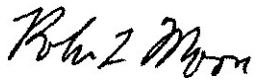
Quality and Performance Improvement Program Description

September 2023
MPQD1001

Program Approval

	**08/16/2023**

Robert Moore, MD MPH MBA
Quality/Utilization Advisory Committee Chairperson *Date Approved*

	**09/13/2023**

Steven Gwiazdowski, MD, FAAP
Physician Advisory Committee Chairperson *Date Approved*

	**10/25/2023**

Alicia Hardy
Board of Commissioners Chairperson *Date Approved*

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Program Purpose and Goals

Partnership HealthPlan of California's (Partnership) Quality and Performance Improvement (QI/PI) program provides a series of systematic processes to monitor and evaluate the quality of clinical care and health care service delivery to all Partnership members. This includes an organized framework to:

- Review activities and identify opportunities to improve the quality of health care services provided
- Promote efficient and effective use of health plan financial resources
- Promote and improve health equity
- Strike a balance between compliance with and performance on regulatory standards
- Partner with internal and external stakeholders to support performance improvement
- Improve health outcomes of our members

The QI/PI program promotes consistency in application of quality assessment and improvement functions for the fullscope of health care services while providing a mechanism to:

- Ensure integration with current community and population health priorities, standards, and goals that impact the health of the Partnership member population
- Identify and act on opportunities to improve care and service
- Identify overuse, underuse, and misuse of health care services
- Identify and act on opportunities to improve processes to ensure patient safety
- Identify and act on opportunities to address disparities in health access and outcomes
- Address potential or tangible quality issues
- Review trends that suggest variations in the process or outcomes of 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 patient safety
- Measure and encourage appropriate use of clinical resources
- Strengthen a culture of continuous quality improvement within the Partnership network

The QI/PI program accomplishes these goals by:

- Systematically monitoring and evaluating service and care provided
- Continuously improving our data and approach to 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 performance improvement are identified
- Addressing overall member experience by improving provider access and member awareness of the health plan's role and responsibilities
- Promoting a culture of learning and improvement through a framework called Pathway to Excellence: Partnership's Framework for Continuous Learning (P2E)

These goals align with Partnership's mission: To help our members and the communities we serve be healthy.

Applying the model of a learning organization, the measurement and analysis of selected indicators and professionally recognized standards of practice underpin the evaluation of QI/PI activities. The objectives of the program are to:

- Engage providers, members, and community stakeholders to improve quality metrics through identifying opportunities for improvement and actingon opportunities that have the greatest impact on member care. These actions are driven by rigorous data analysis, whenever possible, and through a collaborative

atmosphere where new ideas can be explored and tested to enhance learning.
- Improve member experience through enhanced primary care provider (PCP) access.
- Strengthen the data and analytics infrastructure through the development of foundational systems and processes for evaluation of results and decision-making.
- Maintain National Committee for Quality Assurance (NCQA) accreditation and ensure compliance with contractual quality requirements, state and federal quality regulations, evidence-based standards of care, and standards of selected accrediting bodies.
- Equip PCPs to provide recommended high-quality care through provision of information, technical assistance, improvement tools, and financial incentives.
- Optimize value-based programs through measure research and incorporation of best practices.

The objectives, scope, organization, and mechanisms for overseeing effectiveness of monitoring, evaluation, and problem solving activities in the QI/PI program are assessed and revised at least annually.

Scope of Quality and Performance Improvement Program

The scope of the QI/PI program includes the quality of clinical care and of service for all members. The program covers a single product line – Medi-Cal (the name for Medicaid in California). The monitoring and evaluation of clinical issues reflects the population served by Partnership without regard to age group, disease category, or risk status. In-partnership with other Partnership departments, the QI/PI program encompasses all aspects of medical care including:

- Diagnoses and procedures with a wide variation in cost or utilization patterns
- Identifying overuse, underuse and misuse of health care services and prescription medications
- Identifying and addressing racial/ethnic and other disparities in health care delivery or outcomes
- Identifying and addressing access or quality issues related to behavioral health services through delegated contracts
- Promoting cultural and linguistic competence of Partnership staff and network practice sites and providers
- Member experience outcomes
- Facility Site Reviews and ongoing monitoring to assess compliance with patient safety standards
- Ambulatory medical records review
- An assessment of physical accessibility of outpatient providers for seniors and persons with disabilities
- Preventive health care guideline compliance
- Chronic and acute care clinical practice guideline (CPG) compliance
- Continuity and coordination of care between PCPs and specialists, different levels of care, PCPs and other provider types, and PCPs and Behavioral Health Practitioners (through the Care Coordination department)
- Accessibility and quality of primary, specialty, and behavioral health care
- Member grievances (through the Grievance & Appeals department)
- Investigation and resolution of Potential Quality Issues (PQIs)
- Provider satisfaction (through the Provider Relations department)
- Provider credentialing (through the Provider Relations department)
- Supporting clinics in achieving patient centered health homes

The QI/PI program encompasses monitoring and evaluation of care and service in the following settings:

- Acute hospital services
- Ambulatory care, including preventive health care, perinatal care, chronic disease management, and familyplanning
- Emergency and urgent care services
- Behavioral health services* (mental health and substance use disorder)
- Ancillary care services including but not limited to: home health care, skilled nursing care, subacute care, pharmacy, medical supplies, durable medical equipment (DME), therapy services, laboratory, vision, and radiology services

- Long-term care including skilled nursing facility care, rehabilitation facility care, and home health care
- Wellness and Recovery Program

*The QI program scope as it relates to behavioral health services:

Mental Health Services:
Since January 1, 2014, Partnership has provided mental health services for those with mild to moderate treatment needs, pursuant to the Plan's Medi-Cal contract with the State of California. Partnership delegates the administration of these services to Carelon Behavioral Health, formerly known as Beacon Health Options, in all 14 counties served by Partnership and to Kaiser Permanente in five counties where a portion of Partnership members are assigned to Kaiser Permanente. This mandate is detailed in the California Department of Health Care Services (DHCS) All Plan Letter 22-006 (Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services) issued April 8, 2022.

DHCS assigns Specialty Mental Health Services for mental health conditions deemed to be moderate to severe interms of level of impairment (also referred to as serious and persistent mental health conditions or SMI) to County Mental Health Plans (MHPs). These include all conditions that meet the medical necessity criteria pursuant to the DHCS Behavioral Health Information Notice (BHIN) 21-073, issued December 10, 2021.

All mental health QI management and improvement activities are delegated by Partnership to Carelon Behavioral Health and Kaiser Permanente. Partnership oversight of these delegated QI functions is achieved through: 1) annual and ad hoc audits, 2) semi-annual review of QI reports produced by these entities, and 3) discussion of quality management and development of quality improvement projects, (e.g., improved PCP referral forms, review and monitor quality issues related to neuropsychological testing, additional reports related to QI, and access standards).

Wellness and Recovery Program:
On July 1, 2020, Partnership and seven counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) implemented the "Wellness and Recovery" program, a regional substance use disorder services program. In the future, Partnership expects to welcome Lake County to the program. As Partnership does for other services, this program description includes the planned structure of quality and performance improvement activities Partnership uses for the overall program.

The quality infrastructure of the Wellness and Recovery Program is designed to help achieve one of the key goals of the program: the integration of substance use disorder services with the existing physical and mental health service delivery system. It reflects the incorporation of the county-focused quality structure outlined in the state and federal Organized Delivery System (ODS) waiver requirements into the strong, foundational quality structure of Partnership.

Authority and Responsibility

Board of Commissioners
The Board of Commissioners on Medical Care (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 Committee (IQI), 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, businesses, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health departments. The Commission meets six times per year.

The purpose of 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.

Chief Executive Officer
The Partnership Chief Executive Officer's (CEO) primary roles in quality management and improvement are multifold:

- Maintain a working knowledge of clinical and service issues targeted for improvement
- Provide organizational leadership and direction
- Identify new and emerging opportunities to increase accountability by internal and external partners for driving quality and performance improvement
- Participate in prioritization and organizational oversight of quality improvement activities
- Ensure availability of resources necessary to implement the approved QI/PI program

Chief Operating Officer
The Chief Operating Officer (COO) works closely with leaders in Utilization Management to provide accountability for delegates to meet necessary NCQA accreditation requirements and provide strategic leadership and guidance in the review and revision of provider contracts to ensure QI reporting requirements and value based program contingencies are met. The COO also has purview over the Member Services, Claims, Configuration, Grievance and Appeals, Transportation and the Regional Leadership 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 fulfills the need for executive support and accountability for improvements with data quality, coordination of activities between QI and departments including Member Services, and Population Health.

Chief Medical Officer
The Chief Medical Officer (CMO), with the assistance of the members of PAC, Q/UAC, and IQI, is responsible for providing professional judgment regarding matters of quality of care, peer review, clinical, and medical procedures. The CMO is the chair of IQI and Q/UAC and has significant involvement in all QI/PI, Pharmacy, and Health Services activities as well as providing oversight to these programs on a day-to-day basis. The CMO is a Medical Doctor (MD)with an unrestricted license in the State of California.

Northern Region Executive Director
The Northern Region Executive Director supports QI/PI work in the Partnership Northern Region (NR) by leading operational staff based in Eureka and Redding. The Northern Region Executive Director works 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 Executive Director helps garner resources for member and provider facing performance improvement activities while encouraging interdepartmental support for quality improvement initiatives.

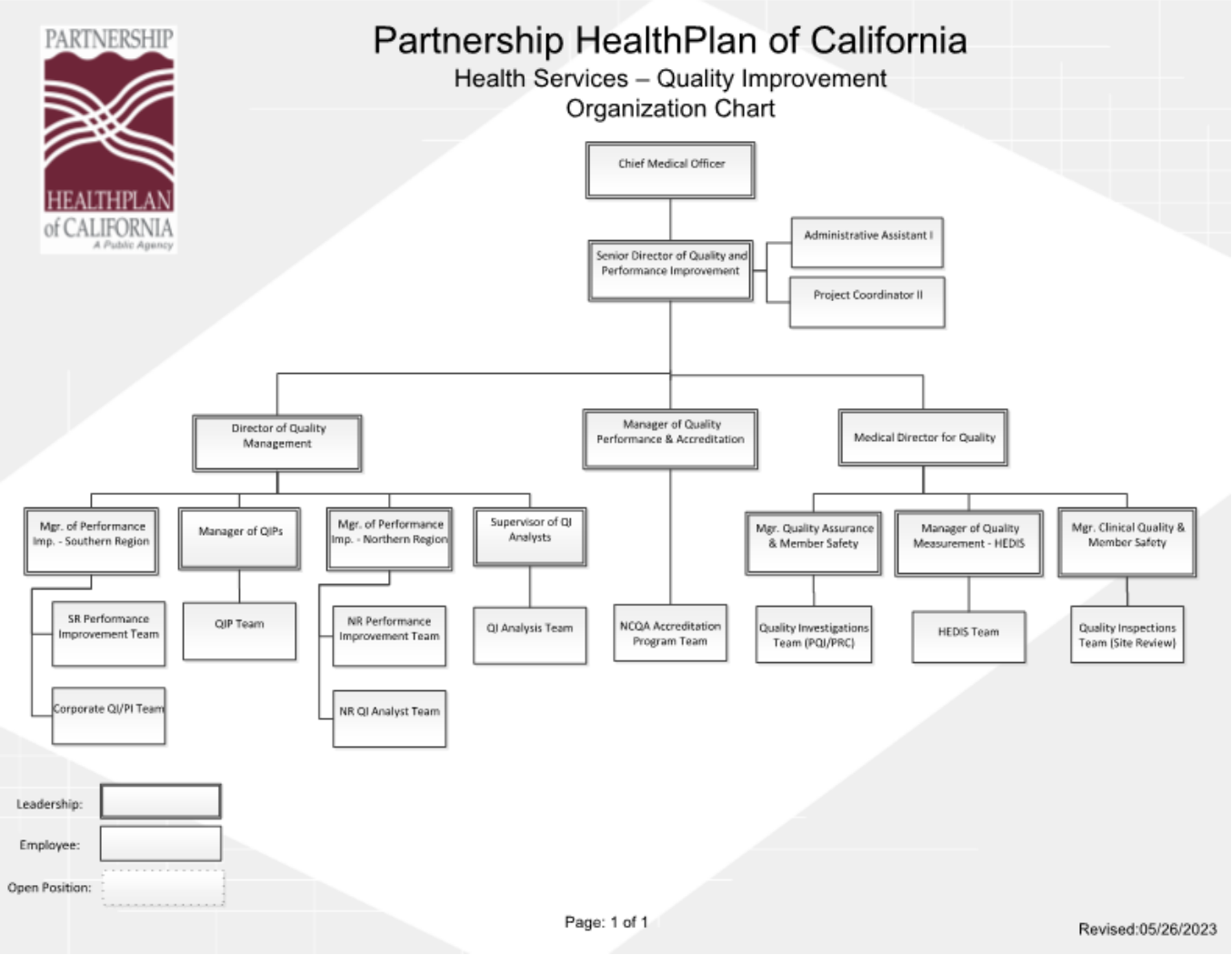
Chief Strategy & Government Affairs Officer
The Chief Strategy and Government Affairs Officer (CSGAO) reports to the Chief Executive Officer and is a peer to the other executive team members. The CSGAO leads the overall strategic direction of the HealthPlan in consultation with the CEO and Governing Board.

This position is responsible for the operations and executive management of Regulatory Affairs and Compliance (RAC); Communications, Legal, Provider Relations, and Project Management/Operational Excellence (PMO) departments. Further, this position serves as Partnership's Compliance Officer, working to ensure the HealthPlan's ongoing compliance with all applicable federal, state, local, and administrative agency statutory and regulatory requirements.

Clinical Director of Behavioral Health
The Clinical Director of Behavioral Health holds an MD/DO, PhD or PsyD credential. With the assistance of the Behavioral Health Leadership Team, this individual is responsible for providing professional judgment regarding matters of quality of care, peer review, and clinical policies and procedures through oversight of Partnership activities in theareas of mental health and substance use disorder services as provided by Partnership's delegated behavioral health providers.

Behavioral Health Leadership Team
The Behavioral Health Leadership Team includes the Senior Director, Health Services; Chief Operating Officer (COO); Behavioral Health Administrator; Behavior Health Manager; and other plan leadership. This team oversees the operations and delegation oversight of Partnership's mental health and substance use disorder services. Partnership's annual audit of Carelon Behavioral Health and of Kaiser Permanente (behavioral health delegates) stipulates that the organizations produce evidence that Behavioral Health Specialists at the level of PhD and/or MD are on their QI Committee or teams that report to their QI Committee. Both organizations meet this standard.

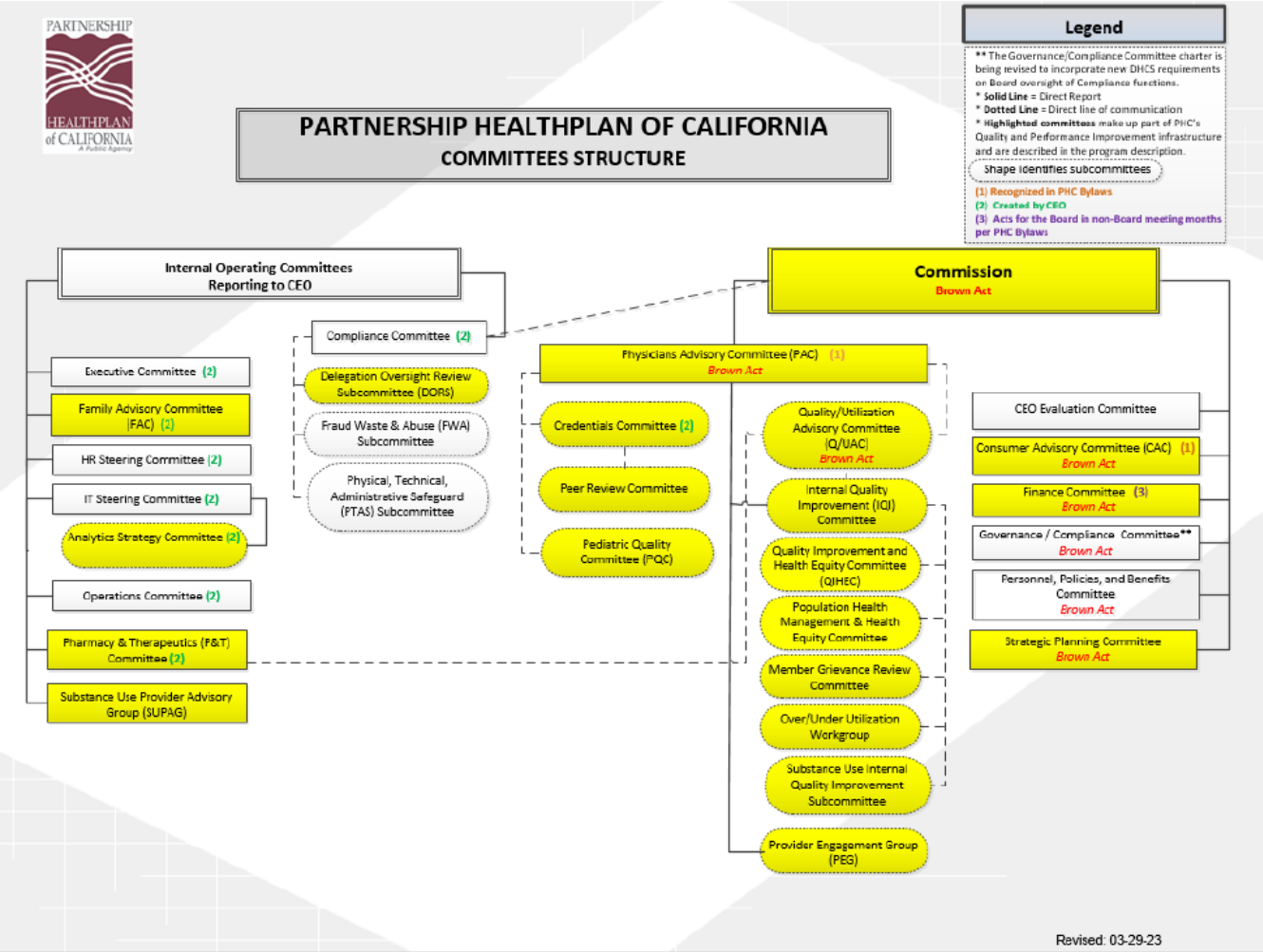
Program Staff
Partnership QI/PI program leadership and corresponding teams are outlined in the organizational chart below.



The QI/PI department is structured to provide governance over the QI program and corresponding work plan. Under the guidance of the CMO, the Senior Director Quality and Performance Improvement and respective directors in QI/PI lead the department in the execution of QI/PI activities outlined in the QI Program Description and QI Work Plan. The department ensures the primary activities related to performance improvement, adherence to regulatory requirements, and the quality and safety of clinical care to optimize members' experience with Partnership are completed through ongoing engagement and the provision of interdisciplinary support to all areas within Partnership.

Committee Functions

Partnership has developed a robust committee structure to support the breadth and depth of multiple facets of QI/PI regulatory requirements and activities. There are several internal operating committees that report to the CEO and a number of external facing committees, principally PAC and four others that report directly to the Board of Commissioners. Certain committees must adhere to state regulations, including the Brown Act, which provides stipulations for making meetings available to the public. The following narrative and diagram describe their organization and reporting structures.



Consumer Advisory Committee (CAC)
The Consumer Advisory Committee (CAC) is composed of Partnership members who represent the diversity and geographic areas of Partnership's membership including hard-to-reach populations. The CAC is a liaison group between members and Partnership, advocating for members by ensuring that the health plan is responsive to the health care and information needs of all members. The CAC meets quarterly, reviews and makes recommendations regarding Member Services' quality improvement activities, provides feedback on quality and health equity initiatives, and serves in the capacity of a focus group. A CAC member(s) serve(s) on the Partnership Board to provide member input and report back to the CAC.

Finance Committee
The Board of Commissioners authorizes the Finance Committee to act on matters of urgency and/or when the Board does not meet. Items approved by the Finance Committee are ratified by the full Board at a subsequent full Board meeting. The Finance Committee is comprised of an appointed group of members from the Board, which encompasses representation from across Partnership's entire service region. The Finance Committee meets monthly.

The Finance Committee has the following authority:

- Review and make recommendations on the annual budget
- Review and make recommendations on financial policy
- Review major capital expenditures
- Monitor the financial status of the organization and overall leadership for better management in alliance with the executive team and other Partnership staff

The Committee also advises the Board of Commissioners on the fiscal impact of any changes pertaining to value-based programs as related to:

- Payment structure
- Annual budget and
- Prioritizing programs

Provider Engagement Group (PEG)
Meetings are held quarterly. This group will include network staff and vary based on subject matter. The purpose of PEG is to educate and update the network about new Partnership programs, benefits, and/or changes mandated by DHCS or Partnership. The Plan staff will target specific network invitees depending upon subject matter to be presented or discussed. Targeted provider audience and invitees include clinic managers, supervisors and other mid-management staff. Minutes of the meetings will be presented to PAC.

Strategic Planning Committee
The Strategic Planning Committee advises the Board of Commissioners and the CEO on long-range strategic issues affecting Partnership. This committee is appointed by the Board of Commissioners and is comprised of some Board of Commissioners' members and other leaders from the community who are not members of the Board. This committee meets on a quarterly basis.

Physician Advisory Committee (PAC)
The Physician Advisory Committee (PAC) monitors and evaluates all Health Services activities and is directly accountable to the Board of Commissioners for the oversight of the QI/PI program. PAC meets at least ten (10) times a year, and, may not convene in the months of July and December, with the option to add additional meetings if needed. Voting membership includes external PCPs, board certified high-volume specialists and non-physician clinicians. A voting provider member of the committee chairs PAC. The Partnership CEO, COO, Chief Financial Officer (CFO), CMO, Medical Director for Quality, Regional Medical Director(s), Clinical Director of Behavioral Health, and leadership from the following departments including; QI/PI, Provider Relations, Care Coordination, Utilization Management, and Pharmacy attend PAC meetings regularly. Other Partnership staff attend on an adhoc basis to provide expertise on specific agenda items. PAC oversees the activities of Q/UAC and other quality- related committees and reports QI/PI activities to the Board of Commissioners.

Credentials Committee
The Partnership CMO, or designee, chairs the Credentials Committee. Committee members include a minimum of five contracted network practitioners. The committee meets monthly, excluding July and December. The functions of the Credentials Committee are to:

- Participate in and make recommendations regarding the structure and process for the credentialing and re-credentialing of providers and licensed practitioners
- Participate in the development, implementation, and annual review of related policies and procedures
- Review and approve Partnership staff recommendations for credentialing of practitioners who meet criteria
- Review and approve Partnership staff recommendations for credentialing of practitioners who do not meetexception criteria
- Review qualifications and circumstantial details for contracted practitioners who meet exception criteria andmake credentialing decisions
- Review and evaluate the qualifications of each practitioner seeking re-credentialing as a contracted provider at least every three years and assure compliance with established criteria
- Review ongoing sanctions monthly and member complaints every six months for each practitioner
- Verify that each provider in the network meets credentialing requirements, including implementation of and adherence to any corrective action plans (CAPs) to meet standards
- Decisions regarding provider credentialing and re-credentialing
- Develop disciplinary or sanction actions of practitioners
- Provide oversight of any delegated credentialing activities

Summary information of credentialing activities is presented to the PAC and to the Partnership Board of Commissioners at the regularly scheduled meetings.

Peer Review Committee (PRC)
The Peer Review Committee (PRC) membership includes external practitioners representing PCPs, board certified specialists and non-physician clinicians. The Partnership CMO Regional and Associate Medical Directors are also voting members of the PRC. Partnership's Performance Improvement Clinical Specialists (PICS RNs) and the Manager, Member Safety - Quality Investigations support the Committee. The Partnership Medical Director for Quality, CMO, or other designated Partnership Medical Director chairs the committee. All committee members are eligible to vote on issues brought before the committee. The committee meets at least quarterly and on an as needed basis. Peer review functions are to:

- Review potential and actual quality issues and provider/member complaints and appeals related to quality of care
- Make recommendations for CAPs and practitioner discipline or sanctions to the Credentials Committee
- Make recommendations on improvements to systems of care based on specific occurrences

Pediatric Quality Committee (PQC)
The Pediatric Quality Committee (PQC) is the clinical advisory committee for the Whole Child Model (WCM) program. The PQC meets at least four (4) times per year with the option for additional meetings if needed.

The membership of PQC includes the Partnership Whole Child Model Medical Director (Chairperson), CMO (Vice Chairperson), Senior Director of Health Services, Pharmacy Director, at least four California Children Services (CCS) paneled clinician providers, CCS Medical Directors designated by each Partnership County, and Nurse Director or Manager as designated by each County CCS program. Other health plan staff and outside experts may make special or periodic reports to the committee or may attend selected meetings by invitation from the committee chair or designee.

Pharmacy and Therapeutics (P&T) Committee
The Pharmacy and Therapeutics (P&T) Committee is comprised of Partnership staff and network practitioners including pharmacists, PCPs, and specialists, including behavioral health. The Chief Medical Officer (CMO) or Pharmacy Director (when designated by the CMO) chairs the P&T. The committee makes decisions and

recommendations on development and review of the medical benefit drug formulary, pharmacy policies and procedures, new drugs, and drug approval criteria. The P&T meets quarterly, providing regular activity reports and recommendations to PAC, the approval authority for P&T related activities. The P&T Committee also serves as Partnership's Drug Utilization Review (DUR) Board. Partnership's DUR Board conducts retrospective analysis on drug utilization to identify patterns of fraud, waste, and abuse or inappropriate or medically unnecessary care. In addition, the DUR Board makes recommendations for education programs and bulletins to improve drug safety and therapeutic outcomes.

