acceptance testing was completed during this period. PQD dashboards are expected to be updated based on HRP source data in September 2023, following implementation. (Note, exact timing of refreshing PQD dashboards is contingent on the final implementation timing of HRP. The estimated timeline is subject to change.)

The use of data to identify health inequities is a key organizational focus and identified as a new goal under the PQD 2022-2023 QI work plan. Updates to PCP QIP source data applied in the prior fiscal year enabled more granular and meaningful analysis displayed in the disparity analysis dashboard. Categories for member race and ethnicity were redefined based on updated source data to reflect meaningful demographic groups. Updated categories for member race and ethnicity align with the NCQA standards for reporting of stratified HEDIS measure performance. Internal and external stakeholders were consulted to evaluate current and desired performance metrics for disparity analysis. The disparity analysis dashboard was modified to meet updated stakeholder needs in December, 2022. An evaluation of external stakeholder needs will be used to guide a pilot version of the disparity analysis dashboard for testing with key stakeholders from the primary care network in 2023-2024 fiscal year.

Summary of FY 22-23 PQD Dashboards

Dashboard Name	Data Source	Brief Description	Major 2022-2023 Reporting Enhancements
HEDIS Annual Static - Summary of Performance	HEDIS Annual Measurement Year 2021	MCAS measure performance by Sub-Region and County and color-coded against benchmarks. No composite score for MY 2020.	Measurement Year 2021 HEDIS Final Performance (CY 2022 expected June, 2023)
HEDIS Annual Exploratory	HEDIS Annual Measurement Year 2021	MCAS measure performance by Sub-Region, County and Provider. Color-coded against benchmarks. Stratification by member demographics such as race and gender. Member-level drilldown reports by measure.	Measurement Year 2021 HEDIS Final Performance (CY 2022 expected June, 2023)
HEDIS Scatterplot	HEDIS Monthly 2022	Bubble chart displays measure performance against population size, with break out by various demographic indicators.	2022 Rolling Year and Year-to-Date Performance

Dashboard Name	Data Source	Brief Description	Major 2022-2023 Reporting Enhancements
HEDIS Exploratory – Internal View	HEDIS Monthly 2022	MCAS and NCQA Health Plan Accreditation measure performance by various geographic and demographic aggregates, color-coded against benchmarks. Member-level drilldown reports by measure.	2022 Rolling Year and Year-to-Date Performance
PCP QIP Internal and Provider View	Monthly eReports Clinical data and QIP Non-Clinical calculated data	Payout by measure for the PCP QIP program, with gaps to target, member drilldown, performance against targets and regional averages.	December-2022 final PCP QIP performance. The QIP Stoplight and Final Statement dashboards were added to PQD.
AMR	PCP QIP Monthly AMR data and customized Pharmacy Claims data	Asthma Medication Ratio performance visualized in multiple views including prescriber- and pharmacy-level.	December-2021 (Year-end QIP AMR data) The AMR dashboard was not updated in 2022 due to other high priority projects.
Disparity Analysis	2021 PCP QIP Monthly Clinical Data	Breakout of QIP performance by measure at the plan-wide level, and stratified by ethnicity group. View top 10 providers with largest population size for selected ethnicity groups	December-2022 Geographic View dashboard added to display measure performance across updated categories for race and ethnicity.
Maximizing Visibility of Quality Data	2021 PCP QIP Year-end Score	Rank PCPs year-end QIP total score by county and display population size, increase or decrease over previous year score.	December-2022 PCP QIP Final Data PCP-level stars ratings added to ranked performance chart.
QIP Stoplight Dashboard	2021 PCP QIP Monthly Data	Member gap-to-target analysis, color coded against benchmarks at the parent organization level.	December-2022 PCP QIP Final Data. Updated for provider view in PQD in May, 2023.
PCP QIP Final Statement	2021 PCP QIP Year-end Score	Payment, points and performance by measure for individual providers. Used for PCP QIP payment.	December-2022 PCP QIP Final Data. This dashboard was updated for provider view in PQD in May, 2023 for CY 2022.
Immunization Dose Reports	Custom immunization claims and CAIR data for members	Reports by provider site display immunization dates of service for assigned members. QIP providers can access through eReports.	June-2022 This dashboard was merged with Well Care dashboard in the

Dashboard Name	Data Source	Brief Description	Major 2022-2023 Reporting Enhancements
	in immunization population ranges		Preventive Care Reports dashboard in Feb, 2023
Perinatal QIP Dashboard	Perinatal QIP supplemental measure data and custom claims and membership calculations.	Perinatal QIP measure performance is updated quarterly for provider statements.	April-2023 Program updates for ECDS measure added
HQIP Final Statement	Supplemental HQIP Performance data	Calculates payment for the Hospital QIP year-end provider payment.	2021- 2022 fiscal year-end performance
PQD User Activity	Monthly HEDIS and QIP dashboard clicks, internal and external (PCP QIP)	Monitors providers external and internal user clicks in HEDIS and QIP PQD dashboards	June-2023
Well Care Dashboard – Internal View	Custom table for well-care claims for members in measure age ranges.	Reports by provider for well visit dates of service for assigned and special members. Internal staff access through PQD.	June-2023 Added Race/Ethnicity field to member drill-down reports.
Preventive Care Reports – Provider View	Custom table for well care claims and CIS and IMA claims and CAIR data.	Member-level contact information, includes all well care, IMA and CIS DOS for assigned members. Priority flags for member outreach based on age.	Daily refresh in 2023. This dashboard added to eReports for provider access in Feb, 2023

Provider Network Quality Improvement Support and Initiatives

Quality & Performance Improvement Initiatives and Projects

Overview

In 2022-2023, Quality Improvement staff continued focused efforts on priority measures for Partnership based on performance on the DHCS MCAS and/or NCQA accreditation measures.
Partnership increased its understanding of Health Equity (HE) accreditation readiness and began preparing to meet any identified gaps, pursuant to a 2025 Health Equity Accreditation status.

Preparation also began to address upcoming needs surrounding PHC's geographic expansion.

With the effects of COVID-19 subsiding, portions of PHC's provider network have begun to emerge from associated financial, labor, and quality performance challenges, while others have required assistance to reengage in Quality-related work. To accelerate recovery, the Quality Improvement staff increasingly engaged the provider network via in-person meetings, trainings and activities, in addition to many virtual options previously employed during the COVID-19 restrictions. Of note were in-person assessments and relationship building, associated with our Enhanced Provider Engagement strategy, focused on supporting the lowest performers in the PCP QIP clinical measure set. Staff remained committed to the Improvement Academy trainings, joint leadership meetings with large provider organizations, practice facilitation, mandated work collaborations, and other ad hoc support. The themes of the support centered on maximizing opportunities for closing care gaps using clinical and operational workflows, promoting a culture of quality within provider leadership, and building capacity for quality improvement work within provider teams. Internally, QI worked closely with key stakeholders (e.g., Population Health, Pharmacy, Behavioral Health, Medical Directors, regional leadership, etc.) on strategic efforts, including direct to member engagement.

Quality Measure Score Improvement workgroups expanded and were optimized to meet the needs of evolving DHCS MCAS and NCQA Health Plan Accreditation (HPA) measure sets in the areas of Pediatrics, Chronic Diseases, Medication Management, Behavioral Health, Women's Health and Perinatal Care. Via collaboration with internal staff and external partners, such as the Aliados, HANC, and NCCN consortia, improvements were piloted, scaled, and spread to meet the needs of PHC's plan-wide membership in a variety of measures including breast cancer screening, childhood immunizations, and diabetes management and tools such as the Disparity Dashboard.

Utilizing Quality Improvement Programs (QIPs), PHC incentivized improved performance and use of best practices to meet mandated improvements to Clinical and Non-Clinical measures, many of which are aligned to the HEDIS and DHCS MCAS measure sets. Additionally, enhancements to data tools (described in the Quality in Data Governance section), improved visibility and transparency into QIP performance gaps. Improvement was seen across multiple measures from MY2021 to MY2022, notably Asthma Medication Ratio and Well Child Visits within 15 months.

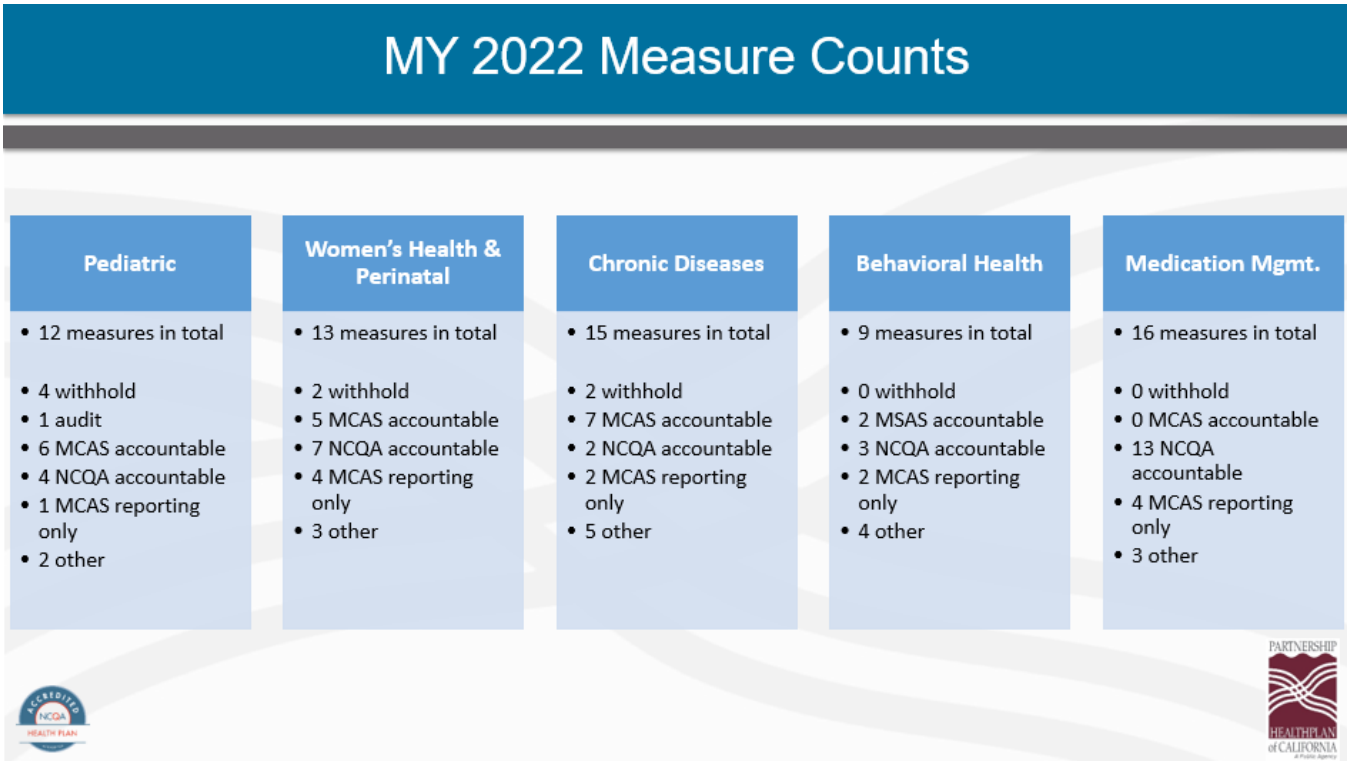
These combined efforts have positioned PHC and our provider network for success in providing PHC members with high levels of care and support.

Quality Measure Score Improvement Team

The Quality Measure Score Improvement (QMSI) team was formed to better coordinate service and performance across the organization and to raise PHC's overall performance on quality measures as defined by DHCS MCAS and by NCQA Health Plan Accreditation (HPA). In recent years, additional teams were formed under the QMSI

team to address the most under-performing MCAS measures with the most recent evolution of the strategy to have the QMSI teams expand their approach to encompass all current and potentially future accountable measures by measure family within each workgroup team: Pediatric, Chronic Diseases, Medication Management, Behavioral Health, Women's Health and Perinatal Care. This approach ensures monitoring and review of all measure performance by workgroup teams where data is available, as well as assessment of gaps and execution of new performance improvement activities.
QMSI workgroups consisted of cross-functional teams led by Quality staff with support from Medical Directors, and representation from across the organization, including: Care Coordination, Claims, Health Education, Office of the CMO, Pharmacy, Population Health, Provider Relations, Quality and/or regional leadership. Below is a description of the measure-family workgroups and what they achieved.

All workgroups analyzed the most recent annual rates for measures included in their respective workgroup set, to understand where there may be an opportunity to implement an intervention and partnered with PHC's HEDIS team to receive data regularly for measures included in workgroups that are not captured in Partnership's Quality Dashboard (PQD). Additionally, workgroups assess current and past efforts that were associated with measures included in the respective workgroup measure set.



Improvement Team Workgroups

Medication Management

The medication management workgroup engaged the pharmacy teams in both regions, reviewed performance scores for relevant measures, and narrowed down the measures of interest to the following: ADD - Follow-Up Care for Children Prescribed (ADHD) Medication: Initiation Phase, PCE - Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroids and Bronchodilators, SPD - Statin Therapy for Patients With Diabetes:

Statin Therapy, POD / OUD-AD - Pharmacotherapy for Opioid Use Disorder, and COU - Risk of Continued Opioid use > 15 days. Of note Academic Detailing on multiple chronic disease states is also being conducted.

Subgroup 1: ADD - Follow-Up Care for Children Prescribed (ADHD) Medication: Initiation Phase. This intervention was a campaign targeting low performing providers, defined as having at least 5 members who qualified for the ADD measure within a 6 month period and performed below MPL. Member specific faxes were sent to the individual prescribers with a patient (6-12yrs of age) with a first fill of an ADHD medication. These providers were found by utilizing the ADHD weekly new start reports generated by PHC's Health Analytics team. The faxes sent included the following: medication name, fill date, a reminder to schedule a follow-up appt within 30 days of starting ADHD medication, and best practices for follow-up care. PHC began sending faxes on 3/8/23. For this pilot, the initial target was 25 faxes and then conduct an analysis, however as this was completed earlier than expected the sample size was increased to 50 faxes. Follow-up calls were conducted to confirm fax receipt. PHC then continued to monitor claims for follow visits approximately 4 weeks after the initial RX fill date. PHC anticipates analysis to conclude by the end of June to see if informing the provider increases initiation phase appointments.

Subgroup 2: **PCE - Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroids and Bronchodilators.** This intervention was started in Jan 2022, with project implementation in March 2022. It uses the Collective Medical 72hr COPD Exacerbation ED event report to select PHC primary members who are <7 days from their ED event. The goal of the project is to send a timely notification to PCP's when one of their patients is seen in the ED for a COPD exacerbation. By doing this PHC hopes to improve baseline COPD management by triggering a PCP follow up visit, reduce future ED visits, and issue a timely prescription for a bronchodilator and/or steroid if deemed necessary. Care Notes are put in Collective Medical if there is an acute care gap (missing oral steroid/and/or bronchodilator after ED discharge) from the ED. The faxes to PCP notify them of: The ED event, Last 90 days of members pharmacy fill history, COPD exacerbation acute care gaps (lack of oral steroid and bronchodilator issued for exacerbation), and COPD Maintenance therapy gaps (LABA or LAMA if missing). The AIM for this project was to increase PCE-steroid to 50th percentile and PCE-bronchodilator to 75th percentile by June 2022. The following results have been observed: PCE HEDIS numbers have improved for both sub measures, improvement in both maintenance and acute care prescription gaps, improved ED readmit rates within 90 days for non-high utilizers, the intervention did not change the PCP rate of office visits within 30 days of ED event, and care notes impact was hard to quantify. PHC plans to continue this project for an additional 12 months with the following change: reduce to a spot check model for outcomes checking 25% of events each month. This will decrease the manual time spent evaluating outcomes. PHC also hopes to identify more opportunities for impacting ED utilization such as case management referral for those with no PCP visit claims but many ED events.

Subgroup 3: SPD - Statin Therapy for Patients With Diabetes: Statin Therapy. 2 interventions for this measure also reported in Chronic Disease Workgroup

1. Diabetes Project: This intervention was part of a larger project in which PHC performed both member and provider outreach for Diabetes Management as a whole. Patients selected for this intervention included: Adults age 51-64 who have diabetes (on Diabetes medication), are not on a statin medication and have an A1c > 9. The first PDSA was to involve members in the program, develop a relationship, and gather patient's knowledge on disease. This helped PHC prepare for the second phone call and be more tailored to that particular patient's needs. The second PDSA focused on diabetes medication management and adherence as well as discussion of A1c education. Pharmacists discussed the

medications the patients were currently on, any issues they may have, as well as make suggestions to the provider if appropriate. These suggestions could be to change the medication for improved compliance, due to adverse reactions, suggestions for addition of therapy or other appropriate recommendations based on current guidelines. The pharmacists also discussed A1c, explaining what it was, its importance, and how often it should be monitored. Again, if appropriate the provider was notified that the member may be due for an A1c draw. The third PDSA had a focus on blood pressure medication management and statins. The pharmacists discussed any current blood pressure medications they may be on, discussed blood pressure and readings, as well as made recommendations if appropriate. They also discussed the importance of statins and guidelines suggesting that the patient should be on that medication. If the patient was not the provider was informed that it is recommended to be added to their medication regimen. The pilot program has been completed. Results noted were as follows: 1st PDSA goal: 20% agree to a second call, result: 71%. Goal of having at least 50% of members have an A1c test, result: 76%. Goal of 50% diabetic medication adherence, Result: 82%. Goal of 25% of members having adherence to hypertension meds, Result: 82%. Goal of 25% of the members to have a new start on statins, Result: 8%. After presentation to the stakeholders it was suggested to start a different program in which PHC simplified and focused more on the medication adherence and improvement in those members with an A1c over 9. PHC plans on getting cleaner data from Health Analytics as the data used for this pilot was old (from 2021) not making it the best to utilize for such a project. PHC also plans on doing more provider fax interventions by faxing on all members that require addition of statins instead of just the members enrolled in the program. This new project is currently under construction and will hopefully be live by the end of 2022-2023 pending updated data.

2. Statin Fax Pilot. This intervention is a pilot of provider outreach regarding statins. Gap lists were ran for 2 clinics (1 South and 1 North). The chosen clinics for this pilot were Woodland Clinic and Shasta Community Health Center. PHC chose 3 providers for each clinic that had more than 5 patients but around 10 patients on the gap list. Pre-approved Chief Medical Officer signed faxes were sent to those providers with a list of their patients on the Statin gap list. All faxes were completed the first week of May. Pharmacy AA called to verify receipt of fax as well as verified the correct fax number. Next steps are to perform a lookback in 60 days to see if any providers have added a Statin to the patient's care. After evaluation PHC will discuss outcomes and success/changes to pilot.

Subgroup 4: **POD / OUD-AD - Pharmacotherapy for Opioid Use Disorder.** For this measure, it was recommended to focus on obtaining a baseline measure as the activity for this fiscal year, and not a specific improvement activity. This continues to be evaluated and pharmacy work has been done for DUR (drug utilization review) around opioid safety of use with buprenorphine. Pharmacy will continue to evaluate this measure given the challenges with the Medi-Cal Pharmacy carve out and sensitive nature of the disease state.

Subgroup 5: **COU - Risk of Continued Opioid use > 15 days.** For this measure it was noted to do further Investigation with no action, only track and monitor PHC's responsibility. Investigation on this has been completed. Attempting to manage this intervention appears highly manual in process and would take a lot of staff hours to follow and manage. The challenges are lack of control given carve out, reporting capabilities, and the need to monitor daily to capture the timing of less than 15 days of use. Pharmacy plans to continue to investigate while evaluating ongoing PHC responsibility for this measure to see what interventions can be reasonably done to influence measurable outcomes.

Follow-up Care for Initial ADHD Medication

In 2022, the transition of pharmacy services from Partnership HealthPlan to Medi-Cal Rx combined with the PHC system outage in March 2022 led to a prolonged delay in receiving timely pharmacy claim data. As a result, the process for identifying and validating new start ADHD medication was delayed and the intervention for prescriber notification was put on hold until March 2023.

Beginning March 8, 2023, notifications were sent to select providers whose patient was recently started on an ADHD medication. To build upon the previous intervention, the following changes were made to the intervention:

- Sending individual prescribers notification through fax instead of U.S. mail for faster turnaround.
- Providing the date that the follow-up appointment must be completed by based on the pharmacy prescription claim record (30 days from fill date).
- Targeting lower performing providers: Providers that had at least five members that newly started ADHD medication within a 6-month lookback period (7/2022-1/2023) and performed below the HEDIS ADD Initiation Phase MPL based on claims data. Follow-up visit rates were determined based on follow-up appointments billed with an ADHD diagnosis.
- Performing follow-up calls to confirm fax was received.

A member-specific fax was sent to the provider if all of the following were met: 1) the member was confirmed to be appropriately included in the HEDIS ADD Initiation Phase denominator, 2) the provider was included in the list of lower performing providers (see bullet 3 above) and 3) the provider fax number could be confirmed from a reliable source (e.g. PHC Provider Directory, practice location website).

For the initial pilot, 25 members with initial prescription start date (IPSD) from March 1, 2023 to April 11, 2023 were evaluated for new start follow-up. Faxes were sent to 7 providers on behalf of 25 members, from March 8, 2023 to April 18, 2023.

Based on encounter data captured through May 15, 2023, 9 of the 25 members (36%) had an appropriate follow-up care visit within 30 days of their IPSD, and are counted towards the ADD initiation phase numerator. As a comparison, the aggregate performance of the same group of prescribers from July 2022 through January 2023 was 28.81%.
Note: These are preliminary results, as the sample size is low at this time. The plan is to continue this intervention until 50 faxes are sent. In addition, the outcomes of this intervention may not be fully realized until MY2024 HEDIS reports are available (IPSD 3/1/23 – 4/11/23 falls under MY2024).

Sending provider fax notifications with a reminder for when the follow up appointment must be completed and a follow up call within 48 hours to confirm fax was received appears to be more effective in improving measure performance vs no intervention. Pharmacy will continue to send provider fax notifications to increase follow-up care visit rates. Additionally, Pharmacy plans to conduct small test of change with direct member engagement to enhance the current provider fax intervention.

Chronic Disease

The Chronic Disease Workgroup reviewed the assigned measures to develop strategies around the measures with the greatest performance gaps. Measures of focus for this year included: HbA1c Poor Control (>9%) (CDC), Controlling High Blood Pressure (CBP) and Adult Immunization Status(AIS). AIS was removed as a focus for this workgroup mid-year due to the conflicting and inaccessible tracking for measure performance. The workgroup added Colorectal Cancer Screening (COL) in its place. Throughout the year, the group worked to document disparity data for all measures assigned to the workgroup.
To focus on Diabetes Management, the workgroup developed educational materials for providers and members on Continuous Glucose Monitors/Insulin Pumps (CGI/IP), Podiatric Footwear and Medical Nutrition Therapy (MNT). Claims data was gathered pre- and post- distribution to determine if appropriate interventions for diabetes

management are being utilized. Treatment Authorization Requests (TARs) for the same time period will be monitored for decrease in denied TARs for CGM/IPs which are not deemed medically necessary. Additionally, measurement year data will be reviewed to track score improvement.

The workgroup has championed multiple efforts with Population Health including community Hypertension Intervention events, Diabetes Intervention Analysis, and PDHI/Healthy Living Tools engagement. The Community Hypertension event was originally planned for Black members with hypertension, but was later expanded to include all members. Members were screened by a mobile van (MOBEC), and if their blood pressure was high, were encouraged to visit their PCP. Additionally, members were able to complete paperwork for the blood pressure cuff distribution program. Events with MOBEC were ongoing through April 2023 and data will be collected in the following months.

Along with partnering with Population Health, the workgroup expanded last year's BP Cuff Distribution project by evaluating patient outcomes. Member data continues to be analyzed with a focus on correlation between BP cuff usage and BP good control. Data collection has been a challenge given data integrity issues in the device tracker, IE device serial numbers noted under member CIN, and this deliverable will be rolled into the next Fiscal year to continue analysis.

The Diabetes Intervention Analysis was a data analysis of the previous years' outreach intervention. Results showed 60% of members who had an outreach and were prompted to visit their PCP scheduled an appointment within 41 days of the outreach call. Due to the success of this pilot, this intervention has been implemented plan wide beginning in April 2023. Lastly, Population Health has tracked ongoing use of PDHI software by members as an NCQA Accreditation requirement. There were ten tools within the Healthy Living Tools in 2022 and twelve available in 2023 which members could access: back care, depression, diabetes management, diabetes prevention, financial wellness, healthy eating, heart disease prevention, physical activity, quitting smoking, stress management, financial wellness, risky drinking (new in 2023) and heart disease management (new in 2023). From June 1, 2022 through the present, tools were accessed 131 times; 77 were accessed in 2022 and 54 were accessed in 2023. Highest rates of access were for depression, stress management and back care.

To focus on colorectal cancer screening, the workgroup has been partnering with Exact Sciences, maker of Cologuard (FIT DNA test) by engaging interested sites in participating in a Cologuard bulk-ordering pilot program. This will allow providers to submit one order for all members who would be appropriate for a Cologuard screening kit instead of completing each order separately in the EHR. The workgroup will be tracking each participating site's colorectal cancer (CRC) screening rates and identifying whether this CRC screening tool has improved overall measure performance rates. There are currently six participating sites. Results are pending pilot program completion.

Behavioral Health

After an assessment of performance for all Behavioral Health measures, the following deliverables were identified as priorities of focus for the 22/23 year:

- Review performance rates for measures in communication with analytics team to ensure regular dissemination of rates throughout year
- Create a repository to document all current or previously conducted work associated with measures included in the Behavioral Health Workgroup set, so there is a resource that can be referred to for opportunities and key learnings. All Behavioral Health grants and performance improvement projects are outlined in this document.

- Track Mercy Hospital Pilot addressing follow up after ED visit for substance use (FUA) and/or mental illness (FUM); Follow up after high intensity care for substance use disorder (FUI). While the Mercy Pilot was put on hold, it was replaced by a partnership with Shasta Regional to serve the same purpose. The Behavioral Health Workgroup has partnered with Care Coordination to track this effort.
- Track Behavioral Health data, specifically focusing on the data sharing component that is included in the Memorandums of Understanding (MOUs) that will be executed with County Behavioral Health departments.
- Partnered with Population Health to develop a program to address DHCS requirements for depression measures (DMS, DRR, DSF, CDF) and tracked their progress through the workgroup.
- Conducted evaluation of sites that have already started participating in Electronic Clinical Data Systems (ECDS) implementation in the PCP QIP and shared best practices with remaining providers not included in PHC's Modified QIP to address all depression measures (DMS, DRR, DSF, CDF). Directed interested sites not already participating in ECDS incentive to the PCP QIP Team.

