Quality Improvement Program Evaluation

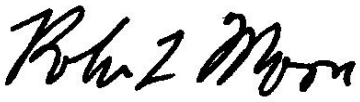
2023-2024

EVALUATION PERIOD

(JULY 1, 2023 – JUNE 30, 2024)

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Approval of Quality Improvement Program Evaluation

	**08/14/2024**

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

	**09/11/2024**

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Board of Commission Chairperson

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Quality Improvement Overview and Program Oversight

QI TRILOGY

Scope of Data and Results Reported in the 2023-2024 Quality Improvement (QI) Program Evaluation

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

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

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

The QI Program accomplishes these goals by:

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

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

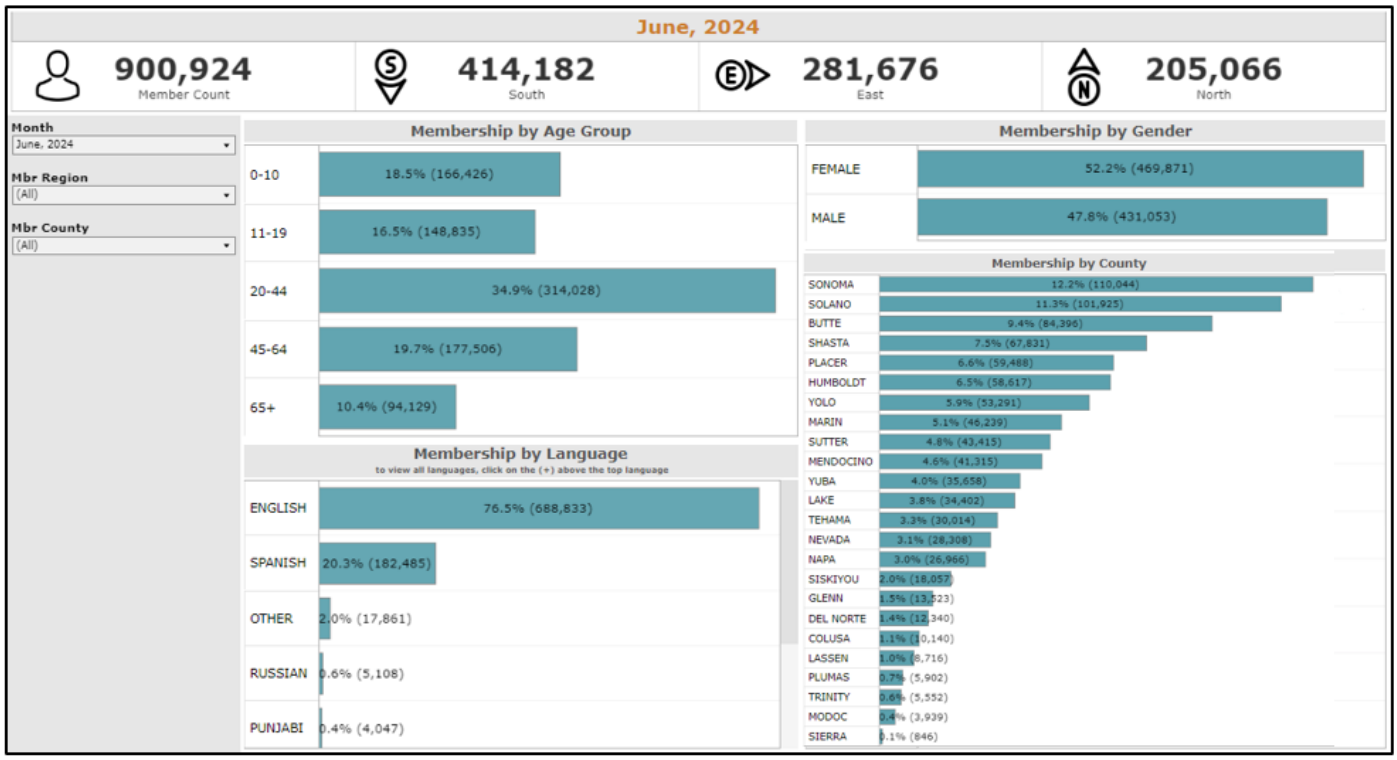
evaluation does not include detailed results from the Grievance and Appeals Department, Pharmacy Department, Utilization Management, Care Coordination, or Population Health Departments. Separate evaluations address these functional areas. Additionally, the Quality and Performance Improvement Department partners closely with its Health Equity and Population Health Departments, as defined in Partnership's Quality Improvement and Health Equity Transformation Program (QIHETP) Description. The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system to address improvements in the quality of care delivered by all of its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to members. The Quality Improvement and Health Equity Committee (QIHEC) oversee the QIHETP and the program's overall effectiveness is evaluated in a separate annual evaluation, which complements this overall program evaluation.

The 2023-2024 QI program covers Medi-Cal lines of business across 24 counties: Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo and Yuba. Associated quality improvement initiatives and programs are designed to encourage appropriate care at the right time while being cognizant of resource utilization. Initiatives target areas of under-use, misuse, and overuse in addition to exploring different strategies and payment models for improving access to care and the care of medically complex patients.

The time period of this evaluation is July 1, 2023, to June 30, 2024. Since Partnership's last evaluation (fiscal year 2022-2023), Partnership's total membership has increased from 696,686 (as of July 1, 2023) to 900,924 (as of June 1, 2024). This significant growth rate is the result of Partnership's ten county expansion, effective January 1, 2024, as well as new coverage of 27 to 49 year olds with unclear documentation status, also effective January 1, 2024.

The following counties represent Partnership's most recent geographical expansion, commonly referred to as the East Region: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Across all 24 counties, 52.2% of Partnership members are female and 47.8% are male. Caucasians represent (39.1%); Hispanic (33.3%); Unknown (13.7%); members who identify as "Other" (4%); Black (3.5%); Native American (1.8%); Filipino (1.1%); Asian/Pacific Islander (1.4%); Asian Indian (1.5%); and Vietnamese (0.4%). English speakers comprise 76.5%; followed by Spanish (20.3%); Russian (0.6%) and Punjabi (0.4%). Members ages 0-10 comprise 18.5%; members ages 11-19 comprise 16.5% of the population; followed by members ages 20-44 (34.9%); members ages 45-64 (19.7%); and 10.4% of Partnership's membership is 65 or older.

Below is a summary of membership by county.



Quality Improvement Program Structure

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

In fiscal year 2023-2024, QI resources continued supporting the development and testing related to the transition from Partnership's prior core claims processing system, Amisys, to the new core claims processing system, HealthRules Payor® (HRP®). This new system's implementation target of August 2023, as shared in the prior annual evaluation, was delayed in May 2024. A new implementation timeline is pending re-baselining activities, inclusive of QI, with an announcement expected by the start of fiscal year 2024-2025. In parallel, QI joined the organization-wide effort in preparing for Partnership's 10-county geographical expansion, effective January 2024. The launch in January 2024 represented a 38% growth in membership versus the close of calendar year 2023. Within the QI Program, the expansion of reporting and accountability for HEDIS® measures, defined under the DHCS Managed Care Accountability Set (MCAS) and required for NCQA Health Plan Accreditation (HPA), continue to increase the complexity and scope of work in not only quality measurement and reporting, but also in performance improvement activities. Improving quality measure scores across ever-expanding measure sets is essential to

demonstrating Partnership's commitment to delivering the highest quality care possible to its members. Partnership's achievement of this aim is evaluated on an ongoing basis by DHCS and in Partnership's 2023-2024 organizational goal to achieve at least a 3.5 STAR health plan rating as an NCQA accredited health plan. Lastly, in latter 2023-2024, the QI Program was expanded to account for early planning and preparations for Partnership's new Dual Eligible Special Needs Plan (D-SNP), planned for launch by January 2026. This product line offering is specifically defined as an Exclusively Aligned Enrollment (EAE) D-SNP. Partnership aims to become a Medicare Medi-Cal Health Plan, joining other managed care plans across California, in offering members eligible for both Medi-Cal and Medicare the opportunity for one plan to manage all of their benefits, including care coordination and other wraparound services.

These complexities and aims resulted in the following program structure highlights across 2023-2024:

- The Chief Medical Officer (CMO) maintains executive leadership with a Senior Director of QI overseeing a fully integrated Quality Department across all Partnership regions. The director level roles include the Director of Quality Management and the Medical Director for Quality. Together, the CMO and senior leaders of QI work across the organization and with external partners to achieve the aim of Partnership's 5-Star Quality Strategy and stated objectives in the corresponding QI Tactical Plan.
- A cross-section of representatives from the QI Program supported the plan-wide Geographical Expansion Project Team with increasing QI activities in 2023-2024. The focus of QI has been to assure newly contracted providers from the expansion counties, deemed Partnership's Eastern Region, are proactively engaged and onboarded with particular focus in helping them understand how they can be successful within Partnership's QI Program. This project team continues to work collaboratively through the end of 2023-2024. In order to sustain the resulting growth across the QI Program, several new QI positions were identified and added, with further details included in the Quality Improvement Departmental Changes section. From a program structure standpoint, this growth resulted in the formation of a new team, the Quality Improvement Program and Project Management Team (PPMT).
- The Quality Improvement Program and Project Management Team (PPMT) formed in early 2023-2024 through promotion and recasting of previously designated staff under the Southern Region Performance Improvement Team. This team is responsible for executing a spectrum of work that includes longstanding QI program activities central to fulfilling DHCS Quality regulatory requirements and NCQA Health Plan Accreditation deliverables. This spectrum also includes transitioning successful pilots from the regional Performance Improvement Teams for further scaling. Then, with continued results, this team leads conversion to sustained program offerings plan-wide. They are also the QI Team tasked with providing project management structure, accountability, and urgency to new initiatives and work brought forward by DHCS, internal customers, the provider network, and community partners.
- The formation of the PPMT permitted greater focus on regionally driven performance improvement activities in the existing Northern Region (NR) and Southern Region (SR) Performance Improvement Teams. This was particularly needed given the geographical expansion coupled with continued focus in legacy counties on driving quality measure score improvement interventions and initiatives, inclusive of new efforts to identify and reduce health disparities within quality measure performance. The NR PI Team integrated Tehama County into their workloads, while the SR PI Team integrated the remaining nine new counties.
- Northern and Southern Region Performance Improvement Teams continue to lead the five (5) measure-focused improvement workgroups under the Quality Measure Score Improvement Initiative (QMSI). Each workgroup is responsible for a specified measure domain and has 1-2 designated leaders to facilitate cross-

departmental analysis and review of quality measure performance, assess and initiate new interventions to address prioritized care gaps.

- In 2023-2024, Partnership continued the Enhanced Provider Engagement (EPE) strategy, which represents an expanded approach to coaching providers around quality improvement. The EPE stratifies PCP provider organizations by performance in priority quality measures, with current focus on provider organizations who have historically been low performers on the PCP Quality Incentive Program and disproportionately serve communities who have historically experienced healthcare inequities. This year saw several organizations added to the participant list while others improved to the point of graduating to more traditional coaching and engagement strategies.
- In contrast, the Quality Improvement Analyst (QIA) Team was disbanded during 2023-2024, with impacted staff either absorbed into existing QI Teams having a dedicated focus within the QI Program or transitioned to other parts of the organization. This followed an executive decision to house all data science activities and tools in the Health Analytics Department, which informed how more advanced analytics in QI will be fulfilled going forward. Staff remaining as QI Analysts are now embedded within the HEDIS®, QIP, or Performance Improvement Teams while staff conducting more advanced analytics have transitioned to other departments within Partnership but outside of the QI Program.
- The CMO and Senior Director of QI continue to work closely with Finance and IT leadership teams in demonstrating a plan-wide analytics strategy. In January 2024, Partnership's Analytics Center of Excellence (ACE) charter was formally approved by executive leadership. ACE is a virtual, permanent, multi-disciplinary team that incorporates IT, analytics and QI subject-matter-expertise, in addition to the expertise of other business owners. The primary role of ACE is to ensure analytics are aligned with the organization strategy and help achieve analytics maturity. It drives and coordinates organization-wide analytic governance activities, prioritizes major cross-functional analytic projects, and facilitates the Analytics Council. ACE works with departments, like QI, to assure efficiency and reduce redundancy; promote training, education and mentoring of data analysts; drive standardization of data management and data products; and drive the advancement of innovative analytics. The Analytics Council consists of data analysts across the organization and serves as a forum for discussing data issues, informing staff of new data or tools, developing data standards, identifying training needs, knowledge sharing, and preventing duplication of effort.
- In Fiscal Year 2023-2024, CAHPS® goal efforts pivoted from four (4) distinct workgroups into one (1) collaborative workgroup. This removed cross-department work silos and improved department leadership collaboration by linking goal activities that directly and indirectly influenced member experience. Restructuring allowed external departments to adopt or align with the CAHPS® Score Improvement goal. As a result, implementation of new improvement activities and interventions that targeted workforce development, improved access to care, transportation services, direct-to-member activities, and increased Partnership branding and awareness were the focus and thus supported stronger linkage to Partnership's 5-Star Strategy and the stated objectives of the Engaging Members focus area in the corresponding QI Tactical Plan.
- In 2023-2024, Partnership's NCQA Accreditation Program expanded in scope to prepare for NCQA Health Equity Accreditation. In addition to facilitating successful renewal of Partnership's NCQA Health Plan Accreditation in December 2023, the program team prepared business owners across the organization for Health Equity Accreditation survey readiness, increased progress towards the overall compliance threshold, and confirmed an HEA Initial Survey date with NCQA for June 2025. At the close of 2023-2024, preparations are underway for a full scope HEA Mock Survey scheduled in August 2024.

- In latter 2023-2024, a new role, the Senior Medicare QI Program Manager, was added to the QI Program structure, directly reporting into the Senior Director of QI. This role is designated to work closely with the Medicare Medical Director, Medicare Manager, QI leaders, and other Health Services leaders to develop, implement, and sustain the Model of Care and lead organization-wide implementation of Partnership's CMS Medicare STARS Quality strategy; both of which are crucial to the organization achieving an optimal STARS rating. As a senior individual contributor, this role is key to providing day-to-day quality program management, including working closely with QI staff designated to D-SNP planning and implementation, within existing QI Teams, over the remainder of 2024 through 2025.

Quality Improvement Governance

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

Board of Commissioners

The purpose of the Commission is to arrange for the provision of health care services to qualifying individuals, as well as other purposes set forth in the enabling ordinances established by the respective counties. The Commission promotes, supports, and has ultimate accountability, authority, and responsibility for a comprehensive and integrated QI 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 Program to the Physician Advisory Committee (PAC), which serves as the main Quality Improvement committee. PAC is supported by two (2) other quality committees – the Quality and Utilization Advisory Committee (Q/UAC) and the Internal Quality Improvement (IQI) Committee, which are described in more detail below. The county Boards of Supervisors for each geographic area appoints members of the Commission, which include representation from the community, consumers, business, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health departments. The Commission meets six (6) times per year.

Internal Quality Improvement Committee

The Internal Quality Improvement (IQI) Committee is comprised of appropriate Partnership department directors and staff that track progress towards successful completion of quality initiatives, surveys, audits, and accreditation. The IQI Committee meets 10 times per year, with the option to add additional meetings if needed, and reviews new or revised policies, delegation reports, activities, and other reports specific to quality improvement and utilization management initiatives. Multidisciplinary improvement teams may be designated to complete analysis and intervention recommendations for quality improvement issues and activities. The IQI Committee serves to integrate quality activities organization-wide. Activities and progress are reported to the Quality and Utilization Advisory Committee (Q/UAC) and then the Physician Advisory Committee (PAC).

The IQI Committee met 10 times during fiscal year 2023-2024. Partnership's IQI Committee agenda remained heavy throughout the year, due to the volume of policy changes related to NCQA Accreditation and DHCS requirements. To date, Partnership addressed all agenda items timely. The IQI Committee membership remained stable, consisting of a multi-departmental team that included the necessary level of leadership across departments impacted by policies and procedures moving through the IQI Committee. The meeting structure included a policy pre-review process and dedicated policy review time during the meeting, both of which ensure there is adequate

time for policy discussion. Discussion topics were presented to the committee, and Partnership leveraged these presentations and reports for IQI Committee members to provide input and qualitative feedback. Overall, the IQI Committee structure has been sufficient to provide adequate oversight and support in tracking quality initiatives and providing health plan and/or clinical expertise into policy and procedure review.

Quality and Utilization Advisory Committee

The Quality and Utilization Advisory Committee's (Q/UAC) role is to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. This responsibility includes providing significant input on the QI Program Description, Annual Evaluation, and Work Plan. The committee is required to meet at least 10 times per year, with the option to add meetings if needed. Q/UAC voting membership includes consumer representative(s) and external providers whose specialties are internal medicine, family medicine, pediatrics, OB/GYN, neonatology, or behavioral health, among others. The Partnership CMO (chair of the committee), Clinical Director of Behavioral Health, Medical Director for Quality, and leadership from QI, Provider Relations, Utilization Management, Care Coordination, Pharmacy, Population Health and Grievance and Appeals Departments regularly attend Q/UAC meetings. Q/UAC activities and recommendations are reported to PAC and to the Commission at least quarterly.