Quality/Utilization Advisory Committee (Q/UAC)

The Quality/Utilization Advisory Committee (Q/UAC) is responsible 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. Q/UAC voting membership includes consumer representative(s) and external clinicians who represent hospitals, medical groups, and practice sites in geographic sections of Partnership's service area. Physician members also serve on the Peer Review Committee. The Partnership CMO (chair of the committee), Clinical Director of Behavioral Health, Health Equity Officer, Medical Director for Quality, Manager, Member Safety - Quality Investigations, and leadership from the Health Services departments (i.e., QI/PI, Utilization Management, Care Coordination, Pharmacy, Population Health and Transportation Services), Grievance and Appeals, and Provider Relations departments attend Q/UAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The committee meets monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to PAC and at least quarterly to the Commission.

Activities include but are not limited to:

- Review and approve the QI/PI Program Description, Program Evaluation and Work Plan annually
- Review and approve standardized utilization review criteria and protocols
- Approve and ensure implementation of evidence-based guidelines and policies of medical practice including preventive, chronic care, and behavioral health initiatives
- Analyze summary data and make recommendations for action plans for quality improvement activities
- Assure that appropriate follow-up activities occur for all CAPs and QI/PI activities
- Provide oversight of delegated QI activities except for credentialing activities, which the Credentials Committee reviews

Internal Quality Improvement (IQI) Committee

An internal Partnership committee comprised of appropriate Partnership department directors and staff, the Internal Quality Improvement (IQI) Committee tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation. The IQI Committee meets monthly, at least ten (10) times per year, with the option to add additional meetings if needed, to review policies, procedures, and QI activities. The Partnership CMO (chair of the committee), Health Equity Officer, Medical Director for Quality, Manager, Member Safety - Quality Investigations and Health Services leadership as described for Q/UAC attend IQI Committee meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. Multidisciplinary improvement teams may be designated to complete analysis and intervention recommendations for quality improvement issues and activities. Evaluations and recommendations put forward at IQI represent strategies used in local entity engagement to address deficiencies in performance measures for members 21 years of age or less. The IQI Committee serves to integrate quality activities organization-wide, which are then reported to Q/UAC and PAC.

Quality Improvement and Health Equity Committee (QIHEC)

The Quality Improvement and Health Equity Committee (QIHEC) meets quarterly for analyzing and evaluating the results of Health Equity-related Quality Improvement activities. This includes annual review of the results of performance measures, utilization data, consumer satisfaction surveys, grievance and appeal data, and findings and activities of other Partnership specific committees (e.g., Consumer Advisory Committee, Population Health Management and Health Equity Committee, etc.). This committee shall also be responsible for instituting actions to address health-equity performance

deficiencies, including policy recommendations, and ensuring appropriate measurement and follow-up of identified performance deficiencies.

The QIHEC provides recommendations to IQI and to Q/UAC. Q/UAC provides recommendations to PAC. PAC is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to Partnership members and is comprised of the CMO and participating clinician representatives from primary and specialty care disciplines.

Partnership Members of the QIHEC include (But not limited to): CMO, Health Equity Officer, Associate Director of Grievance and Appeals, COO, Associate Director of Communications, Director of Health Analytics, Senior Director of Quality and Performance Improvement, Director(s) of Care Coordination, Director(s) of Utilization Management, Director(s) of Population Health, Senior Health Educator, Senior Director of Health Services, Director of Pharmacy Services, Regional Medical Director(s), Associate Medical Director(s), Senior Provider Relations Representative Manager, and Senior Director of Member Services. In addition, a broad range of network providers (e.g. Hospitals, Clinics, County Partners, Subcontractors, Downstream Subcontractors, and Members will be solicited to actively participate in the QIHEC.

Population Health Management & Health Equity Committee (PHM&HE)
The Population Health Management & Health Equity Committee (PHM&HE) is an internal committee and serves as a multi-departmental body whose goal is to support the advancement, growth, and execution of population health and health equity interventions at Partnership. The committee consists of Partnership staff representing member, community, regional, and provider facing departments; it also incorporates representatives from Human Resources, Regulatory Affairs, IT, and Health Analytics. The meetings are quarterly to align interdepartmental efforts promoting health equity through member and systemic interventions outlined in the Population Needs Assessment (PNA) Action Plan. PHM&HE ensures Partnership is meeting state and NCQA requirements for health equity, culturally and linguistically appropriate services (including appropriate language access services at all points of contact), health education, and population health management to meet the individual needs of members. PHM&HE also reviews new state and community initiatives to ensure Partnership programs meet these objectives without duplicating interventions from other sectors. This forum provides the platform to review and implement organizational initiatives, and to revise existing programs and services, if needed, to ensure continuous process improvement and program evolution in accordance with the needs of the population. The PHM&HE Committee activities and recommendations will be shared with the QIHEC, Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC) and Partnership's Board of Commissioners.

Member Grievance Review Committee (MGRC)
The Member Grievance Review Committee (MGRC) represents a multidisciplinary oversight forum with representatives from Claims, QI/PI, Office of the CMO, Pharmacy, Care Coordination, Utilization Management, Population Health, Member Services, Provider Relations, and Transportation Services to track and trend Grievances, Appeals, Exempt Grievances, and State Hearing cases. It serves as a collaborative work group to discuss complex cases or improvement opportunities with the following key focus areas: quality improvements, clinical oversight, operationalexcellence, member experience, and regulatory compliance. Findings may be presented in the Q/UAC, IQI, CAC, Delegation Oversight Review Subcommittee (DORS), and/or Substance Use Internal Quality Improvement Subcommittee (SUIQI) meeting. MGRC is held on a quarterly basis.

Over/Under Utilization Workgroup
The Over/Under Utilization Workgroup is an internal Partnership committee that evaluates services that may be over-or under-utilized compared to optimal utilization. The Over/Under Utilization Workgroup meets quarterly. Its goals are to use the results of the analysis to drive quality improvement activities, accuracy of data collection and analysis, and the most cost-effective use of resources. The CMO chairs the committee, and the Health Analytics department supports it. Representatives from Health Services (Pharmacy, Population Health, Health Equity, Quality Improvement, and Utilization Management), Compliance, Member Services, PMO, Provider Relations, and Claims also attend. A summary of activity from the committee is annually reported to IQI and Q/UAC, (as part of the Utilization Management Grand analysis) and Partnership's Compliance Committee.

Substance Use Internal Quality Improvement Subcommittee (SUIQI)
A committee comprised of appropriate Partnership and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for Partnership's substance use disorder services oversight. The Substance Use Internal Quality Improvement Subcommittee (SUIQI) meets at least quarterly. Activities and progress are reported to IQI. This also includes review of:

- Utilization management retroactive and appeals review
- Inter-rater reliability for peer review and utilization management
- Quality of service, quality of facility, and grievances and appeals
- Investigation of potential over-use, under-use, and misuse of services
- Policies related to provision of substance use disorder services

Members of the committee include the Behavioral Health Clinical Director, Behavioral Health Administrator, Behavioral Health Manager, CMO, and representatives from Provider Relations, Member Services, Claims, Compliance, Behavioral Health, and Quality Improvement departments.

Family Advisory Committee (FAC)
The Family Advisory Committee (FAC) is a member advisory group to the CEO and staff of Partnership. The FAC provides a forum for parents, guardians and caregivers of children with CCS conditions to discuss common issues of interest and importance, to create a supportive and informative networking environment and to advocate for members by ensuring that Partnership is responsive to the diversity of health care needs for all members. Minutes from FAC meetings are reviewed by PQC.

The FAC membership is comprised of representatives from throughout Partnership's geographic service areas who advocate for CCS-eligible children of diverse cultures, ethnicities, genders, ages and disabilities. Meetings are held at least four (4) times per year with the option for additional meetings as needed.

The mission of FAC is to leverage the Whole Child Model (WCM) to enhance the quality of how CCS beneficiaries – and their families - experience care.

Analytics Strategy Committee
The Analytics Strategy Committee is comprised of the CFO, CMO, Deputy CFO, Senior Director of Health Services, Director of Financial Planning and Analysis, Director of Enterprise Information Management, Director of Population Health, Senior Director Quality and Performance Improvement, Director of Health Analytics, and Associate Director of Data Warehouse. The Committee meets periodically throughout the year with the following strategic foci:

- Prioritize and communicate efforts between Data Governance Council, workgroups and stakeholders
- Ensure the analytics strategy efforts align with the priorities from the Data Governance Council
- Provide recommendations (including resource allocation recommendations) to the Data Governance Council
- Sponsor, approve and manage plans that support analytics strategy efforts and projects
- Form work groups and define their scope, based on area of expertise and responsibility

Substance Use Services Provider Advisory Group (SUPAG)
The Substance Use Services Provider Advisory Group (SUPAG) monitors Partnership substance use disorder services treatment activities. The committee will meet at least four times per year. Membership includes licensed and certified substance use disorder services providers and clinicians and others involved in substance use disorder care. The Committee also includes county substance use disorder services administration representatives. The SUPAG advises the CEO on issues related to Partnership's administration of the substance use disorder services benefit.

Compliance Committee
The Compliance Committee, chaired by the Compliance Officer, has general responsibility to oversee Partnership's compliance and ethics programs. The purpose of the Committee is to oversee Partnership's

implementation of compliance programs, policies and procedures that are designed to respond to the various compliance and regulatory risks facing the company; provide an avenue of communication among management, those persons responsible for the internal compliance function, and the Commission; and perform any other duties as direct by the Commission or the CEO.

Delegation Oversight Review Subcommittee (DORS)
The Delegation Oversight Review Subcommittee (DORS) comprises representatives from operational departments that have oversight responsibility wherein Partnership has assigned authority to an external entity (delegated entity) to perform on its behalf. DORS meets no less than four times per year and is responsible for overseeing agreements and responsibilities between Partnership and its delegated entities. The Subcommittee is tasked with overseeing that delegates are compliant with all applicable state and federal regulations, contractual obligations, and accreditation requirements.

Note: Meeting frequency indicated with each committee is subject to change based on business needs.

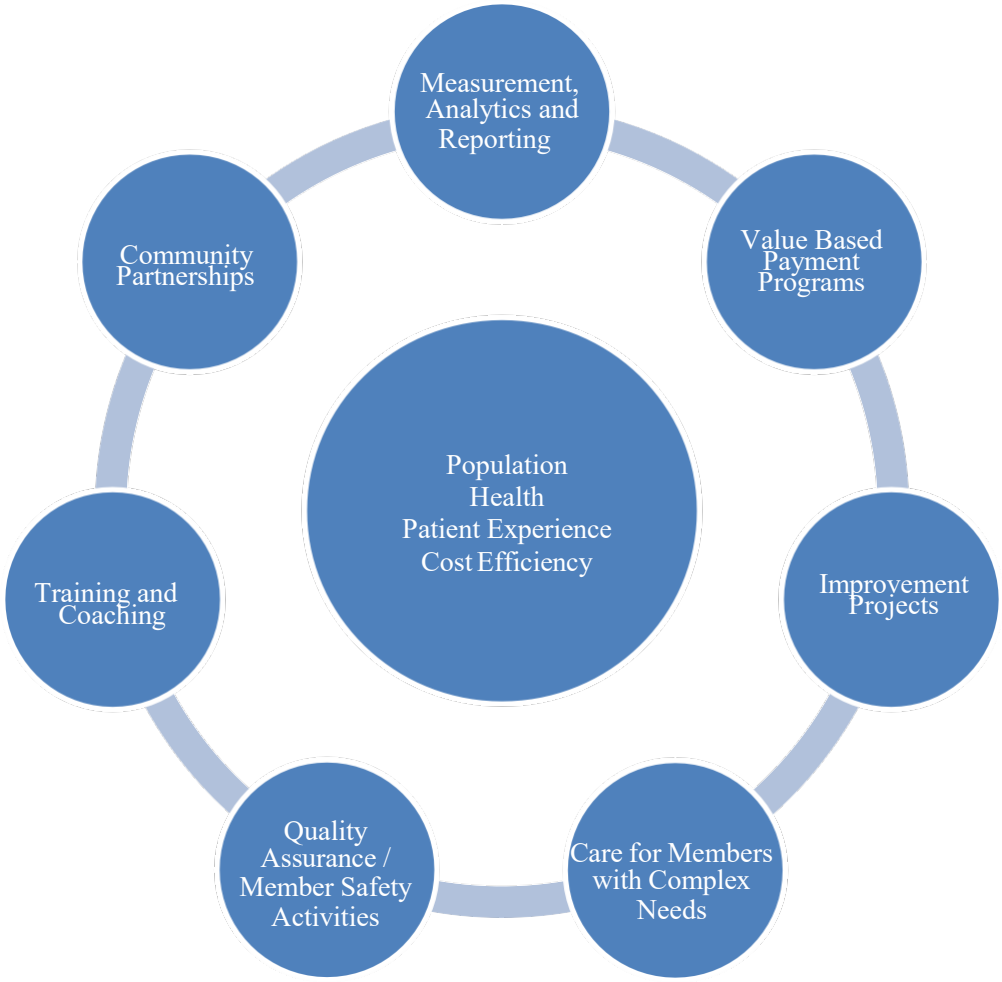
Membership in committees is voluntary and open to all who meet the minimum criteria and who are willing to serve. When positions become available, Partnership looks for committee members who reflect the diversity of our communities. Partnership continually evaluates key diversity factors (including, but not limited to: race, ethnicity, language, gender identity, sexual orientation, disability status, etc.) to ensure that committee membership reflects Partnership's membership and provides diverse views. The committee chair will make a good faith effort to review and verbally report (to committee members) key membership demographic information after the publication of the PHC community report when a position become available, annually. As opportunities presents, special efforts will be made to invite candidates who reflect such attributes to continually encourage diversity within committees.

Approach to Quality and Performance Improvement

Partnership's Quality and Performance Improvement program focuses on simultaneous pursuit of the Institute for HealthCare Improvement (IHI) triple aim – population health, patient experience and cost efficiency – via seven primary levers:

- Measurement, Analytics and Reporting
- Value Based Payment Programs
- Improvement Projects
- Care for Members with Complex Needs
- Quality Assurance and Member Safety Activities
- Training and Coaching
- Community Partnerships

Partnership is also committed to pursuing a fourth aim of achieving equitable health for all of our members. This aim supports an increased understanding of social determinants of health and working to address disparities that impactthe quality and sufficiency of health care provided to Partnership members.



Measurement, Analytics and Reporting

The QI/PI department collects data annually on clinical indicators for Medi-Cal through the Health Effectiveness Data & Information Set (HEDIS®) program. DHCS and NCQA Accreditation are two governing entities that mandate HEDIS® annual reporting. DHCS and NCQA Accreditation select sets of clinical quality measures that are sourced directly from the NCQA measure library and/or Center for Medicare Services (CMS) measure library in which Medicaid managed care plans are required to report. The DHCS and NCQA Accreditation clinical quality measure sets also identify measures requiring stratification by race/ethnicity and language per NCQA designated categorizations. Partnership annually conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, which measures member experience in the last six months across a set of standard questions. In addition, the CAHPS® survey is conducted by DHCS every two years. The CAHPS® survey results, combined with the final rate performance of the HEDIS® clinical quality measures are calculated by NCQA to provide Partnership's overall HealthPlan Star Rating. Partnership participates in compliance audits for HEDIS® and CAHPS® with the state-contracted External Quality Review Organization (EQRO) and Partnership's contracted audit firms to ensure that survey results and measure rate calculations are in accordance with NCQA and CMS specifications. Partnership calculates and reports the performance, including health equity based stratifications, as required by NCQA and DHCS at the reporting unit level. Separately, Partnership reports plan-wide CAHPS® survey results and HEDIS® measure performance results at the reporting unit level for its fully delegated subcontractors. Partnership works with the EQRO to report audited results per due dates defined by NCQA and DHCS annually.

Once submitted to NCQA and DHCS, Partnership further evaluates its performance, and that of its fully delegated subcontractors, versus DHCS established Quality and Health Equity Performance measure benchmarks. The resulting Annual HEDIS® Performance Summary includes analysis of whether or not Partnership, including its fully delegated subcontractors, met or exceeded DHCS established benchmarks. Currently DHCS defines high performance (HPL) for a measure in the Managed Care Accountability Set as being above the 90th percentile of all Medicaid Health Plans nation-wide, as promulgated by NCQA. DHCS defines the minimum performance level (MPL) on MCAS measures as being the *average* score of Medicaid Managed Care plans nationally (i.e. the 50th percentile), as promulgated by NCQA. In reporting units where DHCS defined minimum performance levels MPLs and health disparity reduction targets (yet to be defined) were not met, the QI program and QIHETP teams collaborate to present recommended action plans centered around performance improvement to IQI and Q/UAC. Partnership also responds timely to DHCS actions that may include focused studies, ongoing technical assistance from the EQRO, financial sanctions, administrative sanctions, and/or Corrective Actions in cases where below MPL performance is reported.

Aside from compliance audits for HEDIS® and CAHPS®, Partnership also conducts annual Encounter Data Validation (EDV) studies, at the direction of the state-contracted EQRO. The goal of this annual study is to evaluate DHCS' encounter data completeness and accuracy through a review of medical records for a specified 12-month study period. The study is focused on a member population continuously enrolled to Partnership during the specified study period with at least one professional visit during the study period. The EQRO selects a random sample of members from which Partnership procures corresponding medical records via provider outreach, submitting the records timely using a process defined annually by the EQRO.

Analytics support for the QI program is primarily provided by staff in the Finance, Information Technology (IT), and Quality and Performance Improvement departments. Health analytics including population assessment, case management member stratification, and monitoring of utilization patterns is conducted by the Director of Health Analytics and Health Analytics Analysts who are part of the Finance department. Data Analysts in the QI department and the IT department support the following work:

- Partnership Pay-for-Performance Programs (also known as Quality Improvement Programs or QIPs)
- Sourcing and integration of data for HEDIS® annual and monthly reporting
- Monthly reconciliation of QIP data that is used to support tools for providers to monitor their performance on quality metrics and services
- Partnership Quality Dashboard (PQD) front end development and maintenance of this provider-facing HEDIS® and QIP performance monitoring tool
- Development and execution of data collection plans that identify baseline performance and capture the

impact of performance improvement interventions
- Analysis of performance data to identify areas for improvement, including creating dashboards and reports to actively measure targeted processes and performance changes over time
- Provision of actionable recommendations and informing stakeholders of the impact of key decisions based on available data

In addition to HEDIS® and CAHPS®, summary results from access studies, grievances, Initial Health Appointments (IHA), facility site and medical record reviews, PQIs, targeted improvement projects, performance improvement activities (including practice facilitation and other quality capacity building activities) are presented to IQI and physician committees at least annually. Project measures are reviewed more regularly during improvement team meetings. Partnership completes a robust, comprehensive evaluation annually for major programs and quality improvement projects and initiatives.

At the organization level, the Executive Team and Board of Commissioners review a comprehensive dashboard including metrics across the organization every six months. Each year, the executive team sets organization-wide priorities. In FY 2022/23 there were seven, including; Quality, Access and Equity, Community Partnerships, Operational Excellence, Financial Stewardship, Health Equity, Implementation of the new Claims System and County Expansion.. A board advisory group on Quality meets quarterly to provide feedback and advice on strategic quality issues.

Performance results are shared with external and internal stakeholders through data reports and data presentations given at quality committee meetings, medical director meetings, academic detailing visits, conferences, provider site visits, webinars, and community meetings.

Through Partnership's value-based programs, providers receive reports showing their performance against established thresholds and Partnership network averages (and/or across peer groups) at least annually, but this information is available on a monthly basis for providers participating in certain QIPs. The Primary Care Provider Quality Improvement Program (PCP QIP) provides PCPs aggregate and member-level data through two interactive online tools: eReports and PQD. eReports refreshes twice a week and allows PCPs to identify those members with gaps in preventive and chronic disease care in support of compliance on the PCP QIP's clinical measures. It also allows PCPs to upload additional data to support measure-specific numerator compliance or exclusion criteria. PQD is a Tableau-based online data visualization and analytics tool that supports analysis of Partnership's HEDIS® and PCP QIP performance data.

Substance use disorder services focused performance improvement projects are managed by Partnership and administered centrally. The SUIQI reviews data at least annually from eligibility, claims, encounter, and provider data to analyze adherence to protocols and identification of those in need of services; timely access measures; initial and engagement of clients into treatment; fidelity to American Society for Addiction Medicine (ASAM) requirements; and outcome and recovery data. The SUIQI aligns their efforts, where possible, with the EQRO evaluation processes and support their evaluation criteria.

In addition, review of the substance use disorder service system and its integration into overall Plan services are incorporated into the ongoing Partnership measurement and reporting programs. This includes analysis of member satisfaction (CAHPS®) measures for both children and adults; summary results from access studies, grievances, IHAs, facility site and medical record reviews, PQIs, targeted improvement projects, and training activities. These are presented to SUIQI on an ongoing basis and reported up to SUPAG, IQI, Q/UAC, and PAC at least annually. Substance use disorder services performance reports are also shared at various meetings, trainings, and webinars and community meetings.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Program

Oversight of the CAHPS® program transitioned from Member Services to Quality Improvement in December of 2022. This change is a strategic pathway to excellence whereby leveraging staffing strengths in Health Services and Quality improvement to drive HEDIS® measure and CAHPS® score improvement through interventions and initiatives.

For additional CAHPS program inter-department dependencies related to DHCS and NCQA accreditation requirements please reference the following sections in this document.

- Measure, Analytics and Reporting
- NCQA Accreditation Program Management

Background

CAHPS® is both a member and patient experience survey governed by the Agency for Healthcare Research and Quality (AHRQ) program and its established set of survey design principles and standards.

The intent of the CAHPS® survey, also referred to as the ***Member Experience Survey,*** is administered to capture accurate and complete information about HealthPlan member-reported experiences as well as a level of care within the PCP network.

The survey population includes both adult and children and aims to measure how well plans are meeting their members' expectations and healthcare goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which can help Partnership HealthPlan of California (Partnership) increase the quality of care.

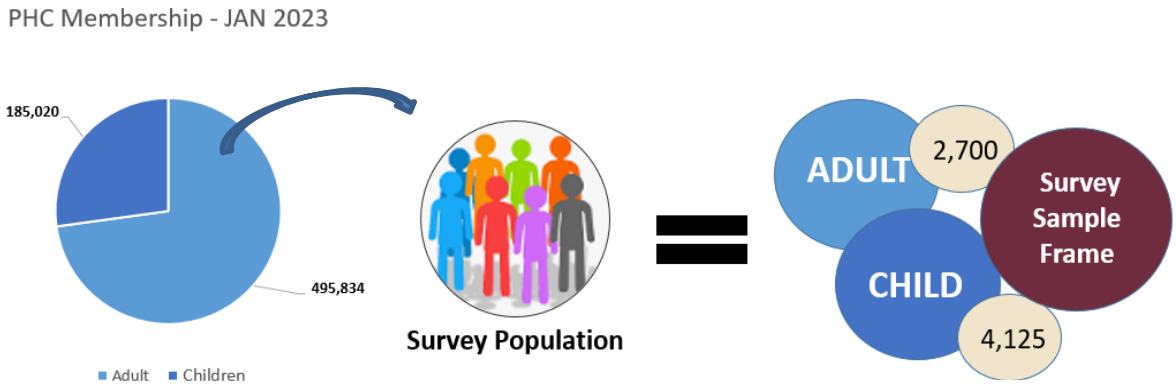
The NCQA requires accredited health plans to contract with certified HEDIS® Survey Vendor to administer the annual survey.

CAHPS® Survey: Vendor, Member Population, Criteria, Methodology, and Results

CAHPS® program administration oversees the annual survey cycle setup through survey campaign completion. Program oversight includes vendor management and contracting with Press Ganey, a certified HEDIS® Survey Vendor. Press Ganey, formerly known as SPH Analytics is an industry leader with more than thirty years of CAHPS®/survey project management, and analytic reporting experience and manages a Health Plan company, book-of-business (BoB) portfolio of more than 80% of our nation's Medicare, Medicaid, and Managed Care Health Plans (MCP) products.

Member Population

CAHPS® program inter-department stakeholders meet each year to evaluate survey results for several factors, one that includes survey response rate comparisons against Partnership, HEDIS®, and Press Ganey (BoB) trends. One outcome is determining the next measurement year survey sample size. Included in the prior year's survey analysis is determining if an oversample of the Partnership member population, adult, child, or both is recommended. The infographic referenced below illustrates the established survey sample frame of our total member population.



- ❖ Adult beneficiaries who are 18 years and older (as of December 31st of the measurement year)
- ❖ Child beneficiaries, who were parents or guardians of those 17 years and younger (as of December 31st of the measurement year)

Survey Member Criteria Basics
The size of the survey sample frame includes qualifying adult and child member populations. Each member must have continuous Partnership primary coverage for the prior year, six months (July 1st – Dec 31st), and have been treated by a contracted provider within our network. The HEDIS® Team is responsible for generating the sample frame. Partnership

Survey Methodology
The survey methodology used is a mixed protocol in English and Spanish language formats to solicit and encourage our members to participate in our measurement year CAHPS® survey period which is between the months of February through May.

			
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

Survey Results
Press Ganey completes a thorough survey analysis comparing current Partnership HealthPlan respondent rates, and measure performance against our year-over-year performance, HEDIS®, and Press Ganey (BoB) benchmarks. Survey performance and qualitative analysis are targeted on the following composite categories.

Rating of Health Plan	Rating of Health Care	Getting Needed Care	Getting Care Quickly
Coordination of Care	Rating of Personal Doctor	Rating of Specialist	Customer Service
How Well Doctors Communicate	Ease of Filling Out Forms		

Press Ganey's analysis, inclusive of a proprietary key driver statistical model enables the CAHPS® program and inter-department stakeholders to make data-driven intervention recommendations.