The workgroup also evaluated race and ethnicity data for the measures included in the workgroup which may be used to drive intervention work within the workgroup next year and address identified disparities.

Pediatric Medicine

After analysis and review of measure performance, the Pediatric Workgroup determined to focus on well care visits, immunizations, lead screening, and fluoride varnish. The following summarizes the work of this team.

PHC's Voluntary Participation in CMS Collaborative to Improve Baby Well-Care Visits

The Centers for Medicare & Medicaid Services (CMS) launched the Infant Well-Child Visit Learning Collaborative in late 2021 as a means to support states in increasing the number of infants receiving high quality care through affinity groups. Partnership applied for and was accepted in the Infant Well-Child Visit Learning Collaborative, working with state health plans, local stakeholders, DHCS, and CMS.

The California state affinity group's focus was to positively impact well child visits in the first month of life, and for each plan to increase their well child visit rate 10% over baseline, while more specifically focusing on visits in the first month of life. Partnership's aim was that 40% of infants whose parents were impacted by the intervention would complete at least 1 well baby visit in the first month of life. For this intervention, PHC's plan was to connect pregnant members to a provider for their baby during their third trimester through a touchpoint in PHC's Growing Together Program (GTP). After completing this intervention cycle, PHC decided to abandon the intervention as there was no billing code to track the connection of members to a provider for their baby before birth, and no members wanted to be connected to a provider for their baby by PHC.

CMS informed all affinity group participants the affinity group will continue through December of 2023, and for the next intervention, PHC has partnered with NorthBay Hospital who will be sharing their list of appointments made before discharge for PHC members and PHC will be contacting members after delivery.

PHC-Wide Launch of Health Kids Growing Together Program

The Well Child Birthday Club pilot was a member incentive outreach initiative aimed at children ages 3-6 years due for an annual well care visit. The pilot was tested extensively and successfully throughout the Northern Region since 2019. In 2020-2021, the Southern Region completed a successful pilot of the Well Child Birthday Club. Each

pilot phase demonstrated a statistically significant increase in Well Care Visit rates for children included in the intervention.

In 2022, QI/PI and Population Health agreed to collaborate further in 2022-2023 to sunset the Northern Region Birthday Club and integrate successful components of the Birthday Club pilots within the plan-wide Healthy Kids Growing Together Program, continuing the focus on children ages 3-6 years. QI/PI and Population Health completed a transition phase of the pilot in December, 2022. During the transition phase, Population Health, with the support of the QI/PI team, developed materials and processes to support the Healthy Kids Growing Together Program's cohort of 57,000 members ages 3-6 years. The Program will continue mailing and phone outreach to caregivers of members ages 3-6 years, offering a $25 gift card incentive for completing a Well Care Visit within 90 days of the child's birthday.

The QI/PI and Population Health teams collaborated on a communication plan for introducing internal and external stakeholders to the new Healthy Kids Growing Together program. The communication plan included articles in Partnership newsletters, announcements in Joint Leadership Initiative (JLI) and regional meetings, education sessions about the program in internal Partnership meetings, and an education session for Partnership's provider network.

To scale the pilot as a plan-wide program with outreach to families of all children ages 3-6 years, transitioning to the Healthy Kids Growing Together Program required several changes to the outreach and incentive distribution workflow during the planning phase and initial months of implementation:

- While outreach mailers were mailed during the month of the child's birthday during the pilots, the Healthy Kids Growing Together Program will send an outreach mailer to the family on the month of the child's birthday, if they have not had a Well Care Visit in at least 11 months.
- Two outreach phone calls to every child's caregiver one week after the outreach mailer was sent was not scalable for the plan-wide Program. For the Healthy Kids Growing Together Program, outreach phone calls are made to caregivers of children with no history of Well Care Visits, starting one week after outreach mailers are sent.
- For the Healthy Kids Growing Together Program, gift cards will no longer be distributed by the Primary Care Provider at the completion of their Well Care Visit. Instead, Partnership distributes gift cards after the caregiver contacts Partnership to attest that the child's Well Care Visit was completed.

The Healthy Kids Growing Together Program launched in January, 2023. Population Health began using a monthly process to identify eligible members, and began mailer and phone member outreach in December, 2022. Gift card distribution began in January, 2023.

Population Health plans to complete an evaluation of the Healthy Kids Growing Together Program in 2024. Early qualitative outcomes of the program as reported from Population Health are promising:

- Many members have taken the initiative to contact Population Health on receiving the outreach mailer to request support in connecting their child with a Primary Care Provider.
- Population Health offers navigation assistance or warm handoffs to associated teams when members reports barriers to scheduling Well Care Visits, such as PCP access difficulties. These interventions are a new opportunity to positively impact the member experience with Partnership beyond the actual incentive offering.

Sixth Grade School Poster Contest Pilot

PHC partnered with Anderson Middle School to host an Immunization Poster Contest, including education through a presentation to grade 6 students on immunizations, and a poster contest. At the beginning of the 2022-23 fiscal year, Quality Improvement oriented Population Health (PHM) on their project processes and shared school contacts and documentation from previous years to help PHM take over the effort. This was a re-boot of a successful Partnership pilot of the same intervention which was successful in 2019, but has been paused due to the COVID pandemic. This intervention is intended to change adolescent knowledge and attitudes around vaccinations leading to increased adolescent vaccination rates, including influencing the knowledge, attitudes and behaviors of their parents as well.

On March 28 and 29 of 2023, PHM's health educators presented to the four grade 6 classes at Anderson Middle School. The presentation included information on vaccines, how they work, and why they are important. After that, students created a poster and short essay related to the importance of vaccines. Among all 4 classrooms, 72 of 102 students submitted posters. The posters were displayed at Anderson Middle School's Open House on May 25, 2023, where they were voted on by attendees. The top 3 winners, and 5 more chosen by participating teachers, received gift cards.

The QMSI Pediatric Workgroup will analyze impact of this intervention on immunizations, and health educators tracked their impact through pre- and post-presentation surveys.

School-Based Immunization Clinic Pilots

With a continuous struggle to increase adolescent immunization rates, PHC deployed a new strategy in late 2022 to engage with local schools to attempt to conduct school-based immunization clinics for the 6th grade population, preparing to enter the 7th grade.

The first immunization clinic was conducted in partnership with Enterprise Elementary School District (EESD) in Redding (Shasta County) along with Shasta Community Health Center (SCHC), who serves a vast majority of the pediatric population in the area, and Redding Drug a local pharmacy. Shasta County Public Health was initially engaged for this event, but shared that they do not have the resources to conduct adolescent immunization clinics outside of their facility and standing vaccine clinic hours. The clinic took place on a Saturday in early August, before the start of school, at SCHC's Enterprise location where 65 students were immunized with the Tdap vaccine. SCHC immunized a majority of the Partnership population and Redding Drug immunized the remaining private pay insured, uninsured and overflow from SCHC (Partnership members). Partnership reimbursed Redding Drug for all students they immunized who were not covered by private pay insurance, as they are not a VFC (Vaccines for Children) provider and cannot be reimbursed. With many learnings from this event, Partnership executive leadership approved to continue to engage schools and work with local pharmacies to vaccinate events, and reimburse pharmacies for any VFC-eligible doses given. Primary learnings included:

- When working with schools to create immunization events, immunizations must be available for free to ALL students, regardless of insurance status
- In counties where Public Health is unable to vaccinate at school-based clinics, there is no safety net accessibility for all students in the current system (this is why Partnership funded the pharmacy). In addition, Partnership's CMO engaged support at the state level to shadow upcoming school IZ events to learn, advocate and ultimately change the system to allow school-based immunization clinics to be available state-wide (CDPH, DHCS and Children Now)
- While local providers can administer VFC vaccines using their stock to their established patients, it may be difficult for providers to navigate vaccinating students who are not their established/active patients due to their own internal policies/bandwidth

- Incentives were a huge draw for students ($25 gift cards for each student, Kona ice and Partnership swag). The gift cards offered were not scalable as Partnership provided incentives only to their members. Employees of the participating organizations funded the remaining member incentive needs in this instance but agreed this cannot be done again – Partnership is investigating alternative incentive options so as to include rewards for all participating students in the future (not just Partnership members).

The second immunization clinic was held in May 2023 at Anderson Middle School (AMS) in Anderson (Shasta County) in partnership with AndersonRX (pharmacy participating in the VFC pharmacy pilot program) and SCHC. For this event. AndersonRX was the sole immunizer and SCHC conducted CAIR lookup. Shasta County Public Health was also invited to attend planning meetings, in the hopes that they will develop a strategy to participate in the future. The event was held during AMS's Open House on a Thursday evening. This event was conducted in coordination with the School Poster Contest program that included education on the vaccines to the 6th grade class that was conducted by PHC's Population Health team (please see the previous "6th Grade School Poster Contest" section for more information). Seven students were immunized: 71% (5) were PHC members and 29% (2) were private pay insurance. 57%(4) received more than 1 dose at this event (either HPV and/or Meng.), which is a direct result of the education previously provided to students. This was a drastic improvement over the previous clinic where students only received the required Tdap vaccine. There were also many learnings form this event, including:

- More promotion of the IZ event needs to be conducted to parents, beginning as early as possible
- Education to students in advance of the event appears to influence kids to request more than the required vaccine (including students telling their parents they need more than the Tdap)
- Some kind of incentive should be offered at all events that would draw students (Like EESD)
- Reimbursement of vaccines to pharmacies is not profitable for the pharmacy and in the current structure, only mission-driven pharmacies will participate. Also, only a few pharmacies in CA are participating in the VFC pilot and the model is currently not scalable in other PHC counties unless AndersonRX is willing to travel outside of Shasta

Between the first and second event, PHC was notified that CDPH has since created an internal committee to focus on making school-based immunization clinics more scalable across CA. PHC recommended having a pilot where a few organizations apply and administer VFC stock to all students at an event, regardless of insurance status and allow flexibility in persons administering vaccines at an event.

Future plans include repeating the previous clinics in the coming year with EEDS and AMS, as well as attempting to branch out and investigate pilot opportunities in other counties.

Expansion of County-Based VaxFacts Websites

In the 2021-2022, PHC launched 3 pediatric-focused, county-based websites to serve as county-specific resources to counter vaccine misinformation. These websites are developed in partnership with local vaccine coalitions, and were designed to be a local, "trusted" resource for parents to find information about recommended immunizations that included local provider and community member videos, representation from trust community organizations and local information about where vaccines are available in their county. Websites have been completed for Shasta, Humboldt and Solano counties. Efforts are currently underway to expand websites to Del Norte, Lake and Mendocino counties, however, due to continued strains on provider organizations and ability of provider staff to dedicate time to this elective project, there has been a delay in completing these websites. PHC's goal for the upcoming year is to complete these 3 new websites along with an additional 2-3 counties.

Improve the Completion of Lead Screening

In the previous year, an internal sub-committee was formed to focus on lead screening and was led by a Partnership Medical Director who is also a Pediatrician. The goal of the workgroup was to increase age-appropriate lead screening rates for children enrolled in Partnership HealthPlan. This committee developed the following strategies to launch efforts focused on increasing lead screening rates:

1. Strategy 1: Reach out directly to clinics with high screening rates to identify best practices and then share them in one-on-one discussions with clinics having low screening rates:
    a. Identified and met with clinical and quality improvement leads in 5 high performing practices, collecting best practices and identifying challenges
    b. Identified lower-performing practices and reached out to schedule one-on-one meetings with clinical and QI leaders through contacts provided by PHC regional teams
    c. Currently meeting with clinical and quality leads from lower-performing practices to share best practices, discuss challenges and problem-solve to increase screening rates
    d. Lead Workgroup following up on issues raised by practices such as billing, testing options, coding and claims data
    e. Lead Workgroup recommending funding in PHC budget for point of care (POC) lead testing machines (LeadCareII)
2. Strategy 2: Engage county public health departments to identify those currently providing lead testing and those interested in offering that service in their county(ies):
    a. Met with Humboldt County Public Health Lab Director to discuss lead testing services offered to Humboldt County practices. Identified successes and challenges. Most significant challenge is low reimbursement. The Humboldt Lab Director is also the Lab Director for Shasta County Public Health Lab and is looking at offering testing services in Shasta
    b. Reached out to the other three PH Labs in PHC regions which include: Sonoma, Butte and Solano County PH Labs. Solano PH lab also serves Yolo, Marin and Napa Counties.
    c. Identified successes and challenges with lead testing offered through Solano PH Lab. Primary challenges have been billing (which may affect claims data and PHC ability to identify testing that has occurred). Working with PHC Claims and Provider Relations teams to understand issues and correct
    d. Scheduling meetings with Sonoma and Butte PH Labs
3. Strategy 3: Support testing access for all clinical practices:
    a. In one-on-one meetings with lower-performing practices, reviewed current processes as well as specimen collection and running of specimen
    b. Encouraged collection of capillary specimen in the exam room, regardless of where specimen is then run, is identified as a best practice from discussions with high performing practices
        i. Practices sending members to commercial lab settings for testing are encouraged to collect the capillary specimen on site in exam room and utilize one of the following: POC onsite, PH lab testing of specimen (using Lead Care II) or sending to commercial lab
4. Additional Activity: Conduct one-on-one discussions with provider organizations to share reminders about the lead screening requirements and recommendations:
    a. Requirement to screen all Medi-Cal enrolled children for lead at 12 months, 24 months and once between 2 and 6 years if not previously tested and document in medical record
    b. Requirement to follow-up on any elevated blood lead levels per CDPH guidance and document

c. Requirement to discuss lead risk and prevention at all WCC's from 6 months to 6 years and document in medical record
d. Requirement to document parent/guardian refusal of testing, including a signed declination by parent or note signed by provider if parent refuses to sign. Reason for declination must be documented if known

Pilot Fluoride Varnish Application Trainings Onsite at Provider Locations

The fluoride varnish measure is vastly underused in our network and has become a focused DHCS measure since it transitioned from a reportable measure in 2022 to an accountable MCAS measure in 2023. To help prepare and get our providers up and running, PHC contracted with a Shasta County Registered Dental Hygienist Advanced Practitioner (RDHAP) to provide dental fluoride varnish application trainings on site to interested providers.

The goal for calendar year 2023 is to complete a total of five trainings in Shasta County and adjacent counties. Outreach has been done to several Shasta County providers, unfortunately only two trainings have been completed. Challenges to complete trainings have been provider interest as well as engagement, as sites are overwhelmed with managing staffing shortages and other operational and funding challenges. One site noted they refer patients to their own dental practice for fluoride varnish instead of relying on the PCP. PHC anticipates with the increased focus on dental fluoride in 2023 and 2024, more providers will engage with PHC.

The Pediatric Workgroup has also had the opportunity to partner with Trinity County Local Oral Health Program to educate their county on the need for dental fluoride as well as help engage Trinity County clinics to take advantage of PHC's sponsored trainings. The first training site, Shasta Community Health Center, has already seen a notable uptick in their amount of applications since the completion of their training. The workgroup will continue to track and trend DFV data into the next fiscal year.

Dollars were proposed to offer more trainings in 2023/2024 with the plan to continue expanding DFV training throughout the entire network.

Women's Health

The Women's Health and Perinatal (WHaP) Workgroup was formally added to the Quality Measure Score Improvement team this year. This group originated in 2018 to engage providers invited to participate in PHC's new Perinatal QIP offering. As a result, this group's focus was initially on engaging providers in perinatal and post-partum measure score improvement activities. But, the discussions organically led to improving other women's health measures: breast cancer screening, cervical cancer screening, and chlamydia screening in women.

Breast Cancer Screening Interventions:

Rates for breast cancer screening declined in the years of the COVID pandemic 2020-2021 and were below the DHCS Minimum Performance Level (MPL) in all four sub-regions in MY2021. This decrease in screening was slow to rebound due a number of member and health systems factors including hesitance for individuals to seek in-person care and limited access to screening appointments at imaging centers. The QMSI work group addressed Breast Cancer Screening rates with several projects.

Mobile Mammography Pilot: Breast cancer screening was below the 25th national percentile in all four Partnership HealthPlan sub-regions and all counties (excluding Napa and Sonoma County) in MY 2021. In an effort to increase

breast cancer screening rates and improve mammogram access in MY 2022, Partnership HealthPlan coordinated with the sole provider of mobile mammography services in northern California, Alinea Medical Imaging, to sponsor mobile mammography events at select provider locations during the second half of the 2022 calendar year.

Partnership HealthPlan reviewed breast cancer screening data across all regions to identify provider organizations as potential mobile mammography event hosts. Participating organizations were required to complete mammograms for at least 25 Partnership HealthPlan members on each day of a sponsored mobile mammography event. After participation was confirmed, pre-event briefings took place between provider staff, Partnership HealthPlan and Alinea Medical Imaging to learn promising practices for mobile mammography events.

Partnership sponsored events took place with 11 provider organizations in three of Partnership's four sub-regions, across 20 sites and over 19 and a half total event days.

Partnership HealthPlan assisted participating provider organizations with member outreach via mailers, event day support, and soliciting member-provided feedback on the event by distributing brief, paper surveys to members upon mammogram completion. Debrief meetings took place between Partnership HealthPlan and participating provider organizations to discuss how the events went, what worked well and what could be improved in the future.

In total, the pilot completed 612 mammograms from all payors, including 475 (78%) Partnership HealthPlan members. On average, 24.3 Partnership members completed a mammogram each day of the event. The estimated average cost per event was $3,100.00, and the estimated average cost per mammogram was $99.00.

Of the members surveyed 70.4% strongly agreed that they were overall satisfied with their mammogram visit at the event, 29.6% agreed, and 0% disagreed that they were satisfied with their mammogram visit. Member survey responses included feeling that the event was: convenient, safe, accessible; that the team was friendly, welcoming and kind; their mobile mammogram was their first mammogram; the process was easy, pain free and gentle; that they hope the service would be continued.

When compared to performance across the plan, breast cancer screening rates improved at a greater rate among members included in the mobile mammography pilot from measurement year 2021 to measurement year 2022. In 2022, 60.3% of members in the mobile mammography group completed their mammogram, whereas Partnership HealthPlan's plan average for mammogram completion was 52.7%.

Mobile Mammography will be adopted and continued as a Partnership HealthPlan program. Provider organizations will be considered for Partnership HealthPlan sponsored events if they are located in areas that are considered imaging center "deserts" (where travel to imaging centers is usually long or difficult) and in counties performing below the 50th percentile benchmark for breast cancer screening.

Well Woman Birthday Club Pilot Phase II in Lake County: In 2022, Partnership HealthPlan's Southern Region initiated the Well-Woman Birthday Club pilot. The Well-Woman Birthday Club was a member outreach initiative aimed at women between the ages 50 to 74 who were due for a mammogram and had not received one in 2019, 2020, 2021 or 2022, with birthdays between the months of June through December. The pilot was a collaboration between Partnership HealthPlan and participating Lake County organizations: Adventist Health, Lake County Tribal Health, Mendocino Community Health Center and Sutter Health. This was the second iteration of a pilot that

had previously included Mendocino and Lake County. The second pilot focused solely on Lake County. This pilot featured a thirty-dollar member gift card to incentivize mammogram completion.

Outreach for this campaign was primarily executed by Partnership HealthPlan via mail and phone calls. "Birthday cards," were designed to include the following:

- A happy birthday message to the member
- Information on mammogram screening, information and instructions on how to receive their gift card
- Instructions to contact their PCP to order a mammogram
- Local imaging center information.

Birthday cards were mailed out in batches for each birth month group the month prior to their birth month. For example, birthday cards went out in September for October birthdays. Phone calls were made by Partnership HealthPlan's Population Health Department to each member the week of their birthday to remind the member of the program, answer questions and assist with mammogram scheduling, if needed. Additional postmarked post card reminders for members were provided by Partnership HealthPlan to be distributed by providers, excluding Sutter.

Virtual meetings between Partnership HealthPlan staff and participating organizations were held monthly. The purpose of these meetings was to share breast cancer screening rates, promising practices, general updates and communication efforts by Partnership and providers. Monthly updates were also sent over email by Partnership to providers. Although imaging center staff were unable to attend the virtual meetings due to scheduling conflicts, they received monthly updates on pilot data and member communication strategies from Partnership.

The goal of the pilot was to have 20% of members included in the Well-Woman Birthday Club complete their mammogram and receive their gift card. Of the 605 birthday cards that were mailed 97 gift cards were distributed (25 of the cards were disbursed at Lake County mobile mammography events), resulting in a 16% fulfillment rate. Seventy-three birthday cards mailed were returned.

Although the results were notable, the goal of the pilot was not achieved. In addition, breast cancer screening rates did not improve at an appreciable rate by the end of measurement year 2022, despite this targeted intervention. The pilot has been abandoned and will not be implemented as a program. The results do not warrant the resources required to sustain the Well-Woman Birthday Club.

Breast Cancer Screening DHCS Mandated Project: For this DHCS Mandated Performance Improvement Project (PIP), Performance Improvement worked with a provider organization from 2021-2023 to improve their Breast Cancer Screening rates. The team tested interventions in multiple PDSA cycles: a series of clinical team trainings focused on Breast Cancer Screening guidelines, workflows and mammogram processes; and a series of mobile mammography events hosted by the provider organization. During the course of the PIP, the provider organization's Breast Cancer Screening rate increased from 55.45% to 62.39%.

Perinatal Care:

Timely prenatal Care, 2 post-partum visits and pregnancy related vaccinations: Activities prioritized addressing the notable decreases in prenatal care occurred from 2020-2021 likely related to limited access and patient hesitance during the pandemic. Vaccination rates which up to 2019 were increasing had dropped in 2020 and 2021.

Provider Education and Engagement around Perinatal QIP and Women's Health Measures: CME/CEU presentations were offered for practices who provide prenatal women's health services highlighting the Perinatal/PCP QIP measures and Partnership resources to support members and practices in accessing these resources. As of June 2023, 11 of the 18 Perinatal QIP provider organizations scheduled presentations for their clinical teams.

Provider Education Articles: 6 articles on various topics around perinatal and women's health measures were submitted to the Provider QIP and Medical Director newsletters in 2022-23.

Member Education: 5 articles were submitted on topics related to perinatal care and resources for the Member newsletters and community health columns in local publications. A member focused brochure was developed regarding breast feeding resources.

Member Engagement: As part of the Growing Together Program administered by Population Health, members were offered a gift card for accessing timely prenatal and postpartum care. In 2022-23, the team planned an intervention to improve their data capture to identify pregnant members earlier in their pregnancies and increase enrollment in the Growing Together Program by 50%. The team began using claims and TAR data as well as provider and self-referrals to identify and outreach to pregnant members. As a result, Growing Together Program enrollment increased by 59% between 2021 and 2022. Of particular note, members identified during their pregnancies (as opposed to after giving birth) increased by 231% between 2021 and 2022. The team plans to continue to refine their methods for using data to identify pregnant members earlier in their pregnancies and take opportunities to support within the Growing Together Program and other Partnership offerings.

Enhanced Provider Engagement to Transform Primary Care

Partnership HealthPlan of California (PHC) reported several HEDIS measures performing below average in Department of Healthcare Services' (DHCS) Managed Care Accountability Set (MCAS) for MY 2021/RY 2022. This ultimately resulted in PHC receiving a Corrective Action Plan (CAP) from DHCS in the fall of 2022.

Given the annual MCAS HEDIS Performance Summary and resulting CAP, PHC revisited its current 5-Star Quality Tactical Plan in August and September 2022 to consider adaptations or new tactics. Particular focus was given to new opportunities emerging with the easing of the pandemic's impact on daily operations across PHC's provider network. Additionally, Partnership wishes to proactively prioritize provider organizations who have the most need for support for opportunities to improve their core capacities and infrastructure; the anticipated Health Equity/Practice Transformation grant opportunity anticipated from DHCS, as being one example.

Upon issuance of the DHCS CAP, members of PHC QI team conducted a cause and effects analysis specific to the below average performance of ten MCAS measures in the Northeast and Northwest reporting units. These low performing measures represented large volumes of northern region based members not receiving preventative care as defined under Women's Health and Child/Adolescent measure sets. This analysis supported the launch of two new tactical strategies cited, under the Engaging Clinical Practices focus area, as additions to PHC's 5-Star Tactical Plan as of December 2022. These additions were implemented plan-wide and are summarized below:

- **Enhanced Provider Engagement:** The Quality Improvement team developed, piloted, and executed a comprehensive provider quality engagement strategy based on prior quality measure performance at the Provider Organization level. This strategy was new in that PHC aimed to deploy interventions for

provider organizations aligned with their past level of Primary Care Provider Quality Improvement Program (PCP QIP) performance.

In 2023, Enhanced Provider Engagement focuses on the Provider Organizations with the lowest performance on the PCP QIP, and introduces a measure-agnostic Needs Assessment as its central intervention. Assessing provider organizational needs, versus focusing on only a provider site's lowest performing measures, was key to addressing root causes and barriers in transforming practices in delivering high quality preventive care. Provider coaching offerings beyond the successful Practice Facilitation program was extended, incorporating other tactics to better meet provider's current capacity for quality improvement work and successfully engage in improvement.

To date, Enhanced Provider Engagement consists of several stages:

- Completion of a Needs Assessment and corresponding Supplemental Survey. The Needs Assessment tool that was chosen was based on UCSF's Building Blocks of Primary Care, which is designed to assess the organizational change of a primary care practice as measured against the 10 Building Blocks of High Performing Primary Care.
- Partnership then summarizes the Needs Assessment for the Provider Organization and makes recommendation for impactful quality interventions.
- Coaching with planning and implementation of interventions designed to impact core quality improvement capacity and measure performance.

- **Modified PCP QIP for Low Performing Providers:** Partnership developed and implemented consequences for Primary Care Provider Organizations with persistent low performance in PHC's PCP QIP. Phase 1 initiated progressive consequences starting in MY2023 for Provider Organizations who are assigned more than 1,000 Partnership members and who earned less than 25% of their clinical points for the MY2022 PCP QIP. The Modified QIP assignment includes several CAP requirements for Provider Organizations qualifying, including:
  - Reduction of QIP clinical domain measure set from ten to four measures. Renewed provider focus on four preventive care measures reflects PHC's highest priority for improvement under DHCS MCAS. The total available PCP QIP dollars was made available to the Provider Organization within their modified QIP but was spread equally over the four measures. To increase focus on the modified measure set, providers who transitioned to the Modified PCP QIP were not eligible to participate in Non-Clinical or Unit of Services measures in MY2023.
  - Required Partnership Executive meeting with Provider Organizations' Board of Directors in 2023, to improve their understanding of Partnership's Quality program and their organization's PCP QIP measure performance.
  - Required participation in Enhanced Provider Engagement coaching with PI team.
  - Demonstrated improvement in QIP measures to 25% of clinical measure points to exit CAP by next MY.