Q/UAC met 10 times during fiscal year 2023-2024. Partnership's Q/UAC agenda remained heavy due to the volume of policy changes related to maintaining NCQA Accreditation and new DHCS requirements largely associated with California Advancing & Innovating Medi-Cal (Cal-AIM) and other All Plan Letters. Partnership was able to address all agenda items timely. Membership remained steady and quorum was met each meeting. Overall, the Q/UAC committee structure was sufficient and provided adequate oversight and support to the Quality Improvement program and sufficient clinical expertise to support informing policy and procedure.

The Q/UAC agenda is expected to remain heavy for the foreseeable future as Partnership prepares for new State-mandated programs expected in 2024-2025, including further provisions defined under Cal-AIM and demonstrating compliance to DHCS 2024 Contract deliverables. Furthermore, Partnership's addition of 10 new counties to its service area, effective January 2024, continues to impact the QI Program at large.

Physician Advisory Committee Oversight Program

Physician Advisory Committee (PAC) and voting membership included external PCPs, board certified high-volume specialists, and advanced practice clinicians such as certified nurse midwives, nurse practitioners, or physician assistants. A voting provider member of the committee chaired PAC. Per Partnership policy, the committee met monthly, at least 10 times during fiscal year 2023-2024. PAC monitored and evaluated all Health Services activities and was directly accountable to the Commission for the oversight of the QI Program. The parameters for membership and meeting frequency were met for the fiscal year 2023-2024, and activities including review and approval of policies and procedures, QI activities, and evaluations of projects and programs were addressed by an appropriate mix of Primary Care and Specialty physician members who attended. Quorum requirements were met for nine of the ten convened meetings. The Partnership CMO, Medical Director for Quality, Clinical Director of Behavioral Health, and leadership from QI, Provider Relations, Utilization Management, Care Coordination, and Pharmacy Departments attended PAC meetings regularly.

Quality Incentive Program Advisory Groups

As detailed later, Partnership has several incentive programs called Quality Incentive Program(QIPs). QIP Advisory Groups are made up of appropriate Partnership staff and representative providers to assure ongoing collaboration in Partnership's value-based program offerings. Each year they review and recommend measures for the QIPs in which they participate, with each member of the QIP Advisory Group serving for a two-year time period. The QIP Team manages the Advisory Group member list and is responsible for inviting new participants at the conclusion of the two-year service period. Advisory Group meetings are held once per quarter throughout a measurement year for most QIPs and less frequently but no less than twice per measurement year for smaller programs.

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

Quality Improvement Leadership Engagement & Commitment

Chief Executive Officer

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

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

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

In recognition of the need to better engage provider executive leadership at practice sites primarily responsible for driving quality measure performance, the CEO and CMO meet with the executive and senior leadership of ten of our largest primary care provider sites. One (1) to three (3) meetings were held with each of the participating provider organizations in 2023-2024. These meetings have been an effective engagement strategy and will continue in the next FY. The CEO was also a member of the Board Quality Advisory Group, and partnered with the CMO in the consideration of topics and areas to gain further insights and recommendations from Board

members who are also leaders at some of our largest participating network provider sites. The CEO's level of involvement in quality improvement activities was appropriate to ensure executive level accountability in support of the department and organization wide goals and responsibilities.

Chief Operating Officer

The Chief Operating Officer (COO) provides strategic leadership and guidance in all health plan operations. The COO 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 is a regular attendee and ad hoc member of PAC and an engaged participant at NCQA Steering Committee and Executive Quality Measure Score Improvement meetings. The COO's level of involvement fulfilled the need for executive support and accountability for operations key to successful quality improvement interventions, initiatives, and related organization wide goals and responsibilities.

Chief Medical Officer

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

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

- Associate Medical Directors - Assists CMO with utilization management review, review of appeal decisions, and review of Potential Quality Issues (PQI). The level of involvement of the associate medical directors was sufficient for reconciliation of PQIs via the peer review process.
- Medical Director for Quality - Assists CMO by providing physician support for varying activities within the Department, including Performance Improvement, Member Safety, Peer Review, and the Quality Improvement Programs, as well as assisted with utilization management review activities. Late in the 2021-2022 year, this role was expanded to include management oversight of the Member Safety and HEDIS® Teams to support a re-structuring of the Quality Department. The time allocated and scope of responsibilities of the Medical Director for Quality was set appropriately to meet the needs of the QI Department.
- Regional Medical Directors - Works closely with respective counties on quality improvement activities including: liaison to physician leaders, serve as medical leadership at community meetings, support process improvement activities, author/ edit provider and member QI newsletter articles, drive improvements on adult and child measures and foster further collaboration and engagement with providers through regional meetings.
- Medical Director of Medicare Services – This new role was added in 2023-2024 to assure physician leadership in preparations for implementing the Medicare Dual Special Needs Plan (D-SNP) by 2026. This medical director works closely with the CMO and Quality Department to develop policy, strategy, and

tactical activities with Medicare leads designated in other departments across the organization. As D-SNP is implemented, this role will provide medical leadership for Partnership's Medicare activities, including utilization management, quality, care coordination, pharmacy, grievances, and compliance activities. Also assists CMO, as requested, in supporting broader needs to oversee appropriateness and quality of care delivered through Partnership and for the cost-effective utilization of services.

- Chief Health Services Officer - Reports to the CEO but works in close collaboration with the CMO and QI Program senior leadership. Responsible for the day-to-day implementation of Partnership's Utilization Management, Care Coordination and Population Health Management and Health Equity Programs. This position has the authority to make decisions on coverage not relating to medical necessity. This role serves as a standing Member of PAC, Q/UAC and the Peer Review Committee and provides oversight, guidance, and evaluations of ongoing UM activities and programs under their oversight.
- Quality and Performance Improvement Senior Director - Works collaboratively with the CMO to define strategy, develop programs and services, and to evaluate the effectiveness of the QI Program. Together with the QI management team, including the Medical Director for Quality, provides oversight of Facility Site Reviews, investigation of potential quality issues, compliance with NCQA standards, HEDIS® and other performance measure data collection and performance reporting, value based payment programs (QIPs), performance improvement initiatives and programs, external and internal QI training, provider education on the QIPs and HEDIS®, grant application and grant management. This role works to foster greater cross collaboration of QI staff and strategic involvement of other departments to support the execution of tactics defined and maintained under Partnership's 5-Star Quality Strategy.

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

Chief Health Services Officer

The Chief Health Services Officer (CHSO) 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 CHSO also has purview over the Care Coordination, Population Health and Health Equity Departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The CHSO'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**.** Collaborates with the Chief Medical Officer and members of PAC, Q/UAC, and IQI in matters involving quality of care, clinical, and medical procedures.

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.

Quality Improvement Departmental Changes

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

Based on the considerations noted above and the evaluation and assessment of the 2022-2023 QI Program, the following changes were made during fiscal year 2023-2024:

Changes within QI Department

Key personnel changes and Program restructuring in fiscal year 2023-2024:

- Member Safety
  - In 2022, DHCS implemented the use of significantly expanded site and medical records review tools. These tools incorporate >35 new required review elements, resulting in more sites requiring corrective action plans (CAPS), at the conclusion of initial and ongoing periodic Facility Site/Medical Records Reviews (FSR/MRR). To assist site review nurses with the tracking, documentation and scheduling of follow-up reviews related to the increase in CAPs, a Clinical Compliance Coordinator joined the team in July 2022. Over the course of 2022-2023, this new role improved nurse capacity and focus in conducting and completing site reviews. This was invaluable given increased nurse travel in early 2023-2024 in preparation for Partnership's 10 county expansion, effective January 2024. Site reviews and site certifications were required before assigning expansion members to PCPs in expansion counties. Because of these learnings, another Clinical Compliance Coordinator joined the team in January 2024 to assure ongoing success in completing growing site review workloads and to support new activities resulting from recent DHCS findings. The Clinical Compliance Team is leveraging the site review process to address DHCS audit findings on demonstrating the provision and timely completion of Initial Health Appointments (IHA) and Blood Lead Screening (BLS) for qualifying members.
  - Job descriptions and titles for staff devoted to performing quality of care investigations were implemented in January 2024. These changes better reflect the scope of work completed by this part of the Member Safety unit and differentiate it from the team performing FSR/MRRs. The "Manager of Quality Assurance and Member Safety" became the "Manager of Member Safety Quality Investigation"; the "Supervisor of Member Safety" became the "Supervisor of Member Safety Quality Investigation"; and, the "Performance Improvement Clinical Specialists" (nurses) became "Quality Investigator I" or "Quality Investigator II."
  - In March 2024, the Member Safety-Investigations Team welcomed an additional Quality Investigator II nurse. This nurse was an internal transfer from the Care Coordination Team, bringing great work experience and expertise to this role. The growth of the Member Safety-Investigations Team was justified by anticipated increases in caseloads resulting from Partnership's 10 county expansion, which

as of January 2024 equated to a 38% growth in membership. Additional supporting rationale included steady increases in Potential Quality Issue referrals within Partnership's legacy counties over 2022-2023 versus 2019 (pre-COVID).

- Quality Improvement Program and Project Management Team (PPMT)
  - This new team formed in early 2023-2024 through the promotion of a QI Supervisor and her corresponding program/project management staff, previously designated under the Southern Region Performance Improvement Team. In total, five (5) existing staff program/project management positions were re-cast under the newly promoted Manager of Quality Improvement Programs, and an additional project management position was added and filled in February 2024. This new team is responsible for executing on a spectrum of work that includes longstanding QI program activities central to fulfilling DHCS Quality regulatory requirements and NCQA Health Plan Accreditation deliverables. Some examples include oversight and facilitation of the CAHPS® Program, the organization-wide CAHPS® Score Improvement workgroup, QI Trilogy Program, and select NCQA Grand Analyses, etc. This spectrum also includes transitioning successful pilots from the regional Performance Improvement Teams for further scaling. Then, with continued results, this team leads conversion to sustained program offerings plan-wide. An example of this is Partnership's Mobile Mammography Program. In doing so, this team continues the good work designed, developed, and deployed by the PI Teams for continued and measureable improvements. They are also the QI Team tasked with providing project management structure, accountability, and urgency to new initiatives, grant offerings, and work brought forward by DHCS, internal customers, the provider network, and community partners. Examples of this segment of work includes project management leadership for QI's contributions to the organization's geographical expansion implementation plan, DHCS' Equity and Practice Transformation program and Partnership's corresponding Enhanced Provider Engagement strategy.
- Performance Improvement
  - The formation of the PPMT permitted greater focus on regionally driven performance improvement activities in the Northern Region (NR) and Southern Region (SR) Performance Improvement Teams. This was particularly needed given the geographical expansion in Partnership's new East Region coupled with continued focus in legacy counties on driving quality measure score improvement interventions and initiatives, inclusive of new efforts to identify and reduce health disparities within quality measure performance. The NR PI Team integrated Tehama County into their workloads, while the SR PI Team integrated the remaining nine new counties. The NR PI and SR PI Teams work closely together to provide boots on the ground support to the provider network, with emphasis in primary care. Improvement Advisor staffing grew in 2023/2024 through re-allocating staff previously designated as Senior Project Managers and through new positions granted. In total, nine Improvement Advisor positions are allocated, with three presently in recruitment. Improvement Advisors identify and drive actions on organizational and quality improvement needs through Joint Leadership Initiatives and other regional/local collaborations, provider-specific organizational assessments, data analysis, and other discovery activities. The PI Teams provide resources, coaching, education, and hands-on project/program management support to help Partnership's Primary Care Network achieve transformational change necessary to meet regulatory requirements, organizational goals, and sustainably improve care for our members.
- Quality Improvement Analysis
  - The Quality Improvement Analyst (QIA) Team was disbanded during 2023-2024, with impacted staff either absorbed within existing QI Teams or transitioned to other parts of the organization. The departure of this team's supervisor coincided with decision to house all data science efforts in the Health

Analytics Department. As a result, this shifted the appropriate place in the organization for staff fulfilling the Senior QI Analyst role. The talent and expertise of these staff is now being put to great use in Health Analytics and Transportation Departments. The latter of which had new data analytics business needs upon Partnership's vertical integration of Transportation services. All remaining QI Analysts are embedded within the HEDIS®, QIP, or Performance Improvement Teams.

- NCQA Accreditation
  - With the advent of the DHCS requirement to achieve NCQA Health Equity Accreditation (HEA) by January 2026, a new program manager position focused on HEA was added to the NCQA Accreditation Program Team near the end of fiscal year 2022-2023. In 2023-2024, growing workloads were observed given this team's commitment to facilitate Partnership's achievement of HEA while maintaining its NCQA Health Plan Accreditation, all while the health plan is experiencing immense growth. In parallel, a long-standing program manager on the team requested to step down into a program coordinator role, as she prepares for retirement in the next couple of years. To support knowledge transfer within the team, this request was granted which led to back-filling the vacated program manager position with a new staff member in March 2024.
- Medicare (D-SNP)
  - An Improvement Advisor on the SR Performance Improvement Team carries prior work experience in Medicare Quality, positioning her well for promotion into the new Senior Medicare QI Program Manager role at the end of April 2024. This role reports directly to the Senior Director of QI and is designated to work closely with the Medicare Medical Director, Medicare Manager, QI leaders, and other Health Services leaders to develop, implement, and sustain the Model of Care and lead organization-wide implementation of Partnership's CMS Medicare STARS Quality strategy; both of which are crucial to the organization achieving an optimal STARS rating. As a senior individual contributor, this role is key to providing day-to-day quality program management, including working closely with QI staff designated to D-SNP planning and implementation, within existing QI Teams, over the remainder of 2024 through 2025.
- Quality Incentive Programs (QIP)
  - In response to the geographical expansion in 2024, the QIP Team was allocated a new program coordinator role to support increasing QIP administrative tasks and coordination between programs within the overall QIP portfolio. This includes supporting program managers in meeting coordination, communications with provider participants, payment preparation, data validation testing, and newsletter creation.
  - Given the need to develop a D-SNP provider network strategy early in preparation for D-SNP, an additional Program Manager II role was added to QIP Team to support Pay-for-Value and related incentive programming development. This role was filled in May 2024.

Quality Improvement Executive Summary

QI TRILOGY

Executive Summary

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

Partnership's Quality Improvement (QI) Program was successful over the course of fiscal year 2023-2024 in achieving its quality improvement goals and commitments. The structure of the QI Program and its associated work planning process included ongoing monitoring of planned objectives and activities dedicated to improving quality of clinical care, safety of clinical care, quality of service and members' experience.

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

- The NCQA Program Management Team worked with business owners across Partnership to achieve successful renewal of Partnership's NCQA Health Plan Accreditation (HPA) in December 2023. The plan-wide NCQA-related HPA 2023-2024 goal aimed at ensuring continuous compliance of HPA requirements in preparation for Partnership's next HPA survey, scheduled on September 22, 2026. Business owners across the organization continued working with QI in achieving NCQA Health Equity Accreditation survey readiness. The 2023-2024 HEA goal aimed at readiness of all assigned HEA Standards and Guidelines for Initial Survey, scheduled for June 17, 2025. At the close of 2023-2024, an overall compliance rate of 61.1% was achieved and preparations are underway for a full scope HEA Mock Survey scheduled in August 2024. All HPA and HEA goals in 2023-2024 were met and all milestones were completed on time.
- Partnership received its first publicly reported NCQA Health Plan Rating (HPR) in September 2023, reflecting Measurement Year 2022 health plan performance. NCQA assessed Partnership as a 3.5 Star accredited health plan, considered a slightly better than average rating on the five-point scale used nationally. The HPR methodology used by NCQA represents a composite metric of health plan performance under HPA HEDIS® measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey measures. As such, Partnership's QI Program has adapted in recent years to incorporate greater focus on improving both the quality measures defined by the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS), NCQA HPA, and CAHPS® surveys, as each are used to assess the quality of healthcare provided to our members. Partnership continues to evaluate its QI Program under its 5-Star Quality Strategy (last updated in February 2020) and corresponding tactical plan, which is updated quarterly. This framework is reflected in detailed goals and deliverables within Partnership's annual QI Work Plan. This approach has aided Partnership in demonstrating continued organizational focus on improving HEDIS® and CAHPS® scores over 2023-2024, which will continue as a multi-year effort and focus across the health plan. At the close of 2023-2024, Partnership estimates its HPR will be maintained as a 3.5 Star rating, given recently submitted HEDIS® and CAHPS® rates for Measurement Year 2023. The final HPR is pending NCQA assessment and reporting in September 2024.
- Considerable efforts were dedicated to executing Partnership's 10-county geographic expansion, effective January 2024. QI staff invested substantial time and travel to engage early with providers in the Eastern Region, provide detailed onboarding sessions, and orienting them to QI data tools and program expectations. This initial engagement is the precursor to a comprehensive effort that will continue as more data becomes available and as organizations adapt to providing quality care to Partnership members within our provider network.
- In Partnership's legacy counties, QI intensified its coaching efforts across its lowest performing PCP practice tier through our Enhanced Provider Engagement (EPE) strategy. Performance Improvement staff

assessed, supported, and coached lower-performing sites, developing tailored interventions designed to address foundational issues. Improvement advising and project management support were also extended to low through mid-performing practice tiers in pursuit of funding through DHCS' Equity and Practice Transformation (EPT) program, which launched in 2023-2024. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. This included newly contracted providers from the 2024 expansion counties and several tribal health centers.