Path Forward
Develop a comprehensive and strategic CAHPS® program to improve member experience, perception of the health plan, score performance, and direct initiative aligned with the Partnership mission and vision.

The tenets of the program to improve overall member satisfaction, and optimize network adequacy, availability, inclusivity, and equity will require a multi-disciplined, multi-initiative strategy across multiple organizational departments. A fully vetted program strategy will be completed at the end of the fiscal year 2022-2023.

Aiming for the Stars
NCQA Accreditation Health Plan Rating (HPR) rates plans on a scale from 1-5 stars. HEDIS® and CAHPS® scores combined by applying a weighted methodology influence our NCQA Stars rating.

CAHPS® results are an important component of a plan's HPR, an annual report that rates health plans on a scale from 1-5 stars. The HPR is the weighted average of a plan's HEDIS® and CAHPS® measure ratings, plus bonus points for NCQA Accredited plans. NCQA publishes Health Plan Ratings online in September of each year. Ratings are accessible to our members, our stakeholders, and community partners, and nationally accessible to the general public.

Obtaining a NCQA HPR of 5-stars will require a two-to-five-year strategic plan which will be led by the QI Department with the goal of delivering high-quality program management, implementation of improvement initiatives, and being agents of change using the Plan, Do, Study, Act (PDSA) model.

CAHPS® programmatic oversight includes an inter-department collaboration in particular with HEDIS®, NCQA Accreditation Team, and external department partners identified below.

Cross-Department/Team Program Strategic Partners

• Member Services	• Population Health	• Health Services
• Grievances and Appeals	• Administration	• Communications
• Quality Improvement: HEDIS® Team	• Quality Improvement: NCQA Team	• Quality Improvement: Performance Improvement

Strategic organization change of Member Experience coupled with continuous partner collaboration is necessary to support the annual accreditation CAHPS® survey requirements and is critical to achieve and maintain an NCQA 5-Star Rating.

Value Based Payment Programs

Partnership has value-based program in the areas of primary care, hospital care, specialty care, long-term care, palliative care, perinatal care, behavioral health, and enhanced care management. These value-based programs align with Partnership's organizational mission to help our members and the communities we serve be healthy. Partnership uses nine (9) guiding principles for measure development and program management to ensure our members have high quality care and our providers are able to be successful within these programs.

1. Pay for outcomes, exceptional performance, and improvement
2. Offer sizeable incentives
3. Actionable Measures
4. Feasible data collections
5. Collaboration with providers
6. Simplicity in the number of measures
7. Comprehensive measure set
8. Align measures that are meaningful
9. Stable measures

The aforementioned guidelines and design of these programs assure no payments are made directly or indirectly to providers as an inducement to reduce or limit Medically Necessary Covered Services to members, per 42 CFR sections 438.3(i) and 438.10(f)(3). Additionally, these value based programs and corresponding financial payments comply with the requirements of APL 19-005. All financial incentive programs, per contract requirements, are reported in the form, manner, and frequency specified by DHCS.

Primary Care Provider Quality Improvement Program (PCP QIP)

This program provides financial incentives, data reporting, and technical assistance to PCPs to improve key domains of quality: clinical care, patient experience, access and operations, and resource use. PAC reviews and approves proposed clinical measures selected for the PCP QIP. A group of providers and administrators (QIP Advisory Group) across counties and practice types recommend measures for the PCP QIP each year. Following the QIP Advisory Group's recommendations and internal discussions with various Partnership department stakeholders, the draft measures are released to the Partnership provider network during a public comment period. Feedback from the public comment period is shared with the QIP Advisory Group and at internal stakeholder meetings, at which time measure recommendations are forwarded to PAC for review and approval. The measures and detailed specifications can be found on the Partnership website.

Hospital Quality Improvement Program (HQIP)
The HQIP, established in 2012, is a pay-for-performance program for invited hospitals serving Medi-Cal members in the Partnership network. The goal of the HQIP is to improve the quality of care provided to members by offering participating hospitals substantial financial incentives in exchange for meeting selected performance targets.

Participants report on measures across the following measurement domains: advance care planning, clinical quality, operations and efficiency, patient safety, and patient experience. To support improving coordination of care after discharge and increase support for patient self-management, the HQIP includes a readmissions measure for all Partnership adult members admitted to the hospital. Like the PCP QIP, Partnership collaborates with hospital partners and internal Partnership department stakeholders to design the program, and PAC reviews and approves the measures selected. The measures and detailed specifications can be found on the Partnership website.

Specialist Quality Improvement Program (QIP)
The Specialist QIP was developed in 2014 to reward in-network specialists for actively accepting referrals and seeing Partnership Medi-Cal members. In order to participate, a specialist must be contracted with Partnership and be located within the Partnership service region. Specialists who work primarily in an inpatient setting are excluded.

Long Term Care Quality Improvement Program (LTC QIP)
The LTC QIP, launched in 2016, is designed to support and improve the access to and quality of long-term care provided by Partnership's contracted facilities. The pay-for-performance program, overseen by PAC, offers financial incentives for quality that are separate and distinct from the usual reimbursement for services. The measurement domains are clinical, functional status, resource use, and operations/satisfaction. Like the Hospital QIP, the LTC QIP is by invitation only and to participate, facilities must contract with Partnership and sign a Letter of Agreement. The measures and detailed specifications can be found on the Partnership website. After a program suspension in 2021, the LTC QIP returned in January of 2022 and operates as a calendar year quality incentive program.

Palliative Care Quality Improvement Program (PC QIP)
All Partnership contracted Intensive Outpatient Palliative Care provider sites are automatically enrolled in the PC QIP. Providers may earn incentives from the program based on care provided to members who have serious illnesses and have an approved intensive outpatient palliative care treatment authorization request (TAR) on file. Partnership has designed the PC QIP, which offers significant financial incentives to support and improve the access to and quality of palliative care provided by Partnership's contracted palliative care providers. The program also incentivizes the completion of POLST (Physician Order for Life-Sustaining Treatment) for these members and for actively participating in the Palliative Care Quality Collaborative (PCQC) system.

Perinatal Quality Improvement Program (QIP)
The Perinatal QIP provides financial incentives to participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers providing quality and timely prenatal and postpartum care to Partnership members. Participation is by invitation and requires signing a Letter of Agreement. Since its inception as a very small pilot program in 2018, the Perinatal QIP has expanded to include 81 primary care and specialty providers within Partnership's service area. For this incentive program, a simple and meaningful measurement set has been developed and currently includes the following measures: Prenatal Immunization Status, Timely Prenatal Care, Timely Postpartum Care, and Electronic Clinical Data System (ECDS). The ECDS measure has transitioned from an implementation based measure to a program gateway measure requiring providers to submit data through an ECDS in order to participate in the Perinatal QIP.

Behavioral Health Quality Improvement Program (QIP)
The Plan's two delegated mental health administrators, Carelon Behavioral Health and Kaiser Permanente, manage the quality improvement programs for their networks. The Behavioral Health QIP is administered through the Carelon Behavioral Health network and focuses on measurement-based care by utilizing member screenings over time in participating practices to inform clinical interventions and measure results. The QIP for substance use

disorder services focuses on a provider's ability to address members with co-occurring substance use disorder and mental health needs.

Enhanced Care Management (ECM) Quality Improvement Program (QIP)
The ECM Program is a Medi-Cal benefit that replaces the current Whole Person Care (WPC) Pilot and Intensive Outpatient Care Management (IOPCM) activities. Part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the objective of ECM is to motivate, modify, and improve the health outcomes of seven identified groups of individuals by standardizing a set of care management services and interventions, then build upon the positive outcomes from those programs. Starting in Q4 2022, participants are incentivized for three new quality measures focused on depression and blood pressure screenings and the timeliness of care plan data entry. The ECM QIP transitioned from incentivizing the timely reporting of enrolled members in ECM benefits to making timely reporting a gateway measure with the number of enrolled members as the basis for determining the incentive pool amounts for the quality measures. This program will continue to develop as CalAIM becomes active through a four phase roll-out to all counties served by Partnership.

Improvement Projects
Partnership considers a number of factors to determine where and how to focus its improvement efforts. Following analysis of data to identify areas for improvement, as well as opportunities to learn of potential best practices, a significant factor is Partnership's performance on measures for which it is held accountable by DHCS. Another factor is whether an area pertains to the criteria considered for NCQA health plan accreditation.

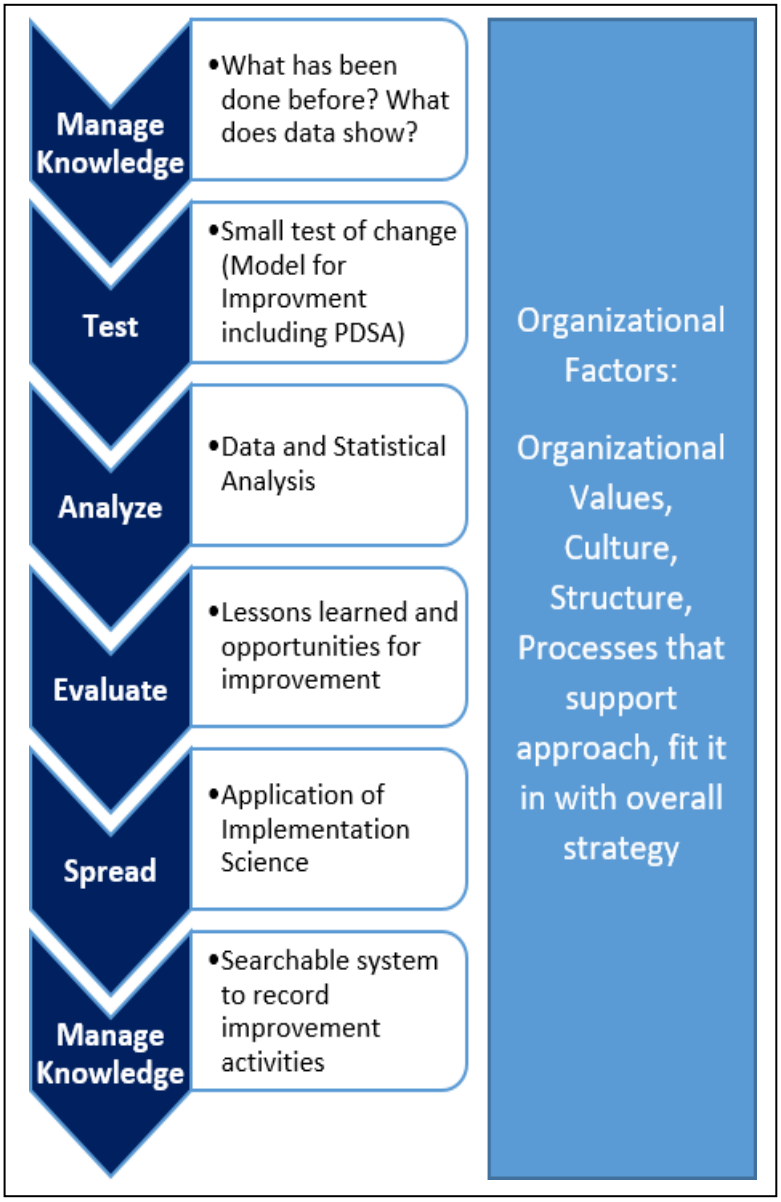
Additional criteria for selection include:
- Meaningful clinical or service areas to both providers and members
- Measures that impact large populations of members
- Over or underutilization of services
- Clinical or service areas where provider variation in practice is greatest
- Clinical or service areas that present opportunities to address health inequities
- Recommendations from the QIHEC's annual evaluation of quality measure performance data. These recommendations are focused on addressing health-equity performance deficiencies and ensuring appropriate equity-focused interventions are identified to reduce health disparities.

Data sources used to determine focus areas include:
- Annual, monthly, and year-to-date performance on HEDIS® measures
- Performance on Partnership's pay-for-performance measures that provide financial incentives to provider organizations to drive improvement, including data on disparities based on factors such as race and ethnicity, preferred language, and zip codes
- CAHPS® and other Member Satisfaction surveys
- Grievances and appeals
- Facility site and medical record review results
- IHA rates
- Utilization data
- County level and/or public health data
- Clinical data derived from Health Information Exchange (HIE) with providers

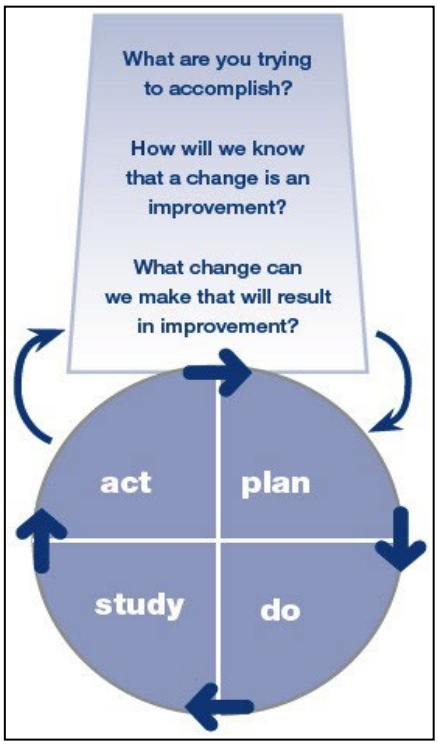
Based on the department that will lead an improvement effort, its leadership and management propose focus areas and projects with guidance from their executive sponsor, other members of the executive leadership team, medical directors, other departments and key stakeholders. For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the QIHETP team supports ongoing QI efforts in the identification of potential quality or equity of care issues, improvement of HEDIS quality measures in context with social determinants of health. For member-facing improvement efforts, CAC and other member focus groups are often consulted.

The QI/PI department is often the lead for many improvement efforts, particularly those that are mandated or due to poor performance on the Managed Care Accountability Set (MCAS), which are the set of measures that Department of Health Care Services (DHCS) selects for annual reporting by Medi-Cal managed care health plans. This can include mandated improvement efforts to meet disparity reduction targets for specific populations and/or measures as identified by DHCS. The QI/PI department also takes the lead on mandated Performance Improvement Projects (PIPs) that are assigned by DHCS. PIPs are led by the QI/PI program based on criteria defined by DHCS and overseen by the EQRO, and include at least annual status reports to DHCS. The involvement of fully delegated subcontractors are considered in both mandated short-term improvement projects (PDSAs) and the PIPs. Once the objective and scope of improvement projects are approved, an improvement team is formed with a lead or project manager and individuals who are involved in the improvement effort. Current year performance priorities are outlined in Partnership's QI Program Work Plan.

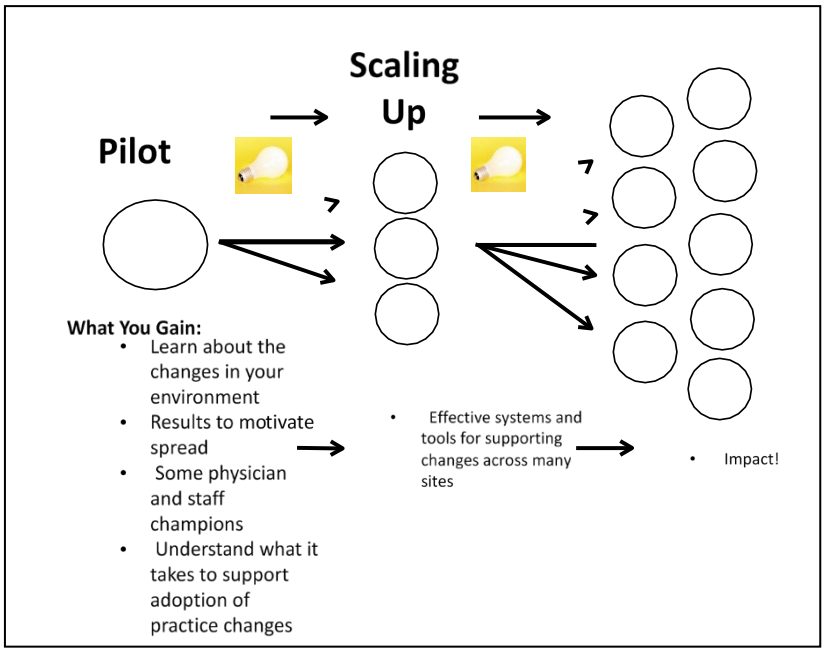
Partnership has developed the Pathway to Excellence (P2E) framework for improvement activities. This framework includes six major components as noted below:



This framework includes several performance improvement methodologies including small tests of change using the Model for Improvement and the Plan-Do-Study-Act (PDSA) cycle, optimizing spread through the application of implementation science with robust project management infrastructure to guide strategic improvement initiatives and targeted improvement projects. Appendix C has a detailed description of the P2E framework.



Partnership supports spreading effective interventions within and across sites and regions as more is known about the problem, resources, and infrastructure needed to support the change on a larger scale. Within provider organizations and throughout Partnership's provider network, spread is challenging and highly dependent on provider organizations' leadership, culture, and quality improvement infrastructure to do this effectively. The figure below outlines this approach.



A list of current year improvement projects and outcomes are available in Partnership's QI Program Work Plan and annual QI Evaluation, respectively.

Care for Members with Complex Needs (CCM)
CCM is a voluntary program that provides tailored interventions aimed at both improving the member's self-management of his/her health, and also increasing appropriate usage of health and medical resources while reducing the inappropriate utilization of health care resources. These goals are achieved by working with the member/caregiver and member's interdisciplinary care team to:

- Educate the member about his or her benefits with managed care and how to use available resources
- Identify and help the member understand his/her medical condition(s)
- Support and encourage self-management skills to promote and optimize the member's personal health goals and well-being
- Coordinate necessary health care services and
- Refer to appropriate medical or social community resources, when applicable

Please see the Care Coordination program description for further information regarding the populations targeted and the specific interventions used for Partnership members.

Quality Assurance and Member Safety Activities
Quality Assurance and Member Safety activities include investigation of PQIs; facility site and medical record reviews; assessing the level of physical accessibility of provider sites including specialists and ancillary providers that serve a high volume of seniors and persons with disabilities; and monitoring IHA rates.

Member safety activities are governed in large part by DHCS directives. To stay aware of updates and guidance on conducting member safety activities, Partnership maintains a multi-department system to monitor and implement regulatory guidance, including but not limited to All Plan Letters (APLs) and contract amendments, like those that inform the QI program. APLs are also available and searchable by all staff via the DHCS website.

<u>Potential Quality Issues</u>
A PQI is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists. A quality issue is defined as a confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process. 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.

PQIs are identified through the systematic review of a variety of data sources, including but not limited to:

- Information gathered through concurrent, prospective, and retrospective utilization review
- Referrals from any Health Plan staff
- Facility Site Reviews
- Claims and encounter data
- Pharmacy utilization data
- HEDIS® medical record review process
- Medical record reviews/audits
- Grievances and Appeals
- Ancillary providers/vendors/delegates such as Carelon, VSP, etc.
- Provider sentinel/adverse events such as provider preventable conditions that are reported as required by the State

All cases are initially reviewed by a PICS RN and then forwarded to the CMO or Medical Director for Quality in accordance with Policy MPQP1016. Medical records and other supporting documentation are collected, and where issues are identified, the provider of concern may be given an opportunity to respond. The CMO/Medical Director for Quality review includes assessment of, but is not limited to, appropriate level of care, appropriate tests, therapy and treatment, technical expertise, referral, consultation, timeliness, and adequate documentation.

The PICS RNs and Medical Directors review potential quality issue cases at PQI rounds. Severity ratings are designated to identify "Practitioner performance," "System issues," or both. Sometimes, multiple provider performance issues or system issues are identified in the same case and rated accordingly. Upon determination by a Medical Director that a case requires review by the Peer Review Committee, the PICS RN prepares the PQI case file for Peer Review (see MPQP1053 for the Peer Review Committee policy). The Peer Review Committee investigates member or practitioner complaints about the quality of clinical care provided by Partnership contracted providers and makes recommendations for corrective action. The Committee also reviews sentinel conditions identified as having quality concerns. Cases with significant concerns are communicated to the Credentials Committee at the recommendation of the Peer Review Committee.

Annual reports are presented to IQI and Q/UAC showing trends related to referral patterns and quality of care concerns.

Pharmacy Department Patient Safety Initiatives

Partnership has a number of activities in place to ensure medication safety and adherence for Partnership members. Theseactivities include:

- *Managing Pain Safely (MPS)*. Pharmacy leads an ongoing multi-year initiative to promote the safe use of opioids.
- The Pharmacy Department uses Magellan pharmacy data to monitor opioid prescribing and utilization against opioid-related HEDIS® measures: HDO (high dose opioids), POD (opioid use 31 days), UOP (multiple prescribers/pharmacies), and BZD/Opioid concurrent use.
- The Pharmacy Department monitors and evaluates naloxone prescriptions to help promote access and utilization to improve patient safety.
- The Pharmacy Department reviews and analyzes drug utilization to identify high-risk members taking antipsychotic and opioid medications and provides interventions against identified risks.
- The Pharmacy Department monitors antipsychotic pharmacy claims to identify suboptimal medication regimens and adherence for members taking antipsychotic medications. Interventions aim to address and reduce risk for metabolic syndrome induced by antipsychotic medications.
- *Smoking Cessation*. In collaboration with Care Coordination, Partnership offers smoking cessation counseling services to member who indicate "yes" on the Health Risk Assessment (HRA) question, "Would you like help quitting?" Functions include provider outreach, educating members on medication adherence to tobacco cessation products, and assisting with enrollment in the California Smokers Helpline program.
- *Latent Tuberculosis Therapy (LTBI) Monitoring*. LTBI 12 dose monitoring to ensure patients receive appropriate therapy and interact with providers and public health officer to ensure completion of therapy and identify patients that may have fallen out of therapy.

Site Reviews

Partnership conducts Site Reviews that include a review of the physical site, medical records, and a review that evaluates accessibility for Seniors and Persons with Disabilities (SPDs). Site Reviews are conducted for primary care, OB/GYN, palliative care, urgent care, and substance use disorder services providers, non-accredited sites and private duty nurses. The internal and external quality improvement committees review the results from the Site Reviews, including review of IHAs, at least annually. Results from Site Reviews are reported to the DHCS twice per year. Results of individual Site Reviews are also reported to the Credentials Committee.

Initial Health Appointments (IHA)

It is a requirement of DHCS that all newly enrolled health plan members receive an IHA with a primary care physician within 120 calendar days of enrollment to the health plan. Partnership monitors these rates quarterly and workswith low performing providers to increase compliance.

In addition to the above, Partnership collaborates with network practitioners and providers to improve IHA compliance by:

- Identifying areas where training is needed
- Identifying and sharing best practices

- Seeking input from network practitioners about systems Partnership can put in place to improve IHA compliance
- Providing technical assistance, resource materials, and training in areas where indicated
- Reminding providers on a monthly basis to review their list of newly assigned members and track outreach attempts to the members
- Publishing provider and member facing newsletter articles
- Providing 1:1 tailored education during the Site Review process via Certified Site Review Nurses
- Sending monthly mailers along with address labels for newly enrolled members so providers can reach out to members and schedule an IHA appointment

Quality Improvement Coaching and Training Support
The Performance Improvement (PI) team offers a variety of coaching and training opportunities to clinicians, administrators and staff to gain quality improvement expertise and to learn from peers. Each initiative prepares provider sites to optimize population health, enhance their patients' experiences of care, promote provider and care team satisfaction, and foster a culture of continuous quality improvement.

Provider Tiering and Enhanced Provider Engagement: In 2022, Partnership began strategic planning to expand provider engagement to engage a wider group of provider organizations (PO's) in building their capacity for quality improvement work. In previous years, Partnership's QI team attempted to engage with providers leveraging mid-year check-ins to try to ensure that providers were on good trajectories to reach QIP targets, and if not help them build a plan to reach their targets through coaching. Moving forward, Partnership is attempting to establish a systemic approach to engaging the provider network. Using the previous year's PCP QIP clinical measure scores, provider organizations are organized into tiers, with coaching programs designed to align with the priorities and needs of the respective organizations.

2023 provider tiers and respective coaching opportunities are:
- Tier 1 PO's (< 33% of clinical points earned in PCP QIP): Modified PCP QIP, Needs Assessment and coaching, relationship building
- Tier 2 PO's (34-79% of clinical points earned in PCP QIP): Practice Facilitation, JLI's, improvement pilot or PIP partnership on established MCAS measures
- Tier 3 PO's (>80% of clinical points earned in PCP QIP): Voices from the Field, innovation pilots on emerging measures
- PO's at any tier: Regional meetings, Improvement Academy trainings

Modified PCP QIP: In 2023, provider organizations with over 1,000 assigned members who earned less than 25% of clinical points on their 2022 PCP QIP are placed on a modified PCP QIP, with a measure set reduced from ten measures to four. A second group of provider organizations with over 500 assigned members who earned less than 33% of clinical points on their 2022 PCP QIP will be placed on a modified PCP QIP in 2024 if their performance on clinical measures remains below 33% in 2023.

Needs Assessment and Relationship Building: The Needs Assessments is the initial step for provider organizations placed on a modified PCP QIP in 2023 or who are at risk of placement on a modified PCP QIP in 2024. Members of the provider organization's leadership team will complete an in-person Needs Assessment with a member of the PI team. The Needs Assessment is a modified version of the Building Blocks of Primary Care Assessment (BBPCA), a tool developed by the UCSF Center for Excellence in Primary Care, and is designed to identify an organization's strengths and improvement opportunities within their quality program.

Completing the Needs Assessment allows the provider organization to assess themselves and fosters relationship building with Partnership; it also provides a framework for prioritizing improvement opportunities and committing to activities to build their quality infrastructure and organization-wide culture of quality.