In March, 2023, PHC assigned 11 Provider Organizations to the Enhanced Provider Engagement program as the Phase 1 cohort. Seven of the Phase 1 Provider Organizations have completed the Needs Assessment interview and subsequent Provider Organization recommendation meetings are underway. Phase 2 of the Enhanced Provider Engagement program, which will launch in July 2023, will include engagement with 13 additional Provider Organizations who are assigned more than 500 Partnership members and who earned less than 33% of their clinical points for the MY2022 PCP QIP. These Phase II Provider Organizations will start with a Needs Assessment and be added to the modified QIP in MY2024 if their scores do not improve by the end of the MY2023 measurement year.

Member Outreach

PHC has attempted to close care gaps and engage members through the use of direct outreach. Outreach may originate from provider requests, or through the identification of members who have not had a visit with their PCP in over 12 months. Unestablished member outreach had originated in the Northern Region and had expanded to the Southern Region, but in the fall of 2022, Quality Improvement, Member Services, and Population Health collaborated to create a plan wide unestablished member outreach process. This new process allowed for a standardized approach that allowed outreach requests to originate from multiple sources but flow through a consistent process. This resulted in a dramatic increase in outreach efforts between July 2022 and June 2023. In the prior 12 month period, PHC conducted 357 calls to address unestablished members. In the current 12 month period, PHC outreached 2,746 members across 11 campaigns. The table below highlights the results of the outreach attempts.

Attempted To Outreach - Total	
Disconnected/Wrong Number	308
Left Voicemail/Message	488
Member Not Engaged in Phone Call	796
Member Agreed to Schedule Appt	71
Member Moved - Gave new Address	14
Member says seen by assigned PCP	85
Member Unaware/Disputed Coverage	8
No Voicemail/Voicemail Full/No Answer	288
Member has OHC, sent active COB	296
New Member	1
Unable to speak with member (other person answered)	35
Other	36
Member will cal PHC back	23
Member Passed Away or Incarcerated	1
No Attempt To Outreach - Total	
Inactive - Benefits Transferred ot Terminated	11
No Phone # in call center	218
Seen at assigned PCP in the last year (Per Claims)	38
Member already called	0
Already Direct Member	29
Grand Total	**2746**

In 2023, member outreach efforts were paused during the state-wide Medi-Cal redetermination effort. Since Medi-Cal redetermination will update contact information for all members plan-wide over a 12 month period in 2023-2024 and remove members who cannot be contacted from Partnership's member rosters, the member outreach workflow would be redundant to the counties' efforts to outreach to these members.

Reduced Missed Opportunities

During FY 2022 – 2023, the QI team developed a dashboard that highlights potential care gaps, with the goal of aiding the Primary Care Provider network in identifying these care gaps and to assist in addressing these gaps in future outreach, especially with focus on established members. Logic used to create the dashboard was validated by sampling the results to identify if there were any false positives. These results were then validated by a Partnership Medical Director to ensure the logic and the sampled results were clinically accurate. This report included logic for the following measures: Cervical Cancer Screening, Child and Adolescent Well Care Visits. The report was then reviewed with two provider partners to solicit their input and compare what was generated through the dashboard's logic to their provider EHR records. From these provider meetings, the team concluded that providers would find use in the tool being made readily accessible with a monthly refresh period. Next steps include updating report logic for monthly data, adding Dental Fluoride Varnish Use as an included measure, and potentially working with the analyst supervisor to evaluate how a pilot dashboard could be made available in an external portal (PQD).

Joint Leadership Initiative

In 2019 the Joint Leadership Initiative (JLI) was implemented in an effort to increase executive level engagement with large contracted provider organizations that have significant room for improvement on quality metrics.

In FY 2022-2023 the following provider organizations participated in the JLI: Adventist Health, Fairchild Medical Center, Mendocino Community Health Center, OLE Health, Open Door, Santa Rosa Community Health, Shasta Community Health Center, La Clinica, and Solano County Family Health Services. Collectively these organizations are responsible for the care of approximately 221,000 PHC members, which is about 33% of the health plan's total membership.

The JLI aimed to provide mutual benefits for these organizations and PHC including:

- Significant improvement of quality scores for PHC
- Maximization of QIP dollars, giving significant additional resources to the organizations
- Improved performance, leading to significant improvement in quality outcomes for members/patients

The FY 2022-2023 QI Work Plan goal for this initiative was to conduct a minimum of two meetings with the participating provider sites. The deliverables included:

- By December 31 2022, develop a tiered system for JLI sites based on quality measure performance. Within the tier system, establish a framework for JLI meeting frequency, as well as content to review. Content will factor the timing within the year, and the urgency of improvement required based on performance. By December 31 2022, schedule and conduct the 2022 fall JLI series that was determined prior to development of tier system.
- By June 30 2023, schedule and conduct all 2023 JLI meetings in accordance with the new tier structure that was developed. By June 30 2023, conduct an evaluation of JLI providers for MY 2022 to determine effectiveness of JLI series.

Overall, the JLI meetings have been well received and have helped improve the relationships with the provider entities. Feedback from participants has also cited that the meetings have allowed focused time to discuss quality issues and provided a platform to discuss provider concerns. When evaluating performance of JLI providers, it was determined that 7 out of 9 participating providers increased their PCP QIP scores between 2021 and 2022. JLI providers improved by an average of 6.89%, while the plan wide average increased 6.41%. One note is that the plan wide average includes the JLI providers, so their performance gain will skew the average upward given JLI providers encompass 33% of the total member population. It was also observed that the average PCP QIP scores for JLI providers was 64%, while the average PCP QIP scores for non-JLI providers was 43%. Further analysis was done to determine if there is an intrinsic bias toward larger practices scoring higher than smaller practices. There were several larger non-JLI providers identified which scored less than 25% of PCP QIP points, which indicates that size does not necessitate higher scoring.

PHC is committed to continuing the JLI into 2024. With the implementation of a tier structure, there has been an overall reduction in JLI meetings. This allows PHC to add more sites to the JLI program, which will most likely come from the new East Region that will be joining PHC in January 2024. PHC will be reviewing which East Region providers may be suitable candidates for JLI after membership volume is made available after go live.

Quality Improvement Training and Coaching

Accelerated Learning

In conjunction with PHC medical directors, the Performance Improvement Team offered six virtual Accelerated Learning sessions to primary care provider organizations between January - April 2023. The webinars aimed to provide clinical background and best practices related to 2023 PCP QIP Measures. The program offered CE/CME credits.

The focus of the webinars and attendance rates are included below:

- Well-Child Visits for the First 15 Months of Life and Childhood Immunizations Status
  - Occurred 01/26/23
  - 77 attendees, representing 32 unique organizations
- Child and Adolescent Well-Care Visits, Screenings, and Immunizations for Adolescents
  - Occurred 02/08/23
  - 49 attendees, representing 25 unique organizations
- Controlling High Blood Pressure
  - Occurred 02/22/23
  - 53 attendees, representing 30 unique organizations
- Diabetes Management HbA1c Good Control
  - Occurred 03/15/23
  - 53 attendees, representing 25 unique organizations
- Asthma Medication Ratio
  - Occurred 03/29/23
  - 62 attendees, representing 25 unique organizations
- Early Cancer Detection (Cervical, Breast and Colorectal Screening)
  - Occurred 04/25/23
  - 67 attendees, representing 33 unique organizations

All six Accelerated Learning trainings featured a leader from a high-performing provider organization as a "Voices from the Field" presenter, allowing these providers to share their best and promising practices with their peers throughout the provider network.

Trainings were advertised on PHC's website, directly emailed to the PCP QIP provider network, placed in the Medical Directors and QI newsletters, and highlighted at regional meetings.

The evaluation responses for the Accelerated Learning webinars were positive. Of those who completed the survey, 100% of the participants rated the topics as relevant and useful. Furthermore, the overall rating for educational learning sessions were between 89% and 100%. The Accelerated Learning webinars will continue to be offered during the 2023-24 fiscal year.

The Improvement Academy piloted offering CE/CME credit for on-demand Accelerated Learning trainings in 2022-2023: Diabetes Management. The training was posted on the Partnership website in April 2023 and marketed to provider organizations in numerous forums (JLI's, regional meetings, provider and QIP newsletters). As of June 2023, 5 individuals have completed the on-demand training and applied for CE/CME credit.

ABCs of Quality Improvement

In FY 2022-2023, PHC hosted three in-person ABCs of QI training series for its provider network, November 2022; March 2023; and April 2023.

- Fairfield Session 1
  - Occurred 11/08/22
  - 47 attendees, representing 13 unique organizations
- Redding (Mountain Valley staff only) Session 2
  - Occurred 3/29/23
  - 7 attendees, representing 1 unique organization
- Redding Session 3
  - Occurred 4/27/23
  - 50 attendees, representing 18 unique organizations

Participants of the trainings included clinicians, front-line staff, quality improvement staff, administrators, and public health professionals. CE/CME credits were offered for each session in the series. The all-day trainings covered a range of topics, including:

- What is Quality Improvement?
- Introduction to the Model for Improvement How to create an aim statement
- How to use data for improvement
- Why and how to establish outcome and process measures
- Tips for developing change ideas that lead to improvement
- Testing changes with the Plan-Do-Study-Act (PDSA) cycle

For each of the trainings completed, at least 95% of the participants reported being extremely satisfied or satisfied with the training. Furthermore, over 90% of participants reported that they now understand the basic components of the Model for Improvement, including how to write an aim statement and outcome and process measures, use data, and develop change ideas. Additionally, participants actively applied the learning objectives to a cumulative project at the end of the session. Participants gathered in teams from their organization to brainstorm a new PDSA project, develop an AIM statement, and generate ideas for data gathering pre- and post-test. Participants rated this portion of the sessions highly, describing the learning experience as actionable.

Health Equity Provider Training Series

In 2022, the Quality Improvement department conceptualized a training for the provider network to serve as an introduction to health equity concepts and equitable care for Partnership members. In developing this concept, the Health Equity Provider Training workgroup developed objectives, goals and an agenda for this training series.

Learning objectives were developed for the following three sessions:

Implicit Bias

- Explain the concept and research associated with implicit bias and provide examples.
- Assess potential consequences of implicit bias.
- Apply strategies to minimize the impacts of implicit bias in the health care setting.
- Identify techniques for effective anti-bias communication, key in patient-centered care.

Defining Health Equity and Strategies to Improve Organizational Practices

- Define health equity and identify ways to support organizational learning and conversations about diversity, inclusion, racial equity, racism, and antiracism into the delivery of service.
- Identify opportunities to operationalize health equity strategies in your day-to-day work.

Toolkit to Support Health Equity Practices

- Review the foundational concepts of the toolkit.
- Describe practice-level opportunities, tips, and resources to strengthen and center racial health equity in care improvement work.
- Learn ways to integrate racial and health equity into your quality improvement activities and goals.
- Review Partnership resources.

The internal workgroup contracted with CPS HR to serve as the vendor to facilitate and develop this training in collaboration with Partnership Subject Matter Experts (SMEs) and stakeholders.

CPS HR has developed the curriculum for the first of three consecutive series for the Health Equity Provider Training.

- Session 1
    - Occurred on 06/13/23
    - 33 attendees, representing 24 unique organizations
- Session 2
    - Will occur 07/18/23

- Session 3
    - Will occur 08/15/23

Each session was approved for CME/CE credits through the American Academy of Family Physicians (AAFP) and the California Board of Registered Nursing for 2.0 contact hours per session. This session also meets requirements for the National Committee for Quality Assurance (NCQA) Population Health Management (PHM) Factor 6, 3A.

At session registration, participants were asked to identify descriptive demographics about their organization and the community they serve. Participants were surveyed on their current organizational work in the field of health equity in terms of intentional efforts, organizational commitments, and current and/or past participation in the Primary Care Provider Quality Improvement Program Health Equity Unit of Service measure. This information will be compared to participants' post session evaluation information to describe organizational change. The post-session evaluation also includes concept evaluation questions and participant feedback for each session. A follow-up evaluation 3-6 months after the last session is completed is planned to assess health equity concept implementation at the organizational level. A Post-session evaluation summary for session 1 will be available after July 1, 2023.

HANC and NCCN Consortia Webinars

As part of the contract with the northern region consortia partners, Health Alliance of Northern California (HANC) and North Coast Clinics Network (NCCN), PHC requested development and delivery of two trainings for our primary care providers, focusing on increasing the knowledge of important quality topics. For FY 2022-2023, these trainings were:

- Advancing Health Equity: Linking Quality and Equity in QI Projects
    - Occurred on 4/18/23 via webinar
    - 159 of registrants, 105 attendees, representing 25 unique organizations
    - Course Description: This webinar presents information from the Roadmap to Advance Health Equity developed by Advancing Health Equity: Leading Care, Payment and Systems Transformation (AHE). The webinar will discuss key topics including: discovering and prioritizing differences in care, outcomes, and/or experiences across patient groups; planning equity-focused projects; and measuring impact
- Mapping Your Way to Improvement: Using Process Maps to Chart the Patient Experience
    - Occurred on 03/02/23 via webinar
    - 120 of registrants, 81 attendees, representing 9 unique organizations

Course Description: This webinar will continue to build skills in using lean thinking and tools to understand the patient experience and identify opportunities for improvement. The session will include overviews of different types of process mapping strategies including value stream mapping to support PDSAs and improvement projects.

Practice Facilitation and Provider Coaching

Practice Facilitation uses the Institute for Healthcare Improvement's (IHI) Model for Improvement framework to build capacity for provider organizations to implement impactful interventions via Plan-Do-Study-Act (PDSA) cycles and other tools, and promote a culture of quality throughout the provider organizations. Improvement Advisors serve as Practice Facilitation coaches, and their role includes the following duties:

- Provide guidance on QI Project team make-up and management
- Work with practice's leadership team on QI infrastructure development

- Provide consultative support and tools for project management of QI projects
- Train and support application of the Model for Improvement methodology. Enable workgroup members to implement changes by providing tools, guiding them through rapid-cycle tests of change, and assisting when obstacles are identified
- Provide best practice change ideas and build capacity for brainstorming
- Build capacity for collection and use of measurement data, assess the effectiveness of changes made
- Support change management aspects of QI projects

In 2022, five provider organizations participated in quality improvement projects with the Improvement Advisors, consisting of two providers in the Southwest Region, and three in the Southeast Region. Each provider organization met with a Practice Facilitator twice a month (though one site met monthly), including site-specific QI team members as well as QI leadership. Multiple provider included team members such as clinicians and clinical support team members in their Practice Facilitation team structure. Providers selected at least one PCP QIP measure to focus on throughout the calendar year.

The 2022-2023 cycle began with four PO's participating in Practice Facilitation, two provider sin the Southwest Region and two in the Southeast Region. In 2023, there were several changes in the PO's participating in Practice Facilitation:

- One Southeast Region PO re-started Practice Facilitation in 2023
- One Southwest PO decided not to continue Practice Facilitation in 2023, due to team formation needs on their QI team.
- Staff transitions on the Partnership PI team led to 2 Southeast PO's transitioning to a new Practice Facilitation coach in April – May 2023.

Outcomes for the Practice Facilitation program in FY 2022-2023 include:

- Four PCP Parent Organizations participated in an evaluation of Practice Facilitation in December 2022. All four providers showed improvements in care gap closures for their measures of focus.
- 100% of respondents agreed or strongly agreed that they found value in the Practice Facilitation program ("My participation in Practice Facilitation was well worth the time I invested.")
- 100% of respondents rated their coach as skilled or highly skilled in 10 coaching behaviors
- Respondents were asked what activities or trainings they would value in 2023's Practice Facilitation program. The top 5 responses, which all received votes from at least 75% of the 9 respondents, were:
    - Training on engaging front line and providers in QI work
    - Training on sustainability and monitoring your successful practices into your operations
    - Training on presentation of data to QI and non-QI staff
    - In person end of the year celebration and presentation with other Practice Facilitation participating providers
    - Tailored ABC's of QI with the participating Practice Facilitation provider sites

The PI team recommends continuing the Practice Facilitation program with the four providers remaining in the program. While staffing transitions on the southern region PI team led to a postponement of the addition of new activities or trainings to the Practice Facilitation program by the end of FY2022-2023, there is a desire to develop new activities in Fall 2023. There is also potential to leverage best practices from the Enhanced Provider Engagement program with Practice Facilitation providers, such as completion of a Needs Assessment survey by each PO's leadership, or training Practice Facilitation teams on the Building Blocks frameworks, especially around Team Based Care and Population Health Management.

As Enhanced Provider Engagement continues and is evaluated in early 2024, there will be a need to further define how this second form of provider coaching will align with Practice Facilitation, and whether there is the potential to merge or better align the two programs.

Expansion of Mid-Year Check-Ins

The NR and SR PI Managers completed mid-year check in meetings with 17 Provider Organizations with more than 1,000 assigned Partnership members, who scored between 30-70% of available points on the 2021 PCP QIP, and who had demonstrated past engagement with Partnership's quality program offerings. Meetings were one hour in length, and reviewed 2021 performance and highlighted best opportunities for meeting measure benchmarks for the 2022 QIP.

From a quantitative measure of effectiveness, the mid-year check ins did not conclusively lead to improved QIP performance in 2022. Of the 17 PO's engaged, 10 PO's saw 2022 PCP QIP scores increase, and 7 PO's saw their QIP scores decrease.

From a qualitative measure of effectiveness, Partnership saw several benefits from the mid-year check in meetings.

- The meetings introduced the PI Managers to quality teams at several of the participating PO's, and strengthened Partnership's relationship with the PO's and knowledge of PO's priorities and initiatives.
- The PI Managers were able to connect multiple PO's with Partnership resources and tools, such as eReports trainings and Accelerated Learning and ABC's of QI curriculums.
- PO's responded well to a visualization of their QIP performance data that highlighted Numbers Needed to Treat (NNT) for each clinical measure. As a result, Partnership designed a new dashboard, the Spotlight Report, that features NNT, for the 2023 PQD launch in Summer 2023.
- The tiered approach to PO's based on QIP performance informed the design of the Enhanced Provider Engagement strategy, which launched in March 2023.

The PI Managers and QI Senior Leadership agreed to abandon the mid-year check ins as an intervention in 2023-24, and will replace this intervention with other programs that will lead to collaborative work between Partnership's PI team and the PO's, including but not limited to:

- Enhanced Provider Engagement (6 PO's from 2022 mid-year check-ins)
- Mobile Mammography (15 PO's from 2022 mid-year check-ins have expressed interest, and meet the criteria for sponsorship)
- Lead Testing focused consultation (5 PO's from 2022 mid-year check-ins have met with Partnership's consulting team)

Expansion of Regional Quality Meetings

For FY 2022 – 2023, the QI Team created a new goal to expand regional quality meetings to the Northern Region. In the past, these meetings have been deployed in the southern regions as a means to address regional quality improvement topics with local stakeholders.

This Fiscal Year, the QI Team expanded this offering to the northwest region (Del Norte and Humboldt counties), hosting the first regional QI meeting on March 28, 2023. The meeting included the following organizations and local stakeholders:

- Changing Tides
- First 5
- Mad River Community
- Open Door Community Health Centers
- Redwoods Rural Health Center
- Southern Humboldt Community Clinic
- Southern Trinity Health Services
- Sutter Coast Community Clinic
- St. Joseph Health
- United Indian Health Services, Inc.

The Northwest Region QI Meeting provided a forum to problem-solve issues related to quality improvement, while also sharing and spreading best practices and highlights from organizations within the region. Measures discussed included: Breast Cancer Screening, Cervical Cancer Screening, Well-Child Visits in the First 15 Months of Life, Child and Adolescent Well Care Visits. Organizations in attendance were sent a survey after the meeting to assess their interest in continuing this meeting structure in the future, and based on survey response, the QI Team will continue the Northwest Region QI meetings on a quarterly basis. The next meeting is currently being scheduled to take place in July 2023, and the team is also working on creating a Northeast Region QI meeting, with a meeting date being proposed to take place in October 2023. The QI team will be continuing this work into the next Fiscal Year.

The Performance Improvement team continues to support several regional quality meetings within the Southern Region in partnership with Regional Leadership:

Solano Quality Improvement Program Initiative (SQIP-I): This monthly meeting is co-sponsored by Partnership and Aliados Health, the FQHC consortium that is active in Solano County. The SQIP-I Workgroup engages four of the largest PCP's in Solano County as a collaborative forum for collective learning and for partnership on quality measures that are best addressed on a systems level. In 2022-2023, the SQIP-I Workgroup's projects included:

- Piloting the Well Care Dashboards developed by the QIP team to show a longitudinal record of individual members' history of Well Child Visits Birth – 15 Months (W30-15) and Well Care Visits for Children and Adolescents (WCV). The SQIP-I providers used the pilot Well Care Dashboards to plan interventions for the W30-15 measure, and gave feedback to refine the dashboard design. In 2023, both dashboards were added to the eReports portal as resources available to the Partnership provider network.
- Engagement on the Mobile Mammography pilot in Fall 2022. Three of the four participating SQIP-I providers held successful mobile events in November – December 2022 as part of the pilot.
- Focused collaborative work on newborn visit workflows, featuring a presentation on newborn transitions of care by Solano County's primary inpatient labor and delivery unit.

Southeast Regional Meeting: This quarterly meeting engages all PCP's in the Southeast Region. In 2022-2023, the Southeast Regional Meeting's topics included:

- Voices from the Field presentations by PCP quality teams describing best practices for measures such as Well Child Visits Birth – 15 Months (W30-15) and Diabetic Retinopathy exams.
-

Lake and Mendocino Quality Meeting: This bi-annual meeting engages PCP's in Lake and Mendocino Counties around quality improvement topics. In 2022-2023, the Lake and Mendocino Quality Meeting's topics included:

- Data Spotlights on quality performance by County for all PCP QIP measures. Provider teams were provided with site-level care gaps to benchmarks for each PCP QIP measure.
- Introduction to 2023 eReports features and timelines, including a demo of the Well Care Dashboards added to eReports in 2023.

- Presentations on childhood vaccination measures CIS-10 and IMA-2, including completion rates by vaccine families and strategic recommendations and best practices for completing influenza and rotovirus series, the two vaccine families that are most frequently missed by children who complete nine of ten vaccine families for the CIS-10 measure.

QI Technical Assistance in partnership with Northern Region Consortia

In prior years HANC and NCCN have worked with Northern Region QI to conduct in-person ABCs of QI sessions. With the onset of COVID-19, PHC switched to a virtual five webinar series. This allowed PHC to utilize all Performance Improvement staff to conduct trainings, which allowed HANC and NCCN to focus on supplemental webinars. While PHC has returned to in-person ABCs of QI sessions, we found the supplemental trainings offered by the consortia partners to be of high value and has elected to keep these trainings in the scope of work. The details of these trainings were noted in the prior section under Quality Improvement Training and Coaching.

PHC, HANC, and NCCN collaborated to maintain a QI Measurement Systems Toolkit, initially developed and launched in 2017. The QI Measurement Systems Toolkit provides background information on the measures defined under HEDIS, Uniform Data Set (UDS), Site Reviews, and the PCP QIP. This toolkit also includes measure by measure data sets reflective of consortia member performance across the varying measurement sets. And, recommended best practices from national change packages and regional interventions are also included by measure. A key component of the toolkit is a measure crosswalk that indicates which measures fall under each measure set, as well as what criteria constitutes denominator and numerator compliance, and any exclusions that exist for the measure. The scope of the crosswalk is primarily determined by the PCP QIP measure set versus attempting to offer a fully inclusive view of all the new measures PHC has taken on via MCAS and NCQA accreditation. The crosswalk acknowledges when a comparable HEDIS measure exists but does not detail the measure specs, given sensitivity around licensing agreements with NCQA. These tools allow organizations to potentially target measures for performance improvement that affect multiple measure sets. The northern consortia also continue to cite this toolkit as a key onboarding tool for health center staff either new to QI or taking on new responsibilities under the PCP QIP.

HANC and NCCN offer great avenues for communicating with the largest Northern Region PCP organizations serving PHC members. In the past year, PHC has leveraged the consortia QI and CMO Peer Networks, which each meet monthly, to share key changes in measure sets, HEDIS/QIP measure education, HEDIS/QIP performance results, and emerging best practices from ongoing regional performance improvement projects. It is also a forum by which barriers to achieving improved HEDIS performance can be openly discussed, informing PHC's HEDIS Score Improvement tactical strategies and dialog with DHCS. The Northern Region PHC team will be sharing RY2022 HEDIS results with the consortia network during an upcoming QI Peer Network meeting.

Other QI Provider Resource Updates and Changes

In 2023, the PI team replaced Quality Measure Highlights, replacing these resources with the PCP QIP Technical Specifications and Measure Best Practices for each PCP QIP measure. Best and promising practices were greatly expanded in the 2023 Measure Best Practices to feature Partnership programs and tools, and include best practices around data and coding, member care, and health equity best practices for each PCP QIP measure.

Frequently Asked Questions (FAQs) documents were developed by the QIP team to support newly enhanced dashboards in the Partnership Quality Dashboard (PQD) called Preventive Care Reports. Each dashboard includes supplemental data for three measures included in the PCP QIP core clinical measure set: Immunization for Adolescents, Childhood Immunization Status – Combo 10, and Well Care Visits in support of the Well Child First 15 Months measure. The Preventive Care Report FAQs document provides descriptive highlights of each measure dashboard including guidance on how to use the data in support of measure score improvement. The QIP team also distributes an educational, bi-monthly email DRIP campaign focusing on helpful tips for using the Preventive Care Reports dashboard and other QIP basics to reinforce on-going performance education provided by the Performance Improvement team.

Value Based Pay-for-Performance Programs

PHC's quality improvement programs (QIP) provided financial incentives, data reporting and technical assistance to providers for improving in key domains of quality: clinical care, patient experience, access and operations, and resource use. The total pay-out for the MY 2021-2022 QIP was approximately $42,867,465.60 across the six QIP programs managed within the Quality Improvement (QI) department.

Primary Care Provider Quality Improvement Program

The Primary Care Provider (PCP) Quality Improvement Program (QIP) Core Measurement Set evaluated four (4) domains of quality: Clinical Care, Appropriate Use of Resources, Patient Experience, and Access & Operations. The Unit of Service measures provided additional dollars for providing specific services such as Blood Lead Screening, Advance Care Planning and etc. All primary care providers who have Medi-Cal members capitated to them are automatically enrolled in the PCP QIP.