- Performance improvement interactions with providers largely leveraged Partnership's Quality Incentive Programs (QIPs), targeting measures reflecting priorities from the DHCS MCAS and NCQA HPA measure sets. Enhancements to data tools improved visibility and transparency into QIP performance gaps, contributing to notable improvements in measures such as Breast Cancer Screening and Diabetes – HbA1C Good Control from MY2022 to MY2023. In cases of consistently low-performing PCP sites, the EPE strategy was coupled with provider entry into the PCP Modified QIP, which involves a narrower measure set with ongoing coaching from an assigned Partnership Improvement Advisor.
- Our steadfast commitment to provider technical assistance was also demonstrated through Improvement Academy trainings, regular joint leadership and operational meetings with larger provider organizations, practice facilitation within mid-performing tier providers, and state-mandated performance improvement collaborations. Improvement Academy trainings, along with a dedicated series of webinars, introduced health equity concepts including discovering and prioritizing differences in care to inform planning equity-focused improvement projects. In practice facilitation and collaborative interactions, provider teams and coaches focused on closing care gaps through interventions within clinical and operational workflows, fostering a culture of quality within provider leadership, and building capacity for quality improvement.
- Quality Measure Score Improvement (QMSI) workgroups were expanded and optimized to address evolving DHCS MCAS and NCQA Health Plan Accreditation (HPA) measure sets in Pediatrics, Chronic Diseases, Medication Management, Behavioral Health, Women's Health, and Perinatal Care. These workgroups focused on measures included in the DHCS Quality Withholds, particularly "Kids and CAHPS®" preventative measures, which are expected to require ongoing effort. Successful interventions resulted through collaboration with internal staff and external partners, including providers, regional consortia, school nurses, and community pharmacies. Through local collaboration, Partnership piloted, scaled, and spread improvements across measures including breast cancer screening, childhood immunizations, adolescent immunizations, lead screening, and well-child visits. New intervention opportunities continue to be investigated and implemented on an ongoing basis to address lagging measure performance across Partnership's service region.
- Within QMSI, each workgroup considered measure performance trends and intervention opportunities through a new lens in 2023-2024, focused on advancing health equity. The Women's Health Perinatal work group identified a need for targeted outreach to Native American/Alaskan Native populations. Disparity analysis within related quality measure performance demonstrate poor pregnancy outcomes occurring at a significantly higher rate for these communities. Partnership outreached clinical practices and tribal health systems to convene and encourage accessing new funding for program development, specific to the perinatal population. With active case management and stronger connections to Community Based Organizations, Partnership anticipates access to perinatal care will improve. Similarly, the Pediatric Medicine workgroup identified significantly different rates of completion of the well child visits amongst 0-30 month aged members within the Black/African American community residing in Solano County. An interdisciplinary team at Partnership, along with local partners in Solano County, completed root cause analysis and brainstorming, resulting in an initial intervention focused on addressing delays in Medi-Cal

enrollment, which have significant impact on completing timely well-child visits. Interventions inclusive of a health equity focus will continue and expand in 2024-2025.

- For the most recent reporting year, representing 2022-2023, CAHPS® Composite Scores reflected drops in scores for child CAHPS® respondents while adult CAHPS® respondents scored more favorably. The results across both surveys, however, warrant continued focus and expanding improvement efforts both on behalf of the health plan and within the provider network. In 2023-2024, CAHPS® Score Improvement activities targeted workforce development, improved access to care, transportation services, direct-to-member activities, and increased Partnership branding and awareness. The impact of these activities and interventions will be closely evaluated versus the anticipated 2023-2024 results, including results from a parallel drilldown CAHPS® survey Partnership placed in the field. This unregulated drilldown survey is intended to give greater insight into member responses in low performing CAHPS® survey questions. Partnership recognizes continued investments in larger scale interventions are necessary to enhance member experience and access to care, which are also key to achieving an improved NCQA Health Plan Rating (HPR).
- The Member Safety Team devoted to potential quality of care issue investigations (PQI) reports referrals in 2023 have returned to pre-COVID levels. As expected, when COVID restrictions eased, the number of PQI referrals increased in the latter part of 2022 and significantly in 2023. PQIs are expected to further increase as a result of the geographical expansion to 10 additional counties. Physician and nurse participation in Peer Review Committee and PQI rounds, inclusive of Partnership medical directors and network providers from diverse specialties, was sufficient to meet the requirements for reviewing and making determinations about PQIs. In January 2024, a Nurse Practitioner from a network provider facility joined the PRC and subsequently, the PRC policy was updated to include Non-Physician Medical Practitioners as voting members. The Member Safety Team devoted to site reviews continues to leverage Facility Site Reviews and Medical Record Reviews to actively cite gaps in Blood Lead Screening and Initial Health Appointment completions on an individual provider basis, including coupling focused audits and just-in-time provider education within the site review process.
- The structure and function of the quality committees remained stable. Overall, the quality committee structure was sufficient and provided adequate oversight and support to the QI Program and provided sufficient health plan and/or clinical expertise to inform and maintain policies and procedures. In 2023-2024, continued focus remained on policy and procedure updates related to maintaining NCQA Accreditation and new DHCS requirements largely associated with Cal-AIM and other mandates. In addition to reporting HEDIS® and CAHPS® annual results, the quality committee structure also received and provided feedback on results from provider access studies, monitoring of grievances and appeals, Initial Health Assessment trends and actions, monitoring of site review results and corrective actions trends, monitoring of potential quality of care issues, evaluations of performance improvement interventions and pilots, and outcomes of the Partnership Improvement Academy activities.
- There were sufficient resources to support the QI Program overall. Given the growing complexity and scope of requirements between DHCS MCAS and NCQA accreditation, Partnership's 10-county geographical expansion in 2024, and preparation for D-SNP, several QI Teams within the QI Program grew in staffing.

2023-2024 QI Work Plan Summary

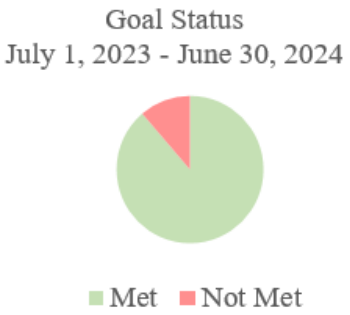
Background

Background: The QI Work Plan is designed to track progress on key Quality Improvement (QI) activities and initiatives throughout the year. Approved by our Board of Commissioners and quality committees, it includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service and members' experience. The Work Plan is set on a fiscal year (FY) 2023-2024 schedule. This update includes progress on activities included in the FY 2023-2024 QI Work Plan from July 1, 2023 to June 30, 2024.

Results:

Of the 62 goals outlined in the 23-24 QI Work Plan, 55 are "Met" and seven (7) are "Not Met".

Goal Status July 1, 2023 – June 30, 2024		
Status	**Total Number:**	**%**
Met	55	88.70%
Not Met	7	11.30%



2023-2024 QI Major Milestones and Activities

The Quality Measure Score Improvement (QMSI) successfully engaged five (5) measure-focused workgroups: Pediatric, Chronic Diseases, Medication Management, Behavioral Health, Women's Health and Perinatal Care. Each workgroup monitored and reviewed all measure performance where data was available, assessed current improvement efforts, identified gaps and initiated new performance improvement activities. Highlights include:

- The Pediatric Workgroup proposed and implemented a new measure in the PCP Quality Incentive Program to incentivize providers to conduct group well-visit cohorts focusing on 0-15 month old population as an expansion of the existing Peer-Lead Group Visits measure.
- The Lead Screening sub-committee developed new strategies to build on previous year's efforts:
  1) Established a Point of Care testing initiative, providing testing devices to selected practices for a 12-month period
  2) Provided lead prevention education to practices that see children
  3) Ensured education included the importance of billing for lead testing
  4) Increased member and provider awareness
  5) Engaged at the State level on Lead Prevention.
- School-focused immunization clinics were expanded following the previous year's successful pilot program. Two (2) immunization events were held in August 2023 before the school year started and three

(3) clinics were held in April and May of 2024. Successes were attributed to pre-event education, enthusiastic school nurse support and a strong program partner.

- Cervical Cancer self-swab pilot launched in January with five (5) strategically selected clinics, designed to develop lessons learned and workflows for allowing patients to collect their own samples in conjunction with clinic staff. The program has been extended into August 2024.
- In FY 2023-2024 there were 67 Mobile Mammography event days with 27 provider organizations at 41 geographical sites, resulting in 1,528 completed mammograms for Partnership members. The Southeast and Southwest Regions reached the targeted PCP Quality Incentive Program Breast Cancer Screening 50th percentile benchmark.
- The Perinatal Quality Improvement Program implemented new "Depression Screening at First Prenatal Visit" measure. Program Managers, Population Health and the HEDIS® Team partnered to educate providers on the change from a gateway measure back to a Unit of Service measure; measure rates remained stable during this reporting requirement change.
- To improve timely ADHD medication follow-up visit rates for newly prescribed members ages 6-12, a pilot was developed to send follow-up provider notices. The fax notification alerts prescribers that their patient filled a new ADHD medication and encourages scheduling a follow-up appointment within 30 days.
- To focus on improving access to colorectal screening, Partnership continued collaboration with Exact Sciences, maker of Cologuard (FIT DNA test), through a pilot starting in June 2023. Partnership engaged interested primary care provider sites, which resulted in the completion of four (4) successful bulk order cycles in 2023. This program expands colorectal cancer screening access by offering a bulk order option to sites for eligible members identified by their primary care provider. Currently, 27 distinct parent organizations in all three (3) regions are participating in various planning and deployment stages. Early results from four pilot sites demonstrated increased use of Cologuard, which Partnership expects to translate into improved colorectal screening rates with continued PCP use of this bulk ordering process.
- The Inspections Team performed 19 Initial Health Appointment (IHA) focused audits and issued 19 Corrective Action Plans, providing opportunities to continue education around IHA guidelines.
- The Inspections Team presented on topics of Blood Lead Screening and Initial Health Appointments at 28 Operations Meetings for Provider Education, sharing updates, reviewing identified gaps in care and fielding questions from providers.
- QI hosted and expanded quarterly meetings in the Northwest and Northeast Regions, providing regional forums to problem-solve issues relevant to quality improvement. Positive feedback was received by participants with requests to continue the series.
- A micro pilot program developed the prototype Missed Opportunities Dashboard receiving positive feedback from participating providers, citing value and specific use cases in data.
- 11 Provider Organizations identified as low performing providers in the PCP Quality Incentive Program and were assigned to the Enhanced Provider Engagement (EPE) Program. Needs Assessments were conducted with 73% of provider organizations, and recommendations were for impactful quality interventions, improving their 2023 PCP Quality Incentive Program scores by an average of 11.5%.
- As part of the EPE program, monthly meetings were coordinated with Modified Quality Improvement Program providers, a subset of PCP Quality Incentive Program participants identified as low performing, and their assigned Improvement Advisors. In these regular interactions, provider teams and their Partnership coaches reviewed their QIP data, performance trends, and continued education about the PCP Quality Incentive Program and online tools. Practice types were assigned to Modified Quality Improvement Program providers ensuring the correct measure set is assigned. Performance results led to

two (2) of the practices graduating back to standard Quality Improvement Program and many saw greater rates of improvement than the plan-wide average

- Following evaluation of the EPE and Modified Quality Improvement Program strategies to assess effectiveness, the programs were expanded in 2024 to be more inclusive by reducing member assignment threshold from 1,000 to 500. Leadership also recognized several practices made sizeable improvements and were further served by an advancement of 25% of their potential QIP earnings to kick-start improvement projects.
- The Improvement Academy: offered six (6) virtual webinars focused on priority MCAS measures; five (5) ABCs of QI in-person sessions encompassing all Partnership regions including the new Eastern Region; implemented a strategy to assess participant's comprehension and application of session concepts, as well as a pre-session evaluation to adjust learning content relative to the learning needs of participants; rebranded the Improving Measure Outcome (IMO) webinar series to better reflect the educational offering and increased promotional efforts; completed the Health Equity 3-session training series with results indicating attendees are likely to implement organizational changes to increase Diversity Equity and Inclusion topics.
- A Program Description of the QI Practice Coaching and Collaboration was drafted, detailing the tiered approach to coaching and collaboration with PCP practices. PI Teams and Regional Medical Directors were all trained on the Program Description at the Improvement Advisors IA Tech meeting June 2024.
- The Annual HEDIS® Project build was completed with data loaded into production January 2024, new Electronic Clinical Data Systems (ECDS) data sources were integrated with auditor approval. Integrated Electronic Clinical Data Systems (ECDS) depression screening, alcohol screening and behavioral health data from external sources to the data warehouse for QI programs and HEDIS® projects.
- The QIP Team developed and implemented a network-facing Disparity Analysis Dashboard, allowing the evaluation of member data by key demographic indicators including race and ethnicity.
- A PCP QIP Kick-off webinar was held to support new Eastern Region PCPs in using data to improve reporting and performance improvement activities. The PCP QIP Team collaborated with the PI Team to conduct welcome meetings with each expansion county provider and complete a series QIP Office Hours.
- The HQIP Team on-boarded six new Expansion County Hospitals into the HQIP, each participating in an individual orientation and receiving education on the new 6-month measure set developed specifically for them.
- In addition to successful renewal of Health Plan Accreditation (HPA), the program was expanded to prepare for Health Equity Accreditation (HEA) and the next HPA survey in 2025. The HPA goal ensured continuous compliance of HPA requirements and the HEA goal ensured readiness of all assigned HEA Standards and Guidelines for Initial Survey targeting for June 2025.

FY 23/24 Work Plan Final Goal Status

Project or Program	Goal	Status Details	Next Steps
2.f. **PCP QIP eReports Systems**	**Goal #1:** By June 30, 2024, 2024 eReports with Health Rules Payor® (HRP®) data will be released, March 1, 2024. Adapt HRP® implementation plan no later than June 2024.	Delayed	Delay due to revised Health Rules Payer® (HRP®) launch date. Deliverables 1-2 will be completed following the implementation of new Core Claims System (HRP).
2.g. **Partnership Quality Dashboard**	**Goal #1:** By June 30, 2024, apply annual development updates of the HEDIS® Monthly Exploratory Dashboard in accordance with identified stakeholder needs.	Delayed	Delay due to revised HRP® launch date. Deliverables 1-3 will be completed following the implementation of HRP®.
2.h. **Data Governance**	**Goal #1:** By June 30, 2024, Develop and test HRP® clinical and non-clinical data for the PQD QIP-PCP project and be ready for Production go-live. Integrate the HEDIS® HRP® data to EDW environment and test PQD-HEDIS® module.	Delayed	Delay due to revised HRP® launch date. Deliverables 3-4 will be completed following the implementation of HRP®.
2.h. **Data Governance**	**Goal #3:** By June 30, 2024, integrate lab and measurement data from Sutter Health into QI processes to use it as supplemental data for HEDIS® and other QIP programs	Delayed	This year's data was received and integrated, however, the data integration process will be changing over the next year. Work on deliverable #2 to integrate the data into HEDIS® and other QIP programs will continue into the next year.
3.c. **Palliative Care Quality Improvement Program (PC/QIP)**	By December 31, 2023, complete CY 2022 PC QIP evaluation.	Delayed	Delays in collecting accurate and complete data following new partnership with Amazon Web Service (AWS), deliverable is

Project or Program	Goal	Status Details	Next Steps
			expected to be complete August 30, 2024.
4.c. Local School Collaboration to Drive Adolescent Immunizations	By June 30, 2024, partner with local schools across the Partnership network to offer immunization clinics and education for students in partnership with local pharmacies and clinics.	Delayed	Deliverable #3 calls for an evaluation of back-to-school immunization events but resulted in minimal interest from Glenn County; Eastern Regional Director will seek other potential partners for this immunization work.
4.g. Healthy Toddlers Growing Together	**Goal #1:** By June 30, 2024, launch and pilot at least 90 days of Healthy Toddlers Growing Together that identifies children ages 12 - 36 months who have never had a well-child visit and offer incentives through their 3rd birthday to attend all recommended visits from date of enrollment.	Terminated	Terminated due to overlap with Healthy Babies and Healthy Kids programs.