Once the provider organization has chosen areas for improvement, Partnership will offer support through various means including; providing coaching, training opportunities, grant application opportunities and resources, and connecting with outside resources.

Practice Facilitation: In 2020, Partnership began offering practice facilitation support to PCP organizations with large member assignments and some existing quality infrastructure, that had opportunity for improvements in clinical performance.

Practice facilitation coaches assist primary care practices in the application of evidence-based best practices to quality improvement activities. Working alongside organizational quality teams, the practice facilitator provides guidance and resources to facilitate system-level changes. The practice facilitator provides a framework for translating evidence-based research into practice by building relationships, improving communication, and facilitating change.

The following are areas where Partnership practice facilitators offer support:

- Provide guidance on interdisciplinary project team formation and collaboration for QI projects
- Project management – provide guidance and tools on framing and managing QI projects
- QI project development and use of QI tools, methodologies, and best practices
- Provide data analytics training and support
- Provide guidance on change management aspects of QI project
- Coach provider organizations on adopting a culture of quality and advancing quality improvement efforts throughout the organization

Partnership Improvement Academy

The Partnership Improvement Academy encompasses different types of training to support and educate provider organizations about quality improvement. The trainings listed below highlight sessions planned for calendar year 2023.

ABCs of QI: This program is a one-day in-person training designed to teach healthcare organizations the basic principles of quality improvement including developing aim statements, measures, and change ideas; how to use data and run charts, and testing change ideas on a small scale. The program is offered regionally on a bi-annual basis in the Redding office (spring and fall 2023) and annually in the Fairfield office (fall 2023).
Partnership

Accelerated Learning: These trainings are 1-1.5 hour webinar learning sessions offering CME/CE and cover the PCP QIP measures. For calendar year 2022, there were six Accelerated Learning sessions offered plan-wide, covering the following areas:

- Asthma medication ratio
- Early cancer detection: cervical, colorectal, and breast cancer screenings
- Controlling high blood pressure
- Diabetes management – HbA1c control
- Preventive care for 0-2 age range: well-child visits, childhood immunizations, and additional screenings
- Preventive care for 3-17 age range: well-care visits, adolescent immunizations, and additional screenings

The objectives of the learning sessions are:

- Overview of clinical measure specifications and threshold definitions
- Present documentation recommendations/highlights to maximize measure adherence
- Review regional performance data on clinical measures, including data that show disparities by race and ethnicity
- Review best and promising practices to close gaps in care
- Showcase Voices from the Field, high-performing providers who present their best practices for closing care gaps
- Overview of performance improvement strategies and tools

The target audience is clinicians, practice managers, quality improvement team, and staff who are responsible for participating and leading quality improvement efforts within their organization.

Framing Health Equity - A Provider Training: This training is aligned with the NCQA Renewal Standard PHM 3, Element A, Factor 6, which requires Partnership "provides at least one training to practitioners in its network on topics of health equity, including cultural competence, bias, diversity and inclusion." Partnership will deliver a three-part webinar series focused on foundation topics aimed at increasing provider understanding of foundational health equity topics, as well as best practices for operationalizing strategies to advance health equity within their practices. This training is scheduled for June through August 2023.

The target audience is quality improvement leaders, executive leaders, clinical leaders, and other administrative leaders who are responsible for establishing a culture of health equity within their organizations.

Northern Region Consortia & Partnership Northern Region QI Collaboration: This partnering occurs formally on an annual basis via a written scope of work agreement under which they jointly promote and support QI capacity building in the clinic setting through trainings, improvement advising, peer-to-peer sharing, and conducting annual clinic profiles/assessments. The Northern Consortia membership is comprised of Federally Qualified Health Centers (FQHCs) in the Partnership Northern Region and represent the largest PCP organizations, in terms of assigned member volume. Partnership benefits from the peer network forums the consortia leaders have established amongst its members' QI leadership and CMOs. The QI Peer Network and CMO Peer Network meet monthly, including longer in-person meetings on a biannual basis. Within these peer networks, Partnership is invited to share measure level education, guidance, and technical assistance on the application of performance improvement tools and methods. These interactions occur either as part of recurring peer network meetings or separate webinar offerings targeting peer network members.

Clinically Led HEDIS® Measure Education: HEDIS® Measure Education is also incorporated into provider interactions with Partnership's Member Safety Team. Partnership Member Safety nurses have unique opportunities through their Site Review visits to build rapport with PCP clinical leadership and staff. During the completion of the medical record review portion of Site Reviews, Partnership nurses incorporate measure education and corresponding medical record-keeping best practices during their reviews with providers.

Medication Management Academic Detailing: Partnership's Pharmacy Department provides provider organizations detailed analysis of their patient's adherence to medication for a number of chronic conditions, to identify opportunities to improve medication management of their condition. Topics covered in Academic Detailing sessions include:

- Increasing prescriber and pharmacist knowledge of the HEDIS® measures for diabetes, hypertension and asthma, Medi-Cal Rx formulary, and proper documentation of diabetes, hypertension, asthma and other diagnoses (e.g., ADHD)
- Analysis of provider organization's pharmacy fill data and measure compliance to highlight prescribing and refill best practices
- Increasing member knowledge and engagement in chronic disease management

Substance Use Disorder Services Support and Training:
The Partnership ODS (Organized Delivery System) Waiver Regional Model training program provides clinicians, administrators and staff with quality improvement expertise from industry leaders and peers. Sites are supported so as to encourage integrated care across the Partnership system, to optimize population health, enhance their patients' experiences of care, promote provider and careteam satisfaction, and foster a culture of continuous quality improvement. Trainings provided on a regular basis include American Society for Addiction Medicine (ASAM) criteria and application; documentation; and key evidence-based practices.

Partnership provides a range of support and services to contracted Regional Model Drug Medi-Cal Providers. These include:

- Training and technical assistance to help providers improve services and clinical documentation and regulatory compliance
- Conduct regularly scheduled chart compliance reviews, offering guidance and written feedback focused on quality improvement of services
- Provision of resources such as sample forms, audit instruments and other tools that would help providers

develop effective systems of quality records management
- Responding to technical questions related to regulations or practices
- Communication with providers and other agencies in order to better understand and interpret program regulations and to address treatment needs
- Responding to grievance and appeals from Partnership members or other concerned individuals in the areas ofaccess, quality, billing, critical incidents or client rights

Community Partnerships

In many cases, the quality improvement efforts that have the biggest impacts on the health of members involve significant community collaboration and coalitions with local entities. Local entities are crucial partners in developing strategies Partnership to address deficiencies in performance measures. Local entities in Partnership's communities engaged in this collaboration include: county health departments (including public health officers), the four consortia that serve FQHCs in Partnership's community, law enforcement, schools, and various Community Based Organizations (CBOs). Many providers in Partnership's network provide health care services to Partnership's members and are also partners in larger community-level interventions. This includes primary care physicians, FQHCs, Rural Health Centers, Indian Health Service HealthCenters, hospitals, long-term care facilities, specialist physicians, hospice agencies, and community pharmacies.

Partnership's participation in community partnerships can be in one of five roles: Leader, Convener, Participant, Funder, and Advocate.

Some current major initiatives involving community partnerships with local entities include:

1. Mental Health Integration
2. Improving Access to Specialty Care Services
3. Developing a Regional Approach to Treating Substance Use Disorder
4. Integrating Medical Records through HIEs
5. Implementing CalAIM including establishing partnerships within each county Partnership serves
6. Improving preventive care quality outcomes for members less than 21 years of age

To further elaborate on the community partnerships, the table below highlights a few examples of current initiatives, specific to mental health integration and treating substance use disorder:

Community Activities		
Wellness and Recovery	**Mental Health**	**School Based Initiatives**
Collaboration with local hospitals to identify strategy for sustainability of CA Bridge SUN Program	Collaborating with counties and Sac Valley Medshare to improve data solution through a single source. Estimated completion date fall 2023.	Providing technical assistance to County Office of Education to develop closed loop referral processes in line with SBHIP requirements.
Shasta County Substance Abuse Coalition	Collaborating with counties to provide resources and support for clients diagnosed with an eating disorder.	
Shasta County Perinatal Substance Using Taskforce	Engaging with non-contracted providers to provide alternate solutions for services to clients with an eating disorder.	
Humboldt County Drug MediCal Huddle	Streamlining processes internally to offer an option for Partnership to take the "lead" on eating disorder cases where county capacity is lacking.	
Solano County LPS/PES County Meeting	Streamlining processes internally with other departments for coordinating care for eating disorders and other mental health conditions.	

Community Activities		
Wellness and Recovery	**Mental Health**	**School Based Initiatives**
SHARC Integrated Care Meeting	Coordinating with other departments to improve reporting measures related to mental health and eating disorders.	
Mendocino County RFP Stakeholder Group		
Solano County Substance Use Coalition		
Shasta County Suicide Prevention Coalition		
Presentation to Drug and Alcohol Mental Health Advisory Board Shasta		
Siskiyou County Opioid Coalition		

Member Input

Members are also crucial partners in informing strategies and interventions Partnership pursues to address deficiencies in performance measures and reduce health disparities. Member input is obtained from member outreach events, member experience surveys, member focus and engagement groups, member grievance and appeals data, CAC feedback, FAC feedback, PCP/specialist access and availability data, Member Services telephone access reports, member suggestions, and member requests for PCP transfers. Consumers are also represented on the Q/UAC and Partnership Board of Commissioners. Various workgroups meet to review the data collected at least quarterly and the workgroups recommend areas for improvement and action plans. These are presented and monitored by IQI. Performance on HEDIS® measures and progress made in other QI activities are shared with Partnership's members through the Q/UAC, CAC, FAC, and member newsletter. Clients of substance use disorder services may also attend and give feedback at the SUPAG. <Supports R.0059 1) and 2)>

Physician and Other Clinician Input

Through Partnership's committee structure, clinicians provide input on the quality improvement program including focus areas, strategies to improve care and service, and effective ways for measuring performance in projects. In addition, clinician input is provided on various projects such as the pay-for-performance programs for primary care, specialtycare, and hospitals. Partnership holds "provider comment periods" where physicians and their staff can provide input on priorities for these programs. Across all work, Partnership solicits input on priorities and interventions through committee meetings and other meetings with provider practices and clinic consortiums.

NCQA Accreditation Program Management

Partnership strives to improve the health status of members and their care experience to become one of the highest qualityhealth 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 DHCS.

Partnership is a NCQA Health Plan accredited organization as of January 2021. HPA

- Provides a framework to guide our operational and quality improvement activities.
- Provides a nationally recognized standard and definition for a high quality health plan, performance against which will allow Partnership to compare ourselves objectively against other high quality plans.
- Offers the only widely available health plan assessment that bases results on clinical performance (HEDIS®) and member experience (CAHPS®).

Partnership is on a journey to obtain NCQA HEA. HEA focuses on the foundation of health equity work. HEA

- Builds an internal culture that supports the organization's external health equity work.
- Collects data that helps the organization create and offer language services and provider networks mindful of individuals' cultural and linguistic needs.
- Identifies opportunities to reduce health inequities, improve care and member experience.

Program objectives are outlined separately for HPA and HEA:

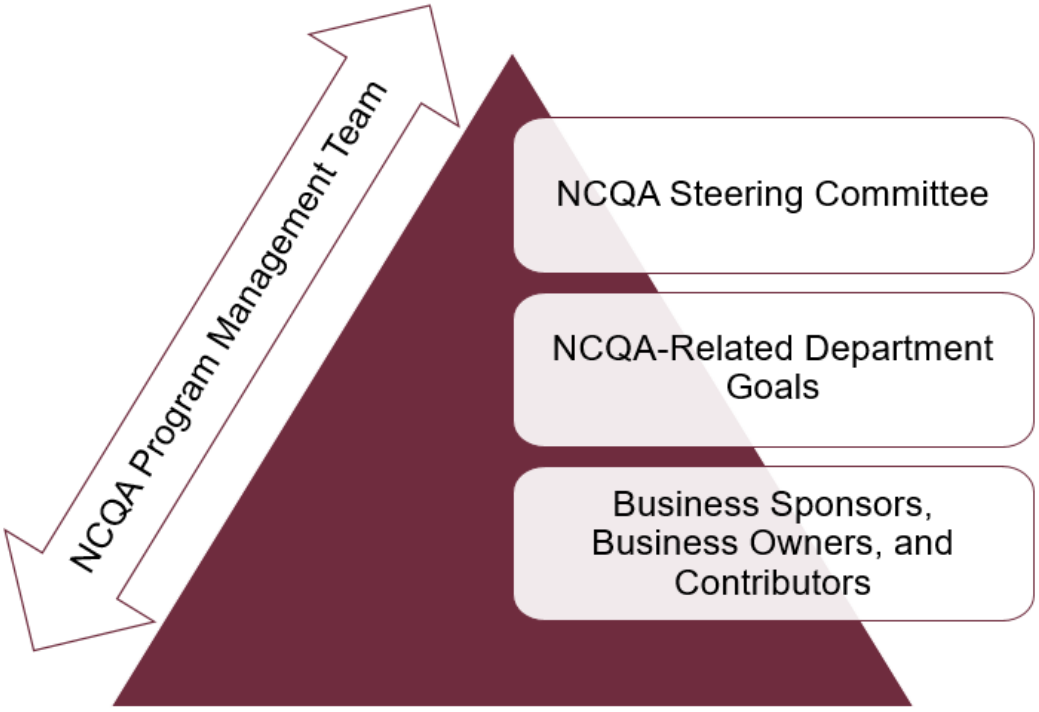
Health Plan Accreditation

- Monitor plan-wide compliance of NCQA requirements through Renewal Survey.
- Successfully submit Partnership's Renewal Survey on October 17, 2023.
- Obtain the renewal of Accredited status by January 2024.

Health Equity Accreditation

- Build a robust ownership structure.
- Build readiness for Initial Survey.
- Successfully submit Partnership's Initial Survey (Targeting June 2025).

The NCQA Accreditation Program is managed via a tiered approach. A description of each tier is provided to define roles and responsibilities for each level of the program's governance.



- NCQA Program Management Team
  - Leads and coordinates efforts across each level of NCQA governance.
  - Manages the plan-wide NCQA Accreditation process, specifically:
    - Updates and maintains ownership of NCQA requirements through a plan-wide project work plan.
    - Updates and maintains the plan-wide evidence submission library, a list of required documents that are used to demonstrate compliance.
    - Identifies data needs and reports completion/approval dates through a grand analysis report schedule.
    - Coordinates a plan-wide mock survey with the NCQA consultant.
    - Reviews and assesses the Standards and Guidelines, coordinates any follow-up questions based on NCQA tri-annual policy update and monthly FAQs.
  - Provides advisory support and guidance across NCQA Accreditation processes, standards/requirements, and HEDIS® and CAHPS® reporting, as needed.
  - Maintains and updates the NCQA compliance dashboard to evaluate progress.

    - Monitors and reports program status, escalates risks/barriers in a timely fashion.
    - Recommends changes to new and/or existing business practices to support and sustain program structure.
    - Facilitates the NCQA Steering Committee.
    - Serves as liaison with Business Owners across the health plan and as the primary liaison to NCQA, consultant, and Medicaid health plans.
- NCQA Steering Committee
    - Leads NCQA Accreditation efforts by defining Partnership's NCQA program vision and purpose and providesoverall strategic direction.
    - Monitors and reviews program progress relative to goals, timelines and metrics.
    - Champions NCQA Accreditation readiness across the organization.
    - Resolves program conflicts and disputes, reconciling differences of opinion and approach.
    - Evaluates and approves major program components including program timelines, resource allocation, budget, risk management strategies, and program management/governance practices.
- NCQA-Related Department Goals
    - Standards are assigned to departments where the Business Owners reside.
    - Any standards that are not managed by Department goals are managed directly by Business Owners.
- Business Sponsor
    - A Partnership leader who holds a Partnership leadership position of Associate Director, Director, Senior Director, orChief, and is usually from the same department as the Business Owner. This person has formal authority/ownership for assigned requirements based on business practices.
    - Supports the Business Owner in achieving compliance and addressing any obstacles or barriers to the work and escalates project risks if needed. Escalation will include, but is not limited to, identifying needs for additional communication with stakeholders from regional counterparts, contributors, operational leadership and the NCQA Steering Committee.
- Business Owner
    - Manages and/or executes the day-to-day work in order to achieve compliance of the assigned NCQA requirements.
    - Maintains deep subject matter expertise across the requirements, which includes reviewing and addressing changes to NCQA standards timely.
    - Collaborates and coordinates activities and deliverables with the contributors. Collaboration will include, but is not limited to, communicating the project's timeline, scope of work, roles and responsibilities.
    - Tracks and reports progress toward compliance with the requirements.
    - Provides periodic updates, at least quarterly, to the NCQA Program Management Team and contributor(s).Updates will include, but are not limited to, progress updates, risks and/or barriers, and staffing changes.
    - Raises issues to the Business Sponsor should challenges occur.
    - Is the primary contact for evidence preparation and responsible for all submissions.
- Contributor
    - A staff outside of the Business Owner's department who holds subject matter expertise related to the assigned NCQA requirement(s).
    - Collaborates actively with the Business Owner to ensure successful completion of NCQA-related tasks. This includes, but is not limited to, providing expertise, data, policies, documents, and/or work deliverables timely to meet NCQA standards.
    - Notifies the Business Owner and the NCQA Program Management Team of any staffing changes.

Partnership's, reaccreditation survey, Renewal Survey, is scheduled for October 17, 2023. As part of the NCQA HPA process, Partnership first reported HEDIS® and CAHPS® annual results to NCQA in June 2022. Partnership will earn its first HPR of 0-5 stars based on HEDIS®/CAHPS® MY2022 performance in September 2023. The table below summarizes key HPA survey dates, as well as HEDIS® and CAHPS® reporting and scoring requirements.

HPA Survey Option	Partnership Survey Status	HEDIS®/CAHPS® Reporting and Health Plan Rating (HPR) Scoring
Renewal	October 17, 2023: Submission of completed HPA Survey December 11 - 12, 2023: Two-day HPA file review audit January 2024 (targeted): Health Plan Accredited	Annual HEDIS®/CAHPS® reporting (MY 2022) in June 2023 and HPR scoring in September 2023 and annually thereafter.

Partnership has begun its process of building readiness to obtain HEA. Partnership conducted a HEA gap analysis in January 2023. Based on the analysis results and recommendations, key stakeholders provided feedback to confirm ownership, indicate resources needed, and outlined planned activities in place to fulfill the HEA requirements. Partnership is targeting an Initial HEA Survey in June 2025, to obtain the new accreditation before the January 1, 2026 DHCS mandated timeline.

Population Health Management Strategies
Since 2017, Partnership has made significant inroads in establishing practices to lay the foundations for creating a Population Health Management (PHM) program. In February 2020, Partnership established the Population Health department. The Population Health and QI/PI departments conduct coordinated work to support the objectives of quality and equitable care and services for Partnership members through the following activities:

- Provision of guidance and updates on the NCQA standards related to PHM
- Participation in creating and executing QI initiatives that address identified health disparities and opportunities for member engagement/strategic program development
- Assistance in evaluation of initiatives, state-mandated work and performance improvement projects to determine the effectiveness of developed PHM programs
- Review and analysis of HEDIS® measure performance to help determine necessary targeted interventions to improve member health outcomes and well-being
- Development of broad-based member outreach strategies designed to engage members and direct them to their PCP
- Review and periodic revision to value-based programs to ensure they are supporting providers in their attempts to complete recommended missing services for members
- Execution of Partnership Improvement Academy workshops and training programs

Both Population Health and QI/PI reside in the larger Health Services department. The Population Health department reports up to the COO and the QI/PI department reports up to the CMO. The Population Health department maintains a series of documents similar to those maintained by the QI/PI department including the Population Needs Assessment, Population Health Management Strategy and Program Description, and Population Health Work Plan, which are first vetted by the PHM&HE Committee prior to being presented at Q/UAC and PAC. Each department is led by a director that has standing meeting time to discuss shared and separate work and priorities.

See the Population Health Management Strategy and Program Description for details.

Cultural Competency

Partnership is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible beneficiaries. The Health Education, Cultural and Linguistic (HEC&L) Program regularly assesses and documents member cultural and linguistic needs to determine whether covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status,

sexual orientation, health status or disability. The HEC&L team also ensures that all culturally and linguistics services are provided in an appropriate manner.

The Population Health department is responsible for the operations of the Health Education, Cultural and Linguistic Services Program. Additionally, CAC and FAC provide recommendations on the development and implementation of culturally and linguistically accessible services.

Partnership's policies and procedures comply with standards and performance requirements for the delivery of culturallyand linguistically appropriate health care services. Partnership has systems and processes to:

- Assess, identify, and track linguistic capability of bilingual employees
- Identify and track linguistic capability of contracted staff in medical and non-medical settings
- Collect data on cultural, ethnic, racial and linguistic needs and prepare biennial analysis to ensure Partnership and its providers deliver services that meet the needs of Partnership's culturally diverse population
- Conduct a PNA every year to: identify member health needs and health disparities to promote health equity; evaluate Health Education, C&L and QI activities and available resources to address identified concerns; and implement targeted strategies for Health Education, C&L and QI programs and services. Please see the PNA for detailed findings and the related Action Plans.
- Provide cultural competence, sensitivity, and diversity training to staff, providers and delegates

Partnership monitors and evaluates the effectiveness of cultural and linguistic services by reviewing and responding to:

- CAHPS®
- Member grievance and appeals
- Reports of utilization of interpreter services by language
- Provider assessments and Site Reviews
- Disparities in HEDIS® data

See the Cultural and Linguistic Program Description (MCND9002) for additional details.

Communication Systems

Partnership communicates its QI/PI program activities internally and externally through the following mechanisms:

Internal Communications

- At least monthly QI/PI department meetings to provide program and project updates, department priorities and identify critical issues and plans of action
- QI/PI directors and managers communicate more frequently with their respective teams and individual staff throughout each month. This is accomplished via meetings, huddles, and email communications.
- The QI/PI leadership team meets monthly with the Senior Director of QI/PI and CMO to assure timely organizational updates, consistent messaging and prioritization across the QI/PI department
- Recurring meetings with PR and Population Health to provide information on key QI/PI projects and other updates on QI programs
- Recurring Health Services Department Leadership Committee meetings to share information regarding improvement activities within the Health Services department
- 5 Star Room QI/PI key information and performance displays in Fairfield and Redding offices
- Department SharePoint pages
- Written department updates provided to all department heads and senior leadership as part of monthly Operations meeting hosted by Deputy COO
- Partnership's internal website PHC4ME
- Quality Measure Score Improvement Team Goal and corresponding cross-functional workgroups categorized and focused by measure domain, including: Pediatric Preventive Care, Chronic Disease

Management, Behavioral Health, Medication Management, and Women's Health & Perinatal Care
- NCQA Newsletter

External Communications

- Quarterly CAC meetings to provider updates on pertinent activities and allow committee members to provide input on initiatives, program design and evaluation
- FAC meetings that occur at least four times per year to share information and solicit input on topics and initiatives that impact CCS members
- Standing Consortia meetings to solicit input from providers
- Regional medical director/quality meetings
- QIP Advisory Groups to solicit input on value based programs
- Periodic feedback from providers via "provider comment periods" on performance metrics and QIP measures
- Quarterly input on QI programs and proposed initiatives via the Board Advisory Group
- Monthly QI/ PI update document that summarizes activities for the QI department and is included in IQI andQ/UAC meeting packets
- Regular updates (at least quarterly) of Partnership website information related to all QI projects and programs
- Member newsletters released two times per year that include articles covering preventive health and QI/PI projects
- Quarterly Provider Newsletters that include articles specific to QI/ PI in the designated "Quality Corner" section of the document
- Outbound and inbound calls and communication fielded by the Member Services department
- Care Coordination calls with members
- Population Health member outcall projects
- Monthly external newsletters (QI, Hospital, and LTC QIPs) that describe activities and training resources related to improving quality of care
- Conferences, trainings, onsite meetings, webinars to share best practices across regions
- ePrompts member level reminders about HEDIS® related preventive health services incorporated into Partnership'sCall Center system, Provider Online Services system, and online Member Portal

Delegation

Delegated activities to contracted providers are reviewed and approved at least annually by DORS, IQI, Credentials and Q/UAC committees. A delegation agreement, including a detailed list of activities delegated and reporting requirements, is signed by both the delegate and Partnership. Partnership delegates QI for behavioral health to Carelon Behavioral Health and QI for behavioral health and non-behavioral health to Kaiser.

- Reporting quality improvement activities and analyses to Partnership on a quarterly or semi-annual basis is done for delegated QI activities
- Evaluation includes a review of both the processes applied in carrying out delegated activities, and the outcome achieved toward quality improvement in accordance with the respective policy(ies) and agreement governing the delegated responsibility
- The DORS, IQI, Credentials, and Q/UAC committees review evaluations and make recommendations regarding opportunities for improvement and continuation of delegated functions
- Partnership QI/PI staff communicates feedback from the DORS, IQI, and Q/UAC to contract providers andincorporates improvement activities initiated in the annual QI/PI work plan

Review by Outside Licensing Agencies or Accrediting Bodies

Medi-Cal is a federal and state-funded program and CMS has delegated administration of the state program to the California DHCS. CMS permission is required in order for the state to delegate program administration to Partnership. The State must document the cost-effectiveness of the program and provide assurance that program beneficiaries are not negatively impacted by this delegation. Partnership operations, including the QI/PI program,

are audited annually by DHCS.

Partnership submits periodic compliance reports to DHCS and undergoes periodic compliance audits. Opportunities for improvement identified through all compliance or regulatory audits are addressed by multidisciplinary teams and corrective action plan development. Implementation of CAPs and other interventions aimed at addressing opportunityfor improvement are reported to the IQI and Q/UAC. Partnership maintains a compliance plan that includes monitoring and reporting of fraud, waste, and abuse. The Partnership Compliance Committee consists of representatives of each department including QI/PI.