Program Goals

The PCP program goals and activities outlined in the FY 2022-2023 QI Department Work Plan were completed and highlighted below.

- Development of measures for the 2023 PCP QIP by December 31, 2022
- PHC adhered to DHCS guidance regarding this program by including a performance threshold for measures that rewarded providers for conducting activities they may already be compensated for through capitation payments
- Supported providers enrolled in the program by hosting webinars, sending quarterly newsletters, and responding to provider inquiries via phone and email in timely manner.
- Continued provider engagement and program activities to support quality (HEDIS) measure score improvement, including monitoring changes to relative improvement methodology, payment methodology, and continuous enrollment requirement
- Supported provider network and respective sites/clinics in their efforts to use data to improve reporting and performance improvement activities through FY 2021-22
- Implement process improvement includes documenting and updating program protocols, new process improvements, and adding lessons learned
- Established provider survey satisfaction baseline focused on improving
    - QIP Effectiveness
    - PCP Provider Support/Customer Service

The PCP QIP program performs annual evaluations. The 2021 Measurement Year evaluation was completed during the fiscal year 2022-2023 and is highlighted below.

MY 2021 PCP QIP Program Evaluation Summary

The PCP QIP offers pay-for-performance (P4P) financial incentives. The intent of P4P is to improve access and quality of care across all clinical domains. The PCP QIP, designed in collaboration with PHC providers, offers substantial financial incentives, data resources, and technical assistance to primary care providers who serve our capitated Medi-Cal members so that significant improvements can be made in the following areas: (1) Prevention and Screening, (2) Chronic Disease Management, (3) Appropriate Use of Resources, (4) Primary Care Access and Operations, and (5) Patient Experience. This evaluation is an analysis of the January 1, 2021 – December 31, 2021, Measurement Year.

Program Performance

PCP QIP performance observed incremental year-over-year recovery from September 2020 to 2021 in the following clinical measures:

- Asthma Medication Ratio
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Diabetes HbA1c Good Control (<= 9.0%)
- Immunization for Adolescents

Provider Experience

The PCP provider engagement survey is administered each calendar year. The intent of this survey is to evaluate prior year PCP QIP program experience in the following categories: Program satisfaction, Organization program awareness, Performance measure tools, Program effectiveness, and QIP team support. The following results were reported:

- Survey respondents provide a positive indication that program engagement and measures are effective
- 92.68% are satisfied with the program
- 97.56% staff is aware of the QIP
- 100% agree QIP drives their QI agenda
- 84.07% are satisfied with the QIP Team
- 85.37% routinely read the QIP newsletter

Recommendations for 2023

- Maintain Stable Measures thresholds: 75% & 50% (full/partial) point targets
- Move from Monitoring to Non-clinical measure set: PCP Office
- Move from Monitoring to Clinical measure set: Retinal Eye Exam
- Adjust the Colorectal Cancer Screening measure age range from 50-75 to 45-75

PCP QIP eReports System

The eReports system is an online tool provided to PCP participants in the PCP QIP. It serves as a means for providers to track their performance under the clinical care domain of the Core Measurement set at both an organizational level and individual site level. Under the 2022-2023 QI Work Plan, the eReports system was successfully enhanced to support the 2023 PCP QIP clinical measure set and released to providers on May 8, 2023.

The information from eReports presents providers with member-level data corresponding to eligibility and compliance status under each measure. eReports data sources are: claims, lab data, pharmacy data, California immunization registry (CAIR) data, and the eReports user supplemental upload data. eReports user supplemental upload data gives the provider the opportunity to upload medical record data to substantiate member compliance where representative administrative data is unavailable.

In the fourth quarter of 2022, the PCP QIP team conducted an eReports audit . There was 75% compliance for Counseling for Physical Activity and 88% compliance for Counseling for Nutrition. In addition, there was 8% non-compliance across both measures. Provider education was incorporated in May 2023 for the annual eReports kick off webinar. Web Team provided the A1c and BCS uploaded data file for QIP team audit in October, 2022.

This represented dates of service that had been uploaded to eReports by provider sites from January 1, 2022, through June 30, 2022. Outreach to providers with requests for medical record documentation was conducted during October 2022 through November 2022. The audit concluded that 32 non critical errors were found with inconsistent DOS but continued to align with QIP and HEDIS numerator compliant criteria. There were 23 critical errors found were medical records were not received for the DOS requested, resulting in members being removed from eReports numerator data, if Pediatric site only.

Given critical errors were found in the 2022 eReports audit, all uploaded dates of service for critical errors were reviewed and removed from the sites numerator data. Data was finalized in eReports production before the close of January's grace period for MY2022. Summary and recommendations from audit-based findings were reviewed at the December 2022 QIP Tech Work Group.

Audited medical record data did not meet the target of 98% accuracy that is required to be considered as a HEDIS data source. Provider education based on common failure modes in audit were incorporated into the MY 2023 eReports Demo Webinar completed May 3rd, 2023. Following the presentation of results of the audit, PHC's CMO approved the following recommendations:

- A1c will follow the controlling high pressure template release and upload scheduled, October 1 through the end of the measurement year grace period.
- BCS will follow the child and adolescent well care template release and upload schedule, first day of the grace period through the end of the measurement year grace period.

Hospital Quality Improvement Program

The Hospital Quality Improvement Program (HQIP) is a pay-for-performance incentive program that began in 2012 for selected hospitals in the PHC network. The purpose of the HQIP is twofold: 1) To help improve the health outcomes of PHC members served by its contracted hospitals and 2) to help participating hospitals assess the quality of care provided to their patients by serving as a guide to their existing quality improvement efforts. To do this, the program offers substantial financial incentives for hospitals that meet specific performance targets, connects HQIP hospitals with regular training opportunities and resources, and hosts an annual Hospital Quality Symposium.

Program Goals

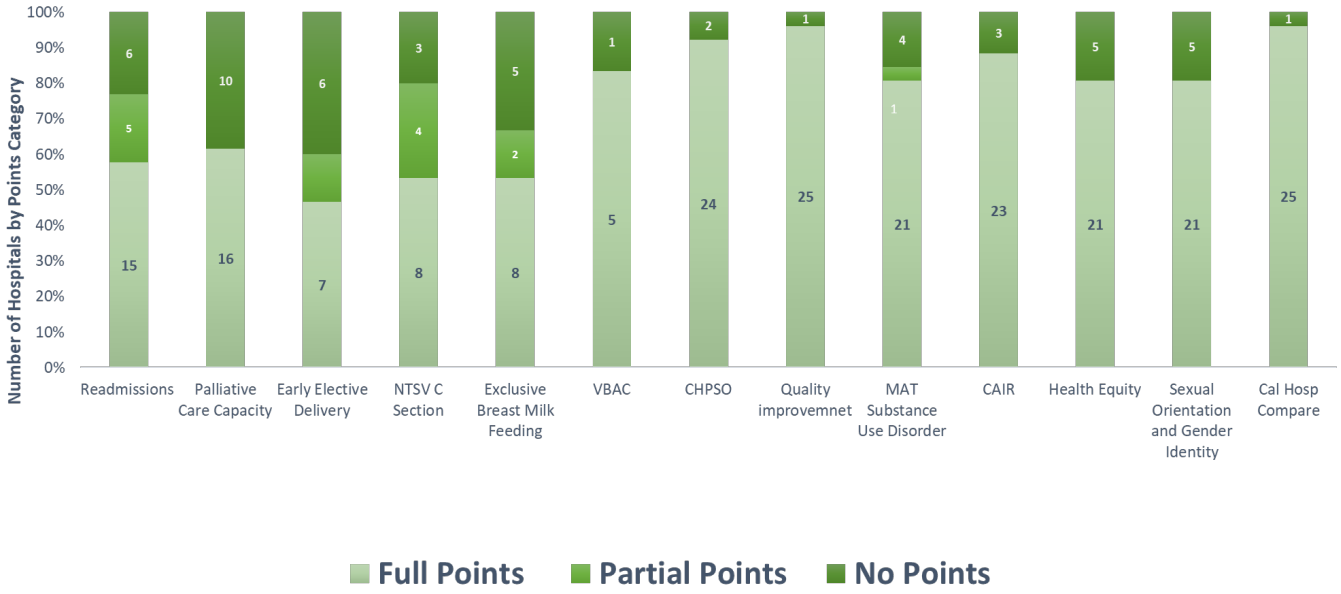
All HQIP Goals and activities defined in the FY 2022-23 QI Work Plan were met. PHC completed development of the 2022/23 Measurement set. PHC also provided ongoing technical assistance to providers throughout the year, conducted an evaluation of the program for the 2021-22 measurement year which is summarized below, with the number of hospitals participating in this QIP remaining at twenty-six (26) hospitals.

PHC conducted ongoing measure performance monitoring on participating hospitals while providing technical support and mid-year performance reports during the 2021-22 Measurement Year.

Completed Goals

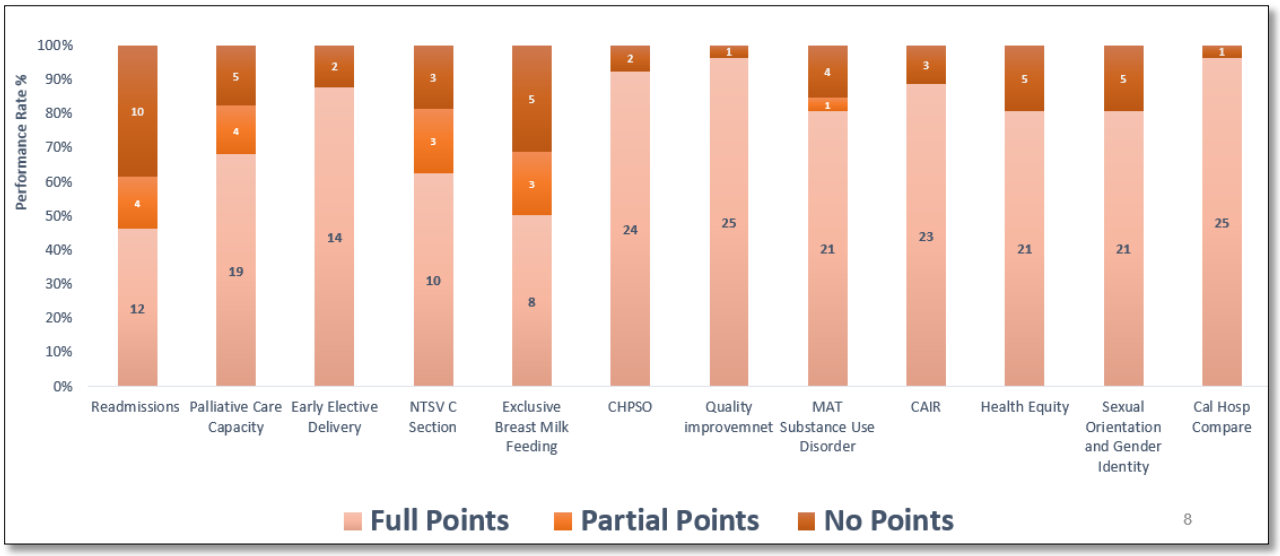
- Development of the 2022-23 measurement set included focus areas in the following domains: readmissions, advanced care planning, clinical quality: maternity care, patient safety and operations & efficiency, and patient experience. Measure development included collaborative efforts with the California Maternal Quality Care Collaborative, Palliative Care Quality Collaborative, California Hospital Patient Safety Organization and Cal Hospital Compare. This resulted in the following thirteen (13) quality measures for hospitals large and small, with and without obstetric services on-site:
    1. Risk Adjusted Readmissions
    2. Palliative Care Capacity
    3. Rate of Elective Delivery Before 39 Weeks
    4. Exclusive Breast Mild Feeding Rate
    5. Nulliparous, Term, Singleton, Vertex Cesarean Rate
    6. Vaginal Birth After Cesarean
    7. California Hospital Patient Safety Organization (CHPSO) Patient Safety Organization Participation
    8. Quality Improvement Capacity
    9. Hepatitis B Vaccination/CAIR Utilization
    10. Substance Use Disorder – Medication Assisted Treatment
    11. Cal Hospital Compare – Patient Experience
    12. Health Equity
    13. Hospital Quality Improvement Platform

Annually, the Hospital QIP compiles a year-end evaluated utilizing performance relative to targets along with performance points distributed by measure. The table blow demonstrates the count of hospitals that fell into each category of achieving full points in the measure, partial points in those measures that offer partial points and no points. Obstetrics based measures represent a count of *only* hospitals offering obstetrics.



MY 2022-2023 Program Focus

Each year, the HQIP team works to make meaningful measures incentivizing continuous improvement with performance targets considered for increase when program-wide performance increases. Starting January, 1, 2024, PHC will go live with expansion into ten additional counties. The HQIP has developed and received committee approval for a 6-month measurement set to be offered to hospitals in the new county regions. The purpose of the 6-month measurement set serves as an introduction for hospitals located in expansion counties to the HQIP. Program focus for 2022-2023 will continue fostering pre-pandemic forward movement in quality improvement efforts with a focus on community partnerships, quality improvement education, readmission reduction strategies and a systemic hospital focus on health equity.



Perinatal Quality Improvement Program

The Perinatal Quality Improvement Program (QIP) is a pay-for-performance program offering financial incentives to participating Comprehensive Perinatal Service Program (CPSP) providers and select non-CPSP providers administering quality and timely prenatal and postpartum care to PHC members.

Program Goals

Perinatal QIP goals and activities in the 2022-2023 QI Department Work Plan encompass a vision of continued/increased provider engagement, HEDIS measure alignment and the maintenance of an internal dashboard to administratively monitor the performance of postpartum office visits and immunizations.

Completed Goals

- Continued successful development of the Perinatal QIP performance dashboard Business Requirements Document (BRD) to visualize participating provider performance on the Prenatal Immunization Status and Timely Postpartum Care Measures and identify providers who meet the program gateway measure. This internal dashboard is refreshed quarterly during the measurement period, and is utilized by the Perinatal QIP team to produce quarterly reports offering participating providers an idea of their on-going performance. Payment data in the dashboard is also utilized by the PHC Performance Improvement team for external stakeholder meetings. Dashboard maintenance and enhancement is accomplished by partnering with PHC's PQD and EDW teams in the completion and implementation of the changes to the PQD dashboard via the BRD with internal performance views of administrative office visits and immunizations data captured through claims/encounter data.
- Partnered with the Population Health – Growing Together Program to develop and implement a monthly reporting and member submission process.
- Aligned Perinatal QIP Clinical Measures to support Quality (HEDIS) Measure Score Improvement strategy.
- Increased provider engagement and support focused improved measure education and programmatic technical support.
- In recent years, the program participation grew from the initial two (2) participating provider sites during the program's pilot phase to twenty-five (25) Parent Organizations representing fifty-four (54) individual sites actively engaged in the program. Through the continued work of PHC's Women's Health and Perinatal Workgroup (WHaP), concentrated efforts took place to offer clinical education and program training to participating providers. Noticeable declines in both timely prenatal care and postpartum care were to be expected in the 2020-2021 measurement year given the overall strain on the healthcare system as a result of the COVID-19 pandemic and expectant parents' reluctance to attend in-person appointments.

Measure Development

Perinatal QIP measures maintain a comprehensive yet simple measure set with the intent to improve HEDIS performance among providers offering prenatal and postpartum services often occurring outside of a PCP visit including:

- Timely Tdap and Influenza Vaccine
- Timely Prenatal Care
- Timely Postpartum Care

- Electronic Clinical Data System (ECDS): Implemented as a programmatic gateway measure for all Perinatal Quality Improvement Program participants

MY 2022-2023 Program Focus

Continue process improvement through proactive collaboration and engagement with internal and external stakeholders. The FY 2022-2023 program evaluation is to take place in January 2024, following the close of program payment in October 2023. Program goals for FY 2022-2023 include:

- Additional development to the PQD Internal Dashboard to allow PHC staff prenatal submission uploads to streamline provider quarterly reporting.
- Continue to engage all major perinatal providers regularly, to maintain the performance on the clinical measures.
- Continue to encourage and support ECDS implementation to meet programmatic gateway and continuation of support to providers who implemented during the FY 2021-22 measurement period.
- Continue to engage in WHaP collaboration and activities to improve maternal health outcomes.
- Collaborate with internal stakeholders to further define data governance and reporting requirements.

Palliative Care Quality Improvement Program

In 2017, PHC began a pay-for-performance program for Palliative Care Quality Improvement Program (PC QIP) providers. The Palliative Care QIP offers sizeable financial incentives to support and improve the quality of palliative care provided to PHC members. In collaboration with Palliative Care providers, PHC has developed a simple, meaningful measurement set to measure quality of care using two measures: Avoiding hospitalization and emergency room visits, and Completion of POLST (Physician Orders for Life-Sustaining Treatment) and use of the Palliative Care Quality Network (PCQN).

Regarding the goals and activities indicated in the 2022-2023 QI Department Work Plan, all intended outcomes were accomplished. PHC conducted ongoing performance evaluation of the participants, continued to use the most meaningful and feasible measures available, offered technical assistance to providers throughout the year, tracked all submissions, validated them, and gave participants updates on their performance

The Palliative Care QIP runs on a calendar year, from January 1 – December 31. Providers are paid based on their performance during two six-month measurement periods. In 2022, the program had 8 participants, and a total payout of ~$1,861,200. Major program activities during 2022 included: new participant outreach and onboarding; webinars, technical assistance, and program communications; work with providers to coordinate data validation and collection for the Palliative Care Quality Collaborative (PCQC) measure; work with analytics to coordinate data collection and validation for avoiding hospitalization and ED visits measure; and distribution of reports to providers.

Program strengths include an opportunity for PHC to decrease utilization and improve quality of care provided to members, strong provider engagement, and connecting providers with useful quality monitoring resources such as PCQC.

Partly due to the aligned incentives of the Palliative Care QIP, the overall financial savings of this program has continued, and the data from PCQC have demonstrated the average performance better than other, non-PHC palliative care programs.

Enhanced Care Management Quality Improvement Program

The Enhanced Care Management Quality Improvement Program (ECM QIP) debuted on January 1, 2022. ECM is a statewide benefit which is part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative organized by the Department of Health Care Services (DHCS). This pay-for-reporting program utilizes Incentive Payment Program (IPP) funds to incentivize providers to present PHC with quality data tied to the timeliness of required ECM program reporting.

All intended outcomes were accomplished for the goals and activities indicated in the 2022-2023 QI Work Plan. With contribution of the CalAIM/ECM Team, major program activities included: provider outreach and onboarding, program communications, report tracking, and incentive payment calculation and distribution.

The ECM QIP runs on a calendar year, from January 1 – December 31, and ECM contracted providers are automatically enrolled anytime throughout the year. All ECM providers are paid quarterly. For the first three quarters of 2022 (January - September), providers were paid based on one measure: timeliness of reporting. For this period, PHC paid out ~$650,850 to 25 participating providers.

In the fourth quarter of 2022, the timely reporting measure moved to a gateway measure and potential incentive dollars for timely reporting were instead placed in an incentive pool available for earning incentive dollars contingent on meeting three new quality measures: ECM Care Plan and Shared Consent forms entered into Collective Medical within 60 days of TAR start date, PHQ-9 Depression Screening, and Blood Pressure Screening. PHC paid out ~$159,629 to 38 participating ECM providers for this last quarter (October - December).

Program strengths include an opportunity for PHC to improve quality of care provided to members and provider engagement. Continued data collection will support potential future quality measures for this program.

Long-Term Care Quality Improvement Program

In 2016, PHC began a value-based purchasing program targeting long-term care facilities. The Long-Term Care (LTC) QIP offers sizeable financial incentives to support and improve the quality of long-term care provided to PHC members. In collaboration with LTC representatives, a simple, meaningful measurement set containing 10 measures was developed. The LTC QIP, different from the PCP QIP, is an opt-in program. All contracted facilities are invited to participate. In 2020, due to the COVID Pandemic, this program was suspended through 2021. In 2022, the LTC QIP restarted with 50 LTC facilities participating in the program.

All intended outcomes were accomplished for the goals and activities indicated in the FY 2022-2023 QI Workplan. LTC facilities' performance will be assessed and changes will be considered for how to better measure performance, including attempts to obtain hospitalization data for PHC members in these facilities. The QIP team continues to explore ways to improve the measures so providers are incentivized to help PHC reduce costs and improve quality. One of the ways this was done is through engagement with partners in the community, and PHC's Advisory Group and Technical Workgroup.

Among the 10 measures, five measures are pay-for-outcome measures that evaluate a facility's performance against a set target. Examples include percentage of high-risk residents with pressure ulcers and percentage of residents who lose too much weight. Since these measures are publicly reported, the QIP team extracts data from Nursing

Home Compare and rewards points accordingly. In 2022, for two of these measures, percentage of long-stay residents who needed or received a flu shot and percentage of residents who received a vaccine to prevent pneumonia, a requirement of LTC facilities to enroll in the California Immunization Registry (CAIR) and enter vaccinations into CAIR was added. Also in 2022, the LTC QIP team established new participation requirements with approval from Executive Leadership that included twice yearly good-standing audits. Participating LTC facilities must be in good-standing according to PHC policy but also must not have citations related to abuse or certain financial sanctions as determined and reported by Nursing Home Compare. LTC facilities are audited for good standing before the start of a new measurement year and mid-way through a measurement year. Any violation of good standing criteria renders the LTC facility incapable of participating in the program and earning incentives, until such time the facility returns to good standing status. In 2022, PHC paid out ~$1,306,449 to 30 out of 40 eligible (in good standing) LTC providers.

Member Safety and Quality Compliance Activities

QI TRILOGY

Member Safety and Quality Compliance Activities

Quality Assurance and Member Safety activities include investigation of Potential Quality Issues (PQIs), Site Reviews (including facility site and medical record reviews), Physical Accessibility Review Surveys (PARS) (which assess the level of physical accessibility of provider sites including specialist and ancillary providers that serve a high volume of seniors and persons with disabilities), and monitoring initial health appointment (IHA) rates.

Potential Quality Issues (PQIs)

A PQI is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care which requires further investigation to determine whether an actual quality of care concern or opportunity for improvement exists. The PQI investigation and Peer Review process provide a systematic method for the identification, reporting, and processing of a PQI to determine opportunities for improvement in the provision of care and services to Partnership members and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity.

Partnership identifies PQIs through the systematic review of a variety of data sources, including but not limited to: 1) Grievances and Appeals; 2) UM (utilization review); 3) Claims and encounter data; 4) Care Coordination; 5) Medical Record Review; 6) Referrals from other health plan staff, providers and members of the community; 7) HEDIS medical record abstraction process; and 7) Facility and Medical Record Site Reviews.

The top three referral sources were Grievance and Appeals, Utilization Management and referrals from Partnership Medical Directors. The rest of the PQI cases were referred by other sources such as the Care Coordination and Pharmacy departments.

Table: A

Region-wide Report (Southern and Northern Regions)	2021		Grand Total	2022		Grand Total
PQI Referral Rate, Count and Membership	Q1/Q2	Q3/Q4		Q1/Q2	Q3/Q4	
PQI Count	69	44	113	59	97	156
Members Months	3,718,066	3,838,655	7,556,721	3,499,163	3,930,395	8,109,019
Rate per 1,000 Members	0.22	0.13	0.18	0.20	0.30	0.23

Table: B

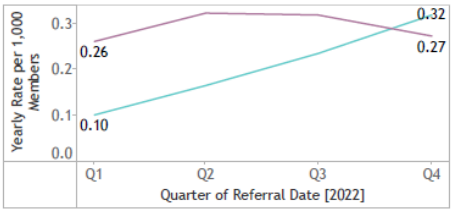
PQI DATA ANALYSIS

Potential Quality Issues
Referral Dates: 2022

PQI Rate, Count and Membership

	2022 Q1		2022 Q2		2022 Q3		2022 Q4		Total
	NORTHERN	SOUTHERN	NORTHERN	SOUTHERN	NORTHERN	SOUTHERN	NORTHERN	SOUTHERN	
Number of Records	12	12	15	20	15	29	13	40	156
Yearly Rate per 1,000 Members	0.26	0.10	0.32	0.17	0.32	0.23	0.27	0.32	0.23
Member Months	551,524	1,423,076	557,653	1,453,122	564,863	1,480,967	571,683	1,506,131	8,109,019

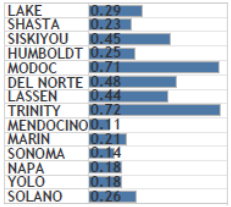
Trend of PQI Rate



Count, Membership and Rate per 1,000 Members by County

	2022 Q1			2022 Q2			2022 Q3			2022 Q4			Grand Total		
	Member Months	Number of PQIs	Yearly Rate per 1,000 M..	Member Months	Number of PQIs	Yearly Rate per 1,000 M..	Member Months	Number of PQIs	Yearly Rate per 1,000 M..	Member Months	Number of PQIs	Yearly Rate per 1,000 M..	Member Months	Number of PQIs	Yearly Rate per 1,000 M..
LAKE	100,946	1	0.12	102,483	2	0.23	104,004	4	0.46	105,447	3	0.34	412,880	10	0.29
SHASTA	212,881	1	0.06	215,884	5	0.28	219,284	5	0.27	222,079	6	0.32	870,128	17	0.23
SISKIYOU	59,664	2	0.40	59,912	2	0.40	60,575	2	0.40	60,942	3	0.59	241,093	9	0.45
HUMBOLDT	186,899	5	0.32	188,442	3	0.19	190,094	3	0.19	192,022	5	0.31	757,457	16	0.25
MODOC	12,259			12,425	1	0.97	12,703			12,984	2	1.85	50,371	3	0.71
DEL NORTE	36,931	2	0.65	37,229			37,546	2	0.64	38,160	2	0.63	149,866	6	0.48
LASSEN	26,898	1	0.45	27,304			27,853	2	0.86	28,253	1	0.42	110,308	4	0.44
TRINITY	15,992	1	0.75	16,457	2	1.46	16,808			17,243	1	0.70	66,500	4	0.72
MENDOCINO	129,662			130,548	2	0.18	132,024	3	0.27	133,373			525,607	5	0.11
MARIN	136,897			142,555	1	0.08	146,839	3	0.25	150,145	6	0.48	576,436	10	0.21
SONOMA	365,659	3	0.10	374,809	4	0.13	383,180	5	0.16	390,369	6	0.18	1,514,017	18	0.14
NAPA	98,046	1	0.12	101,019	1	0.12	103,217	1	0.12	104,797	3	0.34	407,079	6	0.18
YOLO	176,652	1	0.07	179,582	4	0.27	182,777	3	0.20	186,281	3	0.19	725,292	11	0.18
SOLANO	415,214	6	0.17	422,126	8	0.23	428,926	11	0.31	435,719	12	0.33	1,701,985	37	0.26

PQI Rate per 1,000 Members by County



Yearly Rate per 1,000 is defined as: [(Number of PQIs)/(Membermonths)]*12,000
Created by: Liat Vaisenberg (lvaisenberg@partnershiphp.org)

As illustrated in the preceding tables A & B, in 2022, 156 cases were referred for PQI investigation compared to 209 in 2019, 128 in 2020, and 113 in 2021. The variance could be attributed to several factors, particularly the COVID-19 pandemic, which limited member-provider contacts plan wide. As expected, when COVID restrictions eased, the number of PQI referrals increased in the latter part of 2022. Activities to improve the PQI referral system and Medical Director review of Grievance cases to eliminate inappropriate referrals may also have contributed to the decrease in the number of referrals. For example, the implementation of a centralized online referral process helps determine if cases are appropriate to be referred as PQIs. This system also enables the Quality Assurance and Member Safety unit to better track, monitor and manage PQIs.