Please see Appendix (G) for approved 2023-2024 QI Work Plan Summary.

National Committee for Quality Assurance (NCQA) Accreditation

QI TRILOGY

NCQA Overview

(National Committee for Quality Assurance)

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

NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA) Goals

During fiscal year 2023-2024, Partnership achieved the following goals relative to NCQA Accreditation:

1) Departments will sustain key NCQA HPA reporting requirements and maintain up-to-date knowledge of the 2024 HPA Standards and Guidelines.
2) Departments will prepare readiness of all assigned NCQA HEA Standards and Guidelines for Initial Survey, targeted for June 2025.
3) Report HEDIS® and CAHPS® results to NCQA for NCQA HPA by June of 2024

Preparation for HPA Renewal Survey and HEA Initial Survey

The plan-wide NCQA-related HPA and HEA goals were approved by the NCQA Steering Committee for fiscal year 2023-2024. The HPA goal included three (3) milestones aimed at ensuring continuous compliance of HPA requirements in preparation for Partnership's next HPA survey, scheduled on September 22, 2026. For the HEA goal, there were five (5) milestones aimed at readiness of all assigned HEA Standards and Guidelines for Initial Survey, targeted for June 2025. A summary of the goals and outcomes towards obtaining NCQA HPA Renewal Survey and HEA Initial Survey are presented below. The HPA and HEA goals were met and all milestones were completed on time.

HPA Goal: Departments will sustain key NCQA HPA reporting requirements and maintain up-to-date knowledge of HPA 2024 Standards and Guidelines as measured by three (3) milestones:

Milestone 1: Milestone 1 was achieved by all identified departments submitting their 2024-2026 HPA Report schedule by October 31, 2023. All edits to the report schedules have been discussed and reconciled. A new 2024-2026 Report Schedule was created in May 2024, as a result of the re-assessment of ownership of HPA requirements. This new Report Schedule is not yet finalized, and further discussion with the new Business Owner will take place in July 2024.

Milestone 2: Milestone 2 was achieved by the selected departments submitting their completed 2024 HPA Workbooks by February 20, 2024. The 2024 HPA Workbook included acknowledgement of the Summary of Changes, and confirmed the department's Work Plan and Evidence Submission Library, incorporating revisions as needed. Additionally, Business Owners collected attestations from key stakeholders and contributors. The NCQA Program Management Team reviewed all submissions and provided feedback as needed; with all recommendations for edits being addressed. As a result of the proposed changes under 2025 HPA Standards and Guidelines, one department opted not to submit the 2024 HPA Workbook. The NCQA Consultant re-directed the team to align

efforts with the proposed Medicaid behavioral health measures, which NCQA will finalize under the 2025 HPA Standards and Guidelines and make available in August 2024.

Milestone 3: From July 1, 2023 – June 30, 2024, achieve HPA compliance and maintain readiness by completing file reviews and analysis reports.

File reviews for Partnership Files:

- Continued ongoing monitoring of files and shared results of the quarterly file review audits with the NCQA Program Management Team for regular updates at the NCQA Steering Committee. A few areas of opportunities were identified based on the quarterly file review audit results in May 2024. One (1) Pharmacy denial/factor scored "no". The Pharmacy Team confirmed this was a one-time occurrence and will continue to monitor and define medical terms. Meanwhile, several UM denials missed notification timeliness and the reference to UM criterion. UM was faced with an unprecedented increase in TAR volume compared to 2023 as a by-product of the ten-county expansion. UM also encountered staff turnover (loss of veteran, trained, seasoned UM nurses) and staff leaves of absence, which resulted in a staffing gap that impacted operations from the end of Q4 2023 through Q1 2024. UM has re-assessed staffing needs. Additionally, with mass hiring of staff comes the need to onboard and train the new staff members. This process is resource-intensive, which drew from daily operations and led to timeliness challenges that were demonstrated in the Q2 2024 results. Findings from the quarterly file review had been reviewed with the UM supervisors. UM Regulations will resume weekly file reviews going forward.

File reviews for non-NCQA Accredited delegates:

- Continued ongoing monitoring of files to ensure compliance throughout the look-back period. Provided regular updates based on the risk assessed to the NCQA Steering Committee for feedback and decision.
- The Provider Relations Team completed the 2024 annual delegation audits; all delegates met compliance on chart review and no findings were identified.
- The Pharmacy Team conducted quarterly monitoring of their one delegate through March 31, 2024. After this date, the delegate termed their contract with Partnership; therefore, file monitoring is no longer required.
- The Utilization Management Team continued to monitor the UM hospital denials through the annual delegation audits scheduled between April and June 2024. Additionally, UM monitoring of the UM hospital denials took place on a weekly basis and shared feedback with the delegates.

Applicable teams participated in a mock file review with the NCQA consultant in 2024:

- Provider Relations, March 2024 – Recommendations were provided tied to the 2024 HPA Standards and Guidelines. Feedback was shared with the identified credentialing delegate. Subsequently, the credentialing delegate submitted the clarifying documentation and satisfied the NCQA requirement.
- Pharmacy and Utilization Management, April/May 2024 – Issues were identified regarding Upheld Appeals. Both teams were advised to follow-up with the Grievance and Appeals Team for lesson learned and a file review template to adopt. Additionally, the UM Team was advised to follow-up with the CMO to address Same/Similar specialty reviews. The NCQA Program Management Team hosted a meeting with Grievance and Appeals, Pharmacy and UM Teams to finalize a documented process/one unified approach that describes Partnership's process of member appeals.

Analysis Reports

- Applicable teams completed the reports based on the approval date indicated in the HPA Report Schedule. All reports were reviewed and approved by the NCQA consultant.

HEA Goal: Departments will prepare readiness of all assigned NCQA Health Equity Accreditation (HEA) Standards and Guidelines for Initial Survey, targeted for June 2025, as measured by:

Milestone 1: Milestone 1 was achieved by all identified departments acknowledging the 2024 HEA Standards Summary of Changes by September 25, 2023. Business Owners confirmed they reviewed the Summary of Changes and required no clarifications.

Milestone 2: Milestone 2 was achieved by all identified departments submitting their FY 23-24 HEA Work Plans and Report Schedules by November 17, 2023. Business Owners confirmed accuracy of both documents and provided updates as needed. All revisions were reviewed and approved by the NCQA Program Management Team. A new 2024-2026 Report Schedule was created in May 2024, as a result of the re-assessment of ownership of HEA requirements. This new Report Schedule is not yet finalized, and further discussion with the new Business Owner will take place in July 2024.

Milestone 3: Under Milestone 3, Business Owners reviewed and confirmed the information in their HEA Evidence Submission Library. Business Owners completed this activity by the March 29, 2024 due date and all revisions noted have been reconciled.

Milestone 4: Milestone 4 had several activities, all of which were completed timely. These activities included:

1. Business Owners submitted draft documented processes for consultant review by February 29, 2024.
2. Business Owners submitted draft reports for consultant review by the dates indicated in the HEA Report Schedule. As of note, further edits are required under HE 1A. The HR and HE Teams agreed to submit a revised DEI Report and new example of an action taken tied to an identified opportunity with the other evidence submitted for consultant review during the HEA Mock Initial Survey.
3. Business Owners and the NCQA Program Management Team reviewed and reconciled all activities listed under the Action Items Tracker during the bi-monthly HEA Business Owner Check-in Meetings.
4. Business Owners who achieved less than 80% compliance with their assigned HEA requirements completed a Strategic Plan by June 14, 2024 that outlined the activities in place to address the gap(s) and proposed due date(s) to submit evidence for consultant review.

Milestone 5: Milestone 5 was completed with the submission of annotated and bookmarked evidence for the HEA Mock Initial Survey by the June 28, 2024 due date.

The NCQA Program Management Team gained additional FTEs during the fiscal year to allow ample support for both the HPA and HEA programs. Overall, the activities outlined above, along with staff that serve as the NCQA Program Management Team, were sufficient and provided strong oversight to achieve the fiscal year 2023-2024 goals and objectives for NCQA HP and HE Accreditation included in the QI Work Plan.

Compliance with NCQA Survey Standards

Per the 2024 DHCS contract, all Managed Care Plans (MCPs), including Partnership, will be mandated to achieve both NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation (HEA) by January 1, 2026.

Partnership successfully achieved NCQA HPA reaccreditation on December 28, 2023. NCQA requires health plans to undergo reaccreditation every three (3) years, and Partnership's next HPA Renewal Survey is scheduled on September 22, 2026. A three-year Renewal Survey timeline has been developed which outlines all key activities to achieve HPA in 2026. NCQA HEA is a relatively new standards program focused on advancing the delivery of more equitable and culturally and linguistically appropriate services across member populations. The NCQA Program Management Team worked closely with Partnership's NCQA Consultant, and key stakeholders across the organization to estimate Partnership's current performance and develop a readiness timeline to achieve the new NCQA HEA by the mandated deadline of January 1, 2026. As of June 2024, Partnership has received confirmation from NCQA in scheduling our HEA Initial Survey on June 17, 2025.

The NCQA Program Management Team strives to maintain up-to-date knowledge of the NCQA Standards and Guidelines, and recently completed a NCQA training series on the 2024 HPA Standards and Guidelines. Additionally, the team manager and HEA lead program manager attended the in-person NCQA Health Equity Forum in March 2024 to learn from peers across the state for creating and implementing health equity strategies.

NCQA Health Equity Accreditation Planning

The NCQA Program Management Team has built a solid HEA Program structure to ensure compliance with the HEA requirements and prepare Partnership for our formal HEA Initial Survey, scheduled for June 2025. The HEA Program structure mimics that of the HPA Program structure, which has proven to be successful in achieving accreditation. The HEA Program structure includes, but is not limited to, the following activities:

- Host bi-monthly check-in meetings with all Business Owners to ensure tasks are completed as planned.
- Distribute work plans to Business Owners to identify assigned requirements.
- Utilize and share an Action Item Tracker with each Business Owner to ensure timely completion of outstanding tasks.
- Track all HEA evidence by developing an Evidence Submission Library for each Business Owner.
- Maintain HEA Report Schedules for each Business Owner to track data sources, approving bodies and due dates.
- Maintain the HEA Compliance Dashboard to monitor overall compliance by department and the applicable points achieved by month.

The activities completed in the HEA goal kept Partnership moving forward increasing overall compliance from 3.7% in June 2023 to 61.1% compliance as of June 2024. Although this is under the minimum of 80% required to achieve accreditation, non-compliance is primarily related to standard HE 2: Race/Ethnicity, Language (REaL), Gender Identity and Sexual Orientation (SOGI) Data.

A HE 2 Core Workgroup was formed in Fiscal Year 23/24. The primary challenge in driving HE 2 gap closure is a diverse group of Business Owners are required in active and ongoing collaboration to comply with a subset complex requirements. Key participants of the Workgroup included: IT, Quality Improvement, and Health Equity. Other departments, including Member Services, Care Coordination, Population Health, and Compliance, also participated

based on the selected topics. The HE 2 Core Workgroup has drafted policies that describe the process of data collection using the future system, CSquare ("C2"). In addition, materials, including screenshots from C2, call scripts, and assessment forms for data collection are planned as part of the survey submission. The HE 2 Workgroup has also drafted policies that describe the process of managing access to and use of REaL and SOGI data and will explore options of notifying members of privacy protections of the REaL and SOGI data. Due to the delay in HRP® implementation, the HE 2 Core Workgroup will implement a mitigation plan to ensure compliance with HEA Standards and Guidelines and Initial Survey readiness for June 2025.

In preparation for Partnership's Formal HEA Initial Survey, Partnership will conduct a Mock Initial Survey in August 2024. The Mock Initial Survey will be a full scope review of all evidence by our NCQA consultant, who will provide recommendations and address findings on the evidence submitted. Business Owners can also clarify issues and seek guidance during this time. A final report and scoring will be distributed after the conclusion of the Mock Initial Survey. Activities are currently underway to prepare for the Mock Initial Survey, including evidence preparation and review.

CAHPS® and HEDIS® Reporting for Health Plan Accreditation

Partnership was required to formally report MY2023 HEDIS® and CAHPS® for HPA by June 2024. HEDIS® and CAHPS® reporting is a requirement that must be fulfilled annually by accredited health plans in order to maintain their accredited status. A health plan may choose the results of the CAHPS® survey to be reported: Adult CAHPS® or Child CAHPS®. For MY2023/RY2024, Partnership chose to submit the Adult CAHPS® rates. Partnership also successfully reported HEDIS® HPA rates by the June 15, 2024, mandated deadline. Additionally, Partnership submitted the NCQA Healthcare Organization Questionnaire (HOQ) for the required CAHPS® surveys by the December 29, 2023 required deadline.

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

During the next fiscal year, Partnership will continue to work on sustaining compliance of all Renewal Survey requirements through key defined activities, as well as its NCQA Program Management and NCQA Steering Committee structure to assure our readiness for Renewal Survey Accreditation in September 2026.

Partners in Quality

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

As a result of this recognition, provider practices that are first time applicants and are supported by Partnership will also be eligible for a 20% discount for NCQA Recognition programs. This discount opportunity was shared with the Provider network through articles included in Partnership newsletters throughout FY 2023 – 2024. Further support and motivation for the Provider network to achieve and maintain the PCMH recognition is the PCMH Unit of Service measure included in the PCP QIP. Each measurement year, the Provider network has the chance to earn $1,000 per PCP site for achieving or maintaining PCMH accreditation from NCQA, or equivalent from Accreditation Association for Ambulatory Health Care (AAAHC) or The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Key Benefits of Being a Partners in Quality (PIQ) Recognized Organization:

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

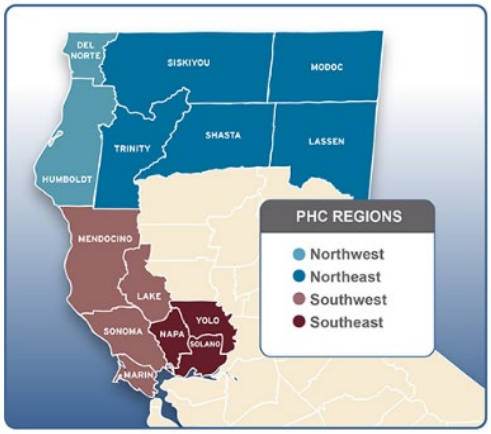
HealthPlan Quality Performance

QI TRILOGY

Overall Summary

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

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

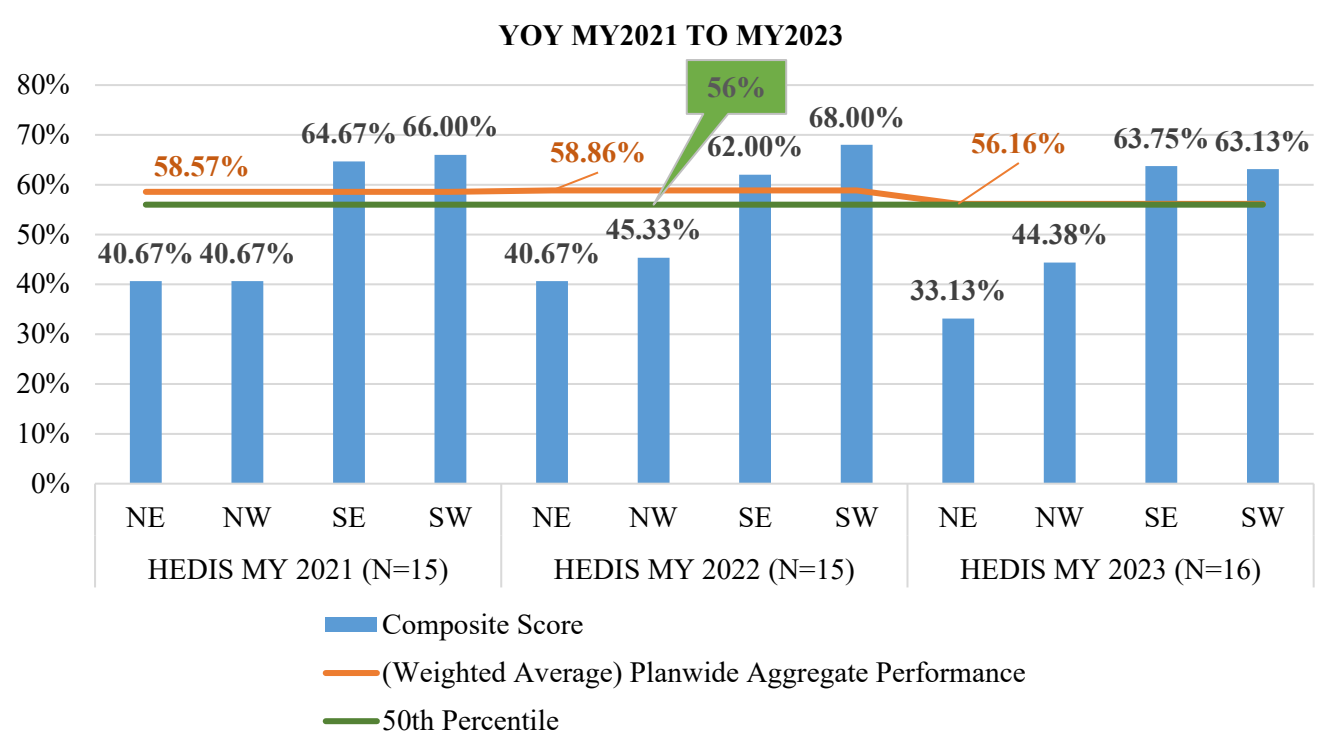


Overall Health Plan Ranking: DHCS Managed Care Accountability Set (MCAS)

DHCS uses a scoring methodology to determine an aggregated Quality Factor Score (QFS), which ranks health plan performance relative to California Medicaid reporting health plans. Partnership adopts DHCS' scoring methodology to determine Partnership's regional and plan-wide composite scores year over year. Each measure in each reporting region is given a score from one to ten (1-10) based on performance relative to national benchmarks. A regional composite score is then calculated by dividing total earned points by total possible points. The plan-wide composite score represents a weighted aggregate score based on the eligible populations by region, given membership is significantly greater in the southern region reporting units versus the northern region reporting units.