Sanctions

Should any sanctions be imposed on Partnership, or if Partnership fails to meet minimum performance levels established by regulatory agencies or purchasers, a quality review team is initiated to develop and implement a corrective action plan. This team at a minimum includes the CEO, CMO, Compliance Officer, Senior Director of Quality and Performance Improvement, Director of Quality Management, Health Services Senior Director, and Pharmacy Director. Action plans and progress reports are shared with Q/UAC.

Annual Quality Improvement Work Plan

The QI/ PI Annual Work Plan is used to track progress on key QI activities and initiatives throughout the year. The document outlines major activities for the QI/PI department and organization as a whole that advance quality and performance improvement. The QI/PI Work Plan supports the comprehensive annual evaluation and planning process that includes the annual review and revision of the QI/PI program.

Approved annually by the Q/UAC, PAC, and Board of Commissioners, the QI/PI Annual Work Plan indicates planned QI activities and objectives, timelines, and accountable person for each activity. It includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service, and member experience. The annual evaluation of the QI/PI program is also listed as a specific activity on the QI/PI Work Plan. Goals and associated deliverables are included in the work plan and progress tracked at the level of deliverables. Forms for providing status updates are sent to staff one month in advance of the semi-annual and annual update deadlines to be completed by work plan contributors.

The work plan also includes information on issues that were previously identified. Updates on the monitoring of these issues is provided semi-annually, when work plan contributors provide status updates on whether deliverables driving goals are complete, on track, delayed or require additional explanation. These issues are tracked in a separate worksheet within the work plan.

Annual Quality Improvement Program Evaluation

The overall effectiveness of the QI/PI program is evaluated in writing annually by IQI and Q/UAC and is approvedby Q/UAC, PAC, and the Commission. The QI Program Evaluation includes:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
- Trending of data on key measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis and evaluation of distinct programs, initiatives and QI-related work as well as the overall effectiveness of the QI/PI program and of its progress toward influencing network-wide safe clinical practices. The summary of effectiveness also addresses the adequacy of the organizational resources involved in the QI/PI program.
- The annual QI Work Plan goals and associated deliverables are informed by the QI Evaluation. The evaluation provides summations and analysis of many of the key activities outlined in the accompanying work plan. In turn, if there are opportunities for improvement identified in the evaluation of prior year initiatives and work conducted to support the goals of the quality improvement program, these opportunities are translated into goals with actionable deliverables for the next year's work plan. The

results in the QI Evaluation, particularly those tied to the need to revisit allocated resources, for committees, standing programs and other related activity are assessed and if changes are deemed necessary, they are reflected in the QI/PI program in the subsequent year.

The following are separate evaluations and not included in the QI Program Evaluation:

- Evaluation of cultural and linguistic competency work plan activities
- Evaluation of Utilization Management and Care Coordination activities
- Evaluation of the Population Health program
- A comprehensive evaluation of member grievance and appeals

A summary of the QI Program Evaluation, including a description of the program, is provided to members or practitioners upon request.

Statement of Confidentiality

Confidentiality of provider and member information is ensured at all times in the performance of QI/PI program activities through enforcement of the following:

- All members of the Q/UAC and Credentials Committee are required to sign a confidentiality statement that is maintained and securely stored in the respective QI or Provider Relations files.
- All QI/PI and Utilization Management documents are restricted solely to authorized Health Services department staff, members of the PAC, Q/UAC, PRC, and Credentials Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to, Peer Review and Credentialing meeting minutes and agendas, QI and Peer Review reports and findings, PQI and QI files, Utilization Management reports, or any correspondence or memos relating to confidential issues where the name of a provider or member are included.
- Confidential peer review documents that are protected by California Evidence Code §1157 are designated "Confidential – Protected by CA Evidence Code 1157."
- Confidential documents are stored in locked file cabinets or restricted network folders with access limited to authorized persons only.
- Confidential documents are destroyed by shredding.
- Partnership has designated a Privacy Officer responsible to oversee compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal privacy laws.
- Partnership maintains administrative structure, reporting procedures, due diligence procedures, training programs and other methods to ensure effective compliance in use and disclosure of members' Protected Health Information (PHI).

Statement of Conflict of Interest

Any individual personally involved in the care and/or service provided to a member or an event or finding undergoing quality evaluation cannot vote or render a decision regarding the appropriateness of such care. All members of the Q/UAC and Credentials Committee are required to review and sign a conflict of interest statement, agreeing to abide by its terms.

Original Date: QI/UM Program Description 04/22/1994 – Effective 05/01/1994
Revision Date(s): 08/16/95
As: Quality Management Program – July 1997
Revision Date(s): January 2000, March 2002, (QD100101) October 2002, September 2004, May 2006, (MPQD1001) May 2007, April 2008, May 2009, October 2009 *(re-signed)*, May 2010, April 2012, March 2013, March 2014, March 2015, March 2016, March 2017, November 2017, *October 2018, February 2019 *(Amended)*, September 2019 *(Amended);* September 2020; September 2021; September 2022; September 2023

*Effective October 2018, Approval Date reflects the month in which the Physician Advisory Committee reviewed and approved.

Appendix A: Quality and Performance Improvement Program Description
Standing Staff Members of Partnership QI Committees

(Does not include external physician or consumer membership;
see committee description for those details)

Partnership Analytics Strategy Committee Standing Members	
Department Represented	**Position Title**
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Senior Director of Health Services
	Senior Director of Quality and Performance Improvement
	Health Equity Officer
	Director of Population Health
Finance	Chief Financial Officer
	Senior Director of Financial Planning and Analysis
	Director of Health Analytics
Information Technology	Director of Enterprise Information Management
	Associate Director of Data Warehouse

Partnership Board Meeting Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer / Deputy CEO
	Chief Strategy and Government Affairs Officer
	Director of Regulatory Affairs and Program Development
	Behavioral Health Services Administrator
	Northern Region Executive Director
	Regional Manager
	Associate Director of Communications and Public Affairs
	Executive Assistant / Board Clerk
Claims	Director of Claims
Finance	Chief Financial Officer
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Director of Care Coordination Operations (NR)
	Senior Director of Health Services
	Senior Director of Quality and Performance Improvement
	Health Equity Officer
Human Resources	Senior Director of Human Resources
Information Technology	Chief Information Officer
Member Services	Director of Member Services
Provider Relations	Senior Director of Provider Relations

Partnership Compliance Committee Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer (also serves as the Compliance Officer)

Partnership Compliance Committee Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
	Senior Director of Northern Region
	Director of Regulatory Affairs and Program Development
	Behavioral Health Administrator
	Regional Manager, Administration (Eureka)
	Regional Director, Administration (Santa Rosa)
Claims	Director of Claims (SR)
	Director of Claims (NR)
Configuration	Director of Configuration
Finance	Chief Financial Officer
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Senior Director of Health Services
	Director of Pharmacy Services
	Manager of Quality Assurance and Member Safety
Human Resources	Senior Director of Human Resources
Information Technology	Chief Information Officer
Member Services	Senior Director of Member Services
Provider Relations	Senior Director of Provider Relations
Project Management/ Operational Excellence	Associate Director of Operational Excellence and Program/Project Management Office

Partnership Consumer Advisory Committee (CAC) Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Behavioral Health Administrator
	Regional Director
	Regional Manager
	Manager of Communications
	Program Manager I, Communications
	Communications Specialist
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Regional Medical Director(s)
	Senior Director of Health Services
	Health Equity Officer
	Director of Population Health
	Manager of Population Health
	Senior Health Educator
	Health Educator
	Supervisor of Pharmacy Operations
Member Services	Senior Director of Member Services
	Senior Manager of Member Services
	Supervisor(s) of Member Services
	Member Service Representative
	Administrative Assistant(s) of Member Services
Grievance & Appeals	Associate Director of Grievance and Appeals

	Manager of Grievance and Appeals
	Supervisor of Grievance and Appeals

Partnership Credentials Committee Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Regional Medical Director(s)
	Associate Medical Director(s)
	Medical Director for Quality
Provider Relations	Senior Director of Provider Relations
	Director of Provider Relations
	Senior Manager of Network Education and Credentialing
	Credentialing Supervisor
	Credentialing Specialist(s)

Partnership Delegation Oversight Review Sub-Committee Standing Members	
Department Represented	**Position Title**
Administration	Director of Regulatory Affairs and Program Development
	Chief Operating Officer
	Compliance Program Manager
	Delegation Specialist
	Associate Director of Operational Excellence and Program/Project Management Office
	Senior Manager of Regulatory Affairs
	Behavioral Health Services Administrator
	Associate Director of Grievance and Appeals
	Grievance and Appeals Compliance Manager
	Manager of Governance and Compliance
	Compliance Auditor
Claims	Director of Claims
	Manager of Claims
Finance	Manager of Business Decisions and Analysis
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Senior Director of Health Services
	Director of Pharmacy Services
	Associate Director of Care Coordination
	Director of Population Health
	Director of Care Coordination Operations (NR)
	Director of Utilization Management
	Manager, Quality Assurance and Member Safety
	Medical Director
	Associate Director of Utilization Management Regulations
	Director of Transportation
	Associate Director of Transportation Programs
	Director of Health Services (NR)
	Supervisor of Health Education
Member Services	Director of Member Services and Provider Relations (NR)

Partnership Delegation Oversight Review Sub-Committee Standing Members	
Department Represented	**Position Title**
	Director of Member Services
Project Management/Operational Excellence	Associate Director of Operational Excellence and Program/Project Management Office
Provider Relations	Senior Director of Provider Relations
	Director of Provider Relations

Partnership Family Advisory Committee (FAC) Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Director of Care Coordination
	Associate Director of Care Coordination
	Senior Director of Health Services
	Senior Health Educator
	Manager of Grievance and Appeals

Partnership Finance Committee Standing Members	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Behavioral Health Administrator
	Northern Region Executive Director (ad hoc)
Finance	Chief Financial Officer
	Senior Director of Accounting/Controller
	Senior Director of Financial Analysis
	Director of Financial Planning and Analysis
	Senior Manager of Financial Planning and Analysis
	Director of Internal Audit
	Director of Facilities
Human Resources	Senior Director of Human Resources (ad hoc)
Information Technology	Chief Information Officer
Provider Relations	Senior Director of Provider Relations

Partnership Internal Quality Improvement (IQI) Committee Standing Members	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Regional Director
	Regional Manager
	Associate Director of Grievance and Appeals
	Manager of Grievance and Appeals
Claims	Claims Department Leadership

Partnership Internal Quality Improvement (IQI) Committee Standing Members	
Department Represented	**Position Title**
Member Services	Director of Members Services Call Center
Finance	Director of Health Analytics
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Medical Director for Quality
	Senior Director of Quality and Performance Improvement
	Senior Director of Health Services
	Director of Health Equity (Health Equity Officer)
	Director of Quality Management
	Director of Population Health
	Directory of Pharmacy Services
	Director, Utilization Management
	Associate Director(s), Care Coordination
	Associate Director(s), Utilization Management
	Manager, Quality Assurance and Member Safety-Quality Investigations
	Manager, Clinical Quality and Member Safety-Quality Inspections
	Manager of Care Coordination Regulatory Performance
	Senior Health Educator
	Associate Medical Director(s)
	Regional Medical Director(s)
Provider Relations/Credentialing	Senior Director of Provider Relations
	Associate Director of Provider Relations

Partnership Member Grievance Review Committee (MGRC) Standing Members	
Department Represented	**Position Title**
Administration	Associate Director of Grievance and Appeals
	Grievance and Appeals Compliance Manager
	Manager of Grievance and Appeals
	Senior Grievance and Appeals Nurse Specialist
	Director of Legal Affairs
	Legal Analyst
	Manager of Governance and Compliance
	Regulatory Compliance Specialist
	Program Manager II
	Northern Region Executive Director
	Behavioral Health Administrator
	Senior Program Manager, Behavioral Health
Claims	Director of Claims
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Manager of Quality Assurance and Member Safety
	Medical Director of Quality
	Director of Pharmacy Services
	Manager of Clinical Pharmacy
	Director of Care Coordination
	Director of Care Coordination Operations

Partnership Member Grievance Review Committee (MGRC) Standing Members	
Department Represented	**Position Title**
	Director of Utilization Management Strategies
	Manager, Member Safety - Quality Investigations
	Manager of Quality Incentive Programs
	Senior Director of Quality and Performance Improvement
	Project Manager II, Quality Improvement
	Administrative Assistant II, Utilization Management
	Health Equity Officer
	Director of Population Health
	Senior Manager of Population Health
	Manager of Population Health
Member Services	Senior Director of Member Services
	Director of Member Services
Provider Relations	Senior Director of Provider Relations
	Senior Manager of Provider Relations Representative
	Program Manager II
	Supervisor of PR Representatives
	Senior Provider Relations Representative
Transportation Services	Director of Transportation Services
	Associate Director of Transportation Services
	Manager of Transportation Programs

Partnership Over/Under Utilization Workgroup Standing Members	
Department Represented	**Position Title**
Administration	Regulatory Affairs Manager
	Regulatory Affairs Specialist
	Senior Director of Northern Region
	Director of Operational Excellence and Program/Project Management Office
Claims	Director of Claims (SR)
Finance	Associate Director, Health Data Analytics
	Senior Manager of Cost Efficiency
	Senior Health Data Analyst
	Manager of Health Analytics
	Project Manager II
	Cost Avoidance Manager
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Senior Director of Health Services
	Medical Director
	Behavioral Health Clinical Director
	Director of Care Coordination Operations (NR)
	Associate Director(s) of Utilization Management
	Director of Pharmacy Services
	Senior Director of Quality and Performance Improvement
	Health Equity Officer
	Associate Director of Housing and Incentive Programs
	Associate Director of Care Coordination
	Director of Population Health
	Director of Utilization Management Strategies
	Director of Pharmacy Services
	Regional Supervisor of Utilization Management
	Director of Quality Management
	Senior Manager of Population Health
	Manager of Performance Improvement
	Manager of Clinical Pharmacy
	Manager of Quality Incentive Programs
	Manager of Care Coordination
	Program Manager
Information Technology	Director of Enterprise Information Management
Provider Relations	Senior Director of Provider Relations
	Senior Provider Relations Representative Manager
	Senior Manager of Provider Relations Representatives
	Senior Manager of Provider Network Education and Credentialing
	Supervisor of Provider Relations Representatives
	Manager of Provider Relations Representatives – NR
	Program Manager
	Senior Provider Relations Representative
	Provider Relations Representative

Partnership Pediatric Quality Committee (PQC) Standing Staff Invites *Note: Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Medical Director
	Chief Medical Officer
	Health Equity Officer
	Senior Director of Health Services
	Director of Pharmacy Services
	Director of Care Coordination

Partnership Peer Review Committee Standing Staff Invites *Note: Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Medical Director for Quality
	Manager, Quality Assurance and Member Safety-Quality Investigations
	Supervisor, Quality Assurance and Member Safety-Quality Investigations
	Performance Improvement Clinical Specialists, Quality Assurance and Member Safety-Quality Investigations
	Project Coordinator, Quality Assurance and Member Safety-Quality Investigations
	Manager, Clinical Quality and Member Safety-Quality Inspections
	Supervisor, Clinical Quality and Member Safety-Quality Inspections
	Clinical Compliance Inspectors, Clinical Quality and Member Safety-Quality Inspections
	Senior Director of Health Services
	Director of Health Equity (Health Equity Officer)
	Regional Medical Director(s)
	Associate Medical Director(s)
	Director of Pharmacy Services
	Behavioral Health Clinical Director

Partnership Physician Advisory Committee (PAC) Standing Staff Invites *Note: Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Clinical Director of Behavioral Health
Finance	Chief Financial Officer
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Population Health, and Care Coordination)	Chief Medical Officer
	Senior Director of Quality and Performance Improvement
	Senior Director of Health Services
	Director of Pharmacy Services
	Associate Director(s) of Utilization Management

Partnership Physician Advisory Committee (PAC) Standing Staff Invites *Note: Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
	Health Equity Officer
	Director of Population Health
	Medical Director for Quality
	Regional Medical Director(s)
Provider Relations	Senior Director of Provider Relations

Partnership Provider Engagement Group (PEG) Standing Members *(Meetings on hold until CEO approval due to Pandemic/State of Emergency)*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Regional Medical Director
Provider Relations	Senior Director of Provider Relations
	Director of Member Services and Provider Relations

Partnership Quality Improvement and Health Equity (QIHEC) Transformation Committee Standing Members	
Department Represented	**Position Title**
Administration	Associate Director of Grievance and Appeals
	Chief Operating Officer
	Associate Director of Communications
Finance	Director of Health Analytics
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Health Equity Officer
	Senior Director of Quality and Performance Improvement
	Director(s) of Care Coordination
	Director(s) of Utilization Management
	Director(s) of Population Health
	Senior Health Educator
	Senior Director of Health Services
	Director of Pharmacy Services
	Regional Medical Director(s)
	Associate Medical Director(s)
Provider Relations	Senior Provider Relations Representative Manager
Members Services	Senior Director Member Services

Partnership Quality/Utilization Advisory (Q/UAC) Committee Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Associate Director of Grievance and Appeals
	Southwest Regional Director
	Behavioral Health Administrator

Partnership Quality/Utilization Advisory (Q/UAC) Committee Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
	Behavioral Health Clinical Director
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordinationand Population Health)	Chief Medical Officer
	Medical Director for Quality
	Senior Director of Quality and Performance Improvement
	Senior Director of Health Services
	Director of Health Equity (Health Equity Officer)
	Director of Population Health
	Director, Utilization Management
	Director, Utilization Management Strategies
	Associate Director(s), Care Coordination
	Associate Director(s), Utilization Management
	Director of Pharmacy Services
	Manager, Quality Assurance and Member Safety
	Manager, Clinical Quality and Member Safety-Quality Inspections
	Regional Medical Director(s)
	Associate Medical Director(s)
Provider Relations	Senior Provider Relations Representative Manager
	Senior Director of Provider Relations

Partnership Strategic Planning Committee Standing Staff Invites *Note: Partnership Staff are not committee voting members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Behavioral Health Services Administrator
	Regional Manager (NR)
	Northern Region Executive Director
	Associate Director of Communications and Public Affairs
	Project Coordinator
	Project Manager, Northern Region
Finance	Chief Financial Officer
	Director of Financial Planning and Analysis
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Health Equity Officer
Information Technology	Chief Information Officer

Partnership Substance Use Internal Quality Improvement Subcommittee Standing Members	
Department Represented	**Position Title**
Administration	Behavioral Health Administrator
	Behavioral Health Clinical Director
	Behavioral Health Manager
	Senior Program Manager, Behavioral Health

Partnership Substance Use Internal Quality Improvement Subcommittee Standing Members	
	Associate Director of Grievance and Appeals
	Grievance and Appeals Compliance Manager
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Behavioral Health Clinical Specialist (NR)
	Behavioral Health Clinical Specialist (SR)
	Manager of Member Safety – Site Inspections
Claims	Supervisor of Customer Service (NR)
Compliance	Director of Regulatory Affairs and Program Development
Member Services	Supervisor of Member Services
Provider Relations	Senior Director of Provider Relations
	Provider Relations Representative (NR)
	Senior Manager of Network Education and Credentialing

Partnership Substance Use Services Provider Advisory Group Standing Members	
Department Represented	**Position Title**
Administration	Behavioral Health Administrator
	Behavioral Health Clinical Director
	Program Manager I, Behavioral Health
	Behavioral Health Manager
	Grievance and Appeals Compliance Manager
Provider Relations	Senior Manager of Network Education and Credentialing

Appendix B: Quality and Performance Improvement Program Description
Partnership HealthPlan Strategic Quality Plan: Achieving Five-Star Quality

2020-2025
Introduction

In 2017, Partnership HealthPlan of California (Partnership) created a HEDIS® measure score improvement strategic plan, directed at dramatically improving HEDIS® scores by sub-region. Two imperatives have led us to a major revision of this plan. First, the HEDIS® score improvement strategic plan did not address thelink between the member experience and overall quality. Second, Partnership is on the road to NCQA accreditation, which includes a number of standards outside the patient experience and clinical quality scores and defines many activities throughout the organization that impact both.

The purpose of this 2020 update to the strategic plan is to clearly articulate the long and short-term initiatives Partnership will engage in over the next five years to achieve 5-star NCQA Health Insurance Plan Rating status. NCQA accreditation is the gold standard for measuring performance of health plans in the United States. Full accreditation by NCQA categorizes overall health plan performance from zero to five stars, analogous tothe Medicare Stars rating system. A 5-star rating is the highest possible score achieved by just 2 of 171 Medicaid plans nationally in 2019; a score of 4-star or above is considered above average, achieved by 40 health plans nationally.

This document serves as a communication tool for Partnership leadership and staff, Board members, providers and other stakeholders and lays a solid foundation from which an operational plan will be created.

This Five-Star Strategic Plan is an elaboration of the first focus area of Partnership's organizational Strategic Plan: to ensure high quality health care to all our members. This strategic plan also aligns with Partnership's vision - to be the most highly regarded Health Plan in California - and its mission, which transcends service to our members to include the greater community, "To help our members, and the communities we serve, be healthy."

Improving quality not only has intrinsic benefits to our members, but it carries intangible benefits to the organization and the community. When quality improvement activities are aligned with the "quadruple aim" of better health, lower cost, better care and caring for the providers, it assists with making the overall health care system function more effectively and efficiently. A focus on quality also improves the reputation of Partnership in the state, allowing further innovation and influence among state-wide stakeholders.Finally, the principles of quality improvement can influence the organization to more efficiently execute on operational priorities not directly related to quality.

Lastly, in 2019, DHCS moved aggressively towards the use of larger scale health plan sanctions for performance on measures that are below average performance. This places additional financial pressure on Partnership to improve quality measure results within our network.

Organizational Values Supporting Quality

To achieve 5-star quality, Partnership must have an organizational culture of quality which is nurtured by the executive leadership team and Board of Commissioners. Core to this culture are these organizational values (from our organizational strategic plan), with aphorisms reflecting these values.

- Partnerships: Fostering strong partnerships with members, providers, and community leaders to collectively improve health outcomes. "Putting our members first."

- Overall focus on Quality: Focusing on continuous quality improvement in every aspect of the organization and in collaboration with our partners. "Doing the right thing right, the first time andevery time."
- Integrity: Set a standard of professionalism, integrity, and accountability. "Striving for perfection, but embracing the opportunity to learn from imperfection. Excellence is achievable!"
- Innovation: Striving to be innovative and seeking creative solutions. "Willingness to challenge the status quo, and insist on change when needed."

In addition, the Partnership leadership team has several conceptual frameworks focused on quality:

- Balancing Compliance and Performance: Balancing rigid attention to regulatory requirements with flexibility and innovation needed to drive improvement. "Not all change is improvement, but all improvement requires change."
- Promoting Health Equity: Ensuring an organizational culture that recognizes the diverse backgrounds of our employees and supports the institution of practices that consider social determinants of health, the impacts of implicit bias and the provision of fair and judicious healthcare and services to meet the broad based needs of our members. "Everyone has a fair and just opportunity to be as healthy as possible."
- Becoming a Learning Health Plan. "Making decisions based on rigorous data analysis wheneverpossible (instead of based on hope or wishful thinking)." "Creating an atmosphere where new ideas can be explored and where strong, independent teams can test these ideas."

The term "Learning Health Plan" is new in this strategic plan, although many associated tactics are not new. More background and explanation is presented next.

Learning Health Plan

A common underlying theme in most Quality Improvement frameworks is that organizations and teams must embrace continuous learning to achieve their highest potential. Tom Nolan, one of the creators of theModel for Improvement, said "What are the necessary and sufficient conditions for improvement in large systems? **Will, ideas and execution!"**

Donald Berwick describes what will, ideas, and execution means:
"Providing **will** refers to the tasks of fostering discomfort with the status quo and attractiveness for the as-yet-unrealized future. Providing **ideas** means assuring access to alternative designs and ideas worth testing,as opposed to continuing legacy systems. And **execution** was his term for embedding *learning* activities and change in the day-to-day work of everyone, beginning with leaders." -Milbank Quarterly, August, 2019

The Partnership Executive Team and Board are committed to making a profound and deep link between the necessities of using a learning health plan framework to best serve our members and our communities.

The fundamental tenets of a Learning Health Plan are:

1. Using the scientific method to optimize implementation of quality improvement initiatives
   a. Building on prior research/experiences
   b. Rigorous and widespread testing of change on a small scale (using the model for improvement framework)
   c. Tracking of information gleaned from small tests of change so others can retrieve this information and build upon it.
   d. Use of control groups (where appropriate)
   e. Careful data and statistical analysis

f. Using a combination of classic project management methodology with the ConsolidatedFramework for Advancing Implementation Science[1] to have a systematic effective approach to program implementation and building internal expertise in these approaches.

2. Having the leadership and staff to support this approach
   a. Communicate effectively about quality and change, through a mixture of data and stories. "No data without a story, no story without data."

A Learning Health Plan avoids widespread implementations of any unproven projects, without measurement of what the outcome is, performing weak or no evaluation of the project, and continuing theproject without knowing if it is effective. While such projects are often related to regulatory mandates, gathering data on their effectiveness or lack thereof can provide valuable evidence for advocating policy change.

Without using the term "learning organization" or "learning health plan," Partnership has been building the infrastructure and leadership to include most of these elements. For example, creating a Project Management/Operational Excellence Department and Team, creating a Health Analytics Team, doing internal trainings through the Learning Management System and external trainings, conducting efficient but meaningful Return on Investment analyses of several programs, and developing a system of storing lessons learned in small tests of change in the quality department are all examples.

By identifying the elements of a strong learning health organization and standardizing our communicationaround the core principles, we will solidify the cultural values around being a Learning Health Plan.