A total of 156 cases were processed and closed to completion. This number, compared to 177 closed cases in 2019, 151 in 2020, and 126 in 2021, reflects the increase in PQI referrals in 2022. Closed cases included four Provider Preventable Conditions (PPC). Providers must report potential PPCs directly via online reporting to the DHCS Audits & Investigation Unit (A&I) after discovery of the event and confirmation that the patient is a Medi-Cal beneficiary.

In accordance with Partnership policy, cases scoring a P2 or P3 or S2 or S3 (refer to the grid below: *Assignment of Practitioner Performance and Systems scores)* are reviewed by Partnership's Peer Review Committee to determine what actions on the part of the health plan are indicated. A total of 11 cases were reviewed by the Peer Review Committee in 2022. Assignment of practitioner performance and system scores are based on the reviewed medical records, other information submitted by the provider, and additional documentation as needed to fully review the case.

A PQI may involve both a practitioner performance issue and system issue. In addition, some cases involve multiple providers who are scored individually. Physician oversight of the PQI/Peer Review process includes weekly PQI

rounds attended by Medical Directors, Associate Medical Directors, the Behavioral Health Clinical Director, a Clinical Pharmacist, the Manager for Quality Assurance & Member Safety, and Performance Improvement Clinical Specialist (PICS) nurses. Cases with significant concerns are communicated to the Credentialing Committee at the recommendation of the Peer Review Committee. Physician and nurse participation in Peer Review Committee and PQI rounds, inclusive of PHC medical directors and network providers from diverse specialties was sufficient to meet the requirements for reviewing and making determinations about PQIs.

The growth strategy for 2020-2021 involved collaborating with the Wellness & Recovery department in streamlining the PQI investigation process and welcoming the Behavioral Health Clinical Director on to the PQI team of physician reviewers. This integration improved our member safety activities pertaining to behavioral and mental health case investigations and outcomes improvement, resulting in faster review and greater visibility into the process. In 2021-2022, we implemented an outreach program to educate and engage individual providers in identifying potential quality issues to promote member safety. In 2022-2023, we continued this goal with an additional outreach to hospitals regarding Provider Preventable Conditions (PPC). We conducted at least 5 in-service sessions to encourage provider-initiated compliance through education, quality of care access improvement activities and promoting internal care reviews regarding the provision and effectiveness of health care services. We also added a Clinical Pharmacist to the weekly PQI rounds to ensure that pharmacy related issues are reviewed by an internal subject matter expert.

Assignment of Practitioner Performance and Systems Scores

Practitioner Performance Severity Scores

P Score	Definition	Action/Follow-up
P0	Care is appropriate.	No action required.
P1	Minor opportunity for improvement. Potential for or actual, minor adverse outcome to member.	An informal letter to the provider may be sent at reviewer's discretion. Response may or may not be required.
P2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for minor or moderate adverse outcome to member.	Letter to provider of concern, requesting a response. May recommend CAP and/or other interventions.
P3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for significant adverse outcome to member.	Immediate communication to provider of concern requesting a response. May recommend CAP and/or other interventions. May be referred to Credentialing Committee with recommendations for PRC.

PUTD	Use whenever the PQI cannot be leveled prior to referral to the Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC).	Referral to the PRO of the Facility of Concern (FOC) or the Provider of Concern (POC).

System Issue Severity Scores

S Score	Definition	Action/Follow-up
S0	No system issue.	No action required.
S1	Minor opportunity for improvement. Potential for or actual, minor adverse outcome to member.	An informal letter to the provider may be sent at reviewer's discretion. Response may or may not be required.
S2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for minor or moderate adverse outcome to member.	Letter to provider of concern, requesting a response. May recommend CAP and/or other interventions.
S3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for significant adverse outcome to member.	Immediate communication to provider of concern requesting a response. May recommend CAP and/or other interventions. May be referred to Credentialing Committee with recommendations for PRC.
SUTD	Use whenever the PQI cannot be leveled prior to referral to the Peer Review Organization (PRO) of the Facility of Concern (FOC) or the System of Concern (SOC).	Referral to the PRO of the Facility of Concern (FOC) or the Provider of Concern (POC).

Site Reviews

Partnership conducts Site Reviews to ensure that primary care providers have the capacity to maintain patient safety standards and practices. Each PCP site is required to pass an Initial Facility Site Review prior to joining Partnership's network. Site Reviews are conducted, at least every three years. DHCS requires that a DHCS Certified Site Reviewer (Registered Nurse) conduct these reviews. PHC follows standards and guidelines outlined in APL 22-017 that was issued on 9/2/2022 and revised 9/9/2022.

DHCS issued updated Facility Site Review (FSR) and Medical Record Review (MRR) Tools that went live on 7/1/2022. These are revisions of the previous 2019 tools that were to go live on 7/1/2020 but were placed on hold due to the public health emergency. During 2021-2022 providers were scored on the 2012 tools, and also scored on the newest tools for educational purposes to prepare them for the new requirements (>35 elements were added to the FSR/MRR tool set). Effective 7/1/22 providers were scored on the newest tools (2022 Version). Currently, Partnership continues to educate sites on the new 2022 FSR/MRR Tools to assist sites in understanding the new requirements. Best practices are shared with the sites to help drive improvement. Education is provided onsite during the exit interview process of site reviews, and is additionally offered as a separate educational session to all sites.

Partnership completed a Site Review Backlog from FY 2020-2021 (related to COVID-19 travel restrictions) on 7/19/22. DHCS accepted all reviews from the backlog. Partnership continues to conduct virtual Medical Record Reviews whenever possible to decrease travel costs and increase one on one site education during each review.

Facility Site Reviews

Overall, the Facility Site Review domain scores remained very high. There are some areas in need of improvement. Through the Facility Site Review process, Partnership identified and communicated to providers where specific improvement is needed with the following areas commonly cited:

- Access and Safety: Medication dosage chart for all medications is kept with emergency equipment.
- Personnel: Cultural and Linguistics Training for staff
- Personnel: Disability Rights and Provider Obligations training for all staff

FSR Performance	2021-2022	2022-2023	Difference
Access & Safety	96%	95%	-1%
Personnel	94%	92%	-2%
Office Management	98%	98%	0%
Clinical Services	95%	97%	2%
Preventive Services	97%	97%	0%
Infection Control	97%	95%	-2%

Medical Record Reviews

Format and documentation domain scores for the Medical Record Review (MRR) remained fairly high – within the 90th percentile range. The number of Adult and Pediatric Preventative measures were greatly increased with the release of the 2022 MRR Tool. Partnership has been working with sites to understand the new guidelines and where specific improvement is needed.

Pediatric Preventive Health most commonly missed points:

- Fluoride Varnish
- Fluoride Supplementation
- Tuberculosis Screening
- Blood Lead Screening
- Pediatric Immunizations
- Initial Health Appointment

Adult Preventive Health most commonly missed points:

- Adult Immunizations
- Tuberculosis Screening
- Depression Screening
- Folic Acid Supplementation
- Initial Health Appointment

MRR Performance	2021-2022	2022-2023	Difference
Format	99%	97%	-2%
Documentation	94%	94%	0%
Coordination of Care	97%	97%	0%
Pediatric Preventive	85%	81%	-4%
Adult Preventive	78%	77%	-1%
OB Preventive	94%	97%	3%

Certified Site Reviewers address areas identified from the review tool that do not meet the DHCS guidelines at the time of discovery during the Site Review. Partnership nurses also use this time to provide educational feedback to provider staff (i.e., handouts on TB risk assessments, reviewing the IHA and any barriers faced by the provider). For some areas, as required by the Site Review protocol, corrective action plans (CAPs) are issued to the provider. An interim assessment is also conducted at the mid-point of the next scheduled review. The interim assessment covers all Critical Elements and any additional CAP criteria from the sites last review (if applicable).

Provider Billing Guide

As part of the FY 22/23 Department SMART Goals, the Inspections Team joined with the Claims team to create a new provider billing guide to assist sites in correctly coding for preventative services. The guide consists of three sections covering Adult, Pediatric and OB preventative services. The billing guide lists the preventative services from the Medical Record Review (MRR) Site Review tool and includes demographics along with the corresponding billing codes. By supporting providers to use the proper billing codes, providers will be able to better demonstrate completion of preventative services required by quality measures and the DHCS Site Review Tools. PCP sites and OB sites are provided with laminated copies of this guide at the Site Review exit interview. (Providers have given us positive feedback and have asked for additional copies of the billing guides to assist their site in better billing practices).

Provider Educational Trainings

Site review measures correspond to priority quality measures defined under the DHCS Managed Care Accountability Set (MCAS) as well as those required for reporting and scoring under NCQA Health Plan Accreditation. Providers are encouraged to engage in educational sessions to drive improvement throughout the communities they serve. Partnership offers educational sessions as needed to our provider network through various forums.
Providers are offered 1:1 educational training sessions with a Certified Site Review Nurse (CSR RN) at every Site Review. Education is provided as requested. Educational offerings are provided through multiple forums such as provider newsletters, the PHC website and regional meetings. Trainings are tailored to each specific site to assist sites with overcoming barriers and to provide best practices.

In anticipation to the new Site Review tools, PHC emailed and offered education to PCP offices focusing on the new 2022 Site Review Tool changes as well as the Initial Health Appointment (IHA). As part of the FY 22/23 Department SMART goal, the inspections team was able to complete 15 individual educational sessions. This is in addition to the education provided at every Site Review exit interview. Partnership will continue to offer 1:1 educational sessions to sites to help support our provider network to be successful.

Improving Blood Lead Screening

Consistent with APL 20-016, Partnership's FSR and Performance Improvement teams have regularly educated providers on Blood Lead Screening (BLS) and anticipatory guidance for all children ages 6 months to 6 years. The Pediatric focused QMSI workgroup meets monthly to discuss pediatric measures. A Lead Sub-Committee was formed from this group to help drive BLS improvement measures. The Lead Sub-Committee has been working with sites to identify and share best practices throughout the network and to also identify both execution and compliance with screening. Partnership hopes to identify areas where we can assist providers (i.e., potential funding for point-of-care testing machines). Identification of all possible options for testing, including engaging public health laboratories, is in process.

Blood Lead Screening flyers are given as part of an educational packet at every Site Review. Education is provided 1:1 while on-site during the Site Review exit interview process. Formal education is also offered through various avenues such as provider newsletters, member facing newsletters, webinars, Partnership's website, etc. Providers regularly receive updated lists of members eligible for BLS testing with the expectation they will use the lists to increase testing. Partnership is currently looking into a process to assist providers in obtaining BLS testing equipment to perform sample collections and/ or testing at their own office so patients do not have to go to a lab. Members also receive notifications and reminders through various sources such as member newsletters, Partnership's member website, mailings, community events, etc.

Physical Accessibility Review Survey

(PARS), aka Part C Review

The purpose of the Physical Accessibility Review Survey is to assess provider sites' physical accessibility for Partnership's seniors and persons with disabilities (SPDs) using a set of standards approved by DHCS. Results from the reviews are made available to Partnership's members through its website and provider directories. The findings of these reviews are informational only. Providers are designated as having either "Basic Access" or "Limited Access."

- Basic Access: Indicates that the facility met all 29 critical elements that identify a site's capability of accommodating SPDs
- Limited Access: Indicates that the facility does not meet one or more critical element related to the six indicators listed below:
    - Parking
    - Interior Building
    - Exterior Building
    - Restroom
    - Exam Room
    - Medical Equipment
- Medical Equipment Access: PCP sites only. Demonstrates if a site has a height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus a patient)

PARS Results for PCP and Specialist Offices July 1, 2022-May 23, 2023

Access Level:	OB	PCP	SPC	Grand Total
Basic	13	52	4	69
Limited	16	61	25	102

Due to the public health emergency, we were unable to conduct new PARS reviews during 2020 and part of 2021.We are now current on all PARS that were postponed previously due to the public health emergency.

Initial Health Appointment

The DHCS contract requires PHC to cover and ensure the provision of an Initial Health Appointment (IHA) to each new member within 120 days of enrollment in the health plan. DHCS released APL 22-030 on 12/27/22 with new guidance on the IHA. The IHA includes a history of the member's physical and mental health, an identification of risks, an assessment of needed preventive screens or services and health education, and the diagnosis and treatment plan of any diseases. Provider sites are required to document attempts to reach members who missed their scheduled IHA and to ensure that all new members are seen by their provider within the 120 day timeframe.

Providers are educated on the IHA through Provider Newsletters, regional meetings and at Site Review visits. Additional educational trainings are offered at every Site Review exit interview and through various forums. Providers are given a monthly list of newly enrolled members, enabling and reminding providers to reach out to these members to schedule their IHA within the 120 days. Members also receive a letter encouraging them to complete their IHA. Newly enrolled members are also encouraged to contact their newly assigned PCP to complete their IHA if the member calls Partnership.

Internal and external quality improvement committees review the results of completed Site Reviews, including the review of IHA compliance, at least annually. This allows an opportunity to provide constructive feedback regarding existing processes. In addition, an IHA Collaborative meeting is held biannually to discuss interdepartmental IHA activities. Multiple Partnership departments are a part of this collaborative process.

The methodology for determining IHA compliance is used to better identify the members in the denominator. The two instances a member would populate in the denominator would be:

- Brand new member to the health plan
- A previously enrolled member's first month back to the plan, who wasn't continuously enrolled for 120 days in the past eight months, prior to the new member month

For example, if a previously enrolled member's first month back, establishing membership with the plan was August 2022, Partnership would look back from December 2021 – July 2022 to see if the member was continuously enrolled for 120 days (IHA final denominator eligible) at any point. If they were, they would be excluded (would have been captured previously), and if they were not, then, they would be due for a new IHA between August 2022– November 2022 (120 days)

Partnership is currently working on strengthening our internal data analysis by reviewing coding and reporting procedures.

Due to the difficulty of achieving a high rate of success in this measure, Partnership continued efforts to influence performance on a provider-by-provider basis through the site review process.

Improvement Activities

- **Efforts Made During Site Reviews:**
    a. A focused audit is planned for FY 23/24 in addition to the members reviewed in a typical Medical Record Review (MRR). Clinical Compliance Inspectors will assess for a completed IHA for members in their first 120 days. A Corrective Action Plan (CAP) will be issued to providers that do not meet APL 22-030 standards. Sites will be educated on improvement methods as needed.
    b. Sites receive a monthly list of new enrollees and are educated to document their outreach attempts to new members. If they attempted contact three times and documented each attempt, they are compliant for that member. Partnership provides spreadsheets for the sites to document their efforts, as many sites do not wish to open a new chart before the member is actually located and establishes care. These spreadsheets are reviewed during the Site Reviews.
- **Miscellaneous Continuous Efforts:**
    a. The Site Review Team worked with Provider Relations and Member Services departments to increase efforts to inform members and providers of the need for members to come in for the IHA. A collaborative meeting is held quarterly.
    b. Newsletter articles: Information continues to be shared through our Provider and Member Newsletters. These articles are available on the Partnership website.
    c. IHA Provider education is available on the Partnership website including a webinar for Providers.
    d. Newly credentialed providers are educated on the IHA requirement and a new member packet is sent to members informing them of the importance of an IHA.

Delegation Oversight

Partnership's oversight of QI activities delegated to DHCS subcontractors/NCQA Delegates is reviewed and approved at least annually by the Delegation Oversight, IQI, and Q/UAC Committees. A delegation agreement, including a detailed list of activities delegated and reporting requirements, is mutually agreed upon by Partnership and the entity. Currently Partnership contracts with two entities, Carelon (formerly known as Beacon Health Options) and Kaiser Foundation Health Plan to administer non-specialty mental health consistent with NCQA standards.

Latent TB Infection – 12 Dose Treatment

The Pharmacy department led an intervention to track, monitor, and evaluate member adherence to the 12-dose Latent Tuberculosis Infection (LTBI) treatment regimen. The goal was to identify and address gaps in the LTBI 12-dose treatment regimen resulting from non-adherence, inappropriate prescribing, and/or identified medication dispensing issues. A health plan clinical pharmacist retrospectively identified members who were non-adherent to their 12-dose treatment regimen (consisting of Isoniazid and Rifapentine) for LTBI and notified the treating clinician of the member's gap in therapy or failure to complete therapy.

A total of 20 provider notifications were sent on May 4, 2023 via fax with health plan findings and to address the identified concerns with the member's non-adherence to the prescribed treatment. After each fax, the pharmacy department called to confirm the office received the fax.

Of the 20 prescriber notifications sent, two (2) members restarted LTBI therapy and are pending completion of LTBI therapy. The other 18 outstanding notifications will be monitored for restart or change in therapy through June 30, 2023. Though the goals for identification and notification of treatment gaps were met, only two out of the 20 identified treatment gaps at this time resulted in the desired outcome for restart and completion of LTBI therapy. One possible reason for the low rate of restart or change in LTBI therapy may be due to the retrospective process for identifying incomplete therapies. To increase the desired outcome of completion of LTBI therapy for fiscal year 2023-2024, the clinical pharmacist will review medication claims weekly for new starts of LTBI treatment to monitor for adherence and completion. We believe a concurrent review for non-adherence will create a more timely notification and increase prescriber response to address treatment gap vs the previous retrospective review and notification process.

As needed, the health plan pharmacy technician or clinical pharmacist will also contact the dispensing pharmacy to assist with coordinating Isoniazid and Rifapentine refills or identified inappropriate dispensing.
The clinical pharmacist will continue to track LTBI therapy gap and non-adherence as well as validate pharmacy claim data from Medi-Cal Rx. Pending data sharing agreements (DSA) with county health departments, Partnership's Pharmacy intends to expand LTBI monitoring from the current LTBI 12-dose treatment regimen to all LTBI treatment regimens. Partnership has also proposed to the California Department of Public Health (CDPH) that it consider an interface between the MediCalRx prescription data with CalREDIE, the health information and management system used by County Public Health departments and CDPH. They are exploring this option further. If CDPH does this, it will remove the need for PHC to independently monitor TB and LTBI treatment compliance.

Quality in Member Experience

QI TRILOGY

Care for Members with Complex Needs and Community Partnerships

Care for Members with Complex Needs

With the goal of improving HEDIS rates for PPC-Pre, PPC-Post, W15, and to comply with California AB2193 (Maternal Mental Health Screening, 2018), PHC's Care Coordination department decided to review and revise the Growing Together Program to reflect AB2193 for maternal risk of depression screening and continued focus on HEDIS measures to support and reinforce maternal participation in prenatal and postpartum appointments, obtaining well-child exams for children within the first 15 months of life, and encourage members to take advantage of mental health services during and after pregnancy. Screening tools were developed in 2021 to work with women who are progressing with a healthy pregnancy and well babies, and the team worked to improve early identification of pregnant women in 2022. When the team identifies a pregnant, postpartum, or baby that might need additional services, the team will submit a referral into Care Coordination for case management.

Complex Case Management

PHC's Care Coordination (CC) Department has updated necessary Complex Case Management (CCM) activities to meet the DHCS and new NCQA requirements for continuous compliance and improvement. NCQA has released a new online auditing tool that the CC department with the assistance of the NCQA Team has attained access to ensure that cases are meeting compliance with the new NCQA Auditing Tool. CCM Cases are being audited continuously to ensure compliance with NCQA standards and identify further training and tools to support staff, primarily Nurse Case Managers or Social Workers who perform the CCM assessment. The CC Department has performed pilot studies on December 2022 to determine how to increase CCM program reaches and what recommended strategies the staff can use to identify members that fit for the CCM program. CC Department has collaborated with PR to send a fax blast regarding the CCM program on January 2023. On September 2022, CC Department has also attached the CCM Flyer with the PHC Contacts Mailing when sending out information to members and on May 2023 the PHC Website was updated with Care Coordination information to further increase CCM program visibility. The CC Department continues to ensure that they are survey ready with their CCM programs and services and would continuously promote CCM program to the members.

Community Resource Web Pages

Partnership has recognized that community resources provide significant support to its member population and their health and well-being. In December 2018, PHC's Population Health Team created web-based community resource pages that show the various resources available in each county by resource type. New resources are added to the existing pages as they are identified. The community resources pages are organized by county and use pictographs and titles to be mindful of readability and education-level, ensuring easy access for all literacy levels. The Population Health Team validates all resources pages no less than annually, and shares county resource page web links with providers, members, and community-based organizations to promote the programs and services offered within a member's community.

Services and Patient Experience

A vulnerable time for a member is when they are transitioning across settings. Care Coordination's Transitions of Care Program (TOC) continues to assist members in transitioning across different settings (hospital to home or other levels of care), across benefits (exhausting residential treatment service benefits for substance use disorder or transitioning from curative care to hospice care), or transitioning from pediatric to adult care. Care Coordination have reports in place to identify members that have been discharged from the hospital with a length of stay longer than five days, and complex members that are transitioning from pediatric to adult care. Members are vulnerable to lost information across the care continuum, fragmented care, and may have difficulty navigating the health care system. Case leads offer assistance in connecting members with outpatient resources, clarifying prescriptions, educating on benefits and available resources, and establishing/re-establishing care with providers. Age specific assessments are utilized to ensure the complexity of age-specific needs are not left neglected.

103 Adult TOC Satisfaction Surveys were completed between January 1st and December 31st, 2022. The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Adult TOC Satisfaction Survey. The average score ranged from the lowest at 2.79 to the highest at 3; above the goal average of 2.5. The results of the Adult TOC surveys reveal a high satisfaction rate amongst the members surveyed. Our Adult members report good outcomes with this program and we will continue providing this benefit.

Survey Questions	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my health issues.	2.94	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager)	3	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.91	Yes
After working with the case management team, I feel my ability to manage my healthcare needs is better.	2.91	Yes
My health has improved since working with my case management team	2.95	Yes
I was able to safely transition between Providers with the help of my Care Team	2.88	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with my case management team.	2.79	Yes
I was provided the available equipment, medication and/or services that were needed.	2.94	Yes

95 Pediatric TOC Satisfaction Surveys were completed between January 1st and December 31st, 2022. The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Pediatric TOC Satisfaction Survey. The average score ranged from the lowest at 2.85 to the highest at 2.99; well-above the goal average of 2.5. The results of the Pediatric TOC surveys reveal a high satisfaction rate amongst the members surveyed. Families report good outcomes with this program for our Pediatric members and we will continue providing this benefit.

Survey Questions	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my child's health issues.	2.99	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	2.99	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.95	Yes
After working with the case management team, I feel my ability to manage my child's healthcare needs is better	2.93	Yes
My child's health has improved since working with our case management team	2.87	Yes
I was able to safely transition my child between Providers with the help of my Care Team.	2.87	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	2.85	Yes
My child and I were provided with the available equipment, medication and/or services that were needed.	2.98	Yes

Housing Grant

In 2022, Governor Newsom and the Department of Health Care Services (DHCS) created the Housing and Homelessness Incentive Program (HHIP). HHIP is a State initiative that allows PHC and it's 14 counties the possibility of earning up to $89 million for projects relating to housing and homelessness. In order to earn funds, DHCS state-set targets must be met by working with each Counties' Continuum of Care (CoC). Many of the targets pertain to CalAIM; others to our ability to effectively collect and share information on the housing status of our members, and perhaps the most difficult to achieve measures related to measurable reductions in the number of persons experiencing homelessness, and increases in the longevity of those that are housed staying housed.

Many PHC departments are involved in the HHIP program, including the ECM/CS teams, Population Health, IT, PMO and the Regional Directors. A new Associate Director was hired to take the lead in collaborating with the counties and their COCs.

As of May 2023, PHC has received a total of $12,127,995 of the HHIP funds which have been disbursed to counties based on their Local Homeless Plan (LHP) allocation. PHC has distributed another $640,000 to fund providers thru Street Medicine and Outreach grants to build capacity in Street Medicine and Outreach services. This funding will be matched by many of the counties to assist with meeting the Street Medicine/Outreach HHIP Measure as defined by DHCS.

The counties/CoCs are focused on the following areas to meet HHIP Measures:

- Service Coordination: PHC is working with the county and the CoCs to identify the CalAIM services that should be reimbursed as well as coordination of both HHIP funding with CalAIM services.

- Permanent Supported Housing Services: PHC is working with the CoCs and the counties on reviewing current capacity as well as how to expand and build capacity of these services under HHIP, HHAP and federal grant funding.
- Emergency Shelter: The county and CoC continue to analyze ongoing need for emergency shelter investments and the degree to which these needs might be minimized through the expansion of other housing activities and the collaborative focus on prevention of homelessness. HHIP funding is used to the degree that investments are needed. PHC is also working with the partners to identify potential grant or other funding sources to sustain these services.
- Rapid Rehousing: While these services are provided to a lesser extent, the CoCs are reviewing expansion of Rapid Rehousing using HHIP and other sources of funding.
- Interim Shelter Support: CoCs continue to analyze the ongoing need for interim shelter investments and the degree to which these needs might be minimized through the expansion of other housing activities and the collaborative focus on prevention of homelessness.
- Shelter Improvements: HHIP funding is used to support these improvements.
- Street Medicine: PHC is working with providers to build capacity to provide services to current unsheltered, unhoused members where they live. In June 2023, PHC used a portion of the HHIP funding to award grants to street medicine providers to help with capacity building. The counties have agreed to match the grant award with their HHIP funding to help support these providers and the street medicine programs.
- Data Infrastructure/Systems Support: HHIP funds are being used to fund data sharing and data infrastructure activities so that Homelessness Management Information Systems (HMIS) data can be shared between PHC and the CoC/County. Some HHIP funds are being used to support updates to county Coordinated Entry Systems (CES).