The Quality Compass 2023 Benchmarks, which were developed based on national MY2022 performance, are the most currently available benchmarks. These benchmarks were used by Partnership to determine percentile rankings and the following composite scoring year over year analysis. Annually each fall, DHCS releases a dashboard indicating the plan's regional Quality Factor Scores and associated rankings to other health plans. The results of this ranking will be published upon the release of this information and will be utilized by DHCS to assess mandated improvement activities and any sanctions.

MY2023 HEDIS® Composite Performance Year Over Year Comparison: DHCS Managed Care Accountability Set (MCAS)



➢**Reported Measures held to MPL MY2019:** ABA, AMM-Acute, AMM-Cont, AMR, AWC, BCS, CBP, CCS, CDC-H9, CDC-HT, CHL, CIS-10, IMA-2, PPC-Pre, PPC-Post, W15, W34, WCC-BMI, PCR

➢**Reported Measures held to MPL MY 2022:** BCS, CBP, CCS, CHL, CIS-10, HBD-H9, IMA-2,FUM-30, FUA-30, LSC, PPC-Pre, PPC-Post, W30-0-15, W30-15-30, WCV

➢**Reported Measures held to MPL MY 2023:** AMR, BCS-E, CBP, CCS, CHL, CIS-10, HBD-H9, IMA-2,FUM-30, FUA-30, LSC, PPC-Pre, PPC-Post, W30-0-15, W30-15-30, WCV

Note: *MY2023/RY2024: Total Points Earned: 290 Points out of 640 Total Points (16 measures included)*

- In MY2023 there were 18 measures held accountable to the MPL. The chart above shows 16 measures, excluding the DEV and TFL-CH measures. Both of these new measures are held accountable to the State's designated minimum performance level (MPL), which utilizes the CMS FFY 2022 State Median as the MPL benchmark. To date, DHCS has only established the MPLs for these new measures and therefore these measures are not included in composite scoring and year over year comparisons.
- The NCQA Quality Compass 2023 Benchmarks reflected increases for several measures, contributing to declines in final percentile rankings versus MY2022.

MY2023 continued to host two (2) required separate audits:

- DHCS / MCAS required reporting: Health Service Advisory Group Auditor (this report's focus)
- NCQA HEDIS® Health Plan Accreditation / HPA: Advent Advisory Auditor

In MY2023, Partnership observed an increase in overall membership by approximately 5.80%, which resulted in an increase in the eligible population across a subset of measures. A contributing factor to this growth occurred as the state did not begin to reinstate Medi-Cal eligibility re-determinations until April 1, 2023 and the effect on eligibility did not begin until mid-year in 2023. The overall impact of resumed re-determinations is expected to

bring greater stabilization to membership over the next 1-2 years. Additionally, Partnership observed a slight increase in membership in the age range of 50 years and older which is likely a result of the expanded scope of Medi-Cal which began on May 1, 2022, in which immigration status was no longer a determining factor for eligibility for full scope of Medi-Cal for those age 50 years and older.

Partnership observed an increase in pharmacy and mental health claims impacting multiple measures. Integration of new data sources is ongoing and contributed to an overall improvement in a subset of clinical measures.

Additionally, in MY2023 Partnership focused on collecting new Electronic Clinical Data Systems (ECDS) data to primarily support the depression screening measures, which are presently designated as reporting only measures by DHCS. This required the primary source verification process mandated and audited by NCQA and its certified auditors. The ECDS data collection method is still new to many providers; many of whom are still learning to ensure their EHR system and source data align, as is required for primary source verification. Consequently, Partnership was only able to integrate ECDS data from eight (8) providers. We are continuing efforts to collect and integrate this data utilizing an NCQA data aggregator, which we are currently piloting.

NCQA released a number of changes to HEDIS® measurement specifications that applied to MY2023 including the following:

- Deceased Members, General Guideline 16: Exclude members who die any time during the measurement year. Deceased members were previously considered an optional exclusion.
- Race and Ethnicity Stratification (RES), General Guideline 31: Listed additional measures which have instructions to categorize members by their RES. Added instructions on reporting "Unknown" race and ethnicity category values.
- Exclusions: Moved all optional exclusions to required exclusions.
- Palliative Care Direct Reference: In measures where palliative care is specified as a required exclusion, added a direct reference code for palliative care: ICD-10-CM code Z51.5
- Frailty Cross-Cutting Exclusion: In measures with the frailty cross-cutting exclusion (i.e. exclude members 66 years and older with frailty and advanced illness), updated the number of occurrences of frailty required. Increased from one (1) to two (2) required occurrences of frailty.

Additionally, NCQA released changes to an existing clinical measure used in DHCS MCAS for MY2023:

- Breast Cancer Screening (BCS-E) using ECDS methodology replaced Breast Cancer Screening (BCS), which was an administrative measure.

Partnership successfully launched our HEDIS® MY2023/RY2024 data collection and reporting audits incorporating all changes as noted above.

DHCS MCAS Accountable Measures

In MY2023/RY2024 HEDIS® Annual Final Reporting, DHCS is holding managed care plans (MCPs) accountable and imposing financial sanctions on 18 selected Hybrid and Administrative measures performing below the minimum performance level (MPL -50th national Medicaid percentile) by reporting region, up from 15 accountable MCAS measures in MY2022.

Results of an additional 24 MCAS measures were reported, but were not part of the accountability measure set in MY2023 ("reporting only measures"). The full list of MY2023 MCAS measures can be found on the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Accountability-Set-Reporting-Year-2024.pdf. Of special note, in December 2023, DHCS released three (3) new LTC measures designated as reporting only:

- Number of Outpatient ED Visits per 1,000 Long Stay Resident Days (HFS)
- Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization (SNF-HAI)
- Potentially Preventable 30-Day Post Discharge Readmission (PPR)

The same 15 MCAS measures from MY2022 continued into MY2023. The three (3) new accountable measures added include reinstatement of the Asthma Medication Ratio (AMR) measure, which was paused in MY2022, but was previously an accountable measure. Two (2) controversial non-HEDIS® measures were also added, based on the 2022 CMS Core Measure Set: Developmental Screening in the First Three (3) Years of Life (DEV), an administrative measure specified by CMS and Topical Fluoride for Children (TFL-CH), an administrative measure specified by the Dental Quality Alliance (DQA). Per recently released APL 24-004, DHCS designates MPLs for CMS Core Set measures in the current MY using previous Federal Fiscal Year (FFY) benchmarks as its basis.

Much of the measure performance analysis that follows is based on the performance of the 16 accountable MCAS measures per NCQA Quality Compass 2023 Benchmarks, developed on MY2022 performance.

The table below indicates measures that fell below the MPL in MY2023:

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

Measures	NORTHEAST	NORTHWEST	SOUTHEAST	SOUTHWEST
Asthma Medication Ratio (AMR) - Asthma Medication Ratio*	●	●		
***Breast Cancer Screening (BCS-E)*	●	●		
Cervical Cancer Screening (CCS)	●			
Childhood Immunization Status (CIS) - Combo 10	●	●		
Chlamydia Screening in Women (CHL) - Total*	●	●		
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	●	●	●	●
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total*		●	●	●
Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)	●			
Immunizations for Adolescents (IMA) - Combo 2	●	●		
Lead Screening in Children (LSC)	●		●	●
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care		●		
Well Care Visits (WCV) - Total*	●	●	●	
Well Child 30 (W30) - Well child visits for age15-30 months*	●	●	●	
Well Child 30 (W30) - Well child visits in the first 15 months*	●	●	●	●

Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).* ***NOTE**: This report excludes measures reported to DHCS not held to DHCS MPL. ***BCS-E in historical measurement years was named BCS. HBD -*

HbA1c Poor Control is an inverted measure; a lower rate results in a better performance. AMR is a new measures held to MPL for MY2023.

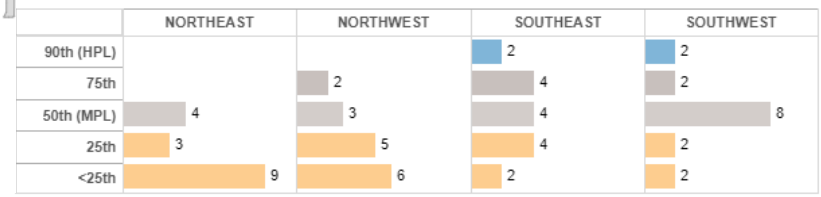
Where measures remained in the MCAS in MY2023, the next table shows that Partnership observed a number of measures within our four (4) reporting regions that declined or improved in percentile ranking relative to prior years. Improvement observed resulted from a number of performance improvement activities led and/or supported by Partnership and our contracted provider network, which is outlined in more detail within subsequent sections of the Quality Improvement Evaluation.

Regional Performance Rates MY2023/RY2024:

Regional Distribution of Measures by Percentile Ranking

MCAS Performance Relative to Quality Compass® Medicaid Benchmarks

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



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

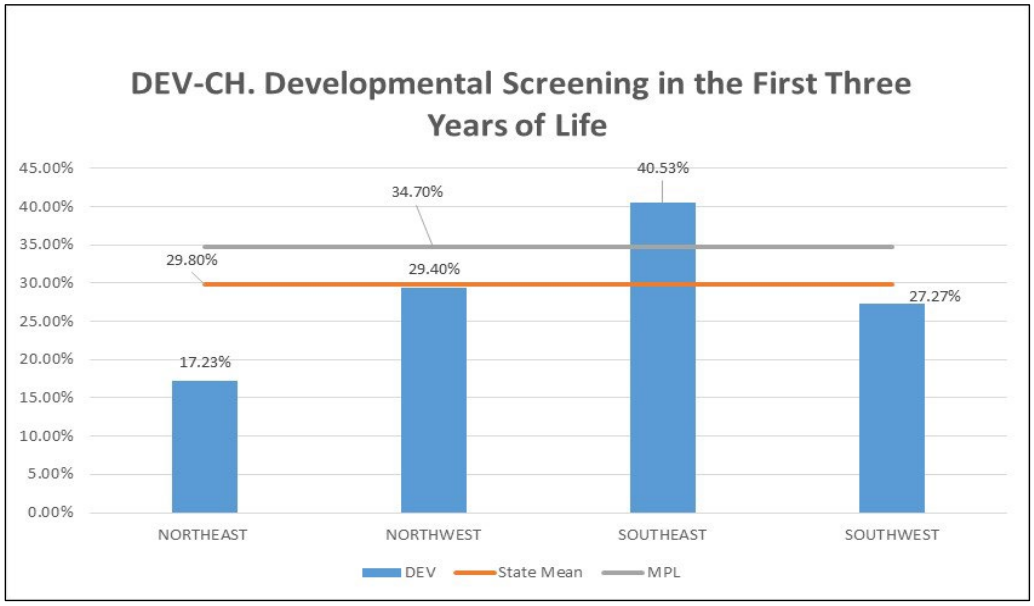
Regional Performance

Measures	NORTHEAST		NORTHWEST		SOUTHEAST		SOUTHWEST	
	MY2022	2023	MY2022	2023	MY2022	2023	MY2022	2023
Asthma Medication Ratio (AMR) - Asthma Medication Ratio*		<25th		<25th		50th		50th
***Breast Cancer Screening (BCS-E)*	25th	25th	<25th	<25th	75th	75th	50th	50th
Cervical Cancer Screening (CCS)	25th	<25th	25th	50th	75th	50th	90th	50th
Childhood Immunization Status (CIS) - Combo 10	<25th	<25th	<25th	<25th	75th	75th	50th	50th
Chlamydia Screening in Women (CHL) - Total*	25th	<25th	25th	25th	50th	50th	50th	50th
Controlling High Blood Pressure (CBP)	50th	50th	50th	50th	50th	50th	75th	50th
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total*	90th	50th	75th	25th	90th	25th	75th	25th
Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)	75th	25th	75th	75th	50th	75th	75th	75th
Immunizations for Adolescents (IMA) - Combo 2	<25th	<25th	<25th	25th	90th	90th	90th	75th
Lead Screening in Children (LSC)	<25th	25th	<25th	50th	<25th	25th	<25th	25th
Prenatal and Postpartum Care (PPC) - Postpartum care	50th	50th	90th	75th	90th	90th	90th	90th
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care	75th	50th	50th	<25th	25th	75th	90th	90th
Well Care Visits (WCV) - Total*	<25th	<25th	25th	25th	25th	25th	25th	50th
Well Child 30 (W30) - Well child visits for age15-30 months*	<25th	<25th	25th	25th	25th	25th	25th	50th
Well Child 30 (W30) - Well child visits in the first 15 months*	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th

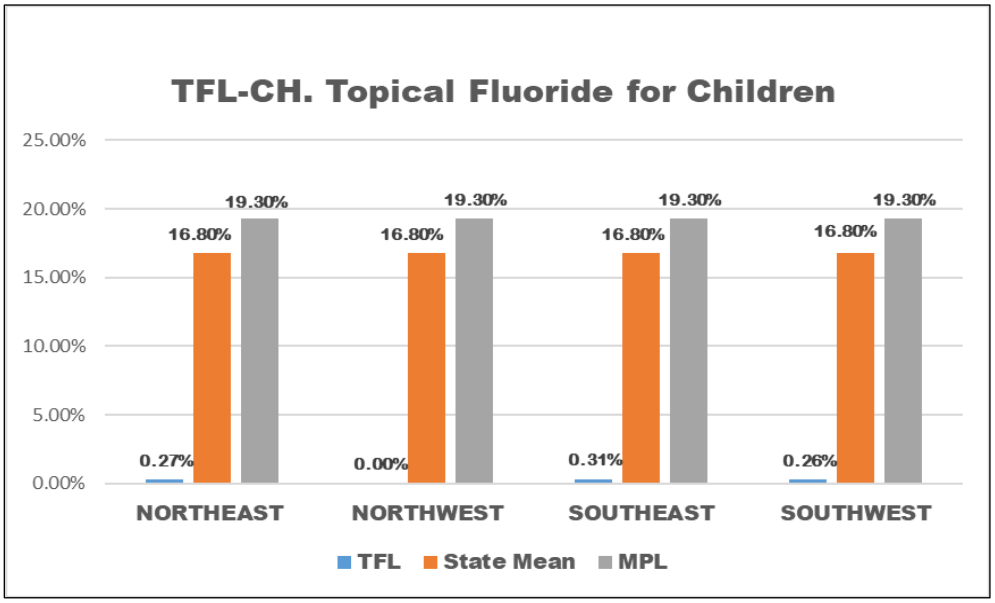
	Regional Performance				National Medicaid Benchmarks			
Measures	NORTHEAST	NORTHWEST	SOUTHEAST	SOUTHWEST	25TH	50TH	75TH	90TH
Asthma Medication Ratio (AMR) - Asthma Medication Ratio*	49.92%	58.54%	69.61%	66.50%	58.94%	65.61%	70.82%	75.92%
***Breast Cancer Screening (BCS-E)*	50.00%	45.64%	59.95%	57.06%	47.09%	52.60%	57.48%	62.67%
Cervical Cancer Screening (CCS)	45.97%	58.72%	59.84%	61.75%	50.85%	57.11%	61.80%	66.48%
Childhood Immunization Status (CIS) - Combo 10	8.03%	18.98%	44.53%	37.47%	24.57%	30.90%	37.64%	45.26%
Chlamydia Screening in Women (CHL) - Total*	49.23%	51.78%	59.02%	57.40%	49.65%	56.04%	62.90%	67.39%
Controlling High Blood Pressure (CBP)	61.34%	63.14%	64.29%	64.75%	55.47%	61.31%	67.27%	72.22%
Developmental Screening in the First Three Years of Life (DEV) - Developmental Screening*	17.23%	29.40%	40.53%	27.27%				
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	30.34%	31.60%	27.35%	34.81%	47.01%	54.87%	64.29%	73.26%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total*	38.85%	32.46%	29.85%	30.00%	27.75%	36.34%	42.67%	53.44%
Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)	38.81%	33.15%	31.32%	33.06%	44.77%	37.96%	33.45%	29.44%
Immunizations for Adolescents (IMA) - Combo 2	20.19%	31.87%	51.82%	47.93%	29.44%	34.31%	40.88%	48.80%
Lead Screening in Children (LSC)	51.09%	64.96%	61.07%	59.37%	49.61%	62.79%	70.07%	79.26%
Prenatal and Postpartum Care (PPC) - Postpartum care	81.36%	82.19%	87.50%	93.71%	73.97%	78.10%	82.00%	84.59%
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care	85.30%	79.00%	88.75%	93.71%	79.63%	84.23%	88.33%	91.07%
Topical Fluoride for Children (TFL - CH) - Topical Fluoride for Children - Total*	0.27%	0.00%	0.31%	0.26%				
Well Care Visits (WCV) - Total*	41.64%	48.03%	47.79%	49.45%	42.99%	48.07%	55.08%	61.15%
Well Child 30 (W30) - Well child visits for age15-30 months*	56.09%	65.44%	65.20%	67.47%	62.07%	66.76%	71.35%	77.78%
Well Child 30 (W30) - Well child visits in the first 15 months*	39.25%	45.26%	36.83%	46.28%	52.84%	58.38%	63.34%	68.09%

Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).* ***Note:* *This report excludes measures reported to DHCS not held to DHCS MPL. ***BCS-E in historical measurement years was named BCS. HBD - HbA1c Poor Control is an inverted measure; a lower rate results in a better performance. AMR is a new measures held to MPL for MY2023.*

In MY 2023/ RY2024 the Developmental Screening in the First Three Years of Life (DEV) and the Topical Fluoride for Children (TFL-CH) measures are newly held accountable to the DHCS minimum performance level (MPL). Performance of both of these measures are presented below using the CMS FFY 2022 State Medians as the designated MPL benchmarks.