Process of Developing 5-Star Strategic Plan

Leaders in the Quality Improvement (QI) Department created this strategic plan with input from Partnership leadership and staff via the HEDIS® Score Improvement team and the Analytics, Care Coordination, Population Health, Information Technology (IT), Member Services, Pharmacy and QI departments.

The scope of this strategic plan is rooted in the emerging field of population health management. Population health management, in the context of a health plan, requires assessment and analysis of member needs, stratifying the population into risk tiers and defining segments for targeted interventions. Once population segments are identified, the health plan engages available resources to improve the health and wellbeing of the plan's assigned membership on both an individual and aggregate level. This is distinct from approaching population health with a public health approach –which would encompass coordinated and multi-sector efforts to improve the quality of health for an entire community or communities— an approach which is beyond the scope of this strategic plan.

The Quality Improvement department will lead the implementation of this strategic plan, collaboratively and in partnership with other departments and providers, respecting capacities and competing priorities.

Evaluation

Partnership is committed to testing new approaches and scaling up when new approaches are successful. The QI department will lead efforts to support processes and systems for learning and monitoring progress on the implementation of the NCQA 5-Star Strategic Initiative Plan, and sharing evaluations with Partnership leaders and our community partners.

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[1] Keith, R.E., Crosson, J.C., O'Malley, A.S. *et al.* Using the Consolidated Framework for Implementation Research (CFIR) to produce actionable findings: a rapid-cycle evaluation approach to improving implementation. *Implementation Sci* **12,** 15 (2017)

Environmental Factors

The following strengths and weaknesses within the organization and opportunities and threats external tothe organization were taken into consideration when drafting this strategic plan.

Strengths	Weaknesses
• NCQA Interim Accreditation status attainted - many standards (notably the Population Health Management standards) directly support improved HEDIS® scores. • Significant programming and ability to offer technical assistance to bolster primary care capacity for quality and clinical improvement • Robust pay-for-performance program and commitment to value-based processes. • Supportive data systems including eReports and Partnership Quality Dashboard • Increasing cross-department collaboration • Strong HEDIS® Medical Record ReviewProject processes • New member portal building an infrastructure to outreach to members • Growing internal analytic capacity and standardized data sets support population health analysis • Recent assignment of largest direct member categories to PCPs so that PCP QIP applies	• Competing priorities: major system implementations, multiple goal teams, efforts to comply with NCQA standards, new benefits, new regulatory mandates • Many databases still not integrated or standardized • Data governance processes not deeply institutionalized • Preventive or coordination services Partnership offers are not widely understood or utilized by members • Member input not deeply integrated into member-facing improvement efforts • Limited Partnership experience in outreaching tomembers to close HEDIS® gaps • Collaboration across Partnership departments sometimesnot prioritized over core departmental work. • Confined "single views" of member; gaps in care not visible across health plan data systems • Regional disparities in access and health risk factors
External Opportunities	**External Threats**
• NCQA First Survey Accreditation (11/2020) – roadmap to becoming higher quality plan • Provider network and communities support improved clinical performance and are willing to partner (e.g., Joint Leadership Initiative) • Provider partner bright spots with best practices and excellent quality scores • Pilot programs to enable greater accuracy of member contact information. • Preparation for MediCare Duals Special Needs Plan (D-SNP) • MCHC for all: Enhanced Care Management and In Lieu of Services proposals • Aligned Proposition 56 incentive funding	• Judicial threats to the Affordable Care Act (risk aversion) • Lethargic CMS response to DHCS proposals impact scope and speed of DHCS policy changes • Changing regulatory environment with increasing risk of financial sanctions and other penalties • Proposed changes to public charge policy (decreased enrollment) • Primary care site staff turnover (providers, nurses, medical assistants) • Member access to PCPs for care • PCP capacity for outreach • PPS providers (provider primary care for over 75% of members): PPS system reimburses based on volume, not services provided (removes some options for incentivizing quality activities) • Natural disasters and power outages • Pharmacy Carve Out

HEDIS® Score Improvement Aim Statement

The Partnership Five Star Quality Strategic Plan Aims to achieve the following:

1. A weighted average of all accountable DHCS MCAS measures >50th percentile (in year 1) with yearly improvement afterwards in three years, all individual measures performance will be above the 50th percentile.
2. ≥25th percentile in all adult and pediatric CAHPS® measures year 1; with yearly improvement afterwards
3. 80% of applicable points earned in each standard category of NCQA accreditation standards, including Must Pass elements

These are ambitious goals and will require a significant amount of investment, collaboration, and focus. The Managed Care Accountability Set (MCAS) will grow from 19 measures for measurement year (MY) 2018 to 36 for MY 2020. With the new MCAS measures, the minimum performance level increased from the 25th to the 50th national Medicaid percentile.

See Appendix E for HEDIS® performance in measurement year 2018.

Focus Areas, Goals and Objectives

This strategic plan is centered on five key focus areas: 1) Engaging Clinical Practices 2) Engaging Members 3) Data Infrastructure 4) Accreditation Standards and 5) Access. Specific activities, timelines, resources, and evaluation benchmarks will be developed in an operational plan. See Appendix A for a visual depiction(process map) of Partnership's Achieving Five-Star Quality focus areas and goals.

Focus Area 1: Primary Care Practice Ability to Deliver High Quality Health Care

Partnership recognizes the critical role PCPs play in improving clinical quality performance, as well as optimizing utilization, maximizing access to care and enhancing the patient experience. A central theme within this focus area is to better equip PCPs to provide recommended high quality care through provision of information, technical assistance, improvement tools and financial incentives.

Focus Area 1: PCP Delivery of High Quality Care

Goals	Objectives
A. Supply Actionable Care Gap Data to PCPs	• Optimize: eReports • Optimize: Partnership Quality Dashboard (PQD) • Study: Integrate ePrompts into Provider OnlineServices • Expand: Unblinded quality data sharing • Promote: Electronic Health Record (EHR) workflow optimization, including integration with CAIR
B. Technical Assistance to Support Provider QI Capacity	• Optimize: Mandated PDSA/PIPs/Site Reviews/Prop56 • Expand: Technical assistance offerings, provider education and coaching for large and medium sizedpractices • Sustain: General QI training: ABCs of QI • Adapt: Measure-specific trainings and webinars • Evaluate: PCP leadership development • Study: Partnership leverage for promoting health equity through providers
C. Optimize Pay for Performance Programs	• Optimize: PCP QIP • Optimize: Perinatal QIP • Optimize: Hospital QIP

Focus Area 2: Partnership Engaging Members to Improve Quality Metrics

There is a significant opportunity for Partnership to expand direct-to-member engagement activities to improve MCAS and HEDIS® scores. The goals within this focus area will require Partnership to take on new initiatives and/or expand current initiatives that provide actionable data to Partnership staff, leverage contacts with members through in-reach and outreach, and increase Partnership's presence in communities. Direct health plan contact with members complements the outreach conducted by providers. Partnership Network providers are diverse in size, staffing and resources and may be limited in outreach capabilities for a variety reasons, including competing priorities or absence of supportive technology or workflows. In other instances, members are not assigned to or directly managed by a PCP (e.g., direct members) or the member may have considerablemovement across PCPs during the HEDIS® measurement year.

Focus Area 2: Partnership Engaging Members to Improve Quality

Goals	Objectives
A. Supply Actionable Care Gap Data to Partnership Staff and Members	• Integrate: Prompts into Essette • Integrate: ePrompts into Call Center • Integrate: ePrompts into Member Portal
B. Increase Partnership Member-Engagement Capacity	• Pilot: Reminders into Care Coordination workflow • Study: Integration of reminders into Member Services workflow • Expand: Train Partnership staff on targeted qualitymeasures • Study: New and updated member incentives • Increase: Member input into engagement process • Expand: Partnership Outbound engagement activities • Develop: Digital Engagement Solutions
C. Other Strategies for Member Engagement	• Test: Leverage Community Health Workers/CareManagers on Quality Measures • Study: ED and inpatient settings • Test: Outreach to direct members • Expand: Outreach through identification and participation in grassroots community activities

Focus Area 3: Data, Analytics, and Knowledge Management

A critical element to improving MCAS and HEDIS® quality scores lies in Partnership's ability to strengthen data and analytics infrastructure. Additionally, in order to function under the Learning Health Plan framework, foundational systems and processes need to be developed and established to strengthen how data and improvement study results are evaluated and used in decision-making to further optimize the rate of qualityimprovement. Four goals will help improve the organization's infrastructure needed to support and assessprimary care and member interventions.

Focus Area 3: Data, Analytics, and Knowledge Management

Goals	Objectives
A. Actionable CareGap Data to PCPs, Partnership staff and members	• Objectives in Focus Area 1, Goal 1 • Objectives in Focus Area 2, Goal 2 • Expand: Pilots on improving member contact information • Align: Health education tools on Member Portal with quality measures
B. Data Quality, Timely Access and Completeness	• Optimize: Configuration of new core claims system • Implement: Provider Master Data Management • Expand: Data Dictionaries • Operationalize: Data Stewardship Program • Expand: Health Information Exchange (HIE) • Expand: Clinical Data Repository (CDR) • Operationalize: Partnership Data Governance structure
C. Supportive Analytics	• Expand: Well-constructed Data Marts • Build: Comprehensive member data (Member 360) • Optimize: Analysis and presentation of annual quality measure results • Optimize: Leverage rolling-year monthly HEDIS® data • Integrate: Equity analysis with improvement activities
D. Learning HealthPlan Framework	• Expand: Knowledge Management infrastructure • Develop: Standardized scientific approach to small tests of change • Study: Standardized approach to scaling up/implementation

Focus Area 4: Achieving Health Plan NCQA Accreditation

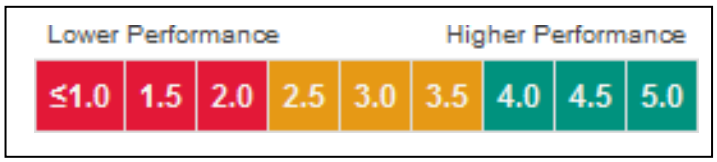
The provision of high quality healthcare to our members is fundamental to Partnership's vision and mission. Wewant to be one of the highest quality health plans in California. NCQA Health Plan Accreditation supportsthis goal by:

- Providing a framework to guide our operational and quality improvement activities. (Many of the activities outlined in the standards are best practices that should be pursued regardlessof our accreditation goals.)
- Providing a nationally-recognized standard and definition for a high quality health plan, performance against which will allow Partnership to compare ourselves objectively against other high quality plans.
- Offering the only widely-available health plan assessment that bases results on clinical performance (HEDIS®) and member experience (CAHPS®).

In the summer of 2019, Partnership received formal Interim Accreditation Status, receiving 50 out of 50 total possible points. Interim Accreditation ensures organizations have a basic structure in place to meet expectations for consumer protection and quality improvement. Interim Accreditation status indicates a strong position and readiness of an organization to move forward with formal First Survey Accreditation, which covers the full scope of the standards and requirements, including HEDIS® and CAHPS® reporting.

First Survey Accreditation is planned for late 2020-early 2021. As noted earlier, two years after that the HEDIS® and CAHPS® scores will be integrated to give a star rating from 0 to 5.

5-Star Scale



As part of the process for setting appropriate goals and areas of focus, the NCQA Project Management Team reviews the accreditation scoring methodology on an annual basis to appropriately apply updates, changes or modifications. Broadly, here are the categories in which we have extracted as areas of focus,which are resource intensive and have significant cross-departmental impact, expressed as goals:

Focus Area 4: Achieving NCQA Accreditation

Goals	Objectives
A. Pass all "MustPass" Elements	• Optimize: Internal file review • Optimize: Delegated file review • Optimize: Delegates following NCQA Standards • Align: Department Goals
B. Strengthen "Grand Analysis" Improvement Activities	• Optimize: Utilization Management • Improve: Member Experience • Optimize: Network Adequacy and Availability • Implement: Population Health Management • Implement: Continuity and Coordinationof Care • Non-Behavioral • Behavioral
C. Prepare for MediCare	• Measure: Baseline MediCare HEDIS®Measures • Address: MediCare HEDIS® Gaps • Evaluate: MediCare incentive programoptions for patients and providers • Plan: Support for overall quality oversight

Focus Area 5: Improving Member Experience through Improved PCP Access

Background: In the 2019 Partnership CAHPS® survey, the areas below the 25th percentile for adult and children werealmost exclusively in the area of perceived access to services. Since the CAHPS® survey will account for about one-third of our accreditation score and is also slated to become an MCAS measure, it is imperative that Partnership explore additional activities to improve PCP access. While the access composite scores in CAHPS® include questions related to specialty access, only PCP access will be included in Focus Area 5. Activities related to increasing specialty access will be covered in the Access and Availability Grand Analysis required as part of NCQA accreditation.

From July-October, 2019 multiple stakeholders[2] were asked to give feedback and suggestions for increasing access to PCPs in the Partnership service area.

> The 54 ideas that were generated were categorized by the degree of control the Clinical Practice has overthe factor, the degree of control the Health Plan has over the factor, as well as a categorization of the cost, effort and effectiveness of each suggestion. See Appendix D for the details.

Prioritization Process:
We eliminated those suggested interventions that were high cost (3-4) and low estimated effectiveness (1). Additional changes were made, based on feedback from Executive Committee. This leads to these 17 objectives, grouped into four goals.

[2] Nine Joint Leadership Initiatives, Physicians Advisory Committee, Strategic Planning Committee, Medical Directors of Partnership, Board Advisory Group on Quality, Executive Committee at Partnership, Operations Committee at Partnership

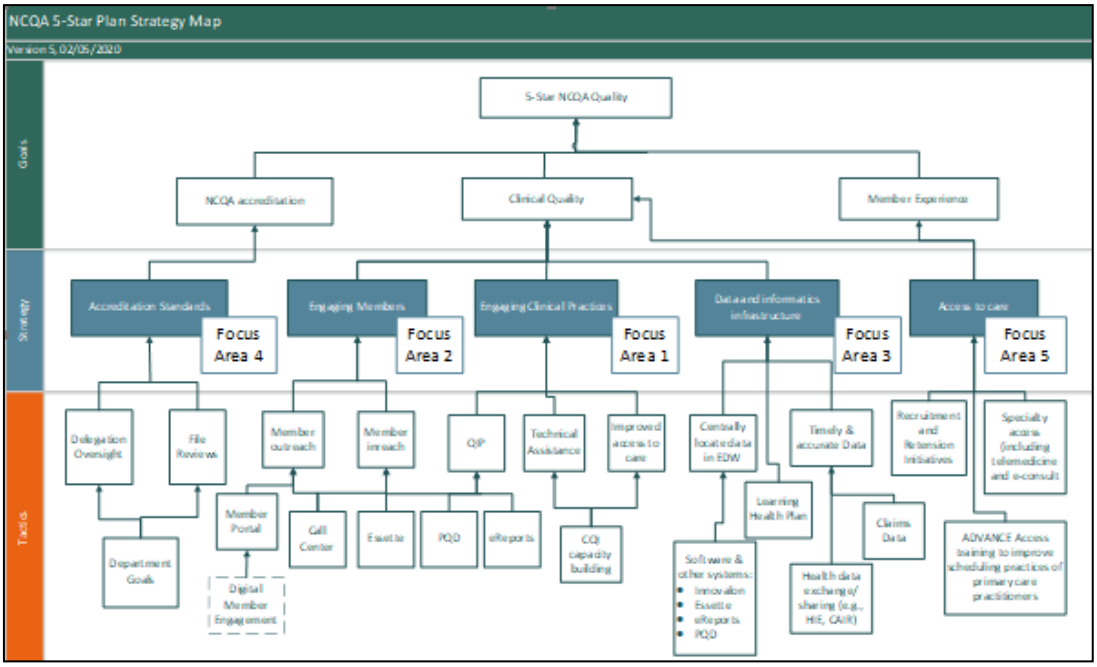
Focus Area 5: Improving Member Experience through PCP Access

Goals	Objectives
A. Recruitment	•Implement: Marketing to Residents within Partnership region •Implement: Marketing to Residents outside Partnership region •Implement: Marketing to out-of-state primary care Residents originally from Partnership counties •Explore: Support partner job search •Study: Support J-1 visa process
B. Retention	•Test: Optimize HPSA scores in shortage areas •Implement: Support providers in completing application/processfor loan repayment •Study: Increase PCP organization reimbursement for sites with greatest challenge via adjustment of PCP-QIP by recruitment difficulty factor •Study: Coordination among local agencies providing supplemental dollars for loan repayment, signing bonus, etc. •Implement: Advocacy for new and larger loan repaymentprograms by state/federal government. •Test: Vetted Locum Tenens providers to provide vacationcoverage •Planning: Proposal for structure for providing social support to providers
C. Alternative Access Options	•Implement: Promoting the leveraging Phone/Video visits toincrease access •Implement: On demand video visits for urgent care •Promote: Advanced Access methodology
D. Learning	•Implement: Exit Interviews of Clinicians leaving the region •Implement: Interview practices that are very successful inrecruiting strong staff

Conclusion

This Partnership Strategic Plan for Achieving Five Star Quality provides a roadmap for using the overall structureand framework of NCQA, modified by requirements of DHCS, to substantially improve quality and ultimately achieve a 5-star rating by NCQA by 2025.

Appendix A – Partnership Strategic Quality Plan



Pathway to Excellence

Partnership Framework for Continuous Learning

Final Workgroup Report June, 2021

Workgroup Members:
Robert Moore, MD MPH
Mark Netherda, MD
Erika Robinson
Nancy Steffen
Caron Lee
James Devan
Naresh Vemparala
Farashta Zainal

From Quality Measure Score Improvement Team Goal #4:

SMART goal #6:

Partnership's transformation as a Learning Health Plan: Define a framework/plan for expanding knowledge management infrastructure relative to best practices in quality measure improvement and operationalizing standardized approaches to small tests of change through scaling and wide-spread implementation.

Milestones:

Final report presented to the executive HEDIS® Measure Score Improvement team by June 30, 2021

Table of Contents

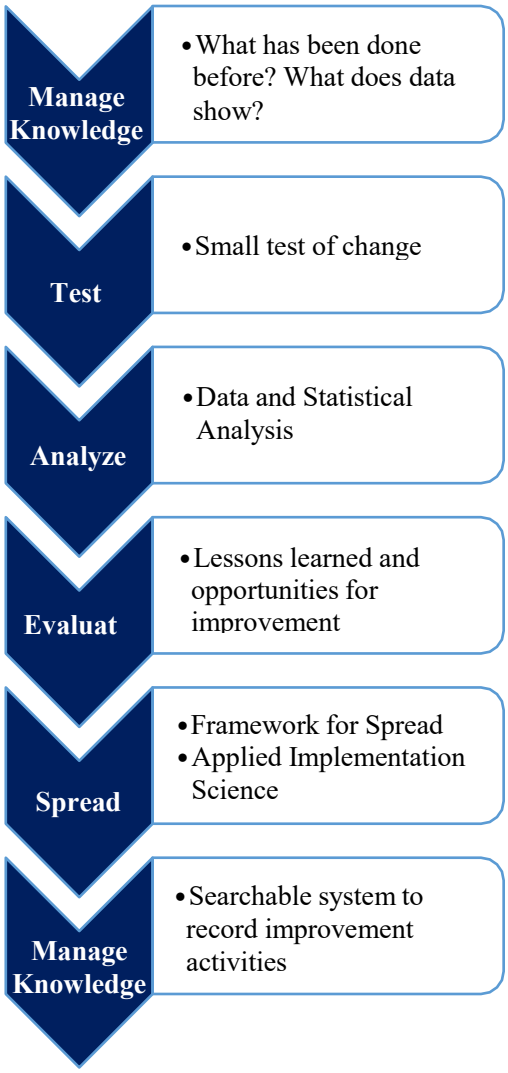
Executive Summary

For years, Partnership's QI Program Description (and DHCS itself) has highlighted the Model for Improvement, whichincludes the well-known PDSA (Plan Do Study Act) cycle as a guiding framework for improving the quality of health are of our members. Yet, as we accumulated positive experience with many small tests of change, Partnership'soverall health plan ranking (comparing a subset of HEDIS® scores with the scores of other health plans) was improving slowly. Recent reports on relative performance on Pediatric Health measures has highlighted lower performance in Partnership's northern regions, which could have an impact Partnership's success with absorbing additional rural counties. While small tests of change (PDSAs) are a key framework in improvement activities, they are not sufficient to achieve larger scale long lasting improvement.

Partnership updated its 5-star Strategic Plan in 2020, and is executing a comprehensive tactical plan related to this plan. A central goal was NCQA accreditation, achieved in January 2021. HEDIS® scores for measurement year 2021 will be the baseline year for rating the health plan on NCQA's 5-star HEDIS® scoring. The COVID pandemic and the Health Edge core claims processing implementation have had a notable negative impact on energy that can be spent by Partnership and our providers on improving health care quality measures. As we move into late 2021 and 2022, we must be ready to re-energize our provider network to improve clinical outcomes.

In 1990, Peter Senge outlined the components of what he called a "learning organization," in his book *The Fifth Discipline: The Art and Practice of the Learning Organization*. The highest performing organizations are the strongest learning organizations, he argues, and they have specific disciplines that characterize being a learning organization. About a decade ago, the term "learning organization" was expropriated by a variety of Health Care Organizations to become a "learning health system." Different organizations and authors had different ideas of what the "system" was, ranging from a geographic system to an integrated delivery system to the entirehealth care delivery system in the United States.

Over the past year, a workgroup of Partnership's HEDIS® score improvement team explored how these concepts of a "learning organization" and a "learning health care system" could be applied to a health plan. The resulting framework is composed of five elements, shown in the diagram below (knowledge management has a role at the beginning and end of the process, so is presented twice):



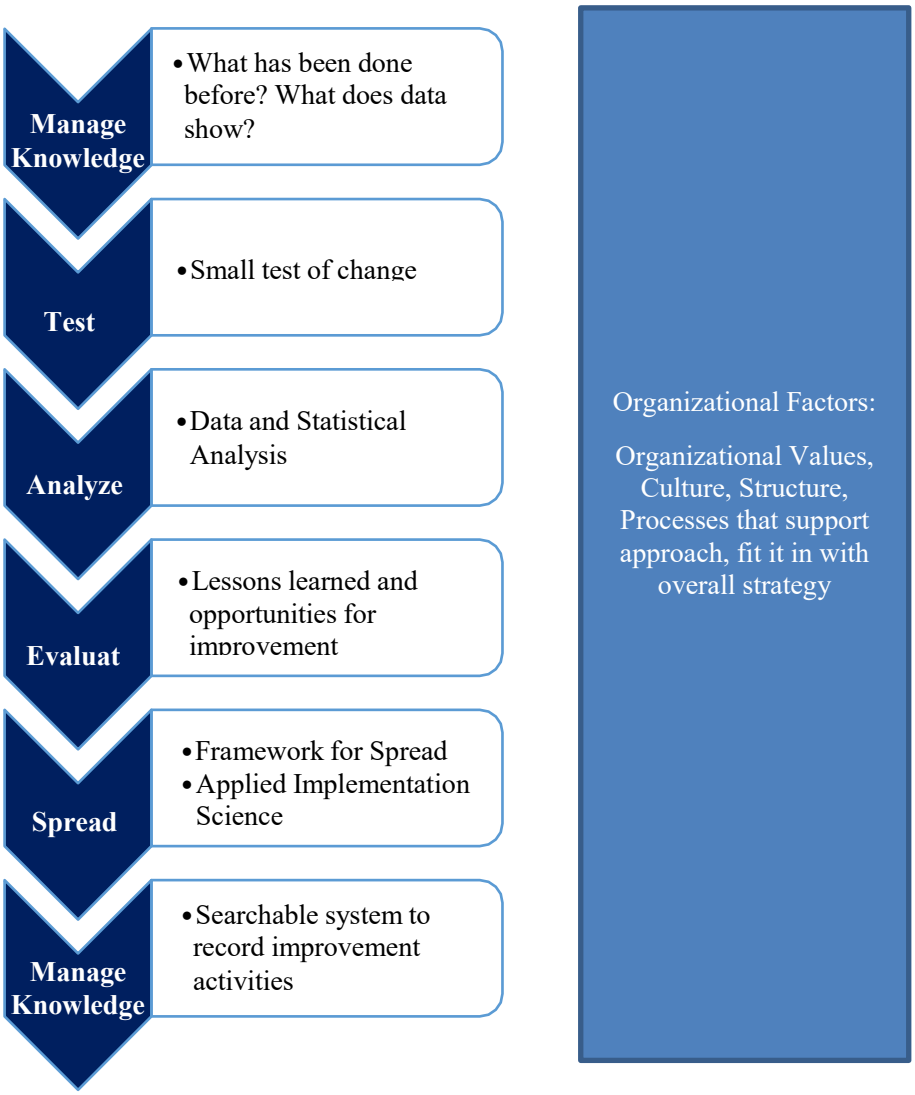
This document provides an overview of each of these key elements, including current activities at Partnership as well as a summary of the academic literature on each topic. Next, several leadership activities and overarching activities are described as critical elements to optimize the successful use of these five elements. We end with a plan for further developing our framework in the 2021-2022 fiscal year and beyond. We believe that adoption of this framework will provide critical support for our NCQA stars status, and contribute to our vision, to be themost highly regarded health plan in California.

A detailed description of the Pathway to Excellence framework can be found after the 2022 update activities section below.

2022 Update and Activities Related to the Pathway to Excellence Framework

Background:

Traditional QI frameworks are missing several key components essential for optimal testing of new ideas and implementation of successful tests. In 2020 to 2021, Partnership researched frameworks and ideas that were missing from traditional QI frameworks into one overarching framework, called the Pathway to Excellence. Major components are summarized here:



A detailed white paper with references is available on Partnership's internal website (Partnership4Me), along with a number of recorded presentations on each of the topics above.