The HHIP grant ends after the final submission of Measurement 2 data October 31, 2023 with final payment to occur in March 2024.

Access to Care

Annually, PHC collects data from a variety of sources to evaluate all aspects of information related to Network Adequacy to ensure PHC provides members with adequate network access for needed healthcare services. The provider types covered include primary care clinicians, medical specialists, pharmacies and hospitals. PHC follows both the DHCS and NCQA requirements. A detailed analysis of access to care data is included in the Assessment of Access and Availability (NET 3) Grand Analysis Report, included in the Appendix (A). The following provides a preliminary high level summary of the data available to date.

Analysis was conducted in collaboration between the Quality Improvement, Provider Relations, and Health Analytics teams. Based on opportunities identified, interventions are defined and measurable goals are set, to improve network adequacy.

The schedule for annual data collection and analyses of access to care data sources follows a timetable that spans several months. The results are available later in 2023 and included in the Plan's Network Management Grand Analysis Report. The following access to care findings reflect information included in the 2022 Network Management Grand Analysis Report.

- **Member Grievances**
  For the reporting period of January 1, 2021 through December 31, 2021, PHC did not meet the goal of less than 1.19 access grievances reported per 1,000 members. As COVID-19 continued to impact providers' availability to see patients, PHC experienced an 45% increase in access related grievances.
- **Member Appeals**
  For the reporting period of January 1, 2021 – December 31, 2021, PHC did not meet the threshold of less than or equal to 0.15 per 1,000 members for access to care appeals and second level grievances. PHC had 77 more total Appeals and Second Level Grievances in 2021 than in 2020 resulting in an increase of 32%.
- **Out of Network (OON) Requests**
  For the period of March 2021 - February 2022, as a plan, PHC met the goal of less than 20 per 1,000 members for referrals. The data on out-of-network referrals by specialty type shows 73.1% of total out-of-network referrals are to a specialist. This is a 13.5% decrease from 2021.When breaking the referrals down by county we see a higher rate of referrals coming from Modoc, Siskiyou, Del Norte, and Lassen. These counties are considered rural and border Oregon which often times require out of network requests to specialists which don't exist in the rural counties. Rural counties often are limited in specialty types because the patient population is too small for a specialist to maintain a viable practice.
- **Practitioner Availability (Ratio and Geographic Availability)**
  - *Measured through the 2022 Network Adequacy Report Availability of Practitioners (NET 1, Element B, C).* Primary Care Practitioners overall, Family Practice, and Pediatrics all achieved a "met" score for number of practitioners to members for the reporting period. Although PHC experienced a 4.7% increase in total membership as compared to 2021, it has been able to maintain access to primary care for all ages by the addition of 11 new Family Medicine Physicians to the network. The Provider Recruitment Program provides incentives for Primary Care practitioners to join our network and PHC is actively recruiting for all categories of Primary Care, specifically in our rural areas that traditionally have a lower number of providers. The six high volume specialties utilized by members remained unchanged from last year (2021). The six specialties include; Obstetrics/Gynecology, Cardiology, General Surgery, Orthopedic, Ophthalmology, and Dermatology. Plan-wide, the provider ratio standards and geographic distribution for all high volume specialist providers were met. No plan-wide interventions are indicated.
  - Plan-wide, the provider ratio standards and geographic distribution for all high impact specialist providers were met. No plan-wide interventions are indicated.
- **Practitioner Accessibility (Appointment Time Standard)**
  Measured through the 2022 Third Next Available Appointment Provider Survey
  - Plan-wide, all availability standards were met for all categories of primary care providers.
- Plan-wide, we met our > 80% performance goal for all high-volume specialties except one. Ophthalmology fell outside the appointment standard in two rural northern region counties.
- **Member Experience**
  The 2021 -2022 CAHPS Composite Scores taken from the ME7 CAHPS Results Report revealed a marked drop in scores for adult respondents in both categories of "Getting Needed Care" and "Getting Care Quickly". Although PHC received 53 more completed surveys than in Year FY 2020-2021, the higher sample size contributed to a lower response rate by 1.9%. Results from the ME7 Report Child Response showed a decrease in "Getting Care Needed" while "Getting Care Quickly" increased from the previous

year. PHC received 22 more completed surveys than in Year 2020-2021, with that said, the higher sample size contributed to a lower response rate by 2.9%.

Member Services Access

Member Services (MS) monitors and analyzes call center performance internally and with our delegates based on industry standard service level agreements:

- 80% of calls answered with in 30 seconds
- 30 second average speed of answer
- 10% or less abandonment rate (the amount of calls that drop once connected with a respective support queue)

In addition, Member Services monitors and analyzes delegate call center performance which are submitted for review quarterly from our delegates where Partnership tracks and trends against established performance thresholds reporting out through our delegation oversight meetings (DORS). The delegates that are in MS purview are:Kaiser, Carelon (formerly Beacon), MTM (during this reporting year), and Carenet.

For the reporting year, all delegates with the exception of Carenet consistently met performance standards which prompted a corrective action plan that is actively being addressed and Carenet has shown marked improvement.

To further support the course correction for Carenet, MS has established a joint operation meeting with Care Coordination who oversee the Nurse Advise Line (NAL) piece of the partnership and have identified an opportunity for Carenet to report cleaner stats by breaking out reporting by afterhours support vs NAL.

Opportunities for Improvement

PHC recognizes the ongoing issue regarding access to primary and specialty care in our rural northern counties. While some members were outside the time or distance standards for primary care, specialty care, and hospital services, this is not due to lack of contracting with an available service provider. There are no qualified providers who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. PHC requests and receives approval for Alternative Access Standards (AAS) on an annual basis for the geographical areas that fail to meet the standard. If a member lives in an area where services are not covered, PHC will help those members with making the appointment and arrange transportation to see the specialists that are not within the time or distance standard.

Activities to Improve Access

Primary Care Initiatives

- Primary Care Pilot: for Adoption of Direct to Member Telehealth services with TeleMed2U. The Team plans to conduct a pilot with three primary care clinics to achieve a 5% adoption of Direct to Member specialty visits using baseline visit data from 2020. The project will include selection of pilot sites, development of grant documents and deliverables with a planned start date of July 1, 2022 or sooner.
- Continue support of our primary care recruitment program in the northern regions and evaluate the additional recruitment of Nurse Practitioners and Physician Assistants to Primary Care practices with a focus on Family Medicine to increase access.
- Continue support of the primary care QIP program to maintain the current primary care network.

- Work with primary care providers to ensure only appropriate referrals are issued and support eConsult expansion in order to access specialists for consultations.
- Leverage transportation benefits to help members get to available practitioners in their area.

Specialty Access Initiatives

- Telehealth Specialty Provider Assessment: The Team will select five specialty physicians who provided at least 20% of outpatient visits to PHC members via telehealth in the past year. Interviews with these providers will help PHC learn more about how telehealth was used during the pandemic, understand the barriers to staff and patient adoption of this mode of care and determine their future plans for use of telehealth will be in a post pandemic environment.
- Provider Specific Access Plan: The Team will develop a provider specific improvement plan with at least one provider by analyzing specialty use rates, wait times for specialty appointments and member satisfaction rates using clinic-specific information The framework for this project may be utilized as a template for work with other clinics in the future.
- Evaluate Additional eConsult Provider: The Team will evaluate the implementation of a pilot project with RubiconMD. The evaluation will include financial and operational impacts of offering an additional eConsult vendor to one or more PHC providers. The Team will work with RubiconMD to define the parameters of the pilot and present recommendations to the Executive Team for a "proceed/don't proceed' proposal by December 31, 2021.
- Leverage transportation benefits to help members get to available practitioners in their area.

CAHPS® Program | Member Experience

Overview

Partnership HealthPlan of California (PHC) measures the Member Experience through monitoring of annual regulated and non-regulated surveys, and grievance and appeals reporting. The Member Experience and respective quality outcomes are driven and measured by interdepartmental health plan coordinated efforts that support operational and strategic member and provider-focus activities. Our commitment to ensuring our members receive high-quality healthcare services and excellent customer service directly aligns with PHC's mission and vision.

In 2021 PHC achieved National Committee for Quality Assurance (NCQA) Accreditation. The organizational commitment to quality is rooted in our mission. The method and accreditation requirement for how our members rate our service is through an annual survey regulated by the **CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®)**.

The survey and member experience analysis of PHC health plan delivery and identification of improvement opportunities cover the Measure Year MY 2021, and Reporting Year RY 2022. The analysis herein will interchangeably reference this period as measure year, or MY 2021-2022. Also included in the evaluation is the 2022 Grievances and Appeals Annual Report, and the continuous monitoring of complaints, grievances, and appeals data through the end of fiscal year FY 2022-2023.

Our Approach to Analysis

The applied methodology includes qualitative and quantitative analysis of current and prior CAHPS® MY 2021-2022 survey responses, internal member-reported data, sector trends, and benchmarks.

Medicaid Healthcare Health Plan Trends

PressGaney, formerly known as SPH Analytics is an industry leader with more than thirty years of CAHPS® survey project management, and analytic reporting experience. Managing a Health Plan company book-of-business (BoB) portfolio includes more than 80% of our nation's Medicare, Medicaid, and Managed Care Health Plans (MCP) products.

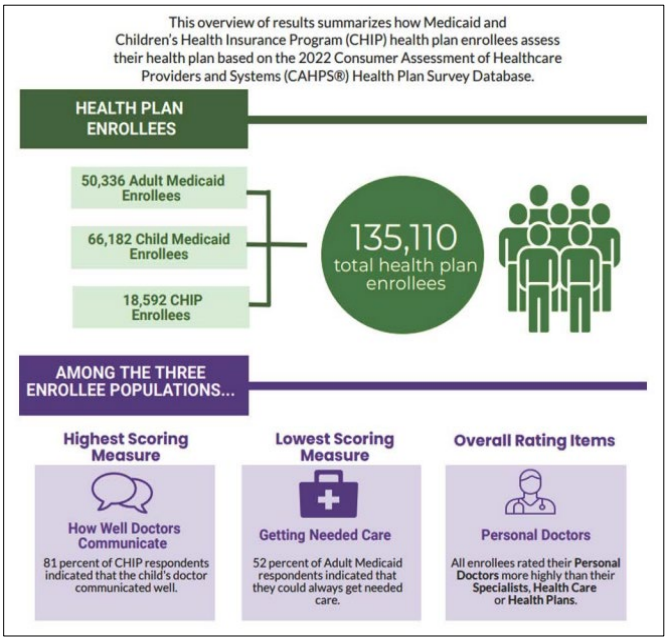
PressGaney completed a thorough CAHPS® 5.1 H portfolio data analysis of their administered MY 2021Medicaid Adult and Child samples, survey responses include 169 Plans / 39,089 respondents. Their analysis compares the current PHC HealthPlan respondent rate and measures performance against our year-over-year performance, HEDIS®, and PressGaney book-of-business (BoB) benchmarks. The SPH Analytics BoB is used to monitor health plan trends by comparing side-by-side aggregate scores over the past four years.

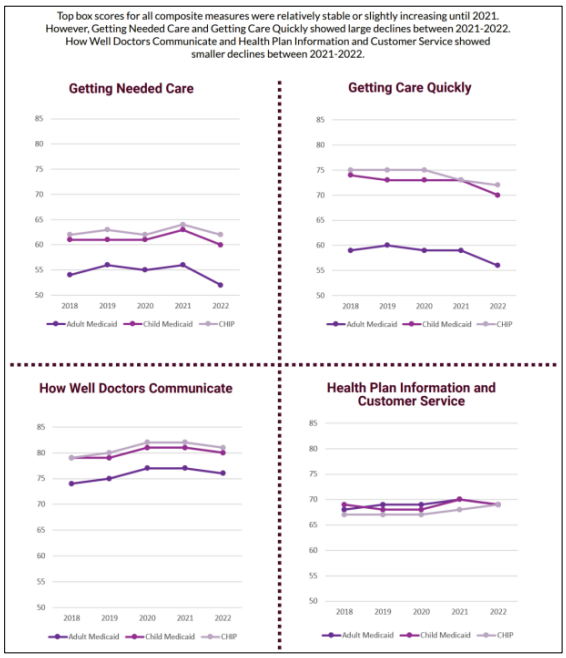
MY 2021-2022 Trend Highlights

- **COVID-19 Impact:** The pandemic caused significant disruption throughout most of 2020 and continues through today. The disruption is reflected in the variation we've seen in health system experience scores over the last few years.
- **Medicaid Adult Population:** Among the Medicaid Adult population, several measures declined by more than 1% compared to last year. The biggest decreases were in the ***Rating of Health Care, Getting specialist appointments, and Getting urgent care.*** These noted declines correlate to Partnership MY 2021-2022, ***Getting Needed Care, and Getting Care Quickly.***

- **Medicaid Child Population:** Among the Medicaid Child population, several measures declined by more than 1% compared to last year. The biggest decreases were in the ***Rating of Health Care, Getting specialist appointments, and Getting needed care.*** These noted declines correlate to Partnership MY 2021-2022, ***Getting Needed Care.***

Analysis includes the use of the Agency for Healthcare Research and Quality (AHRQ) 2022 Health Plan Survey Database, chart book. This external source provides insight into the enrolled nationwide Medicaid population. Infographics are shown in the tables below. According to analysis performed by consultant, ZAHealth, the AHRQ chart book median Medicare/Medicaid response rate dropped from 64% in 2010 to 35% in 2021, and hypothesized that half of the respondents are Medicaid enrollees.





To view the full 2022 chart book: *https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2022-hp-chartbook.pdf*

Medicaid Healthcare Sector Conclusions:

The survey data indicates a post-COVID lag in service delivery derived from CAHPS® survey responses. Noted, the AHRQ chart book declining composite measure are similar areas of focus to the PHC MY 2021-2022 CAHPS® scores; ***Getting urgent care,*** and ***Getting needed care,*** both scored lower relative to pre-COVID scores. Similarly, the PressGaney BoB Medicaid Adult and Child population noted that several measures declined by more than 1% compared to MY 2020-2021. The biggest decreases were in the ***Rating of Health Care***, ***Getting specialist appointments***, and ***Getting urgent care***.

Most scores rose at the beginning of the pandemic, but ***Rating of Health Plan and Coordination of Care*** are the only measures still rated at least 1% higher than they were in RY 2019. ***Getting urgent care and Flu Vaccine*** are both 3% lower than their RY 2019 scores. While the Child composite score, ***Getting Care Quickly*** is an area of concern, with the 2022 composite score 3.6% lower than it was in RY 2019. Most of that comes from a more than 6% drop in the ability to get routine care from its high point in RY2020, at the beginning of the COVID pandemic.

Member Experience Data

The data collected through regulated and non-regulated surveys coupled with member-filed grievances and appeals provide insight into our health plan delivery system. These sources provide indicators of member satisfaction or dissatisfaction.

CAHPS®

The survey sample frame size includes qualifying Adult and Child member populations. Each member must have continuous PHC primary coverage for the prior year, 6 months (July 1st – Dec 31st), and have been treated by a contracted provider within our network. ***Annual survey results provide a retrospective data set on key NCQA ratings and composite measures.***

Grievances and Appeals

The Grievance & Appeals (G&A) Department is responsible for investigating, monitoring, and reporting member dissatisfaction regarding their experience with Partnership's Medi-Cal plan. Routine G&A reports shared internally and externally provide present insight into service dissatisfaction.

CAHPS® Survey Methodology

As illustrated in the table below, the survey applies a mixed-method protocol in English and Spanish language formats to solicit and encourage our members to participate in the CAHPS® survey, including mailers, online survey, QR-Code smart device access, and reminder phone calls. The survey period occurs between the months of February through May each year.

			
Letter/Questionnaire Month One: 1st Mailer Month Two: 2nd Mailer	Reminder and Follow-up calls for non-responders Month Two: Reminder Call Month Three: Follow-up Calls	Online Survey	QR-Code Smart Device Access for Online Survey

CAHPS® MY 2021-2022 Survey Results

Initial MY 2021 / RY CAHPS® survey analysis, intervention pre-planning, and collaboration between the Quality Improvement (QI) and Member Services (MS) Departments included a thorough transition of survey administration and documentation of processes.

The annual CAHPS survey administered in 2022 to cover member experiences through dates of service in 2021. Analysis and evaluation included a combination of external and internal data sources coupled with key stakeholders and senior leadership guidance to improve the member experience through improvement activities and interventions.

Respondent Rate Trending

Internal stakeholders analyzed the MY 2021-2022 CAHPS® survey results for Adult and Child populations. The strategy to oversample in both populations, Adult 100%, and Child 150% did not yield the desired respondent rates. Survey participation is a noticeable declining trend with the PressGaney BoB and AHRQ Medicare/Medicaid chart book rates.

Adult			
PressGaney BoB Survey Responses			
2020	2021	2022	Trend
15.5%	14.8%	12.2%	
PHC Survey Responses			
15.0%	16.0%	14.1%	

- Adult: Oversample size of (2,700-66 ineligible) responses, 372 completed 14.1% (2,634/372) compared to prior MY 2020-2021, 16.0%.

Child			
PressGaney BoB Survey Responses			
2020	2021	2022	Trend
12.6%	12.8%	10.2%	
PHC Survey Responses			
16.5%	17.4%	14.5%	

- Child: Oversample size of (4,125-69 ineligible) responses, 587 completed 14.5% (4,056/587) compared to prior MY 2020-2021, 17.4%.

Respondent Rate Analysis

- ❖ The BoB respondent rates for both populations continue to trend downward over the past three survey cycles.
- ❖ Relative to PHC respondent rates, the health plan performed above the average Press Ganey BoB rates (169 Plans). *For two of the three adult survey cycles, and all three for child.* Conversely, rates have kept pace with reduced respondent rates comparing 2020 through 2022.

Performance thresholds used CAHPS® and HEDIS Quality Compass benchmark targets based on MY 2020-2021 performance for FY 2022-2023 performance targets. The rating measures and composite measures PHC target for measure year MY 2021-2022 was set at or above the 25th percentile. The CAHPS® measure composite, rating, and categories are shown in tables 1[a], and 1[b] below.

Table 1[a]: CAHPS® Composite and Rating Measure Targets

CAHPS COMPOSITE MEASURES	TARGET
Getting Needed Care	All rating and composite measures are: ≥ 25th percentile
Getting Care Quickly	
Getting Care Coordination	
Customer Service	
CAHPS RATING MEASURES	
Rating of Health Plan	
Rating of All Health Care	
Rating of Specialist Seen Most Often	
Rating of Personal Doctor	

Table 1[b]: CAHPS® survey results are measured against the eight CAHPS® composite categories listed below.

• Rating of Health Plan	• Rating of Health Care	• Rating of Specialist
• Coordination of Care	• Rating of Personal Doctor	• Getting Care Quickly
• How Well Doctors Communicate	• Getting Needed Care	• Customer Service

The MY 2021 CAHPS® survey results and measure performance on Rating and Composite Measures for the Adult and Child Surveys and measures below the 25th percentile are referenced in Tables 2 and 3 below.

Tables 2: Adult CAHPS® Composite - Adult Response rate 14.1%

	ADULT CAHPS Composite	2020-2021 (16% Response Rate) Sample Size 2,025 Total Returns 319	2021 Percentile Rate	PHC Benchmark	PHC Benchmark Met?	2021-2022 (14.1% Response Rate) Sample Size 2,700 Total Returns 372	2021 Percentile Rate	PHC Benchmark	PHC Benchmark Met?
Rating Measure	Rating of Health Plan (% 8, 9, 10)	74.0%	15th	PHC ≥ 25th	NO	69.9%	<5th	PHC ≥ 25th	No
	Rating of All Health Care (% 8, 9, 10)	77.9%	61st	PHC ≥ 25th	Yes	70.0%	<5th	PHC ≥ 25th	No
	Rating of Personal Doctor (% 8, 9, 10)	84.0%	56th	PHC ≥ 25th	Yes	77.6%	6th	PHC ≥ 25th	No
	Rating of Specialist Seen Most Often (% 8, 9, 10)	81.3%	23rd	PHC ≥ 25th	No	82.3%	34th	PHC ≥ 25th	YES
Composite Measure	Getting Needed Care (% Always or Usually)	81.6%	33rd	PHC ≥ 25th	Yes	76.0%	7th	PHC ≥ 25th	No
	Getting Care Quickly (% Always or Usually)	80.3%	29th	PHC ≥ 25th	Yes	72.9%	5th	PHC ≥ 25th	No
	*Care Coordination (% Always or Usually) YR2020-2021 94 responses	88.6%	79th	PHC ≥ 25th	Yes	81.3%	15th	PHC ≥ 25th	No
	*Customer Service (% Always or Usually) YR2020-2021 94 responses	85.6%	9th	PHC ≥ 25th	NO	87.2%	25th	PHC ≥ 25th	YES

***N\A = Not reportable due to insufficient sample size (less than 100)**

Table 2: Measure Performance Comparison

The comparison table shown above illustrates Adult CAHPS® survey composite scores by measure years; MY 2021-2022, and MY 2020-2021.

- Adult Rating Measures compared to prior MY reflects a notable PHC benchmark **decrease** in three (3) out of four (4) in; ***Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor,*** and an **increase** in ***Rating of Specialist Seen Most Often.***
- Adult Composite Measures compared to prior MY are similar to rating measures, with a **decrease** in three (3) out of four (4) in; ***Getting Needed Care, Getting Care Quickly***, and ***Care Coordination***, and an **increase** in ***Customer Service.***
- Adult oversampling strategy contributed to meeting the reportable threshold of 100 survey responses for each rating and composite measure.

The Adult survey response relative to PHC-covered members indicates we continue to have dissatisfaction with member access which influences health plan ratings. Stakeholders determined that continued intervention focused on; ***Getting Needed Care and Getting Care Quickly*** composite measures and ***Rating of Health Plan*** would be in scope for the CAHPS® Score Improvement (CSI) Department Goal for FY 2022-2023.

Table 3: Child CAHPS Composite - Child Response rate 17.4%

	CHILD CAHPS Composite	2020-2021 (17.4% Response Rate) Sample size 3,300 Total Returns 565	2021 Percentile Rate	PHC Benchmark	PHC Benchmark Met?	2021-2022 (14.5% Response Rate) Sample Size 4,125 Total Returns 587	2021 Percentile Rate	PHC Benchmark	PHC Benchmark Met?
Rating Measure	Rating of Health Plan (% 8, 9, 10)	84.8%	26th	PHC ≥ 25th	Yes	82.2%	11th	PHC ≥ 25th	No
	Rating of All Health Care (% 8, 9, 10)	82.8%	6th	PHC ≥ 25th	No	83.7%	<5th	PHC ≥ 25th	No
	Rating of Personal Doctor (% 8, 9, 10)	87.2%	9th	PHC ≥ 25th	No	89.0%	26th	PHC ≥ 25th	Yes
	*Rating of Specialist Seen Most Often (% 8, 9, 10) YR2020-2021, 77 responses	79.2%	5th	PHC ≥ 25th	No	81.6%	6th	PHC ≥ 25th	No
Composite Measure	Getting Needed Care	80.7%	9th	PHC ≥ 25th	No	79.6%	10th	PHC ≥ 25th	No
	Getting Care Quickly	81.1%	5th	PHC ≥ 25th	No	84.1%	25th	PHC ≥ 25th	Yes
	*Care Coordination (% Always or Usually) YR2020-2021, 90 responses	84.4%	30th	PHC ≥ 25th	Yes	85.3%	34th	PHC ≥ 25th	Yes
	Customer Service	88.7%	45th	PHC ≥ 25th	Yes	89.4%	60th	PHC ≥ 25th	Yes

***N\A = Not reportable due to insufficient sample size (less than 100)**

Table 3: Measure Performance Comparison

The comparison table shown above illustrates Child CAHPS® survey composite scores by measure years; MY 2021 and MY 2020

- Child Rating Measures compared to prior MY 2020 did not meet or exceed the PHC 25th percentile target in three (3) out of four (4); ***Rating of Health Plan, Rating of All Health Care, and Rating of Specialist Seen Most Often***. Although the ***Rating of All Heath Care*** measure did not meet or exceed the PHC benchmark, an observed improvement is noted. Completing the rating measure set is an observed **increase of** over 1% in the ***Rating of Personal Doctor.***
- Child Composite Measures compared to prior MY 2020 did not meet or exceed the PHC 25th percentile benchmark in one (1) out of four (4) in; ***Getting Needed Care***, noted is a minimal **decrease.** ***Getting Care Quickly***, ***Care Coordination and Customer Service*** **met** or **exceed** the PHC 25th percentile target.
- Child oversampling strategy contributed to meeting the reportable threshold of 100 survey responses for each rating and composite measure.

  The Child survey responses relative to PHC-covered members indicates we continue to have dissatisfaction with member access and correlating impact to member experience which influences health plan ratings. Stakeholders determined that continued intervention focused on; ***Getting Needed Care and Getting Care Quickly*** composite measures would be in scope for the CAHPS® Score Improvement (CSI) Department Goal for FY 2022-2023.

2022 Grievances and Appeals (G&A) Data

There was a total of 3,338 closed G & A cases in calendar year 2022, compared to 3,387 in MY 2021. These cases are broken into two groups. Grievances which accounted for 2,556, and Appeals and Second Level Grievances, which accounted for 762. The G & A analysis attributes 1,055 (41%) of 2,556 closed grievance cases to be related to access, followed by 1,278 (50%) closed cases for attitude and service.

The G & A performance thresholds are set based on prior year performance, and targets are set at the level of each NCQA grievance and appeal category, and a summary threshold for annual performance was also established (see the second column of tables 4 and 5), this data represent all member filings within the 2022 calendar year. ***For additional details please reference Appendix H: 2023 First Quarter Grievance & Appeals Pulse Report.***

Table 4: Grievances Only

Grievances Only Reporting Period: Annual 2021 vs. 2022								
	Previous Period: 2021			Current Period: 2022				
NCQA Category	Grievances	Avg PHC Mship	Grievances p/1,000	Grievances	Avg PHC Mship	Grievances p/1,000	Threshold	Threshold Met?
Access	934	610,183	1.53	1,055	638,303	1.65	1.68	Yes
Attitude/Service	1,462	610,183	2.40	1,278	638,303	2.00	2.64	Yes
Billing/Financial	239	610,183	0.39	113	638,303	0.18	0.43	Yes
Quality of Care	71	610,183	0.12	105	638,303	0.16	0.13	No
Quality of Provider Office	39	610,183	0.06	4	638,303	0.01	0.07	Yes
TOTAL	2,745	610,183	4.50	2,555	638,303	4.00	4.95	Yes

G&A met the threshold for Access, Attitude/Service, Billing/Financial, and Quality of Provider Office-related categories for Grievances. However, the threshold was not met for Quality of Care (QOC) concerns, as G&A has seen a 67.6% increase in QOC Grievances cases in 2022, despite a decrease in overall cases.