Note: This measure is held to the DHCS MPL rate of 34.70%; The CMS FFY 2022 state median of 29.80% is used for the benchmark for the DEV measure.



Note: This measure is held to the DHCS MPL for the dental or health services rate of 19.30%; The CMS FFY 2022 state median of 16.8% is used for the benchmark for the TFL-CH measure.

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

As an NCQA-Accredited Health Plan, Partnership is required to report HEDIS® and CAHPS® annually. This reporting started in June 2022 for MY2021. Reporting for MY2023/RY2024 will be formally assessed by NCQA for Partnership's publically reporting Health Plan Rating (HPR).

- Health Plans are given the option to choose to report the Adult CAHPS® survey results or Child CAHPS® survey results.
- Partnership chose to report the Adult CAHPS® survey results for MY2023.
- There were 44 HEDIS® measures requiring plan-wide level reporting for the HPA Annual Project.
- At the close of 2023-2024, Partnership awaits NCQA's formal assessment and final HPR for MY2023. Partnership has utilized NCQA scoring methodology and anticipates achieving a 3.5 Star Rating.

NCQA has released the current Health Plan Rating Methodology: (Plan-wide)

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

MY2023 HPA Star Rating Results

Partnership Projected HPA Star Rating Results with the Adults CAHPS® Survey Results:

Estimated Star Rating with Child CAHPS® Survey Results:

HEDIS HealthPlan Accreditation Star Rating Scoring MY2023 With Child CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2022	TOTAL ACCRD Score MY2023	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	59.5	153	155	193.5	3.25210084	4.0
Patient Experience	7.5	12	9	13.5	1.800	2
Prevention and Equity	18	39	52	66	3.667	3.5
Treatment	34	102	94	114	3.353	3.5

Estimated Star Rating with Adult CAHPS® Survey Results:

HEDIS HealthPlan Accreditation Star Rating Scoring MY2022 With Child CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2021	TOTAL ACCRD Score MY2022	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	60	135	156	191.5	3.191667	3.5
Child CAHPS Rating	7.5	18	10	15		
Patient Experience	10.5	14	14	21	2.000	2
Prevention and Equity	14.5	34	39	50.5	3.483	3.5
Treatment	38	83	103	125	3.289	3.5

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

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

The table below provides a summary of Primary Care Provider (PCP) Quality Incentive Program (QIP) measures included in the Measures Managed Care Accountability Sets (MCAS) for Medi-Cal Managed Care Plans Measurement Year 2023 | Reporting Year 2024.

Measurement Year 2023 | Reporting Year 2024			
HEDIS® Measures	**MY2022 PCP QIP Measures**	**MY2023 PCP QIP Measures**	**Alternate Measure in PCP QIP Measures**
Adult Body Mass Index (BMI) Assessment (ABA)			
Antidepressant Medication Management: Acute PhaseTreatment (AMM-Acute)*			
Antidepressant Medication Management: Continuation PhaseTreatment (AMM-Cont)*			
Asthma Medication Ration (AMR)*	X	X	
Breast Cancer Screening (BCS)*	X	X	
Cervical Cancer Screening (CCS)	X	X	
Childhood Immunization Status (CIS) – Combo 10	X	X	
Chlamydia Screening in Women (CHL)*			
Comprehensive Diabetes Care (CDC-H9) – HbA1c PoorControl (>9.0%)*	X	X	For the PCP QIP, we use the inverse of this measure: Good Control, HbA1c Good Control
Comprehensive Diabetes Care (CDC-HT) – HbA1c Testing			
Controlling High Blood Pressure (CBP)	X	X	
Immunizations for Adolescents (IMA) – Combo 2	X	X	
Prenatal and Postpartum Care (PPC) – Postpartum Care			
Prenatal and Postpartum Care (PPC) – Timeliness of PrenatalCare			
Weight Assessment and Counseling for Children/Adolescents(WCC) – BMI Assessment			
Well-Child Visits in the First 15 Months of Life: Six or MoreWell-Child Visits (W15)	X	X	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years ofLife (W34)			
Eye Exam for Patients with Diabetes (EED)		X	

Measurement Year 2023 | Reporting Year 2024			
HEDIS® Measures	**MY2022 PCP QIP Measures**	**MY2023 PCP QIP Measures**	**Alternate Measure in PCP QIP Measures**
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)		X	
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)		X	
Child and Adolescent Well-Care Visits (WCV)	X	X	
Colorectal Cancer Screening (COL)	X		

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

For Partnership's full summary of HEDIS® MY2023 performance, please refer to Appendix (F).

Quality in Data Governance

QI TRILOGY

Data Governance

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

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

The Enterprise Data Warehouse (EDW) Team, within IT, built a new data warehouse system with the data from HealthRules Payor® (HRP®) (the new claims system) and integrated member, claims, and provider data to Data Warehouse and DataMarts. QI Teams utilize this data for some of their critical applications and processes.

After the infrastructure in the EDW was built with data coming from HRP®, the Provider Quality Dashboard (PQD) for the Quality Incentive Program (QIP) was then developed and tested using HRP® as a source. Building the PQD database was successful and this data was able to be fed into the HRP® version of the dashboards. Going forward into the next year the data will continue to best thoroughly tested in preparation for HRP® go live.

Data Stewardship

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

The goals and deliverables set for FY 2023-2024 included the following:

- Integrate the data from the new claims systems (HRP®) into all QI processes. This would include both HEDIS® and PQD.
- Integrate membership, claims, and provider data from the HRP® claims system into the EDW DataMart.
- Integrate Sutter supplemental data into the QI processes including the HEDIS® project.

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

A successful connection was made with Sutter to ingest their supplemental data, which could be used toward their quality measurements. In the past fiscal year, this data was able to successfully be included in Sutter's PCP QIP measurement scores and assisted us in gaining more data on our members while they were able to improve their program scores. The current connection was a one-time feed and further process improvement will take place next year to gather this data more frequently and use it in the HEDIS® project.

Analytics Center of Excellence

Partnership's Analytics Center of Excellence (ACE) is a virtual, permanent, multi-disciplinary team that incorporates IT, analytics and business expertise. The goals of ACE are to ensure that analytics is aligned with the organization strategy and help achieve analytics maturity. The role of this entity is to drive and coordinate analytic governance activities, operationalize the analytics strategy, identification and prioritization of major cross-functional analytic projects, organize and facilitate communication and collaboration among all the ACE teams, drive data literacy programs, coordinate with analytics teams to assure efficiency and reduce redundancy, promote training, education and mentoring of data analysts, drive standardization of data management and data products, and drive the advancement of innovative analytics. The ACE Project Charter was developed and approved in January 2024.

The ACE is composed of five (5) groups or entities: The Analytics Steering Committee oversees the activities of the ACE groups and reports to the existing Data Governance Council. It is formed by representatives of the business units, IT and the Lead Team, and meets every other month, or as needed. The Lead Team is the coordinator of the hybrid model business unit and is responsible for realizing the functions of the ACE described above. The Lead Team interacts with the other groups, aka, the Governance Personnel, the Analytics Council, and the business to perform its functions. The Analytics Council consists of data analysts from the different departments or business units, and it is conceived as a forum for the data teams to discuss data issues, inform of new data or tools, contribute to the development of data standards, identify training, knowledge sharing, and prevent duplication of effort. The Data Governance group is involved in developing and maintaining the data stewardship program.

Partnership Quality Dashboard

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

The PQD is maintained by staff in Partnership's QI, IT, and Finance departments. Annual dashboard development involves evaluation of project data needs, documentation of business requirements, data and dashboard development, and user acceptance testing. Ongoing maintenance of dashboards throughout the year involves monthly warehousing of both HEDIS® and QIP source data and issue resolution. PQD training is a key project activity conducted throughout the year.

All PQD project goals and deliverables outlined under the 2023-2024 QI Department Work Plan were successfully accomplished during the fiscal year. The continued PQD goal to reconcile changes to impacted PQD data under HealthRules Payor® (HRP®) integration continues. Business rules for mapping primary care provider identification numbers under the new HRP® provider data structure were identified and shared with stakeholders. Other business

rules defining data linkages were identified for source data projects (eReports, Inovalon), to help minimize delays during implementation. Source data validation and user acceptance testing was completed and continues. PQD dashboards are expected to be updated based on HRP® source data, following implementation. (Note, exact timing of refreshing PQD dashboards is contingent on the final implementation timing of HRP®, pending announcement since the May 2024 delay.)

The use of data to identify health inequities is a key organizational focus and was identified as a new goal under the PQD 2023-2024 QI Work Plan. Internal and external stakeholders were consulted to evaluate current and desired performance metrics for disparity analysis. The disparity analysis dashboard was modified to meet updated stakeholder needs, and an evaluation of external stakeholder needs was used to guide a pilot version of the disparity analysis dashboard for testing with key stakeholders from the primary care network in 2023-2024 fiscal year.

Summary of FY 23-24 PQD Dashboards

Dashboard Name	Data Source	Brief Description	Major 2023-2024 Reporting Enhancements
HEDIS® Annual Static - Summary of Performance	HEDIS® Annual Measurement Year 2022	MCAS measure performance by Sub-Region and County and color-coded against benchmarks. No composite score for MY2020.	Measurement Year 2022 HEDIS® Final Performance (CY 2023 expected June, 2024)
HEDIS® Annual Exploratory	HEDIS® Annual Measurement Year 2022	MCAS measure performance by Sub-Region, County and Provider. Color-coded against benchmarks. Stratification by member demographics such as race and gender. Member-level drilldown reports by measure.	Measurement Year 2022 HEDIS® Final Performance (CY 2023 expected June, 2024)
HEDIS® Scatterplot	HEDIS® Monthly 2023	Bubble chart displays measure performance against population size, with break out by various demographic indicators.	2023 Rolling Year and Year-to-Date Performance
HEDIS® Exploratory – Internal View	HEDIS® Monthly 2023	MCAS and NCQA Health Plan Accreditation measure performance by various geographic and demographic aggregates, color-coded against benchmarks. Member-level drilldown reports by measure.	2023 Rolling Year and Year-to-Date Performance
PCP QIP Internal and Provider View	Monthly eReports Clinical data and QIP Non-Clinical calculated data	Payout by measure for the PCP QIP program, with gaps to target, member drilldown, performance against targets and regional averages.	December-2023 final PCP QIP performance. The QIP Stoplight and Final Statement

Dashboard Name	Data Source	Brief Description	Major 2023-2024 Reporting Enhancements
			dashboards are also available in PQD.
AMR	PCP QIP Monthly AMR data and customized Pharmacy Claims data	Asthma Medication Ratio performance visualized in multiple views including prescriber- and pharmacy-level.	December-2023 (Year-end QIP AMR data)
Disparity Analysis	2023 PCP QIP Monthly Clinical Data	Breakout of QIP performance by measure at the plan-wide level, and stratified by ethnicity group. View top 10 providers with largest population size for selected ethnicity groups	December-2023 Geographic View dashboard added to display measure performance across updated categories for race and ethnicity. Dashboard is available to the provider network through eReports.
Maximizing Visibility of Quality Data	2023 PCP QIP Year-end Score	Rank PCPs year-end QIP total score by county and display population size, increase or decrease over previous year score.	December-2023 PCP QIP Final Data PCP-level stars ratings added to ranked performance chart. A guest access link will be made available to the network on the Partnership website for 2023 PCP QIP performance.
QIP Stoplight Dashboard	2023 PCP QIP Monthly Data	Member gap-to-target analysis, color coded against benchmarks at the parent organization level.	December-2023 PCP QIP Final Data. Updated for provider view in PQD in May, 2024.
PCP QIP Final Statement	2023 PCP QIP Year-end Score	Payment, points and performance by measure for individual providers. Used for PCP QIP payment.	December-2023 PCP QIP Final Data. This dashboard was updated for provider view in PQD in May, 2024 for CY 2023.
Perinatal QIP Dashboard	Perinatal QIP supplemental measure data and	Perinatal QIP measure performance is updated	

Dashboard Name	Data Source	Brief Description	Major 2023-2024 Reporting Enhancements
	custom claims and membership calculations	quarterly for provider statements.	
Hospital QIP (HQIP) Final Statement	Supplemental HQIP Performance data	Calculates payment for the Hospital QIP year-end provider payment.	2022-2023 fiscal year-end performance
PQD User Activity	Monthly HEDIS® and QIP dashboard clicks, internal and external (PCP QIP)	Monitors internal and external provider user clicks in HEDIS® and QIP PQD dashboards.	N/A
Well Care Dashboard – Internal View	Custom table for well-care claims for members in measure age ranges	Reports by provider for well visit dates of service for assigned and special members. Internal staff access through PQD.	N/A
Preventive Care Reports – Provider View	Custom table for well care claims and CIS and IMA claims and California Immunization Registry (CAIR) data	Member-level contact information, includes all well care, IMA and CIS DOS for assigned members. Priority flags for member outreach based on age.	Link added for provider access May 2023.Daily refresh in 2023 through 2024.

Provider Network Quality Improvement Support and Initiatives

QI TRILOGY

Quality & Performance Improvement Initiatives and Projects

Overview

In 2023-2024, our Quality Improvement (QI) Team continued to focus on priority measures for Partnership HealthPlan of California, guided by performance indicators from the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) and the National Committee for Quality Assurance (NCQA) accreditation measures.

We made significant strides in understanding Health Equity (HE) accreditation readiness, laying the groundwork to address identified gaps and aiming for 2025 Health Equity Accreditation. Additionally, we began developing a Dual Eligible Special Needs Plan (D-SNP) product line and its accompanying Model of Care (MOC).

Considerable efforts were dedicated to executing Partnership's geographic expansion. Our QI staff invested substantial time and travel to engage early with providers in the Eastern Region, preparing sites and orienting them to data tools and program expectations. This initial engagement is the precursor to a comprehensive effort that will continue as more data becomes available and as organizations adapt to providing quality care to Partnership members.

Post-pandemic challenges related to COVID-19 have led to significant changes in the provider network, including mergers, acquisitions, and closures. The pandemic accelerated clinician retirements and reduced services, particularly in areas like obstetric care. While some quality measures have rebounded to pre-pandemic levels, others, such as vaccination rates, continue to decline due to shifting public messaging on efficacy and importance.

Our QI Team intensified efforts in various tiers of engagement through our Enhanced Provider Engagement (EPE) strategy. We assessed, supported, and coached lower-performing sites, developing tailored interventions designed to address foundational issues. Support was also extended to organizations seeking state-directed payment funding for equity and practice transformation initiatives. Our commitment to the Improvement Academy trainings, joint leadership meetings with major provider organizations, practice facilitation, mandated work collaborations, and other ad hoc support remained steadfast. The focus of this support was on closing care gaps through clinical and operational workflows, fostering a culture of quality within provider leadership, and building capacity for quality improvement within provider teams.