Activities of 2022-23

During 2022, Partnership steadily worked on rolling out the Pathway to Excellence (P2E) Framework, building on an implementation plan created in 2021. Major activities of 2022 and planned activities for 2023 are listed here:

1. Creating in internal website to make P2E materials easily available to Partnership staff.
2. Formal presentations on each of the major topics:
   a. Overall Pathway to Excellence Framework, including coverage of theory of knowledge and learning.
   b. Knowledge Management
   c. Small Tests of Change
   d. Data and Statistical Analysis, including a sub presentation on Using the Data We Have (Health analytics and Data Governance work to continue into 2023).
   e. Evaluation methods
   f. Using Applied Implementation Science to Optimize Spread of Tested Ideas
3. These presentations were given internally:
   a. Operations Leaders

b. Medical Directors
c. Health Services Directors and Managers
d. Recorded for others to review (new staff, new leaders, etc.)
e. Board Quality Advisory Workgroup

4. Externally, the overall framework was adapted and presented to:
   a. Partnership's Hospital Quality Symposium
   b. The California Hospital Quality Council's annual Quality Forum
   c. Additional forums planned for 2023: CPCA Quality meeting in March.
5. Incorporating the major principles of the P2E framework in thinking about our everyday work. (Will continue in 2023)
6. Special focus on Strategic Knowledge Management (KM) Activities (all ongoing, continuing in 2023)
   a. Shared Drive Cleanup by HS departments
   b. SharePoint site cleanup
   c. Use of One-Note for Knowledge Management
   d. Master list of abbreviations updated and posted to SharePoint
   e. Principles for updating external website for KM created.
   f. Use of PowerDMS for Knowledge Management (Plan to implement after fall 2023)
   g. Microsoft 365 and its role in updating KM infrastructure (including external website). Planned for 2023.
   h. IT backup of KM materials on shared drive (2023 topic)

Framework Development

The Pathway to Excellence: Partnership's Framework for Continuous Learning was developed by a workgroup of the HEDIS® Score Improvement Goal Group. The workgroup met monthly to discuss and flesh out different aspectsof this framework and to systematically review the academic literature related to the different elements. A review of pre-existing activities that contribute to these elements was tabulated. Interviews of external organizations working on this framework were initiated, and will continue as our understanding of the framework elements expands.

Original Pathway to Excellence Whitepaper and Plan (2021)

Initially, the workgroup was named "Learning Health Plan" as an extension of the "Learning Health System" concept, but with feedback from the executive team and Partnership's board advisory committee on quality, the framework is renamed "Pathway to Excellence: Partnership's Framework for Continuous Learning."

Workgroup Members:

Robert Moore, MD MPH
Mark Netherda, MD
Erika Robinson
Nancy Steffen
Caron Lee
James Devan
Naresh Vemparala
Farashta Zainal

The workgroup developed this document, an annotated bibliography, several PowerPoint presentations summarizing the key concepts, and notes summarizing the monthly meetings.

Continuous Learning as a Quality Framework

Roots in Partnership Culture

The Mindset of Continuous Learning is rooted in Partnership's organizational culture.
Several of Partnership's organizational values (listed on the Partnership website) support different aspects of quality:

1. Partnerships: Fostering strong partnerships with members, providers, and community leaders to collectively improve health outcomes. "Putting our members first."
2. Overall focus on Quality: Focusing on continuous quality improvement in every aspect of the organization and in collaboration with our partners. "Doing the right thing right, the first time and every time. Excellence is achievable! Striving for perfection, but embracing the opportunity to learn from imperfection."
3. Integrity: Set a standard of professionalism, integrity, and accountability. "Willingness to challenge the status quo, and insist on change when needed."
4. Innovation: Seeking creative solutions. Apply knowledge in new ways.

In addition, two key organizational principles specifically support aspects of being a learning organization:

1. Balancing Compliance and Performance: Balancing rigid attention to regulatory requirements with flexibility and innovation needed to drive improvement. "Not all change is improvement, but all improvement requires change."
2. Continuous Learning: "Making decisions based on rigorous data analysis whenever possible (instead of based on hope or wishful thinking)." "Creating an atmosphere where new ideas can be explored and where strong, independent teams can test these ideas"

The mindset of continuous learning can be expressed in these three credos:

1. We are all very proud of Partnership, the work we do and the systems we have developed. Nonetheless, werecognize that we as individuals and as a company can do better.
2. We strive as individuals to be curious and continuously learn.
3. We also strive as an organization to learn and grow.

While these are organization-wide values, this document will focus on the applications of continuous learning to our work to support our strategic goal of becoming a 5-Star NCQA recognized health plan. This includes work related to improving quality and performance in these Partnership departments: quality, pharmacy, care coordination, utilization management, health analytics, and population health. Of note, some parallel activities in Partnership's operational departments are being organized by the OpEx/PMO department.

Organizational leadership activities are critical for applying this work. This includes ensuring that activities are related to organizational priorities, that staff are supported and motivated, that staff work well cross-departmentally, and that the overall organizational culture is supported.

Knowing is not enough; we must apply. Willing is not enough; we must do.
- Johann Wolfgang von Goethe

Definitions of Learning

Two useful definitions of learning are:
Learning (noun):

1. Process of acquiring information, knowledge or understanding/wisdom
2. The process by which (tacit) knowledge is *created* through the transformation of experience

Note that these definitions are very different from the concept of Machine Learning, a form of Artificial Intelligence (AI), defined as the use and development of computer systems able to learn and adapt without following explicit instructions. We will *not* be addressing machine learning in this report.

Another important distinction is the difference between Learning, Innovation, and Invention. In contrast to learning, innovation and invention are defined as follows:

Innovation (noun): The creation, development, *and implementation* of a new product, process or service, withthe aim of improving efficiency, effectiveness or competitive advantage.

Invention (noun): brand new concept or idea which may not be completely defined/fleshed out/proven.

Learning Organization and Quality Improvement

The idea of a learning organization was defined and popularized in Peter Senge's 1990 book, *The Fifth Discipline: the Art and Practice of the Learning Organization*. His definition of a

Learning Organization (noun): An organization that facilitates the learning of its members and continuously transforms itself.

In the book, Senge details the Five Disciplines of a Learning Organization:

1. Personal Mastery
2. Mental Models
3. Shared Vision
4. Team Learning
5. Systems Thinking

In this context, learning is used as an adjective, modifying organization.

Early reference to the importance of learning in Quality Improvement work also uses learning as an adjective, modifying activities. This is summarized by Don Berwick's analysis of a quote by Tom Nolan, the creator ofthe Model for Improvement:

> "What are necessary and sufficient conditions for improvement in large systems? **Will, ideas, andexecution**!"
>
> - Tom Nolan, creator of the Model for Improvement

> "Providing **will** refers to the tasks of fostering discomfort with the status quo and attractiveness for theas-yet-unrealized future. Providing **ideas** means assuring access to alternative designs and ideas worthtesting, as opposed to continuing legacy systems. And **execution** was (Nolan's) term for embedding *learning* activities and change in the day-to-day work of everyone, beginning with leaders."
>
> - Don Berwick, founder of the Institute for Healthcare Improvement

Learning Health System: Another use of learning as an adjective is Learning Health System, first used by the National Institute of Medicine in 2007, to mean that evidence based medicine would be applied reliably throughout the health care delivery system:

> "A learning healthcare system is designed to generate and apply the best evidence for the collaborative healthcare choices of each patient and provider; to drive the process of discovery as a natural outgrowthof patient care; and to ensure innovation, quality, safety, and value in health care."

Evidence based medicine is given a broader definition:

> "to the greatest extent possible, the decisions that shape the health and health care of Americans—by patients, providers, payers, and policy makers alike—will be grounded on a reliable evidence base, willaccount appropriately for individual variation in patient needs, and will support the generation of new insights on clinical effectiveness."

Immediately after this, a subsequent explanation drives back to "information from clinical experience" andclinical effectiveness of interventions.

The Institute of Medicine considers learning as building a knowledge base and translation of this knowledge regularly in the course of patient care.

In the decade that followed, the term learning health system was used in many different senses, depending onhow the author thought about the word "system":

1. U.S. Healthcare Delivery **System**
2. Academic Medical Center as a **System**
3. **System** of translating research into practice
4. Integrated Healthcare Delivery **System**
5. Local or Regional Healthcare Eco-**system**
6. Data Management or Health Information Exchange **System**

We bring this diversity of views to your attention so the reader will be aware that this term is fraught, not tochoose one concept of a Learning Health System over another.

Pathway to Excellence Framework Overview

What does the Pathway to Excellence look like?

1. Decisions and conclusions are based on rigorous data analysis whenever possible (instead of based on hope or wishful thinking), while creating an atmosphere where new ideas can be explored.
2. Within this framework, strong independent teams test these ideas, quantitative and qualitative evaluation is performed, knowledge gained is organized for future retrieval, and successful practices are spread effectively.

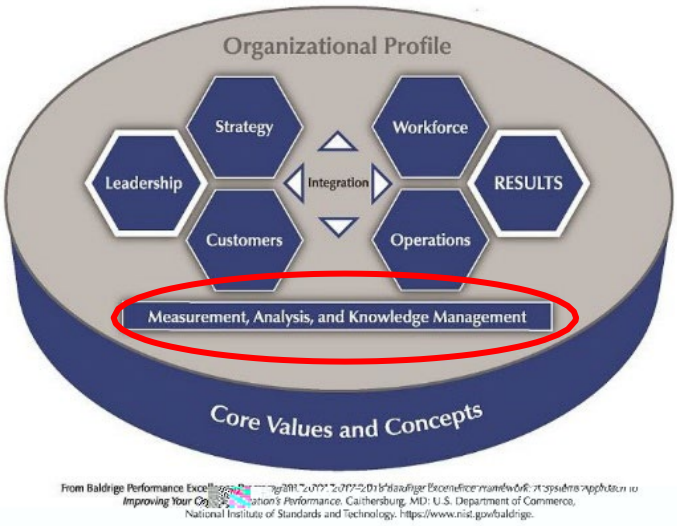
How does this work fit in with other Quality Frameworks?

The Pathway to Excellence Framework shares some themes with two other major quality frameworks: The National Baldrige Award for Quality criteria and the Shingo Model of lean management.

Baldrige Criteria: Four of underpinnings of the Baldrige criteria relate to the *Pathway to Excellence* Framework:

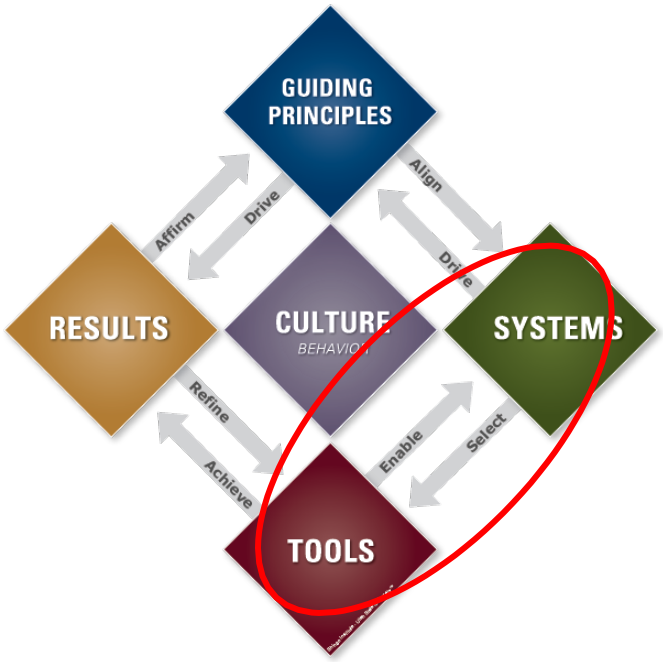
1. Organizational learning
2. Focus on Success and Innovation
3. Management by Fact
4. Delivering Value and Results.

The Organizational Profile of the Baldrige Criteria are shown on the figure below. Of special note, the overarching concepts of measurement, analysis and knowledge management identify three of the elements shared with the *Pathway to Excellence* framework. Also shared is the idea that organizational core values andconcepts underpin the effectiveness of the quality framework.



From Baldrige Performance Excellence Program. 2017-2018 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance. Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology. https://www.nist.gov/baldrige.

Shingo Model: The **Shingo model** of operational excellence asserts that successful organizational transformation occurs when leaders understand and take personal responsibility for architecting a deep and abiding culture of continuous improvement. Leaders lead culture; nurturing the organizational culture is at thecenter of the model. The Shingo Model includes an improvement system, improvement tools, a work system and a management system. While the Shingo model focuses on Purpose, Process, and People, the learning framework described in this paper at Partnership focuses on Process. Process values/principles/behaviours include: continuous improvement, seeking perfection, embracing scientific thinking, and focusing on the process.



Partnership Strategic Plan: The Pathway to Excellence framework will be applied to the first area of emphasis in thecurrent Partnership strategic plan (see below): Access to High Quality Care.

Pathway to Excellence Framework:

After consolidating our information on the Pathway to Excellence Framework, we can summarize this Partnership Framework for Continuous Learning as:

1. Using the scientific method to optimize implementation of quality improvement initiatives
   - Learn from the past: Building on prior research/experiences
   - Small Tests of Change: Rigorous and widespread testing of change on a small scale (using themodel for improvement framework)

- Knowledge Management: Tracking of information gleaned from small tests of change so otherscan retrieve this information and build upon it.
- Careful data and statistical analysis with use of control groups, where appropriate
- Implementation and Spread: Using a combination of classic project management methodologywith the Consolidated Framework for Advancing Implementation Science while having the leadership and staff to support this approach

2. Communicate effectively about quality and change, through a mixture of data and stories. "Nodata without a story, no story without data."

The following sections will summarize each element in greater detail.

Knowledge Management

Background Concepts

Knowledge Management as a field of study has a rather limited literature in relation to health care. There are several journals (including The Journal of Knowledge Management Practice and the Journal of Knowledge Management) and a few books that focus on this area (one is *Strategic Knowledge Management: Driving Business Results by Making Tacit Knowledge Explicit* by Arun Hariharan published in 2015).

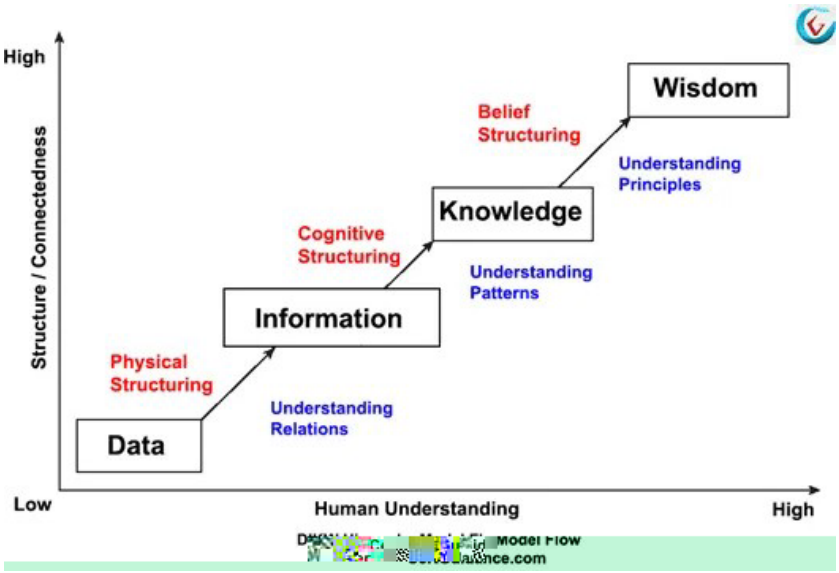
We begin with a brief overview of definitions and philosophy of knowledge.

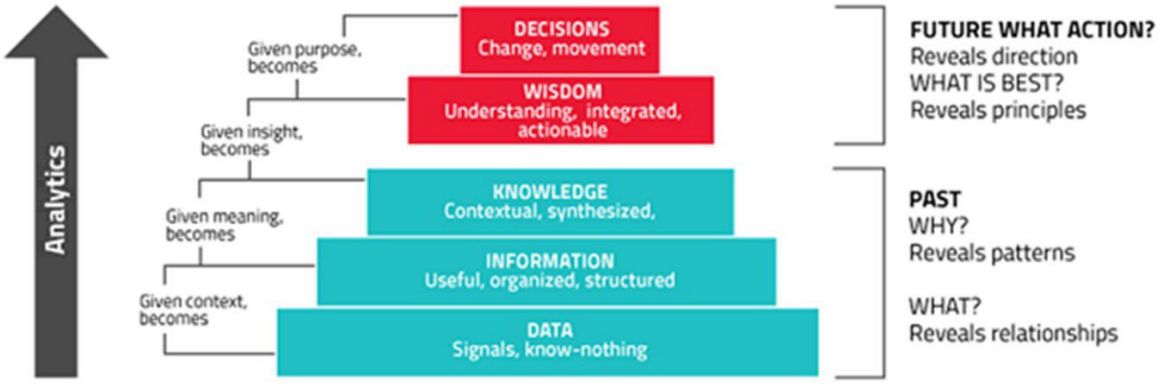
Definitions: Two useful definitions of knowledge are:

1. True belief or understanding of the relations which things and ideas bear to each other and to themselves (Originally from Greek philosophers)
2. Processed information (see below)

DIKW Framework: A key conceptual framework for related knowledge and learning is the Data Information Knowledge Wisdom (or DIKW) Framework, illustrated both as a graph and a pyramid, below. Each level is part of a hierarchy:

a. Data, which is physically structured and related to make
b. Information, which is cognitively structured and pattern recognition to make
c. Knowledge, which with belief structuring and principle definition makes
d. Wisdom, which can be used to prospectively make decisions about future courses of action.





Categories of Knowledge

Categories of Knowledge within an organization can be divided us as follows:

- Individual knowledge: within the brain of an individual, based on their experience, learning or analysis = ***tacit knowledge.*** This tacit knowledge may be possessed by an **expert within** an organization, or by a known **outside expert** who is consulted when needed.
- Individual knowledge: written down or recorded for reference by one person = ***explicit individual knowledge.*** Converting tacit knowledge to explicit knowledge is a central goal in the field of knowledge management.
- Group knowledge: written, recorded or programmed processed information for use by multiple individuals in an organization = ***explicit group knowledge.*** Explicit group knowledge may be derived from either internal sources or from systematic review of external sources. Explicit knowledge is storedin some sort of **knowledge base**, written down on paper or in an electronic format.

Essentials of Strategic Knowledge Management

The overall aim of Knowledge Management is to ensure that knowledge that is relevant to the business, fromany source internal or external, is available at the right place at the right time to enable the right person in thecompany to make the right decisions and implement them so they you achieve the organization's strategic business objectives.

There are three core goals of Knowledge Management

a. Easy and effective application of knowledge/reuse of knowledge. "Use the knowledge you have available."
b. Avoid reinventing knowledge (instead: build on prior knowledge). Don't "reinvent the wheel"
c. Create new knowledge. Apply what has been learned previously to try out new ideas/processes, and measure how well they work.

To robustly apply the principles of Knowledge Management to an organizations two levels of analysis and workmust be conducted:

1. Organizing knowledge and filling gaps (every few years, strategic work)
   a. Identify knowledge capabilities critical to business success (start with 3-5 processes)
   b. Identify a knowledge champion and community of experts for each process to ownknowledge repository of that process.
   c. Conduct knowledge inventory and infrastructure inventory to describe knowledge assetsand map knowledge, divided into internal, external, explicit and tacit. Research should include customer, data, business, market and regulatory framework
   d. Identify knowledge gaps and infrastructure gaps
   e. Define **strategic initiatives to bridge gaps**

2. Applying knowledge to spread or generate new knowledge (ongoing tactical activity)
   a. Storing, vetting, categorizing and transmitting knowledge
   b. Implementing initiatives using knowledge (AKA knowledge translation)
   c. Measuring business results (against benchmarks along with non KM based interventions)

Strategic Initiatives to Bridge Gaps

Broadly, there are three major **categories** of Strategic Knowledge Management Activities:

1. Organizing Explicit Knowledge
2. Organizing Tacit Knowledge
3. Application of existing Knowledge

Major activities in each category are described:

Organizing Explicit Knowledge:

1. Develop a process for gathering knowledge systematically from external sources
2. Develop a standard process for knowledge contribution
   a. Succinct high level summary
   b. Best practices funnel/vetting
3. Establish standardized processes for content management
4. Establish documentation standards for best practices/case studies/lessons learned when project fails

Organizing Tacit Knowledge:

1. Establish communities of practice with knowledge manager (AKA moderator)
2. Organize and define subject matter experts, with the best mechanism to consult them
   a. Pull: mechanism to look for expert in the topic at hand and reaching out to them for input.
   b. Push: experts reach out with information (newsletters, articles, emails etc.)
   c. Combination of Push-Pull: intermediary for contact with experts

Application of Existing Knowledge:

1. Systematic mine knowledge (pull)
a. Gathering information from high performers in a structured way.
b. Review current operational data daily: what needs to be done today? "Use the data we have"
2. Content dissemination (push) (Don't leave it to "chance or choice")
a. Knowledge sharing seminars
b. Publication/dissemination of best practices (newsletter, email)
3. Develop "closed loop processes" to ensure regular review of knowledge for possibility of spread.
4. Determine scope for process for spreading: small scale vs. company-wide
5. Ensure a process is developed for capturing result of knowledge replication/spread, including new knowledge.

Examples of strategic initiatives to bridge gaps that may be selected include:

a. Implementing supportive technology tools
b. Formation of communities of practice
c. Sharing best practices, case studies, lessons learned, both internal and external.
d. Define processes for knowledge sharing (contribution) and knowledge reuse (implementation)
e. HR activities to change culture
f. Corporate learning programs
g. Creating access to experts
ii. Hiring
iii. Consulting
iv. Trainers

Information Technology Resources for Knowledge Management

Features: Here are some features of knowledge management that need IT support:

1. Tools for collaboration and communication between team members
2. Mechanism for storing list of experts with areas of expertise
3. Potential support for other Knowledge Management processes
4. Support of leadership activities promoting Knowledge Management
5. Managing the programs selected to be the organization's **Knowledge Base**: Storing internal and external explicit knowledge contribution, with ability to search and find easily, as well as push certaincontent. This includes knowledge replication and business results.

Contents: Information to be organized within the Knowledge Base includes:

1. Best practices
2. Case Studies
3. Lessons learned
4. Standard documented processes
5. QI projects
6. Innovative ideas
7. FAQs
8. Internal benchmarking
9. e-learning modules
10. Other training material
11. External reports on markets, customers, competitors, regulatory environment, technology trends.

A review of Partnership IT tools that are currently used for some sort of Knowledge Management (and which could beleveraged to better manage additional knowledge) include:

1. Shared drives (baseline data, many other documents)
2. Outlook: email
3. SharePoint: Partnership4Me (document organization)
4. Public Website posting of knowledge for sharing with external partners
5. Microsoft office tools: Excel, Word, PowerPoint, Visio
6. Workfront: has review process and project management functions.
7. PowerDMS: review process for submitted documents. Note that PMO has selected this to be used for capturing end of project write-ups.
8. Prezi (entire 360-degree view)

Supportive Leadership Activities for Knowledge Management

Three key elements of a supportive leadership culture are

1. Sharing of ideas (Interpersonal relationships, professional trust)
2. Willingness to build on others' ideas
3. Giving credit for origination of knowledge

Some techniques that can included to achieve these are:

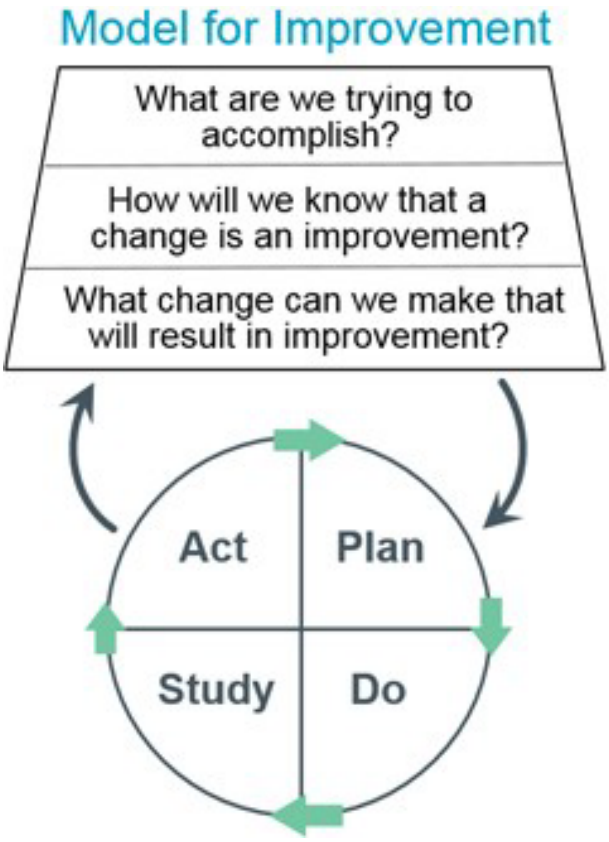
1. Link Knowledge Management to formal recognition (awards), incentives and/or performance evaluation system
2. Capturing measured results: process and outcome measures
3. Capturing and spreading narratives/survey results
4. Senior leadership attention to Knowledge Management and inclusion in strategic planning and organizational dashboards.
5. Designating resources to maintain/curate Knowledge Base over time to assure ease of access andlocation at the right place/time

Small Tests of Change

Framework Options

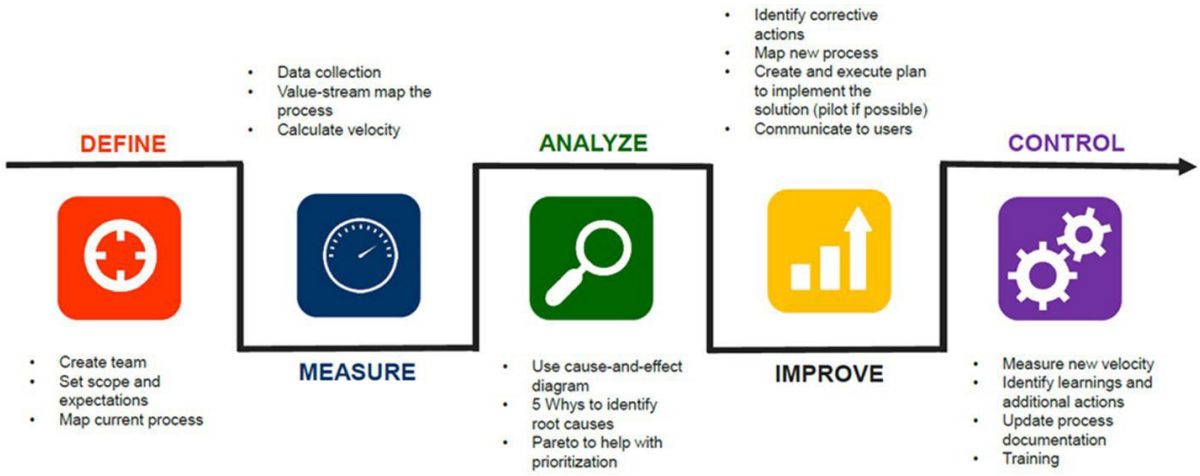
Broadly, when considering a small test of change, we start with a problem and a process.