Although our membership increased by 4.4% in 2022, from 610,183 to 638,303, the total number of cases filed per 1,000 members decreased from 4.50 to 4.00.

COVID-19 has continued to impact providers' availability to see patients through 2022. The most frequently reported QOC concern was regarding treatment plan disputes, which accounted for 58% of the cases.

Quality of Care	
# Reported Concerns	
PRV Service	81
RAF Process	15
The TAR Process	6
Scheduling Appt	2
DME	1
Total	105

For example, members disagreed with the provider's treatment plan to have them attend a methadone clinic, to be weaned off their pain medication. The member felt that because they only took three (3) Vicodin per day, this treatment plan was excessive.

Table 5: Appeals & Second-Level Grievances

Appeals & Second Level Grievances Reporting Period: Annual 2021 vs. 2022								
	Previous Period: 2021			Current Period: 2022				
NCQA Category	Appeals & SLG	Avg PHC Mship	Appeals & SLGs p/1,000	Appeals & SLG	Avg PHC Mship	Appeals & SLGs p/1,000	Threshold	Threshold Met?
Access	278	610,183	0.46	332	638,303	0.52	0.50	No
Attitude/Service	34	610,183	0.06	47	638,303	0.07	0.06	No
Billing/Financial	329	610,183	0.54	382	638,303	0.60	0.59	No
Quality of Care	0	610,183	0.00	1	638,303	0.00	0.00	No
Quality of Provider Office	1	610,183	0.00	0	638,303	0.00	0.00	Yes
TOTAL	642	610,183	1.05	762	638,303	1.19	1.16	No

Access, Attitude/Service, and QOC Appeals & Second Level Grievances (SLG) increased by more than 10%, due to the overall increase of cases. For example, QOC cases went from zero (0) cases in 2021, to one (1) case in 2022. It is also important to note that the total number of Appeals & SLGs increased by 19%, but membership only increased by 4.6%, thus causing the categories to exceed the threshold.

Considering membership growth, the total number of cases filed per 1,000 members increased from 1.05 to 1.19.

CAHPS® Score Improvement (CSI) Interventions

In FY 2022-2023, the goal-setting approach was slightly different to account for CAHPS® program development and organizational change from a team goal to a department goal structure.

Oversight of the CAHPS® survey transitioned from the Member Services to the Quality Improvement Department in December of 2022. This change was to better align with industry best practices and strategic pathway to excellence, by leveraging the strengths of the Quality Performance Improvement program and project management team. The program focus is to drive HEDIS measure and CAHPS® Score Improvement (CSI) through interventions and initiatives.

QI Department CAHPS® Score Improvement (CSI) Goal

The transition of CAHPS® survey oversight and administration to QI positioned the QI department to develop a programmatic-framework and lead intervention activities in collaboration with key stakeholders throughout the organization and QI Department CAHPS® Score Improvement (CSI) goal participants. The CSI department goal structure included four (4) separate workgroups as outlined in the table below.

Quality Improvement Lead ***CAHPS® Programmatic Oversight and Administration***	Office of CMO Medical Directors Regional Office	Human Resources T&D/Workforce Development	Population Health Management	Member Services
	Finance (Health Analytics)	Communications Community Relations/ Policy	Provider Relations	PMO/OpEx
CAHPS® Program Oversight Workgroup	Data Analytics Workgroup	Member Experience Workgroup	Access Workgroup	Total Participants
14	**17**	**14**	**19**	**42**

Survey analysis of current and prior measure years indicates a continued decline in health plan delivery member abrasion derived from low composite and ranking scores in Adult and Child populations related to Access, Health Plan Ratings, and Member Experience.

Measure outcomes of MY 2021/RY 2022 survey results influenced the CAHPS® Score Improvement goal this fiscal year which aims to address overall member experience, emphasizing improvement to equitable access to care. The approach included the implementation of short and long-term interventions, that target workforce development, expand primary care access and favorable member experience, and increase health plan branding and promotion.

In collaboration with key stakeholders and senior leadership, the QI department developed four (4) FY 2022-2023 department goals and respective milestones. A participant-diverse and cross-department reach produced productive workgroup outcomes under one goal - to improve the Member Experience. A summary of each goal and accomplishment by the workgroups is shown in the table below.

Workgroup	Accomplishments
CAHPS® Program Oversight Workgroup	

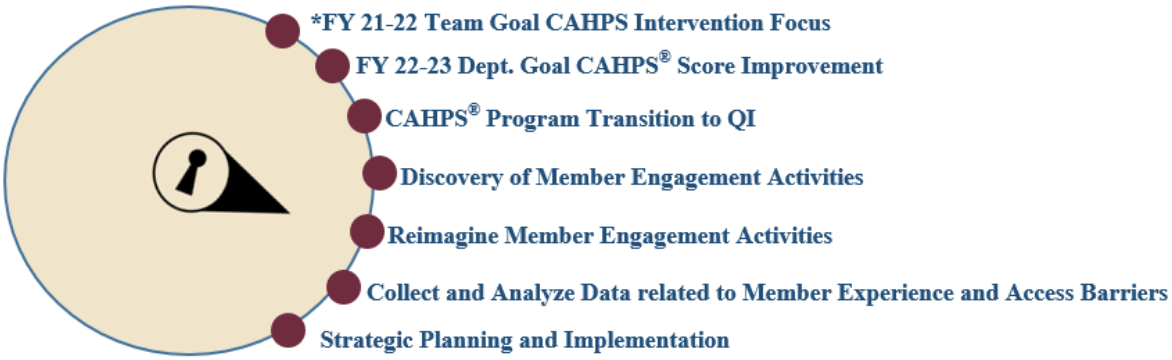
Goal 1: By June 30, 2023, the CAHPS® Score Improvement goal aims to address overall member experience with an emphasis on improving equitable access to care. The CAHPS® Program Oversight workgroup is responsible for overseeing the administration of the CAHPS® program and may provide guidance to sub-workgroups that drive and supports the completion of goals/milestones, relative to the CAHPS® program. Using data-driven decisions, the overarching CAHPS® goal aims to define, develop, and drive strategies focused on improving a favorable perception of the HealthPlan rating, access, and overall member experience.	• CAHPS® survey administration transition, from the Member Services to the Quality Improvement department. • Created CAHPS survey administration and created desktop procedures to be used in the development and oversight of the new program. • Established a CAHPS® program charter. • Developed program and primary drivers within the CAHPS® programmatic framework. Tenets of the program will offer proactive, reactive, monitoring, and long-term strategies aimed to improve a favorable perception of the HealthPlan. Targeted focus: Access, Member Experience, and HealthPlan Rating. The outcome aims to maintain consistent activities and interventions that offer no disruption of improvement drivers as we transition through each fiscal year's CAHPS® survey results and process. • Key stakeholders joined the first ACAP CAHPS® collaborative which aims to; focus on current and prior years adult and child population data analysis, consultative support on proposed improvements; and collaboration with local and national Medicaid plans.
DATA ANALYTICS WORKGROUP	
Goal 2: By June 30, 2023, the CAHPS® Score Improvement goal aims to address overall member experience with an emphasis on improving equitable access to care. The Data Analytics sub-workgroup will drive the data discovery, reporting, and analytics to inform and support goal period intervention activities.	• Created a report repository of existing tableau dashboards, routine reports, and on-demand Business Object reports. • Identified two dashboard reports to monitor claims/member data specific to; Specialty Office Visit Report, and PCP Office Visits Report • Member Experience workgroup activities led to additions to the Specialty Office Visit dashboard • Trended and analyzed existing CAHPS® survey results by county. • Formalized and documented methods to correlate CAHPS® survey results to interventions • Analyzed MY 2022-2023 CAHPS survey results, G & A Pulse report, and other identified data to support the development of the Member Experience Grand Analysis report.
MEMBER EXPERIENCE WORKGROUP	
Goal 3: By June 30, 2023, the CAHPS® Score Improvement goal aims to address overall member experience with an emphasis on improving equitable access to care. Using MY 2021/RY 2022 CAHPS® survey results the Member Experience sub-workgroup will implement short and long-term interventions[1], which improve the perception of the HealthPlan and member experience through provider engagement, incentives, marketing, and promotion of the HealthPlan with the intent of improving the overall member experience.	• Modified existing Population-Health in-person survey and call campaigns by adding two questions related to member experience. This new member engagement data paved the way for a new pilot where collected data is reviewed monthly. Identifying satisfaction or dissatisfaction indicators, used for operational or provider network changes. • Leveraged social media to establish PHC brand awareness, and improve communication and awareness about the member experience survey and whom to contact if they have questions or concerns about their coverage. • Incorporated the use of QR codes on printed materials distributed at community events and member mailers This provides access to on-demand information without barriers.
ACCESS WORKGROUP	

Goal 4: By June 30, 2023, the CAHPS® Score Improvement goal aims to address overall member experience with an emphasis on improving equitable access to care. Using MY 2021/RY 2022 CAHPS® survey results the Access Improvement sub-workgroup will implement long-term interventions[1], which improve the perception of the HealthPlan and member experience through workforce development, primary care access, and pediatric specialty care access.	• Analyzed pediatric outpatient TAR denials to identify opportunities for reducing the number of denied TARs, employing strategies to improve submission of appropriate TARs and reduce the number of TARs overturned upon appeal. • Reviewed access-related grievances for pediatric members to better understand dissatisfaction with access to services. • Simplify member communications focused on the Child population to reduce member abrasion with reduced technical verbiage related to the top three TAR Denials; Orthotics, Dental Anesthesia, and Genetic testing.

[1] **Intervention Definitions:** • Short Term: Approximately a 6-month intervention, by which, at its conclusion, analysis, and evaluation of its impact is to be completed to determine the next steps (adopt, adapt, abandon) • Long-Term: Approximately a 12-month intervention, by which, at its conclusion an analysis and evaluation of its impact is to be completed to determine the next steps (adopt, adapt, abandon).

Member Experience | Move the Dial

As the CAHPS® Program Administration transitions into FY 2023-2024 we conclude this evaluation with highlights of FY 2022-2023 accomplishments of the collective efforts of nine (9) organization-wide departments, and four (4) sub-workgroups, totaling 42 individual participants illustrated below. In addition, lessons learned that the CAHPS® oversight stakeholders plan to include in the recommend improvements to implement next fiscal year.



Lessons Learned

The CAHPS® program provides programmatic structure and resource commitment to effectively administer NCQA requirements and influence organizational change to improve member experience and health plan ratings.

Our approach and discipline to leverage team strengths will afford the necessary skill set to apply a mixed methodology, including quality improvement tools and program management principles of; plan, do, study, act (PDSA), lean, root-causal-analysis, data analytics, qualitative and quantitative analysis will drive improvement. As the team identifies new opportunities or lessons learned we are continuously exploring, and identifying pathways to improve. The established program is designed to be flexible to adapt and pivot between each fiscal year. The list below represent a blend of potential interventions and lessons learned.

- ❑ Listen more through all established member engagement channels and determine whether these are adequate. Member focus groups are a potential intervention under evaluation.
- ❑ Operational awareness of member-supporting activities and internal/external communication. An operational improvement to remove work silos between departments is under review and consideration.
- ❑ Continue to support PHC branding and broader member and community awareness of the importance of CAHPS survey participation.
- ❑ PHC Transportation, support, collaborate, and evaluate member experience with the Transportation Services Department and take timely action with what we learn.
- ❑ Workforce Development, Partner with Workforce Dev Associate Dir and regional staff to:
    - Support local activities to bolster residency programs by engaging residents to help improve retention
    - Provide resources to help update and analyze PCP vacancy data and support other Workforce Development tactics linked to improving Access
- ❑ Telehealth, where applicable support PMO regional-based telehealth to improve member and provider utilization and the influence of improving access and member experience.
- ❑ Develop key preventative indicators (KPI) to resolve service line issues quickly. An operational improvement pilot is under review and consideration.
    - Develop satisfaction thresholds and targets.
    - G & A complaints to identify member service delivery dissatisfaction themes.
    - Population Health Management community member engagement survey and call campaign data
    - Transportation member satisfaction data collection, analysis and if applicable proposed interventions
    - Develop a process to quickly identify service delivery issues through real-time data with the intent to proactively investigate, validate, and implement solutions to improve member satisfaction.
    - Remove operational barriers, TAR denials, and provider training opportunities.

Please see Appendix (E) Member Experience (ME 7) Report for a complete review of the FY 2022-2023 analysis, and interventions implemented and proposed FY 2023-2024 programmatic interventions.

Web Based Member Information Assessment

Report purpose

The Quality and Accuracy of Information report tracks the quality results of the information provided to Partnership members received during a 1) telephonic inquiry call to Partnership Member Services department 2) general inquiry sent via e-mail to the Member Services department and 3) Partnership's website (self-service, Member Portal) on line tools at https://member.partnershiphp.org/.

Frequency of reporting

Member Services reviews the quality and accuracy of the information that is provided monthly for telephonic and e-mail inquiries and website self-service yearly, and summarizes the results annually.

Indicators/Metrics

1. Telephonic Response Quality – Goal of 95% accuracy
2. Quality & Accuracy Related Member Complaints - One offs addressed with individual staff. If there are 3

instances at any time accumulated from the entire department, this will result in refresher training for entire department

3. Website Self Service Quality – Goal of one attempt measured using a rating of 3 (of 5) or higher
4. Website Self Service Accuracy - Goal of 3 (of 5) or higher
5. General Inquiry (via E-mail) Response Quality – Goal of 95%

Data Sources and Methodology

1) Telephonic Response Methodology
Data Source: Annual Telephonic Quality and Accuracy Evaluation

Member Services leadership annually tests call center staff on the quality and accuracy of telephone support as it relates to: Referrals and authorizations, eligibility and benefits along with member's financial responsibilities.

The Member Services management team determines the quality and accuracy of the telephonic support utilizing the test, **Eligibility and Financial Responsibility Knowledge Check**

Testing is done through the LMS training tool for staff; this tool tracks and trends individual and overall results. Supervisors review individual staff testing results and provides a departmental summary to be reviewed by the Member Service management team to address any deficiencies identified and determine next steps. We have set our performance standards at a minimum of 90% pass for individual staff members and a minimum goal of 95% for the collective department. If the management team identifies any departmental trend(s) within the deficiencies, they will place the individual(s) and (or) the department on a corrective action plan (CAP). Additionally, the management team provide their analysis to the Member Services Quality & Training Supervisor to develop any of the following: updated desktop materials, instructive email notices, and/or training workshops for the Member Service Department. Annually, the results are summarized in the quality and accuracy report analysis, which is presented to the Member Experience Sub-Committee for review and approval.

2) Quality & Accuracy Member Complaints

Data Source: Member phone call or Email
Member complaints against PHC staff are documented by Member Services Supervisors. This includes complaints filed due to staff providing misinformation or not enough information related to a member's Financial Responsibility, Referrals and/or Authorizations. If the supervisors identify a training opportunity, they will provide additional training for the staff member.

PHC Grievance Department provides Member Services an annual report including details on all PHC staff related complaints. If trend(s) are identified the Member Services Quality & Training Supervisor will develop any of the following: updated desktop materials, instructive email notices, and/or training workshops for the Member Service Department. Above and beyond the annual reporting and analysis, there is an established feedback loop to address any instance of misinformation closer to real time. Should the Grievance department note misinformation provided, it is shared with the staff's respective supervisor for feedback and coaching.

3 & 4) Website Self Service Quality Methodology

Data Source: https://member.partnershiphp.org

10 of partnership's newest staff members audit the website functionally and ease of use on an annual basis for the following elements through a computer based survey tool. New staff members are used to leverage their lack of experience in navigating the Member Portal to ensure ease of use and gain their fresh perspective regarding the

quality of the information provided. The staff members rate 1 being a poor experience, versus 5 being an excellent experience with the Member Portal functionality. There is an established performance threshold of 3.0 for any of the respective question/actions. The staff members determine the quality and accuracy of the web functionality based on the following:

- **Changing a primary care practitioner**
  - Was it easy to do?
  - Was the staff member able to change a PCP?
  - Was it completed in one attempt?
- **Determining how and when to obtain referrals/authorizations**
  - Was it easy to find?
  - Was the staff member able to determine how and when to obtain referrals and authorizations for specific services?
  - Was it completed in one attempt?
  - Was the information provided useful?
- **Determining benefits and financial responsibility of a service**
  - Was it easy to find?
  - Was the staff member able to find the language that stated members have no financial responsibility?
  - Was it completed in one attempt?

Audit findings are summarized and reviewed annually. The annual report is presented to the Member Experience Sub-Committee for review and approval. Any question/activity that has an average score below 3.0, feedback is provided to the web development team with recommendations for improvement as needed.

5) Email Methodology
Data Source: Emails submitted via https://member.partnershiphp.org

Member Services auditor selects 10% of all e-mail inquiries, at a maximum of 10 inquires or whichever is fewer per month to audit. The auditor determines the quality, accuracy and timeliness of the e-mail response to the member inquiry based on the quality, accuracy and timeliness of information provided to the member by the Member Service staff utilizing the following categories:

E-mail Etiquette
1. Identified themselves to the member
2. Response protects member's PHI
3. Response projects professionalism and politeness
4. Correct spelling, grammar and punctuation

Resolution
5. Appropriately identified member reason for email inquiry
6. Offered the most appropriate and accurate solution to meet the member's needs
7. Communicated at a level that the member would understand

Timeframes and Documentation
8. Delivered appropriate acknowledgment or resolution response within 1 business day of receipt of member's request.
9. Resolution completed by end of following business day
10. Member's record is documented according to policy

Audit findings are entered into the Member Services audit database, this tool tracks and trends individual and overall results. Individual audit results are reviewed with the staff member's Supervisor and overall departmental results reviewed by the Member Services Management team to address the deficiencies identified and determine next steps. If the auditor identifies any trends within the deficiencies (meaning an aggregate score that falls below

the performance threshold of 95%), they provide their analysis to the Member Services Quality & Training Supervisor to develop any of the following: updated desktop materials, instructive email notices, and/or training workshops for the Member Services department. Annually the results are summarized in a formal analysis that is presented to the Member Experience Sub-Committee for review and approval.

Results

Quality and Accuracy:

1) Telephonic Quality and Accuracy

Year 2023		Year 2022	
Check Question	**Quality and Accuracy Question Scores**	**Knowledge Check Question**	**Quality and Accuracy Question Scores**
Question 1	99%	Question 1	100%
Question 2	99%	Question 2	100%
Question 3	100%	Question 3	100%
Question 4	100%	Question 4	100%
Question 5	100%	Question 5	100%
Question 6	100%	Question 6	100%
Question 7	100%	Question 7	100%
Question 8	100%	Question 8	100%
Question 9	100%	Question 9	100%
Question 10	100%	Question 10	100%
Question 11	100%	Question 11	100%
Question 12	98%	Question 12	81%
Question 13	100%	Question 13	93%
Question 14	100%	Question 14	96%

Department Testing Participation

- **2022 - [33 of 37 staff tested, 4 new hires]**
- **2023 – [32 of 33 staff tested, 1 leave of absence]**

All qualified Member Services call center staff were tested on the quality and accuracy of referrals, authorizations, eligibility and benefits along with member's financial responsibilities. Compared to 2022 test results which showed that questions 12 and 13 fell below the 95% performance standard, in 2023, no questions fell below the 95% threshold which points to our training and approach being sufficient in regards to these areas.

2) Quality & Accuracy (Member Complaints – Voice of the Customer)

2022-2023

Date Received	Date Closed	Issue	Resolution
N/A	N/A	N/A	N/A

During the 2022-2023 evaluation period, there was a decrease in complaints against staff at 17 total (down from 21 the previous reporting period) none of which were tied to misinformation regarding referrals, authorizations & financial responsibility (RAFR).

2021-2022

Date Recvd	Date Closed	Issue	Resolution
1/8/2021	2/3/2021	The member is upset because he was told that he could be reimbursed for a COVID-19 test that he took while out of his county. The member states he is now being denied reimbursement.	Call was reviewed and forwarded to Member Services supervisor as a training opportunity for MSR to give clear directions when discussing reimbursement.
2/22/2021	3/22/2021	Member called PHC on 12/7/2020 to inquire where he could go for a COVID test because he needed to be able to work. Member stated MSR told him he could go wherever he wanted and PHC is not denying any COVID testing. Member is upset the process is taking so long and the MSR told him PHC will pay for any testing. Member would like to be reimbursed for the $150 COVID test.	Concerns were shared with Member Services Management team. Training opportunities identified and provided.
7/6/2021	7/15/2021	Grievance against PHC MSR said that audiology provider is not contracted with PHC.	MS Supervisor reviewed the member's record and confirmed everything was followed correctly by the Representative. MSR confirmed that audiology provider is in fact a contracted provider.

During the 2021-2022 evaluation period, there were a total of 21 complaints against staff and only 3 that would fall into the potential categories of misinformation regarding referrals, authorizations & financial responsibility (RAFR). Of the 3 grievances captured, 2 were found to have coaching opportunities as listed above in resolution. The individual staff were coached but being we did not exceed our threshold of 3 total, a department refresher was not required.

3 & 4) Web Quality & Accuracy

Year 2023

Changing Primary Care Practitioner:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg Rating
Was it easy to do?	4.00	3.00	3.00	5.00	5.00	5.00	4.00	5.00	2.00	5.00	4.10
Was the staff member able to change a PCP?	4.00	3.00	4.00	5.00	5.00	5.00	4.00	5.00	1.00	5.00	4.10
Was it completed in one attempt?	1.00	3.00	4.00	5.00	5.00	4.00	3.00	5.00	1.00	5.00	3.60
Determine How/When to obtain Referrals/Authorization:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg Rating
Was it easy to find?	2.00	3.00	5.00	5.00	5.00	5.00	5.00	4.00	3.00	4.00	4.10
Was the staff member able to determine how and when to obatin referrals and authorizations for specific servcies?	4.00	3.00	5.00	5.00	3.00	5.00	5.00	5.00	3.00	4.00	4.20
Was it completed in one attempt?	2.00	3.00	5.00	5.00	5.00	5.00	5.00	3.00	2.00	5.00	4.00
Was the information provided useful?	4.00	3.00	5.00	5.00	4.00	5.00	5.00	5.00	4.00	5.00	4.50
Determine benefits and financial responsibility of a service:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg Rating
Was it easy to find?	5.00	5.00	5.00	3.00	3.00	5.00	5.00	4.00	2.00	4.00	4.10
Was the staff member able to find the language that stated that members have no financial responsibility?	5.00	5.00	5.00	4.00	2.00	5.00	4.00	5.00	2.00	5.00	4.20
Was it completed in one attempt?	5.00	5.00	5.00	4.00	2.00	4.00	4.00	3.00	1.00	4.00	3.70

Year 2022

Changing Primary Care Practitioner:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg Rating
Was it easy to do?	4.00	4.00	1.00	4.00	4.00	3.00	5.00	5.00	3.00	5.00	3.50
Was the staff member able to change a PCP?	4.00	4.00	1.00	4.00	4.00	1.00	4.00	5.00	5.00	5.00	3.40
Was it completed in one attempt?	3.00	4.00	1.00	2.00	2.00	1.00	5.00	5.00	5.00	5.00	3.20
Determine How/When to obtain Referrals/Authorization:											
Was it easy to find?	4.00	4.00	3.00	3.00	3.00	1.00	1.00	1.00	4.00	2.00	2.80
Was the staff member able to determine how and when to obatin referrals and auhtoirzations for specific servcies?	3.00	4.00	3.00	1.00	1.00	1.00	1.00	3.00	4.00	2.00	2.70
Was it completed in one attempt?	3.00	4.00	3.00	3.00	3.00	1.00	1.00	1.00	4.00	1.00	2.60
Was the information provided useful?	3.00	4.00	4.00	4.00	4.00	1.00	1.00	4.00	3.00	2.00	3.10
Determine benefits and financial responsibility of a service:											
Was it easy to find?	4.00	4.00	1.00	4.00	4.00	4.00	2.00	1.00	4.00	1.00	3.00
Was the staff member able to find the language that stated that members have no financial	4.00	4.00	1.00	4.00	4.00	4.00	2.00	3.00	3.00	1.00	3.10
Was it completed in one attempt?	4.00	4.00	1.00	4.00	4.00	4.00	2.00	1.00	5.00	1.00	3.10

Analysis

- While several of the website testing questions fell below our average performance threshold of 3 points in 2022, the 2023 testing results show an improvement in all categories and met all satisfactory thresholds. The questions that fell below threshold last year were related to determining how/when to obtain referrals/authorizations. We have captured the 2022 scores that fell below performance thresholds, with the respective increase in 2023's reporting:
    - Was the information easy to find? - 2.8 (2022), improved to – 4.1 (2023)
    - Was the staff member able to determine how and when to obtain referrals/authorizations for specific services? – 2.7 (2022), improved to – 4.2 (2023)
    - Was it completed in 1 attempt? – 2.6 (2022), improved to 4.0 (2023)
- Highest increases in test scores were for the referral/authorization portion of the testing which prompted action the previous year (Captured in the "Opportunities for Improvement" section below)

Quality and Accuracy:

3) Telephonic Quality and Accuracy

Year 2023		Year 2022	
Check Question	Quality and Accuracy Question Scores	Knowledge Check Question	Quality and Accuracy Question Scores
Question 1	99%	Question 1	100%
Question 2	99%	Question 2	100%
Question 3	100%	Question 3	100%
Question 4	100%	Question 4	100%
Question 5	100%	Question 5	100%
Question 6	100%	Question 6	100%
Question 7	100%	Question 7	100%
Question 8	100%	Question 8	100%
Question 9	100%	Question 9	100%
Question 10	100%	Question 10	100%
Question 11	100%	Question 11	100%
Question 12	98%	Question 12	81%
Question 13	100%	Question 13	93%
Question 14	100%	Question 14	96%

Department Testing Participation

- **2022 - [33 of 37 staff tested, 4 new hires]**
- **2023 – [32 of 33 staff tested, 1 leave of absence]**

All qualified Member Services call center staff were tested on the quality and accuracy of referrals, authorizations, eligibility and benefits along with member's financial responsibilities. Compared to 2022 test results which showed that questions 12 and 13 fell below the 95% performance standard, in 2023, no questions fell below the 95% threshold which points to our training and approach being sufficient in regards to these areas.