Internally, QI collaborated closely with key stakeholders, including Population Health, Pharmacy, Behavioral Health, Medical Directors, and regional leadership on strategic efforts, such as direct member engagement.

Quality Measure Score Improvement (QMSI) workgroups were expanded and optimized to address evolving DHCS MCAS and NCQA Health Plan Accreditation (HPA) measure sets in Pediatrics, Chronic Diseases, Medication Management, Behavioral Health, Women's Health, and Perinatal Care. These workgroups focused on measures included in the DHCS Quality Withholds, particularly "Kids and CAHPS®" preventative measures, which are expected to require ongoing effort. Through collaboration with internal staff and external partners, such as Aliados, the Health Alliance of Northern California (HANC), and North Coast Clinics Network (NCCN) consortia, we piloted, scaled, and spread improvements across measures including breast cancer screening, childhood immunizations, adolescent immunizations, and well-child visits.

Partnership incentivized improved performance and the adoption of best practices through Quality Incentive Programs (QIPs), targeting Clinical and Non-Clinical measures aligned with NCQA Health Plan Accreditation (HPA) and DHCS Managed Care Accountability (MCAS) sets. Enhancements to data tools improved visibility and transparency into QIP performance gaps, contributing to notable improvements in measures such as Breast Cancer Screening and Diabetes – HbA1C Good Control from MY2022 to MY2023.

These combined efforts have positioned Partnership HealthPlan of California and our provider network to deliver high levels of care and support to our members.

Quality Measure Score Improvement

The Quality Measure Score Improvement (QMSI) effort continues to better coordinate service and performance across the organization and to raise Partnership's overall performance in quality measures, as defined under DHCS MCAS and NCQA Health Plan Accreditation (HPA). This effort involved team formation under QMSI to encompass all current and potentially future accountable measures by measure family within each workgroup team: Pediatric, Chronic Diseases, Medication Management, Behavioral Health, Women's Health and Perinatal Care. Each workgroup monitored and reviewed all measure performance where data was available, assessed current improvement efforts, identified gaps and initiated new performance improvement activities.

QMSI workgroups consisted of cross-functional teams led by Quality and included representation from across the organization, such as: Care Coordination, Claims, Health Education, Office of the CMO, Pharmacy, Population Health, Provider Relations, Quality and/or regional leadership. The following summaries include what each measure-family QMSI Workgroup Team achieved in 2023-2024.

Improvement Team Workgroups

Medication Management

The medication management workgroup engaged the pharmacy teams in both regions, reviewed performance scores for relevant measures, and narrowed down the measures of interest to the following:

1. Statin Adherence 80% project (SPD=Statin therapy for Patients with Diabetes): encourage members to refill their statins on time
2. ADD measure project (ADD=ADHD medication monitoring): provider intervention including faxes to document the first fill of ADHD medication with a reminder to schedule the follow up within 30 days
3. POD (Pharmacotherapy for Opioid Use Disorder) measure: Fax intervention to both pharmacy and providers to inform when a member is three (3) days late refilling buprenorphine to prevent late fill
4. PCE (Pharmacotherapy management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation) measure project: fax to provider when member has a recent COPD exacerbation Emergency Department (ED) event to inform provider as well as provide fill history and any gaps in care noted
5. AMR (Asthma Medication Ratio) Pilot analysis: Registered Pharmacist (Rph) outreach to members who have had a recent Asthma ED visit to consult on asthma self-management and medications with follow-up calls as well as notification to the PCP regarding the ED visit, fill history and recommendations.

Pharmacists had an introduction session to Plan-Do-Study-Act (PDSA) cycles and met regularly as subgroups to create workflows, build templates, prepare updates, etc. The workgroup met about once a month. All projects are

currently in a completed hold status pending next steps planning due to significant decreases in pharmacist staffing. Below is a highlight of activities for the measure subgroups:

Subgroup 1: Statin Therapy for Patients with Diabetes (SPD) Adherence Project:
The intervention for this measure was to address statin adherence rates for members who do not meet the SPD – Adherence 80% measure requirements. Pharmacy identified members and pharmacies on the gap list to target and contacted pharmacies to explain the project and confirm engagement and willingness to participate. Members with Diabetes Mellitus (DM) aged 40-65 with a PDC (proportion of days covered used to measure medication adherence) of 70% to 84.9% or greater were targeted. Project was implemented as of September 18, 2023. The project consisted of a fax or email notification sent out once weekly to four (4) participating pharmacies with members who were past due or would be due for a statin fill in the next seven (7) days in an attempt to help pharmacies readily identify and engage the members to refill their statins on time. Outcomes were tracked two (2) weeks after the email/fax was sent out to determine effectiveness. 67% of the notifications sent to pharmacies resulted in a refill. 57% of members requiring refill reminders who had an initial PDC between 70% to 84.9% had a final PDC of > 80% by December 31, 2023.

Conclusions and thoughts:

- Small sample size and lack of control group limits conclusions drawn.
- Only pharmacies with low prescription volume had time to participate.
- Refill rates for statins appear to improve when notifications were sent.
- May increase PDC for members with an initial PDC of 70% - 84.9%.
- Intervention period of at least 180 days would improve chances of reaching PDC over 80%.
- Can be conducted by a pharmacy technician with pharmacist oversight.
- Obstacles are pharmacy buy-in needed, only targets small number of members, and difficultly reaching members.
- Consider an approach were all pharmacies receive a quarterly report showing which of their patients are late on refilling their statin. The pharmacies can decide on whether or not to address the late refills.

Subgroup 2: ADD measure project (ADD=ADHD medication monitoring) Initial Visit
The goal of this project was to improve timely ADHD follow-up visit rates for children newly prescribed and dispensed an ADHD medication by sending a fax of 1st fill with 30-day appointment reminder. The team utilized weekly ADHD new start reports generated by Health Analytics to identify Partnership primary members ages 6 - 12 years old that have filled a new ADHD medication. Each week, the Pharmacy Team sent fax notifications to prescribers alerting them that their patient has filled a new ADHD medication, and encouraging scheduling a follow-up appointment within 30 days of the medication fill date. A follow-up call was made after the fax was sent to confirm receipt. In this case, faxes instead of mail were used due to the time sensitive nature of the project. Faxes contained member-specific information, such as medication name, fill date, as well as a reminder to the prescriber to schedule a follow-up appointment within 30 days of starting ADHD medication treatment. Note, the fax also included the date that the follow-up appointment should be completed by based on RX claim history. Initially the intervention was aimed at targeting lower performing prescribers. This was defined as prescribers having at least five (5) members that met the inclusion criteria for ADD measure within a six (6) month lookback period (IPSD July 2022 - January 2023), based on the ADHD weekly new start reports, and performed below the Minimum Performance Level (MPL) (44.51%) based on follow-up visit claims data.

We began sending faxes March 8, 2023. After sending the fax, a follow-up call was placed to confirm receipt, ensuring the correct fax number was on file. Beginning July 28, 2023, faxes were sent to all members identified in the weekly ADD new start report (i.e. no longer limited to low-performing providers).

A total of 332 faxes were sent on behalf of members from March 8, 2023 through December 29, 2023. A total of 145 of those members received appropriate follow-up care with their prescriber within 30 days of starting their new ADHD medication, which translates to a rate of 43.67% for the intervention group. This is an improvement from the baseline rate of 40.09% (rate from MY2022). The results suggest that continual communications with prescribers through these faxes may be beneficial in ensuring appropriate and timely follow-up care for these children.

Subgroup 3: POD (Pharmacotherapy for Opioid Use Disorder) measure project

The Pharmacy Team identified members on buprenorphine med for opiate use disorder. The focus of this project was on pharmacy outreach via fax, using daily reports to identify those who are three (3) days overdue. Once identified, a fax was sent to the dispensing pharmacy to have them evaluate and refill medication, if appropriate. We also included a survey in an attempt to better understand pharmacy workflows. The goal was to achieve 10% of identified members, whose pharmacy received a faxed letter from Partnership, filling a buprenorphine-based medication before the 8th day mark (per the POD HEDIS® measure). Between September 18 – September 22, 2023, over 190 claims were reviewed, 80 members identified and 74 letters were generated and faxed. Thirty (30) of the members had a claim within five (5) days of the fax, thereby meeting the goal of a 10% fill rate. Four (4) pharmacies returned the survey with notes ranging from fill performed, to unable to contact, and cannot contact for refill of controlled substances. It was noted that most were new RX's issued so possibly no refills, needing appointments, etc.

PDSA two (2) involved a provider notification pilot requested by the Senior Manager of Behavioral Health for a small group of prescribers to notify them when their members are late so that they can better address timeliness. In total, 14 letters were sent, with 31 members on the tracker who were removed when a fill was identified. Approximately one (1) or two (2) members were added per day.

PDSA one (1) involved pharmacy outreach via fax. The intervention was conducted between September 18 and September 22, 2023:

- 77 members were identified for the intervention and their dispensing pharmacies received a faxed letter.
- 28 of 77 members (36.4%) had a fill within five (5) days of faxed notification (by day seven (7))
- Four (4) of 77 faxes were returned by the pharmacy with the survey completed.
- Last year, this measure was in the 20% range; meaning over 70% of qualifying members have a gap and fail the measure. After this project, there was a 35% fill rate, demonstrating evidence of some improvement.

PDSA two (2) involved prescriber outreach via fax. Five (5) prescribers from New Life Clinic agreed to participate. This intervention was conducted between September 28 and October 27, 2023.

- 24 claims (for 17 members) were identified for the intervention and the prescribers from the New Life Clinic received a faxed letter. Due to scheduling conflicts, two (2) of the 24 faxes were sent late.
- Six (6) of the 22 claims (27.3%) had a fill within five (5) days of faxed notification (by day seven (7)).
- Zero (0) of 24 faxes were returned.
- Control group is no intervention: 50 members were identified as being at least three (3) days overdue for their buprenorphine medication. 12 of 50 members (24%) had a fill by day seven (7).

Summary of results: It would appear that pharmacy fax intervention performed better than no intervention (36.4% vs 24%) and provider fax intervention did not perform better than control (22.7% vs 24%).

Subgroup 4: PCE (Pharmacotherapy management of COPD Exacerbation) measure project
The goal of this project was to improve COPD disease management by ensuring members have correct medications to avoid future exacerbations. This intervention started in January 2022 and moved to implementation in March 2022. The aim was to increase the rate defined by the PCE steroid bronchodilator measure. During the first collection period, 213 faxes were sent, with 127 care notes left. Some improvements in measure performance have been observed for this year. This project also looked at the percent of members who had an office visit within 30 days, an acute care gap fixed, maintenance gap fixed, and repeat hospital within 90 days. Improvements in some outcome measures were observed, but not in office visits. This project is running with lower enrollment due to staffing, permitting spot check analysis going forward. Updated results for the last six (6) months are not available yet. This project relies on Collective Medical's COPD exacerbation report within seven (7) days of ED discharge. A fax is then sent to MD to notify, provide a fill history, and any fill gaps observed per guidelines/recommendations, as well as acute management. The staff Rph also leaves a care note in Collective Medical (CM) as well.

Results from the first year show improvements in acute care (PCE) gaps, improvement in maintenance care gaps, and lower subsequent rate of ED visits. Results from a Care Note analysis indicate higher likelihood of being issued both PCE medications in members who have previously had a Care Note on file.

Subgroup 5 AMR (Asthma Medication Ratio) Pilot analysis
This intervention looked at members who appear on the Collective Medical 72-hour asthma ED event report, with an ED discharge within seven (7) days, who are 18 and older. The goal was to improve AMR HEDIS® measure performance and lower repeat ED visit/hospitalization among members reached and educated, compared to those who were not reached. The campaign enrollment was for a six (6) month time span, from August 2022 through February 23, 2023. During this time 226 members were added to the campaign. Enrolled members were followed for six (6) month through August 2023, and were provided member education and asthma plan. Providers were faxed to inform of ED fill history, ED visit, recommendations and asthma action plan. Each member received follow up calls at one (1) and then approximately three (3) months after their initial ED visit. For each enrolled member, outcome data was recorded at six (6) months from their initial ED visit. From August 23 to September 23, 2023 50 members were enrolled, 19 of them received outreach and 31 of them were unable to be reached. The project team is comparing AMR, repeat ED visits, hospitalizations, PCP visits and positive changes in controller medications between the two (2) groups.

Results to date: 228 members were enrolled; 83 members were reached. 129 members were not reached and made up the control group. 179 members were eligible for final data collection and included 65 members who received a phone call and 114 members in the control group.

- 38% of members were reached for the initial call (83/216)
- members who agreed to a one (1) month follow up call equaled 96% (80/83)
- members who completed the one (1) month follow up call equaled 45% (36/80)
- members who agreed to the three (3) month call equaled 88% (32/36)
- members who completed the three (3) month follow up call equaled 53% (17/32).

The percent of members at the AMR target at six (6) months was 56.92% versus the control at 36.84%. The members not at AMR target at baseline, who achieved target by six (6) months, equaled 42.50% versus 23.60%. Members

with an AMR that improved over six (6) months was 47.69% versus 33%. The change in the average number of PCP visits was 1.09 versus 0.22 in the control. The change in average number of ED visits was -.015 versus 0.018 in the control. The change in average number of hospital visits was zero (0) versus 0.0614 in the control.
Compared to the control group (members not reached), members who received a phone call had a higher chance of increasing their AMR after their phone call. Members also showed an increase in PCP visits and a decrease in ED visits for asthma in the follow up period.

Chronic Disease

The Chronic Disease Workgroup reviewed the assigned measures to develop strategies around the measures with the greatest performance gaps. Measures of focus for this year included: HbA1c (glycohemoglobin) Poor Control (>9%) (CDC), Controlling High Blood Pressure (CBP) and Colorectal Cancer Screening (COL). Throughout the year, the group worked to document disparity data for all measures assigned to the workgroup.

Colorectal Cancer Screening: Cologuard

To focus on colorectal cancer screening, the workgroup continued the collaboration with Exact Sciences, maker of Cologuard (FIT DNA test), through a pilot test which began in June 2023. Partnership engaged interested sites, which resulted in the completion of four (4) successful bulk order cycles in 2023. This program expands colorectal cancer screening access by offering a bulk order option to sites for eligible members not seen annually by their primary care provider. Currently, 27 distinct parent organizations in all three (3) regions are participating in various planning and deployment stages. Initial pilot results show increased testing but overall evaluation of impact on Colorectal Cancer Screening rates remains pending.

Promoting Pharmacy Technicians to become Community Health Workers

Community Health Workers (CHWs) are a well-documented approach to bridge the gap between patients and the healthcare system. This is especially true for people managing chronic diseases like hypertension and diabetes. Beginning January 8, 2024, California allows certain organizations to supervise and bill Medi-Cal for CHW services. Because this is a new benefit, it requires some additional effort to build a pipeline and infrastructure to maximize potential. The workgroup chose to focus their efforts on promoting pharmacy staff to train as and perform the role of CHWs, which has been shown to be effective in other states. With collaboration from Partnership Pharmacy Department, a CHW training specifically designed for Pharmacy Technicians was identified and six (6) independent pharmacies were recruited to participate in a pilot. The pilot will involve having a Pharmacy Technician trained as a CHW, credentialed as a Supervising CHW, and start providing CHW services to pharmacy customers. Partnership funded participation in the training. This pilot will continue into next year followed by a pilot evaluation.

Best Practices for at-home Blood Pressure Monitoring and Member Engagement

The Partnership Medical Equipment Distribution Services (PMEDS) program distributes medical devices to eligible members based on diagnosis of related conditions. This program has been distributing blood pressure monitors to members with diagnoses of hypertension and other related conditions since 2020. Research from the Million Hearts Self-Monitored Blood Pressure Program (SMPBP) indicates blood pressure monitors can be effective in reducing blood pressure rates when used alongside patient education, timely monitoring, medication control, and related nutrition, smoking or lifestyle interventions. We analyzed data from CY2023 comparing end of year Controlling Blood Pressure (CBP) measure compliance (values less than 140/90) for members with and without blood pressure monitors. Evaluation of this data presented barriers in documentation, availability of useable data from multiple sources, manual adjustments to data, and data volume. Upon analyzing data from PQD (Partnership Quality Dashboard) and a more comprehensive data set from electronic data warehouse (EDW), a significantly higher

number of members without blood pressure monitors had numerator compliance for the CBP measure compared to a sample population of members who have blood pressure (BP) monitors. The work group has collaborated with a PCP who has experienced success in this measure by utilizing the PMEDS program. Their work flows and interdisciplinary care approach has been documented. The work group will consider piloting a similar interdisciplinary approach with interested PCP Quality Incentive Program (QIP) organizations to increase measure success annually. This may increase measure success by implementing workflow best practices alongside the PMEDS program.