The model for improvement (includes the PDSA cycle is a problem oriented small test of change: In the Partnership run training *ABCs of QI*, the focus is on the basic concepts of Quality Improvement using the Model for Improvement. The Model for Improvement represents a focus on quality improvement, as opposed to using DMAIC or Lean Six sigma for process optimization or Agile for IT implementations that include doing tests of change.

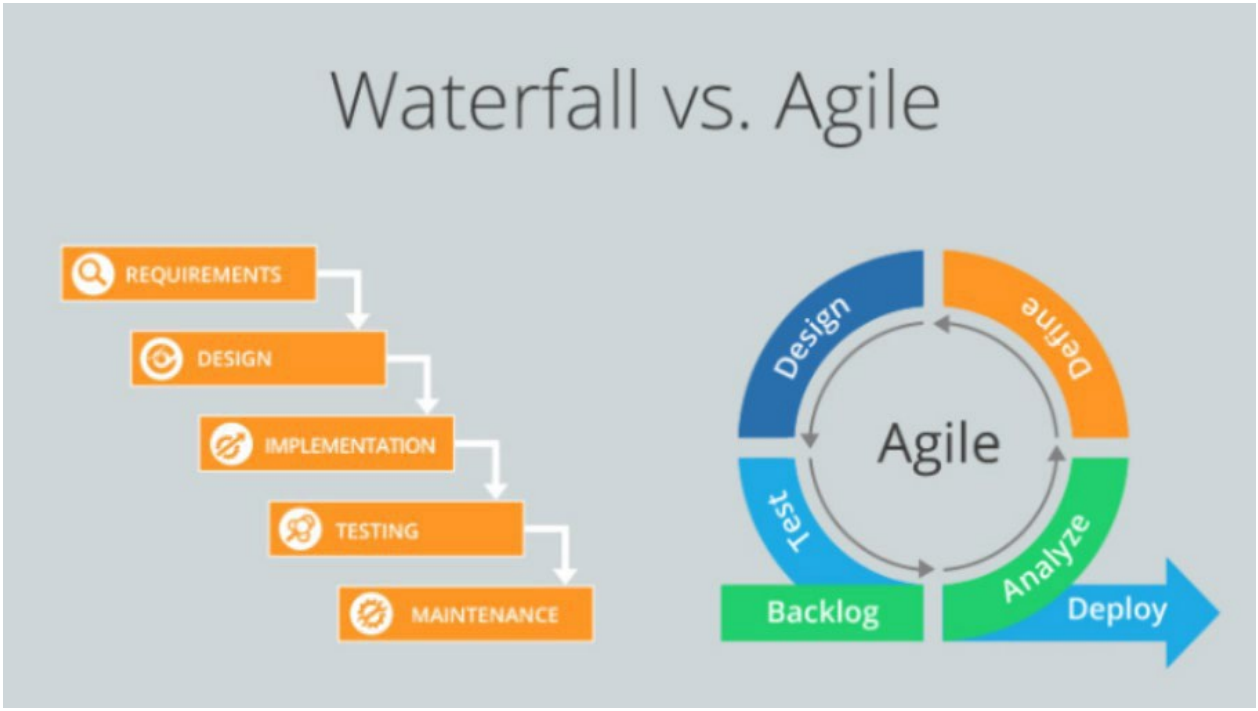


For reference only, we briefly describe DMAIC and Agile; they are not the focus of this document.

Define, Measure, Analyze, Improve, and Control (DMAIC) is a standard process, which often includesapplication of lean/six sigma principles, for process oriented change and optimization.

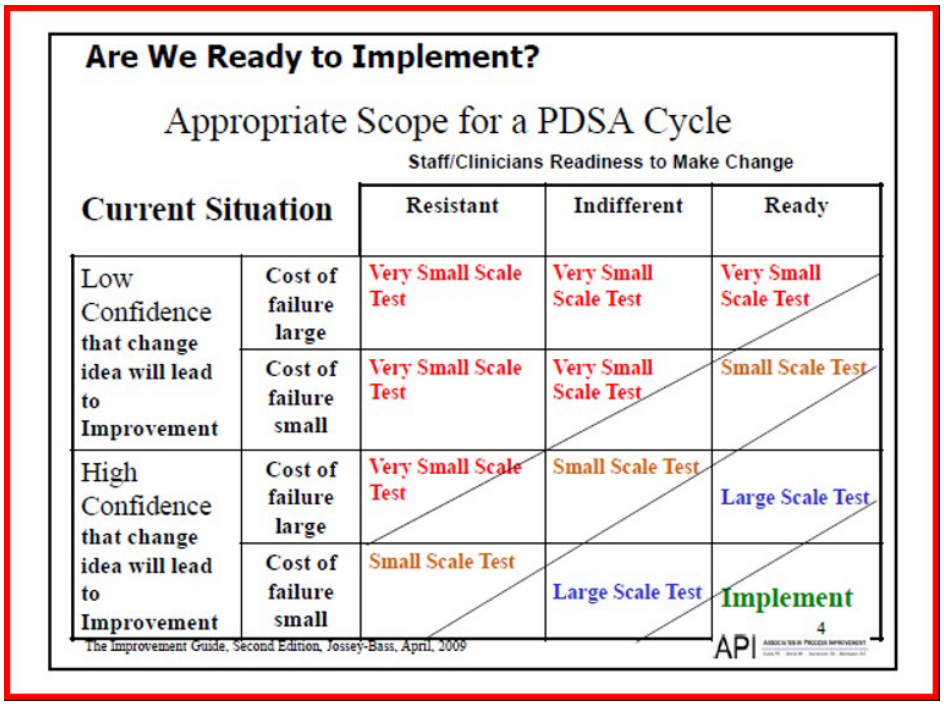


Agile is a method of implementation that combines pilots/tests with scaled implementation, and is contrasted with the Waterfall method of implementation:



Considerations when Planning a Pilot/Small Test of Change

What size test? Is a test of change big enough for outcome to have meaning? There are three factors to consider: *cost of failure, confidence in intervention, resistance to change* as shown in the following graphic:



Here are other key factors to consider when designing a pilot in a way that will inform future implementation/scale-up activities. (Al-Ubaydli, List, & Suskind, 2019):

1. Do the research/pilot results scale to larger markets and settings?
2. When we scale the intervention to broader and larger populations, should we expect the same level of efficacy that we observed in the small-scale setting?
3. If not, what are the important threats to scalability? (Al-Ubaydli, List, & Suskind, 2019)
    a. Statistically underpowered (sample size needed)
    b. Difference in population
    c. Negative economies of scale
    d. Program structure difficult to scale
    e. Dosage of intervention will be less with larger scale
    f. Incentives will be different with larger scale
    g. Inputs (staffing training for example) will be different between pilot and spread
    h. Scaling likely to cause substitution effect that wasn't present in pilot
4. What can the researcher do from the beginning of their scholarly pursuit to ensure eventualscalability?

Data and Statistical Analysis

Analytics Strategic Plan

Partnership is has begun the process of building on a Strategic Data Plan to develop a Strategic Analytics Plan. A Charter has been created and initial work has begun, but the need to convert current analytic reports to draw data from Health Edge, and to validate these mappings, has led to this strategic analytic process to be put on hold.

The charter outlines many excellent definitions, aims and purposes, and so is extracted here:

Project Purpose/Business Justification

Definitions of Data and Analytics

Raw Data: discrete pieces of information that flow into the organization

Processed Data: organized and consolidated raw data, the result of which is more easily manipulated through analysis to generate information.

Data Literacy: Competencies to promote the ability to read, understand, create and communicate data as information.

Data Information Knowledge Wisdom Pyramid: A hierarchy of class of models for representing functional relationships between data, information, knowledge and wisdom

Analytics: Systematic computational analysis of data or statistics, used for the discovery, interpretation and communication of meaningful patterns in data.

Project Purpose

To create a framework for an enterprise-wide analytics strategy to achieve the following value/advantage:

- To be more efficient in how we analyze data, eliminating redundancies, and optimizing teams
- To be confident in the processed data we use and share
- To prioritize and evaluate processed data/analytics project needs efficiently and ensure capacity
- To be prepared to respond to processed data/analytics requests in urgent situations
- To make processed data management and analytics processes more transparent
- To standardize quality assurance, presentation, and documentation of processed data products
- To streamline intake processed data and analytics requests
- To conduct data analysis and program evaluations using sound scientific methods
- To make processed data available for self-service review and analysis by different business units
- To develop innovative solutions for systematic data discovery of opportunities, gaps, or risks thatwould improve financial and/or health outcomes
- To operationalize advanced analytics (prediction models, machine learning, time series, statisticaltesting, data mining, etc.)

Aim Statement
In a 5-year period, to develop an enterprise-wide framework 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. The focus of the effort include: • Define analytic needs for the business • Strengthen or develop policies and procedures for prioritization, management, access, and documentation of processed data products • Review existing data architecture and identify opportunities to optimize structure • Expand self-service analytics tools • Operationalize/integrate advanced analytics • Increase data literacy
Scope
Draft: **In scope:** any data project that involves data analysis or the creation of a report or a specialized dataset to be used for regulatory reporting, operations, or measuring performance, either for financial or health care purposes. **Not in scope:** projects involved in acquiring, processing, or warehousing raw data from main sources (DHCS, providers, other)
Deliverables
Outcome 1: Identify an analytics governance body Outcome 2: Decide on an analytics team structure and role definitions Outcome 3: Develop standards for data products Outcome 4: Develop a comprehensive strategic plan for the next 5 years

Structure of Analytics Strategic Planning

Data Governance Council

- Final decision making body in the data governance structure
- Sets overall direction on health analytics strategy and initiatives
- Advises and empowers the Analytics Strategy Committee to implement an enterprise-wide analytics program

Analytics Strategy Committee

- Prioritizes and communicates efforts between Data Governance Council, workgroups and stakeholders
- Ensures the analytics strategy efforts align with the priorities from the Data Governance Council
- Provides recommendations (including resource allocation recommendations) to the Data Governance Council
- Sponsors, approves and manages plans that support analytics strategy efforts and projects
- Forms work groups and defines their scope, based on area of expertise and responsibility

The Pathway to Excellence Workgroup identified a number of specific opportunities in the data and analytics realm that would be part of the Framework for Continuous Learning:

Partnership should consider documenting and standardizing:

1. Review of **commonly used variables** used in outcomes analysis: sources of bias/confounding; how variables are inter-related
2. Description of **data currently available** for retrospective analysis
3. Major **types of statistical analysis** that applies to health plan level work.
4. Selecting **appropriate test for statistical significance**.
5. **Presentation of data**: best practices/Partnership standards in presentation of data

Partnership should standardize and train staff on the process of taking a data need and formulate a data request withjustification. Four key purposes of reporting on data:

1. Looking for trends and outliers. Trends over time, by year, month. Standard stratification approaches include: Geography, Provider site (and parent organization if PCP), Race/Ethnicity, Aidcode, Homeless status, Presence of major mental health disorder. Results should be shared by number and percentage of total (rates); Ideally with Tableau dashboard.
2. Evaluating the impact of a specified intervention (may be part of rough evaluation or formal evaluation). Report using data from data warehouse or other sources, with citation of data sources clearly indicated.
3. Define a detailed list of either members or sub-population for a particular intervention (the requester should be able to define planned intervention, as this determines the fields of the output). Depending on nature of date needed, raw or aggregate data can be generated from pharmacy, claims configuration (Essette), Claims or Finance.
4. Define a list of providers for a particular intervention (the requester should be able to define planned intervention, as this determines the fields of the output).

What are the data and analytic areas do we need to build internal expertise?

1. Communicating analysis to our provider partners, in a way that is not too complex.
2. More advanced database skills, programming (python, R), google colab

For what areas should we seek outside help?

1. Biostatistics/epidemiology
2. Data scientist (study design)
3. Economics/social science to determine methodologies, creative randomization or alternatives
4. Advanced database and programming expertise

Standards for Evaluation

General approach to Evaluation. We should systematically plan evaluation and analytic approach ahead of time and then iteratively. Some questions to answer:

1. Is it possible to prove something?
2. How scientifically sound is the evaluation? What size of intervention is needed?
3. Since the evaluation plan impacts study design, how will the study change?

On a regular basis in reviewing scientific literature we need to seek out and save evaluation methods done by others researchers, for possible future use. This knowledge should be managed logically.

What are major areas of evaluation methods, which Partnership should consider document and standardize?

1. Options for **randomization**, with explanation of factors to consider in choosing one (include ABtesting as option)
2. Options for **control groups**, with explanation of factors to consider in choosing one
3. Description of **ethical framework**: when is consent needed; when an Institutional Review Boardreview is needed (is publication planned).
4. **Standard template for study design**, including: problem analysis, strategy to manage change, proposed interventions, target population, definition of outcomes and potential unintended consequences, baseline outcome rate, anticipated observations/week, unit of randomization, blinding,and implementation of the randomization strategy
5. **List of options for study design** (See Horwitz reference for options)
6. **Overall evaluation framework** options to consider, with explanation of factors to consider inchoosing one.

Optimizing Spread: Application of Implementation Science

Overview: (Dubner, 2020) gives a definition of Implementation Science: Definition of ImplementationScience:

> *It's the study of how programs get implemented into practice and how the quality of that implementation may affect how well that program works or doesn't work.*

Factors to consider, at least once, when making the decision to do a large scale implementation based on resultsof a successful pilot.

The Consolidated Framework on Implementation (Damschroder, et al., 2009) is a Social science construct that seeks to organize the theoretical frameworks and factors that influence the success of an implementation. For a *larger* implementation, it is probably worth spending some time going through the list to consider strategies for improving the success of this particular implementation. For smaller implementations, it is rarely very helpful.In addition, (Al-Ubaydli, List, & Suskind, 2019) notes these reasons for failure of pilots to spread successfully:

1. Spillover and administration quality impacts direct treatment effects.
2. The participant(s) being unrepresentative of the population in terms of direct treatment effect.
3. The statistical estimation error.
4. Economies/diseconomies of scale in participation costs.
5. The participant(s) being unrepresentative of the population in terms of participation cost. (really asubset of number 2)
6. Economies/diseconomies of scale in implementation costs. (4 and 6 go together).

The Science of Using Science: Towards an Understanding of the Threats to Scaling Experiments (Al-Ubaydli, List, & Suskind, 2019) is a more practical consideration of this topic. Some highlights:

1. Consider the myriad of factors that lead results of pilots to not be generalizable with spread, when designing the pilot or small test of change. Initial backward induction to understand, up-front, potential problems with scaling; think like a policy maker when doing the initial study. ("What could possibly go wrong") (See section on PDSA for a list of these)

2. Due to these characteristics of pilots, which make generalizability problematic, the following are recommended:
   a. More precise statistical summaries of the pilots to assess if they actually worked
   b. More frequent replication before attempting spread: If goal is demonstrating 95% confidencethat small scale pilots will scale, may need about 4 independent studies to show the same thingto overcome the possibility of these biases being present.

3. Once decision to spread has been made: the following are recommended to <u>increase chance of success/fidelity:</u>
   a. Detailing the core elements or "non-negotiables" of the intervention
   b. Ensure the facilitators/project managers/staff understand the "whys" or the mechanism behind the intervention effect.
   c. Look for technology to standardize processes and to check fidelity: Upload data of spread sites in a way that can do fidelity testing as data entered. (see Dubner, below)
   d. Original scientist or pilot person also should play an important role in actual role out of program
   e. Carefully measuring program efficacy when program is scaled: (generation of new knowledge.)

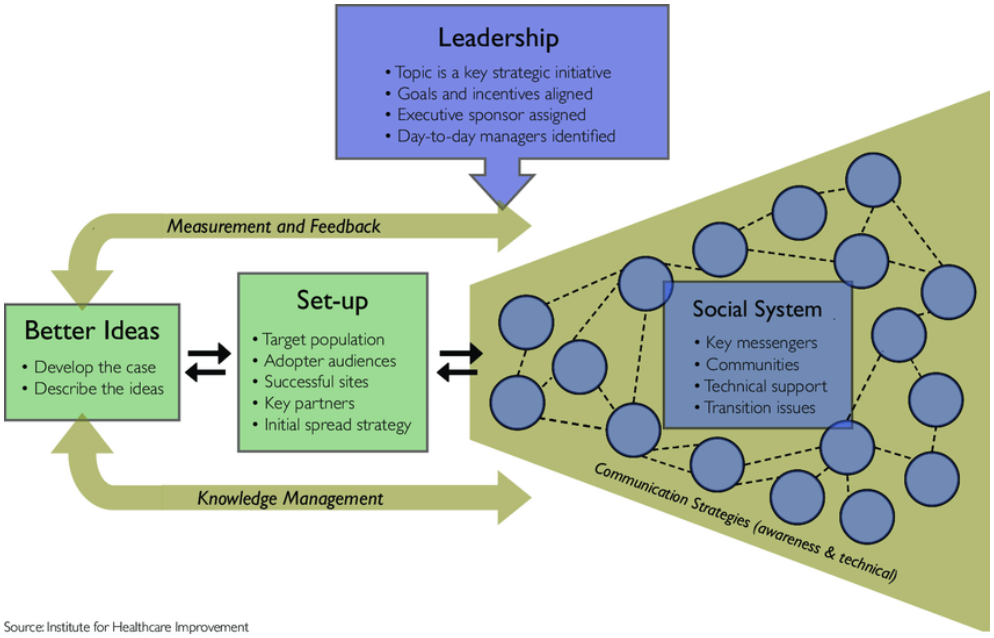
<u>Why spread fails</u>: (Dubner, 2020) summarizes the main five reasons spread/implementation fails:

1. Evidence not there to support scaling in first place
2. Wrong people were studied in the pilot compared to the larger population.
3. Wrong situation was used: voltage drop with change of situation: avoid by preserving "fidelity" oforiginal test. One solution: Upload data of spread sites in a way that can do fidelity testing as dataentered.
4. (Infrastructure/Delivery system of spread very different from system of academic testing.)
5. Need to look at both the supply and demand for the intervention

<u>Elements of successful transitions from projects to programs</u> (Savinsky & Stadelhofer, 2011?) describeselements of successful spread with important pitfalls to avoid.

1. Solidify leadership support
2. Understand current state
3. Define future state
4. Confirm and monitor operational metrics
5. Enlist expertise and appoint a transition leader
6. Engage affected personnel
7. Determine staffing
8. Develop team charters
9. Create and execute transition plans
10. Establish post-transition processes for documentation and evaluation

Framework for Spread (from the Improvement Guide):



Other factors to integrate (from workgroup discussion):

1. For implementations, standard should be a transparency of timeline and milestones
2. Ideally, there would be agreement of what constitutes thorough analysis of animplementation/spread.
3. To manage knowledge of optimal implementations, Partnership should capture examples of case studies towrite up to document best practices in spread, for example: birthday club, Palliative care, MPS, IOPCM
4. Future examples where framework will be helpful include implementation of ECM and Collective Medical Technology's Collective Plan.

Partnership approach to Scale-up and Implementation (Sustainability)

Current Status: Project Review Board (PRB) is the major mechanism for larger, multidepartment projects, for prioritization, estimation of resources and scope. Many, but not all major implementations go through PRB; the trend has been to ensure all do. Considerations: Project management approach, but not always done equally rigorously for every project. Implementations need to be integrated with department and organizational goals. As project becomes a program, there is a transition to Program Management approach to blending into other existing operations—this involves a different skill set than project management.

Organizational Factors

Organizational Factors:
Organizational Values, Culture, Structure, Processes that support approach, fit it in withoverall strategy

In addition to the organization factors listed under the Knowledge Management section, above, the workgroup collected other leadership and organizational activities that would we needed to support the success of the Pathway to Excellence framework.

1. **Nurture Values**: Current Status: Link to communication channels and other activities. Leadersmentoring and demonstrating them. Developing staff expertise. Supportive organizational and management culture. (See separate document)
2. **Systematically review the work we are currently doing,** categorizing by need for knowledge documentation, evaluation, nature of the work, budget, relationship to regulation/quality
3. **Promulgate a Partnership approach** to systematically consider each tactic.

Another view of overall organization framework to support continuous learning activities is from (Bellin Health Case Study, 2015):

1. Cascading structure of Planning, with the 120-day planning cycle forming the core timeline.
   a. 100 days of work, 20 days of evaluating results from last cycle, planning and prioritizing activities/plans for the next cycle. Steps:
      ii. Diagnostic Journey
      iii. Prioritization and Focus
      iv. Organizing the Work
      v. Work Period
      vi. Recalibration
   b. Major systems feeding into this process:
      i. Information gathering: marketing, customer service, strategic analysis, strategicplanning
      ii. System of production/optimization
      iii. System of measurement
      iv. System of improvement
      v. Managed Spread of successful improvements
      vi. System of evaluation
      vii. Building expertise/capturing knowledge (Improvement IQ)
      viii. Strategy room documenting all aspects of this system

Plan for Nurturing Organizational Culture

The workgroup crafted a plan to support supporting the organizational culture towards the principles of the Pathway to Excellence. It is presented here:

What to Share more widely and regularly to promote culture: Key Concepts (see draft PowerPoint)

- Overarching statements of values
- 5 key steps (skip the leadership step for presenting to organization)
- Brief Description of each step

- Key sayings/slogans to represent key ideas in each step: what to do and what not do to
- Use stories to illustrate

Sharing Knowledge about P2E:

- Presentations (Internal and potentially external)
  - Topics:
    - Overview of elements of P2E
    - Knowledge Management
    - Data Analysis/Statistics/Evaluation
    - Small tests of change/scaling up
  - Presentation to leadership teams; record for future.
- Showcased examples
  - Internal: capture, publish, publicize
  - External: lessons learned, capture information
- Smaller Key Message
  - Derived from Larger Presentation
- Slogans
  - Start with those already identified
  - Potential graphics associated with some?

Marketing Paths: Needs timeline and work plan

- Milestones
  - New name selected
  - Plan completed
  - Playbook draft/update
  - Presentations given/saved
  - Awards (Internal and external)
  - External presentations
- Internal communications paths; especially good for smaller key message and slogan
  - Emails
  - Partnership4me
  - Office Hours/VEB
  - Campaign
  - IQI, EQMSI, Ops, Exec
- Durable materials that use name of initiative
  - Trivets
  - Graphics
- Calendar to drip out the slogans etc.
- External communication paths, once core presentation refined
  - PAC
  - Board
  - Board Quality Committee
  - Strategic Planning
  - Clinic Consortia
  - CIN
  - CHCF Leadership
  - CAHP

- LHPC Medical Directors
- State quality convening 2022
- Poster presentation at IHI

Building Leadership Understanding and Commitment

- Incorporate into HS leadership meeting
- After leaders learn about aspects of the LHP, have them give talks to staff

Building Front Line Staff Understanding and Commitment

- LMS training
- Sample Interview questions for staff interviews that demonstrate LHP and ask about traits that would support it
- QI department training (NR and SR)
- Involving staff with aspects of Pathway to Excellence activities that are interesting and outside theirusual work
- Other department trainings/engagement: PMO, pharmacy, medical directors
- Awards for demonstrating aspects of P2E: examples
  - Best graphical presentation of data
  - Evaluation of the year
  - Best case study write-up
  - PDSA of the year
  - Spread process of the year (most likely to be sustained)
  - Project manager of the year
  - Analyst of the year
  - Best meeting facilitator of the year

Plan for Maturing the Framework

Overall Plan

Components of this Framework for Continuous Learning will be divided up and additional detailed documentation based on the recommendation in this document will be generated each year for the next severalyears.
In particular, the work of the Health Analytics Strategy Workgroup will resume in 2022, and may move beyondthe initial focus on analytics to tackle some of the data standardization and evaluation template needs describedabove.

Year 2 Activities

The current plan for activities in year 2 of the Pathway to Excellence are:

1. To spread key concepts in this framework to leadership within the Health Services leadershipteam.
2. To focus on the Knowledge Management section to develop a Strategic Knowledge Management plan and associated action plan, by June 30, 2022. A special area of focus withinthis work will be on regularly reviewing and using data we already have access to.

These will be incorporated into the Quality Measure Score Improvement team goal.

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