4) Quality & Accuracy (Member Complaints – Voice of the Customer)

2022-2023

Date Received	Date Closed	Issue	Resolution
N/A	N/A	N/A	N/A

During the 2022-2023 evaluation period, there was a decrease in complaints against staff at 17 total (down from 21 the previous reporting period) none of which were tied to misinformation regarding referrals, authorizations & financial responsibility (RAFR).

2021-2022

Date Recvd	Date Closed	Issue	Resolution
1/8/2021	2/3/2021	The member is upset because he was told that he could be reimbursed for a COVID-19 test that he took while out of his county. The member states he is now being denied reimbursement.	Call was reviewed and forwarded to Member Services supervisor as a training opportunity for MSR to give clear directions when discussing reimbursement.
2/22/2021	3/22/2021	Member called PHC on 12/7/2020 to inquire where he could go for a COVID test because he needed to be able to work. Member stated MSR told him he could go wherever he wanted and PHC is not denying any COVID testing. Member is upset the process is taking so long and the MSR told him PHC will pay for any testing. Member would like to be reimbursed for the $150 COVID test.	Concerns were shared with Member Services Management team. Training opportunities identified and provided.
7/6/2021	7/15/2021	Grievance against PHC MSR said that audiology provider is not contracted with PHC.	MS Supervisor reviewed the member's record and confirmed everything was followed correctly by the Representative. MSR confirmed that audiology provider is in fact a contracted provider.

During the 2021-2022 evaluation period, there were a total of 21 complaints against staff and only 3 that would fall into the potential categories of misinformation regarding referrals, authorizations & financial responsibility (RAFR). Of the 3 grievances captured, 2 were found to have coaching opportunities as listed above in resolution. The individual staff were coached but being we did not exceed our threshold of 3 total, a department refresher was not required.

3 & 4) Web Quality & Accuracy

Year 2023

Changing Primary Care Practitioner:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg Rating
Was it easy to do?	4.00	3.00	3.00	5.00	5.00	5.00	4.00	5.00	2.00	5.00	4.10
Was the staff member able to change a PCP?	4.00	3.00	4.00	5.00	5.00	5.00	4.00	5.00	1.00	5.00	4.10
Was it completed in one attempt?	1.00	3.00	4.00	5.00	5.00	4.00	3.00	5.00	1.00	5.00	3.60
Determine How/When to obtain Referrals/Authorization:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg Rating
Was it easy to find?	2.00	3.00	5.00	5.00	5.00	5.00	5.00	4.00	3.00	4.00	4.10
Was the staff member able to determine how and when to obatin referrals and authorizations for specific servcies?	4.00	3.00	5.00	5.00	3.00	5.00	5.00	5.00	3.00	4.00	4.20
Was it completed in one attempt?	2.00	3.00	5.00	5.00	5.00	5.00	5.00	3.00	2.00	5.00	4.00
Was the information provided useful?	4.00	3.00	5.00	5.00	4.00	5.00	5.00	5.00	4.00	5.00	4.50
Determine benefits and financial responsibility of a service:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg Rating
Was it easy to find?	5.00	5.00	5.00	3.00	3.00	5.00	5.00	4.00	2.00	4.00	4.10
Was the staff member able to find the language that stated that members have no financial responsibility?	5.00	5.00	5.00	4.00	2.00	5.00	4.00	5.00	2.00	5.00	4.20
Was it completed in one attempt?	5.00	5.00	5.00	4.00	2.00	4.00	4.00	3.00	1.00	4.00	3.70

Year 2022

Changing Primary Care Practitioner:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg Rating
Was it easy to do?	4.00	4.00	1.00	4.00	4.00	3.00	5.00	5.00	3.00	5.00	3.50
Was the staff member able to change a PCP?	4.00	4.00	1.00	4.00	4.00	1.00	4.00	5.00	5.00	5.00	3.40
Was it completed in one attempt?	3.00	4.00	1.00	2.00	2.00	1.00	5.00	5.00	5.00	5.00	3.20
Determine How/When to obtain Referrals/Authorization:											
Was it easy to find?	4.00	4.00	3.00	3.00	3.00	1.00	1.00	1.00	4.00	2.00	2.80
Was the staff member able to determine how and when to obatin referrals and auhtoirzations for specific servcies?	3.00	4.00	3.00	1.00	1.00	1.00	1.00	3.00	4.00	2.00	2.70
Was it completed in one attempt?	3.00	4.00	3.00	3.00	3.00	1.00	1.00	1.00	4.00	1.00	2.60
Was the information provided useful?	3.00	4.00	4.00	4.00	4.00	1.00	1.00	4.00	3.00	2.00	3.10
Determine benefits and financial responsibility of a service:											
Was it easy to find?	4.00	4.00	1.00	4.00	4.00	4.00	2.00	1.00	4.00	1.00	3.00
Was the staff member able to find the language that stated that members have no financial	4.00	4.00	1.00	4.00	4.00	4.00	2.00	3.00	3.00	1.00	3.10
Was it completed in one attempt?	4.00	4.00	1.00	4.00	4.00	4.00	2.00	1.00	5.00	1.00	3.10

Analysis

- While several of the website testing questions fell below our average performance threshold of 3 points in 2022, the 2023 testing results show an improvement in all categories and met all satisfactory thresholds. The questions that fell below threshold last year were related to determining how/when to obtain referrals/authorizations. We have captured the 2022 scores that fell below performance thresholds, with the respective increase in 2023's reporting:
    - Was the information easy to find? - 2.8 (2022), improved to – 4.1 (2023)
    - Was the staff member able to determine how and when to obtain referrals/authorizations for specific services? – 2.7 (2022), improved to – 4.2 (2023)
    - Was it completed in 1 attempt? – 2.6 (2022), improved to 4.0 (2023)
- Highest increases in test scores were for the referral/authorization portion of the testing which prompted action the previous year (Captured in the "Opportunities for Improvement" section below)

5) E-mail Accuracy

Year 2022-2023

Email Inquiries	Goal	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Total
Total Email Inquiries Received	-----	22	39	28	35	30	26	39	26	46	33	64	55	443
# of Submission audited per month	-----	5	5	5	5	5	5	5	5	5	5	10	5	65
% of accuracy of information	95%	100%	100%	98%	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%
% of emails responded to within 1 business day	100%	100%	100%	100%	98%	98%	100%	98%	100%	94%	100%	100%	100%	99%
Numerator	-----													
Denominator	-----													

Year 2021-2022

Email Inquiries	Goal	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Total
Total Email Inquiries Received	-----	20	28	25	33	21	27	24	31	44	27	20	18	318
# of Submission audited per month	-----	5	5	5	5	5	5	5	5	10	5	5	5	65
% of accuracy of information	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% of emails responded to within 1 business day	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	98%	100%	100%	100%
Numerator	-----													
Denominator	-----													

In 2021-2022 - Member Services achieved 100% scoring for quality and accuracy with a slight dip in timeliness of response during January and February. While there was a minimal decrease in timing, we still hit established performance thresholds of 95%. For 2022-2023, we observed negligible dips in accuracy July of 22' and January of 23' respectively. Additionally, there was dip below the 95% threshold at 94% for timeliness in January 2023. We feel this was due to attrition in the lead role and working through change management of merging regional offices. This is a onetime instance and will not be an issue moving forward. While there is no further action needed, we are constantly working to identify operational improvements to ensure better coverage of this communication channel.

Barriers

Seeing the improvements in comparing 2022 to 2023's quality and accuracy measures, there are no observed barriers in accomplishing to meet the established performance thresholds.

Opportunities for Improvement

In 2022 we improved analysis of the referrals, authorizations and financial responsibility quality and accuracy measures by including Grievance and Appeal reporting to capture voice of the customer/member. This resulted in increased confidence and assurance that our staff are in fact providing accurate information to members when these inquiries surface.

Quality in Grand Analysis

NCQA - Grand Analyses

Since the beginning PHC established a strong foundation and framework to engage and build community partnerships with our members, health providers and organizations that serve the tenets of our organizational mission of **"*To help our members, and the communities we serve, be healthy,*"** and vision of **"*To be the most highly regarded managed care plan in California.*"** Our commitment of continuous quality improvement is summarized within the five Grand Analyses herein and in addition the complete analyses are provided in the appendices.

Access and Availability (NET3) Report

As a plan, PHC met its goals related to availability and accessibility of services including, appropriate member to provider ratio standards, geographic distribution of services, accessibility to providers and low rate of out of network referrals, claims and grievance data.

While some members were outside the time or distance standards for primary care, specialty care, and hospital services, this is not due to lack of contracting with an available service provider. There are no qualified providers who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. PHC requests and receives approval from DHCS for Alternative Access Standards (AAS) on an annual basis for the geographical areas that fail to meet the standard. If a member lives in an area where services are not covered, PHC will help those members with making the appointment and arrange transportation to see the specialists that are not within the time or distance standard.
Activities to improve access include:

- Webinars to Improve Efficiency of Scheduling Practices through training in Advanced Access are available to all provider types on the PHC website.
- Development of workflows, policies and procedure for individualized counseling of primary care providers have been developed and put in place.
- Continued support of the Provider Recruitment Program to increase PHC member access to primary care providers across our regions with 11 new family practice providers added to the network.
- Support and expansion of Telehealth & eConsult Unit use.

Please reference Appendix (A) Access and Availability (NET 3) Report for a complete review of the quantitative and qualitative analyses for the learnings while trying meet the stated goals for each measure noted above.

Continuity and Coordination of Medical Care (QI3) Report:

This NCQA Standard examines how PHC monitors and takes action, as necessary, to improve continuity and coordination of care of members across the health care network and delivery system. Specifically, the standard looks at how members move between providers (e.g., Primary Care to Specialty Care) and across settings (e.g., from the Emergency Department back to the Primary Care Office), with both quantitative and qualitative analyses of how PHC performed in examples of these transitions, including identifying opportunities for improvement in these areas.

PHC annually assesses continuity and coordination of medical care opportunities by way of its various quality improvement programs (QIP) to ensure the providers are getting information needed to facilitate smooth transitions

of care when crossing various setting of care. PHC's QIPs are designed for hospitals, perinatal, and primary care providers. The QIP team includes members from the Health Analytics, Population Health, Quality Improvement, Care Coordination, and Provider Relations departments, as well as representation from the Office of the Chief Medical Officer and PHC's regional leaders.

To demonstrate activity for this Standard, PHC reviewed the following measures:

- Member movement across settings:
  - Risk Adjusted Readmission measure that mirrors HEDIS's Plan All-Cause Readmissions
  - Primary Care Practitioners (PCPs) to Emergency Departments (ED) HEDIS performance measure data: Prenatal and Postpartum Care (PPC) - Postpartum rate.
- Member movement between practitioners:
  - HEDIS® performance measure data: Comprehensive Diabetes Care (CDC) - Eye Exam rate.

PHC did not meet all of the set goals for the above reviewed measures.

The Risk Adjusted Readmission measure looks at the rates of member hospital readmissions occurring within 30 days of discharge from hospitals participating in PHC's Hospital QIP (HQIP). The readmission rate is considered an indicator of appropriate discharges, including adequate re-connection with the patient's primary care office at the time of discharge. Awareness of this set of diagnosis codes provides an opportunity for provider education and improvement. PHC can work with providers to be aware of members at risk for these diagnoses. PHC can also assist with care management and coordination to help drive a smooth transition of care and information sharing from the hospital back to the primary care provider. This work will be aided by increased utilization of Sac Valley Med Share, Collective Medical and other record sharing systems by improving awareness of hospitalizations and the sharing of medical information between providers and facilities and between facilities and PHC.

The "Emergency Department (ED) to primary care practitioners" measure looks at the rate of assigned members with an "avoidable ED visit" due to any one or more of a specified set of primary diagnoses. ED visits are a high-intensity service and a cost burden on the health care system, as well as on patients. Some ED events may be attributed to preventable or treatable conditions. A high rate of ED utilization may indicate poor care management, inadequate access to care, and/ or poor patient choices, resulting in ED visits that could be prevented. Each PCP site (all PCP sites with assigned members are PCP QIP participants) had an Avoidable Emergency Department (ED) Visits/1000 Members per Year target. PHC will continue to work with providers on improving access (in-office, telephonic, and virtual) to PCPs through actions like patient education and instructions for accessing advice lines (after hours "nurse lines"), and continued financial supports like the Provider Recruitment Program to attract new providers. The PCP QIP will also continue an existing "unit of service measure" incentivizing PCP offices to provide some level of direct member to provider contact (virtual or in office) for at least 8 hours per week over and above normal clinic hours.

The HEDIS® performance measure: Prenatal and Postpartum Care (PPC) - Postpartum rate assesses effective and timely postpartum care following delivery, specifically measuring the rate of members receiving two postpartum care visits, with one occurring within 21 days after delivery and the other occurring between 22 and 84 days after delivery. Effective and timely postpartum care occurs in the first few weeks after delivery. These visits are essential to support maternal-infant bonding and to ensure that birthing patients have access to breast feeding education, screening and treatment for mood disorders, and appropriate family planning options.

PHC continues to work on interventions to improve provider performance on the postpartum care measure. The Perinatal Quality Improvement Program (PQIP) offers financial incentives to practitioners that provide quality and timely prenatal and postpartum care. Additionally, PHC staff identified high volume perinatal providers to offer targeted educational sessions that highlight the importance of quality, timely postpartum visits and share best practices to achieve higher rates of visits. PHC is continuing the "Growing Together Program" in which pregnant members are offered incentives for completing perinatal care visits, as well as enrolling and engaging in primary care with their infants.

Furthermore, the Perinatal Work Group will examine the rates of postpartum visits through a race and ethnicity lens to determine how a member engagement initiative can offer education and outreach to populations with lower rates of postpartum visits.

Finally, the HEDIS® performance measure: Comprehensive Diabetes Care (CDC) - Eye Exam rate evaluates the percentage of members 18-75 years of age with a diagnosis of diabetes (type 1 or type 2) with a documented timely retinal eye exam. According to the CDC, diabetes is the leading cause of blindness in adults. Regular eye exams are recommended for all people with diabetes in order to detect early changes that can lead to interventions to prevent blindness. This requires members to be referred by their PCPs to eye specialist services for these evaluations. The PCP QIP Comprehensive Diabetes Care - Eye Exam measure was converted to a non-incentivized [monitoring] measure in MY 2020 and that continued in through MY 2021 and into MY2023.)

Prior to the pandemic, many organizations were adopting "tele-optometry" services, which use retinal cameras placed in PCP offices to send digital images of the patients' retinas to optometrists and ophthalmologists for readings and interpretations ("eye specialist services"). Due to the pandemic, with the need for physical distancing and staffing limitations, many organizations were forced to discontinue the use of tele-optometry services. PHC will encourage the revitalization and spread of this practice.

PHC will determine if the activities at successful clinics represent "best practices" that can be duplicated and spread to other sites. Additionally, PHC is collaborating Vision Service Plan (VSP) who provides vision services benefits to PHC members, by providing data on members identified as diabetic and in need of a retinal or dilated eye exam by an eye care professional.

Please see Appendix (B) Continuity and Coordination of Medical Care (QI3) Report for a complete review of the quantitative and qualitative analyses for the learnings for each measure noted above.

Continuity and Coordination of Behavioral Health (QI4) Report:

In 2019 PHC convened a multidisciplinary team to identify appropriate measures for this analysis, to gather and review the data, recommend interventions and select opportunities for improvement. The focus and membership of the team was subsequently narrowed as the specifications, measures and interventions were identified. The current team has members from PHC's Behavioral Health unit, Health Analytics, the Office of the Chief Medical Officer, Quality Improvement, Pharmacy, and Carelon Behavioral Health, the Plan's delegated administrator of mental health services.

Work to analyze, improve and build upon efforts to promote coordination of medical and behavioral health care services across settings, focusing specifically on the performance for two of the measures; Primary or Secondary

Prevention Behavioral Healthcare Program Implementation and Appropriate Use of Psychotropic Medications. The measures address the sharing of information; promotion of treatment of the whole person, and adherence to standard diagnosis and treatment guidelines.

Eating Disorder diagnosis were selected in the measurement of Primary or Secondary Prevention Behavioral Healthcare Program Implementation. Both in 2019 and 2020 fewer than 90% of members diagnosed with an eating disorder received follow-up treatment within 90 days; 75.6% in 2019 and 86.7% in 2020, failing to meet the goal for both years. However, in 2020, 13.3% more cases were diagnosed and treated within 90 days than in 2019. Interventions continue targeting identification of specialties and clinicians, on-going training to establish a broader network, and increased access to telehealth. In 2022 the goal was met as 92.8% of individuals received follow-up treatment within 90 days, a marked improvement over previous years.

The Appropriate use of Psychotropic Medication measure follows the ADD initiation and continuation phases for children prescribed ADHD medication. In 2020, all regions continued to perform below the goal of 50% of the MPL for the initiation phase although there was clear improvement in the Southeast and Southwest regions. Based on claims data captured through May 20, 2021, 75 letters were sent to providers describing the need to follow up with families of children prescribed ADHD medication. 37 of 75 letter recipients (49.33%) had an appropriate follow-up care visit within 30 days of their IPSD, and therefore are being counted toward the ADD Phase 1 numerator. The increase in follow-up care and ADD score among letter recipients over the course of this intervention suggests that this continual communication with providers may be beneficial in driving positive outcomes.

Beginning January 1, 2022, Medi-Cal pharmacy services were transitioned from Partnership HealthPlan of California (PHC) to Medi-Cal Rx. As a result of this transition combined with the late Q1/Q2 2022 PHC system outage, there was a prolonged delay in receiving timely weekly ADHD new start reports. Timely pharmacy claim data reports were not made available until August 2022. The Pharmacy team began their intervention in March of 2023 and a full analysis of the effectiveness of the intervention will take place moving forward as data become available.

Please see Appendix (C) Continuity and Coordination of Behavioral Health (QI4) Report for a complete review of the quantitative and qualitative analyses for the learnings while trying meet the stated goals for each measure noted above.

Pharmacy & Utilization Management (UM1B) Report: Utilization Management

The Annual Utilization Management (UM) Program Evaluation analyzes all aspects of data related to the UM program, identifies gaps and opportunities for improvement, and updates the program as necessary to ensure the program remains current and appropriate.

Key elements in this annual evaluation include program structure, program scope, processes, and information sources, as well as level of involvement of senior-level physicians and designated behavioral healthcare practitioners in the UM program.

In addition, data for member and practitioner experience with the UM process is evaluated to identify improvement and actionable opportunities. This report does not contain Kaiser Permanente or Beacon Health Options data for

evaluation of the UM program. Kaiser Permanente and Beacon Health Options are NCQA accredited, and as such, reports from Kaiser Permanente and Beacon Health Options are reviewed through the delegation oversight process.

Please see Appendix (D) Pharmacy & Utilization Management – UM1B Report: Utilization Management for a complete review of the quantitative and qualitative analyses for the learnings while trying meet the stated goals for each measure noted above. AND Appendix (D) Pharmacy & Utilization Management (UM1B) Supplemental TAR Report.

Member Experience (ME7) Report

Partnership HealthPlan of California (PHC) measures the Member Experience through monitoring of annual regulated and non-regulated surveys, and grievance and appeals reporting. The Member Experience and respective quality outcomes are driven and measured by interdepartmental health plan coordinated efforts that support operational and strategic member and provider-focus activities. Our commitment to ensuring our members receive high-quality healthcare services and excellent customer service directly aligns with PHC's mission and vision.

MY 2021-2022 Survey Results

The survey and member experience analysis of PHC health plan delivery and identification of improvement opportunities cover the Measure Year MY 2021, and Reporting Year RY 2022. The comparison of NCQA composite measure scores by Adult and Child population includes measure years; MY 2021-2022, and MY 2020-2021, and notable findings by population are identified below.

CAHPS® Adult

- Adult Rating Measures compared to prior MY reflects a notable PHC benchmark **decrease** in three (3) out of four (4) in; ***Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor,*** and an **increase** in ***Rating of Specialist Seen Most Often.***
- Adult Composite Measures compared to prior MY are similar to rating measures, with a **decrease** in three (3) out of four (4) in; ***Getting Needed Care, Getting Care Quickly***, and ***Care Coordination***, and an **increase** in ***Customer Service.***
- The adult oversampling strategy may have contributed to meeting the reportable threshold of 100 survey responses for each rating and composite measure.

The Adult survey response relative to PHC-covered members indicates we continue to have dissatisfaction with member access which influences health plan ratings.

CAHPS® Child

- Child Rating Measures compared to prior MY 2020 did not meet or exceed the PHC 25th percentile target in three (3) out of four (4); ***Rating of Health Plan, Rating of All Health Care, and Rating of Specialist Seen Most Often***. Although the ***Rating of All Heath Care*** measure did not meet or exceed the PHC benchmark, an observed improvement is noted. Completing the rating measure set is an observed **increase of** over 1% in the ***Rating of Personal Doctor.***
- Child Composite Measures compared to prior MY 2020 did not meet or exceed the PHC 25th percentile benchmark in one (1) out of four (4) in; ***Getting Needed Care***, noted is a minimal **decrease.** ***Getting Care Quickly***, ***Care Coordination and Customer Service*** **met** or **exceed** the PHC 25th percentile target.
- Child oversampling strategy may have contributed to meeting the reportable threshold of 100 survey responses for each rating and composite measure.

The Child survey responses relative to PHC-covered members indicate we continue to have dissatisfaction with member access and correlating impact to member experience which influences health plan ratings.

2022 Grievances and Appeals (G&A) Data

There was a total of 3,338 closed G & A cases in calendar year 2022, compared to 3,387 in MY 2021. These cases are broken into two groups. Grievances which accounted for 2,556, and Appeals and Second Level Grievances, which accounted for 762. The G & A analysis attributes 1,055 (41%) of 2,556 closed grievance cases to be related to ***access,*** followed by 1,278 (50%) closed cases for ***attitude and service.***

Stakeholders determined that continued intervention focused on access; ***Getting Needed Care and Getting Care Quickly*** composite measures and ***Rating of Health Plan*** would be in scope for the CAHPS® Score Improvement (CSI) Department Goal for FY 2022-2023.

QI Department CAHPS® Score Improvement (CSI) Goal

In collaboration with key stakeholders and senior leadership, the QI department developed four (4) FY 2022-2023 department goals and respective milestones. The CSI department goal structure included four (4) separate workgroups and goals are outlined in the tables below.

Quality Improvement Lead ***CAHPS® Programmatic Oversight and Administration***	Office of CMO Medical Directors Regional Office	Human Resources T&D/Workforce Development	Population Health Management	Member Services
	Finance (Health Analytics)	Communications Community Relations/ Policy	Provider Relations	PMO/OpEx
CAHPS® Program Oversight Workgroup	Data Analytics Workgroup	Member Experience Workgroup	Access Workgroup	Total Participants
14	**17**	**14**	**19**	**42**

Workgroup	Accomplishments
CAHPS® Program Oversight Workgroup	
Goal 1: By June 30, 2023, the CAHPS® Score Improvement goal aims to address overall member experience with an emphasis on improving equitable access to care. The CAHPS® Program Oversight workgroup is responsible for overseeing the administration of the CAHPS® program and may provide guidance to sub-workgroups that drive and supports the completion of goals/milestones, relative to the CAHPS® program. Using data-driven decisions, the overarching CAHPS® goal aims to define, develop, and drive strategies focused on improving a favorable perception of the HealthPlan rating, access, and overall member experience.	
Data Analytics Workgroup	
Goal 2: By June 30, 2023, the CAHPS® Score Improvement goal aims to address overall member experience with an emphasis on improving equitable access to care. The Data Analytics sub-workgroup will drive the data discovery, reporting, and analytics to inform and support goal period intervention activities.	
Member Experience Workgroup	
Goal 3: By June 30, 2023, the CAHPS® Score Improvement goal aims to address overall member experience with an emphasis on improving equitable access to care. Using MY 2021/RY 2022 CAHPS® survey results the Member Experience sub-workgroup will implement short and long-term interventions[1], which improve the perception of the HealthPlan and member experience through provider engagement, incentives, marketing, and promotion of the HealthPlan with the intent of improving the overall member experience.	
Access Workgroup	

Goal 4: By June 30, 2023, the CAHPS® Score Improvement goal aims to address overall member experience with an emphasis on improving equitable access to care. Using MY 2021/RY 2022 CAHPS® survey results the Access Improvement sub-workgroup will implement long-term interventions[1], which improve the perception of the HealthPlan and member experience through workforce development, primary care access, and pediatric specialty care access.

[1] **Intervention Definitions:** • Short Term: Approximately a 6-month intervention, by which, at its conclusion, analysis, and evaluation of its impact is to be completed to determine the next steps (adopt, adapt, abandon) • Long-Term: Approximately a 12-month intervention, by which, at its conclusion an analysis and evaluation of its impact is to be completed to determine the next steps (adopt, adapt, abandon).

Please see Appendix (E) Member Experience (ME 7) Report for a complete review of the FY 2022-2023 analysis, and interventions implemented and proposed FY 2023-2024 programmatic interventions.

Evaluation Conclusion

Evaluation Conclusion

This concludes the FY 2022-2023 Quality Improvement Program Evaluation, which provides an assessment on performance work outlined in the FY 2023-2024 QI Program Description and FY 2022-2023 Work Plan. Partnership's Quality Improvement (QI) Program was successful over the course of fiscal year 2022-2023 in achieving its quality improvement goals and commitments. Partnership is prepared for its Renewal HPA Survey, scheduled for October 2023 and anticipates its first NCQA Health Plan Rating (HPR) as an accredited health plan. Partnership continues to leverage its 5-Star Quality Strategy and corresponding tactical and work plans to demonstrate an increased organizational focus on improving quality measure and CAHPS scores now and into the future. In 2022-2023, Partnership has been able to engage more fully in existing and expanding performance improvement and pay-for-performance strategies and programming. While, at the same time, Partnership faces ongoing challenges where portions of its provider network are still greatly struggling to emerge from associated financial, labor, and quality performance challenges post-COVID-19. This has also adversely impacted long existing access to care challenges faced in our more rural service areas. As Partnership moves into 2023-2024, despite known barriers and challenges in achieving targeted quality performance thresholds, Partnership's QI Program remains committed to striving for its long term goal of achieving a 5-Star HPR. Partnership is also looking forward to continued and expanding collaborations with its providers, members, and community partners to advance health equity and reduce health disparities.

Appendices