Evaluation of Discrepancy between Quality Incentive Program Data and HEDIS® Data by Practice.
At the beginning of this year, the QMSI Chronic Disease workgroup noticed that there was a considerable difference in HEDIS® performance and QIP performance in certain measures in certain counties. An analysis was conducted to understand the difference and see if there are lessons to learn to more accurately reflect our HEDIS® performance. The analysis included providers in Napa and Solano Counties and discrepancies between HEDIS® and QIP in their Controlling High Blood Pressure (CBP) measure and A1C Poor Control. The results of the analysis were that there were two (2) provider organizations that had showed a statistically significant difference between their QIP performance and what their sample HEDIS® performance showed in the CBP measure. In both cases, the QIP performance was higher. A discussion with the larger of the two (2) organizations revealed a significant difference in the QIP data gathering methodology and the HEDIS® data gathering methodology. Members who were considered numerator compliant at the time of data uploads had subsequent blood pressure readings which were above the measure threshold. Reminding PCP QIP organizations to follow up on blood pressure control throughout the year and after initial data uploads can help to mitigate this issue in the future. This analysis showed that no changes to either system were necessary.

Behavioral Health
After an assessment of performance for all Behavioral Health measures, the following deliverables were identified as priorities of focus for the 23/24 year:

- Review performance rates for measures in communication with Health Analytics Team to ensure regular dissemination of rates throughout year.
- Create a repository to document all current or previously conducted work associated with measures included in the Behavioral Health Workgroup set, so there is a resource that can be referred to for opportunities and key learnings. All Behavioral Health grants and performance improvement projects are outlined in this document.
- Track Behavioral Health data, specifically focusing on the data sharing component that is included in the Memorandums of Understanding (MOUs) that will be executed with County Behavioral Health departments.
- Partnered with Population Health to develop and evaluate a program to address DHCS requirements for depression measures (DMS, DRR, DSF, CDF) and tracked progress through the workgroup.
- Completed DHCS mandated fishbone diagrams for Northern and Southern regions assessing root causes for lower rates of follow-up visit for mental illness within 30 days of discharge from ED.
- Evaluated and documented discharge process at Partnership's EDs related to discharge with a diagnosis of mental illness
- Evaluated provider utilization of ER Notification and Alerts features for behavioral health in Partnership's *Provider Online Services*.
- Tracking of DHCS Nonclinical Performance Improvement (PIP) related to Follow-Up After Emergency Department Visit for Mental Illness (FUM).

- Tracking of Partnership's participation in DHCS Behavioral Health Collaborative.

Pediatric Medicine

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

School-Focused Immunization Clinics

With the continuing struggle to increase adolescent immunization rates, Partnership engaged in an initial pilot in August 2022 to engage with a local school to conduct a school-focused vaccine clinic in Shasta County. The pilot was successful and resulted in the following clinics in the 2023-2024 school year:

August 2023 – Expansion of the initial Saturday-clinic pilot with Enterprise Elementary School District (EESD) from 2022:

- Location: Shasta Community Health Centers (SCHC), close in proximity to the school locations
- Eligible students: Entering 7th grade and new for this first time as of this event - students entering school for the first time (3-6 year olds)
- Vaccinators: SCHC and Anderson RX
- Format: Special event day – Hosted meal, snacks, giveaways
- Students vaccinated: 77
- Key Takeaways/Lessons Learned:
  - Be prepared to vaccinate early/one (1) hour before the official event start time (long line formed before the start time)
  - It was an easier process for Anderson RX to vaccinate students who were not established patients of SCHC. Consider Anderson RX to be the sole vaccinator for future events. SCHC willing to host at their clinic again.
  - Many volunteer staff needed to make this event-day work – Over 16 volunteers, and lesson learned that more staff is needed for CAIR-2 look-up and vaccination.
  - Don't underestimate the elective vaccine stock needed – Ran out of stock for Human Papillomavirus (HPV) and Meningococcal.
  - An August event before the start of school is challenging for students to show up and requiring vaccination look up, analysis and insurance verification. During the school year would allow for more preparation in advance (schools can coordinate who is attending in advance and vaccination analysis and insurance verification can be done before the event day).
  - Vaccines for Children Program (VFC) needs more flexibility in their strict requirements of not allowing frozen stock to be transported. This resulted in Anderson RX using their private stock to vaccinate several VFC-eligible students entering school, with Partnership's promise to reimburse them for their expense stock.

August 2023 – New community clinic for "back to school" immunizations in the city of Anderson, taking place the week after the EESD clinic:

- Location: Anderson RX hosted the event.
- Eligible students: Entering 7th grade and entering school for the first time (3-6 year olds).
- Vaccinator: Anderson RX
- Format: Special event day at the local pharmacy for any students to be vaccinated, hand-outs.
- Students vaccinated: 62

- Key Takeaways/Lessons Learned:
  - Be prepared to vaccinate early/one (1) hour before the official event start time (long line formed before start time).
  - Consider addition volunteer staff for California Immunization Registry (CAIR) look-up and vaccination.

Three (3) "during school" vaccine clinics in April and May of 2024 at EESD

- Locations: School campuses, all in Redding (Mistletoe, Parsons and Boulder Creek).
- Eligible students: 6th graders (entering 7th grade in August).
- Vaccinators: Anderson RX and School Nurses (school nurses were pre-approved to be vaccinators under Anderson RX, who provided the vaccine stock).
- Format: Pre-event education was delivered to all 6th grade classes a couple of weeks prior to their event day. After the education was completed, event registration forms provided by Anderson RX were sent home, along with the educational materials provided in class. Anderson RX was able to analyze previous vaccines and verify insurance prior to the event day. The day of the event, students were called one by one from classrooms to the designated, temporary on-campus clinic location, provided their vaccine and snacks, and sent back to class.
- Students vaccinated: 121
- Key Takeaways/Lessons Learned:
  - Education was key to the drastic uptake in HPV and Meningococcal acceptance. 105 Tetanus, Diphtheria, Pertussis (Tdap) was administered, 80 HPV and 77 Meningococcal were also administered (compared approximately on ¼ of students in prior events accepting anything other than the required Tdap vaccine). It is hypothesized that the influence of the student to sway parents to allow them to accept the other, non-required doses after receiving education about them (HPV and Meningococcal) is underestimated.
  - Pre-event sign-ups were key to make the flow of the event day smooth and efficient, however the school shared it is not possible to do this in the August event, prior to the start of school. In the 2024-2025 school year, the August event will be more of a "make up" for vaccines for school entry.
  - Based on the success this year, will look to repeat these on-site school events in the 2024-2025 school year. For expanding to other schools/counties, may need to have a similar evolution, starting off-campus.
  - Only school nursing *enthusiastic* support, promotion, engagement, coordination and communication with families made this event successful. Without such a proactive partner, this would not be successful.
  - California needs more pharmacy VFC providers who are nimble and capable to conduct these types of events, as they can easily vaccinate both private pay and VFC-eligible community members, where many times Public Health and Primary Care providers cannot vaccinate anyone, regardless of their insurance status. Pharmacies also need more reimbursement for events as part of their billing structure.

Launch the State-Mandated Performance Improvement Project (PIP) Focused on Early Well-Care in Black/African American Members in Solano County

DHCS assigned Partnership a Health Equity PIP focused on the Well Child Visit Birth-15 Months (W30-6) HEDIS® Measure for the 2023-2026 time period, based on not meeting the Minimum Performance Level (MPL) of 50th percentile for the W30-6 measure in any Reporting Unit. Partnership and DHCS agreed to focus the PIP on African American rates of completion of the W30-6 measure. Partnership selected Solano County as the population of focus for this measure based on several factors. Solano County has the highest member population of any of

Partnership's counties with a total of 141,387 members as of July 2023. Solano County's Black/African-American population represents 17.5% of total members (24,757), the highest Black/African-American population of any county served by Partnership. The HEDIS® denominator population represented in Solano County's 0-15 months' age for Black/African-American members was 168 in 2022.

During this fiscal year Partnership staff completed a Root Cause Analysis by facilitating brainstorming sessions with three (3) unique groups-SQIP-I, Partnership internal QI, and Partnership interdisciplinary. Responses were then analyzed for themes and occurrences. The largest identified themes impacting 0-15-month well-baby visits for Black/African-American children in Solano County are:

- Member education
- Trust and cultural barriers
- Access
- Provider specific issues

Results from this analysis have been used to further discussions about potential interventions. Other PIP activities to date have focused on planning activities and making a data collection plan. Our first PIP submission to DHCS on September 1, 2023 details the data collection plan, which will use administrative (claims) data exclusively to measure baseline (January 1, 2023 – December 31, 2023) and measurement rates (January 1, 2024 – December 31, 2025) for completion of the well child visit series.

This PIP's initial intervention will likely address delays in Medi-Cal enrollment, which have a significant impact on all families, including African American families, continuity of care with their chosen PCP and on Partnership's ability to capture all well-child visits in babies' first 15 months of life. Since the W30-6 HEDIS® measure is an administrative measure by NCQA's definition, Current Procedural Terminology (CPT) codes on claims are the only way for Partnership to count a well-child visit as completed. One barrier to success with the W30-6 HEDIS® measure is that most newborns are not enrolled in Medi-Cal until their second month of life and often later. Often times, Managed Care Plans (MCPs) have a difficult time linking a baby's Medi-Cal ID with data about their early care captured under Mom's Medi-Cal ID. This can also result in babies being auto-assigned to a PCP that they have not been seeing up to that point, causing disruptions in care.

The delays in Medi-Cal enrollment do not only cause undercounts for well child visits within the W30-6 HEDIS® measure, but also have a disruptive impact on babies' healthcare throughout our provider network, and erode the relationship between the family, clinical team, and health plan. Partnership continues to explore new solutions to help overcome barriers in completing timely well-child visits and measuring well-child visits completed but difficult to capture under W30-6 HEDIS® measure. This will inform this workgroup's improvement activities in 2024-2025.

Improve the Completion of Lead Screening

In fiscal year 2023-2024, the Lead Screening sub-committee continued its work to increase provider compliance with lead prevention program requirements. A Partnership Medical Director, who is both a Pediatrician and former County Public Health Officer, remained the clinical lead on this initiative. The primary goal of the workgroup was to increase age-appropriate lead screening rates for children enrolled in Partnership HealthPlan. This committee developed the following strategies to build on the previous year's efforts:

Strategy one (1): Establish the "Partnering for Pediatric Lead Prevention (PPLP), A Point of Care Testing Initiative Increase practice access to lead Point of Care Devices (POC)."

a. Create a lead POC inbox for all lead-related provider questions and input.
b. Provide POC devices to selected clinical practices, free-of-charge for a 12-month period. At the end of that period, practices take ownership of the device if they meet the testing benchmark, ensuring on-going access to on-site testing. Prioritization is given to low-performing practices and practices without current access to POC testing (or other established testing which allows specimen collection on-site).
c. Partnership's lead initiative project coordinator worked closely with the Lead Care II device sales representative to offer timely training in-person and virtually to ensure the clinic staff were equipped to collect and run specimens.
d. Launch Round one (1) of the initiative in August, 2023 with an informational webinar as well as outreach through the CMO Newsletter and Partnership Provider webpage. 12 applications were approved in this first round.
e. Partnership invited POC-awarded practice clinical and QI leads to engage in small "one on one' meetings with the Partnership project coordinator and medical director to talk about processes, reinforce best practices and review all required lead prevention components of care including documentation of anticipatory guidance at all well-child visits from six (6) months to six (6) years, lead testing at 12 and 24 months (with catch-up testing as outlined by the California Department of Public Health (CDPH)), follow-up of abnormal results and documentation of parent refusal to test with a parent signature. Additional follow-up meetings were scheduled to look at current lead data and trouble-shoot any challenges.
f. Launch Round two (2) of the initiative with an informational webinar in March, 2024. Applicants included those in Partnership's new expansion counties. A total of 26 POC devices were awarded in Round two (2), with devices expected to be delivered in June/July of 2024.
g. Planning for Round three (3) for 24-25 is underway with budget funds requested to support up to 35 additional POC devices.

Strategy two (2): Provide lead prevention education to clinical practices that see children, including best practices identified through outreach to high and low performing practices in 2022-2023.

a. Include lead prevention information on Provider and Member web-pages.
b. Include information about lead prevention and the POC initiative in the CMO newsletter.
c. Include information about lead prevention and the POC initiative in 2023-2024 Medical Director Regional Forums, presented by the Partnership CMO.
d. Participate in CDPH's "Update on The Prevention of Childhood Lead Poisoning: Why Physicians Should Counsel on Lead and Screen for Lead Exposure," webinar presented by Dr. Jean Woo, Public Health Medical Officer, Childhood Lead Poisoning Prevention Branch of the CDPH. This is offered twice annually for providers across the Partnership region. The Partnership Medical Director also delivers content on Partnership's lead testing initiative in this webinar including best practices and POC testing.
e. Provide a cover letter detailing, "Pediatric Lead Testing Requirements," along with quarterly lists of age-appropriate, pediatric enrolled members requiring lead testing.

Strategy three (3): Ensure education for clinical practices includes both information on and the importance of billing for lead testing so that testing numbers may be captured.

a. Earlier project activities identified clinics that were not submitting or inconsistently submitting claims for lead testing, leading to an under-reporting of testing performance. Lead-related education activities now include coding and billing specifics.
b. Follow up on claims data submission for practices participating in the POC testing initiative.

Strategy four (4): Increase member and provider awareness of the importance of lead prevention and lead testing.

a. Media release sent out March, 2024, in the wake of news articles about lead contamination in fruit pouches, to emphasize the possibilities of lead exposure in young children and the need for testing.
b. CMO newsletter in March, 2024, included article reminding providers about lead exposures occurring through food products and other sources with a need for awareness and testing.
c. Parent Newsletter, Winter and Summer 2024 to include lead-related information.
Partnership provided a lead webinar for West County Clinics provider group at the request of the clinical lead May, 2024.

Strategy five (5): Engage at the State level on Lead Prevention.

a. Partnership's Medical Director and Lead Prevention Initiative lead will be a member of the newly formed California Lead Advisory Committee.
b. Partnership is directly working collaboratively with the California Childhood Lead Prevention Program (Dr. Jean Woo), on provider education for the Partnership network.

QI Measures and Claims Investigation Pilot

This was a micro pilot working with QI Analyst and QI Manager to research coding and billing practices for underperforming sites specific to well-child visit (WCV) and W15 measures. Investigation included leveraging the Missed Opportunities Dashboard for two sites: Fairchild Medical Center and Mountain Communities.

The results of research did not identify specific coding errors, but did identify several non-numerator compliant members that had visits during the measurement year with a potential to be converted to a well-child visit. These missed opportunities were shared with the pilot sites along with best practices for addressing opportunities for incorporating preventative care during all patient visits.

Increase HPV and Flu Vaccine Uptake Through New Provider Incentives for Early Administration

In order to address continuing low rates of childhood and adolescent immunizations, the Pediatric workgroup proposed 2 new measures for the 2024 calendar year to incentivize family and pediatric practices for early administration of two (2) immunizations that are the most difficult to gain compliance for these two (2) measures: HPV and Influenza.

HPV incentive: This new unit-of-service measure will provide $50 per assigned member who completes their first dose of HPV between their 9th and 12th birthdays.

Influenza incentive: This new unit-of-service measure will provide $50 per assigned member who completes their initial influenza two (2)-dose series by 15 months of age *and* receives both does within 60 days of each other.

These incentives are currently part of Partnership's PCP Quality Incentive Program (PCP QIP) for 2024.

Promote Pediatric Group Well-Care Visits Through Expanded Provider Incentive

Group Well-Care Visits is one (1) proven strategy to increase completion of these important pediatric preventative care services early in a child's life. The Pediatric workgroup proposed implementing a new measure in Partnership PCP QIP to incentivize providers to conduct group well-visit cohorts in the 2024 calendar year, focusing on the 0-15-month old population. This incentive was approved and is currently part of the 2024 PCP QIP unit-of-service measure, as an expansion of the existing "Peer-Lead Group Visits" measure.

Pediatric and Family practices will be incentivized $1,000 for each cohort of group well-care visits. Each group cohort must meet at least four (4) times across 15 months and have at least 16 members in total attendance. The maximum number of cohorts (groups) per year for reimbursement is 15.

Complete Participation in the Centers for Medicare and Medicaid Services (CMS) Affinity Group to Improve Baby Well-Care Visit Completion

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

The California state affinity group's focus was to positively impact well child visits in the first month of life, and for each plan to increase their well child visit rate 10% over baseline, while more specifically focusing on visits in the first month of life. Partnership's aim was that 40% of infants whose parents were impacted by the intervention would complete at least one (1) well baby visit in the first month of life. For this intervention, Partnership partnered with NorthBay Hospital who shared their list of appointments made before discharge for Partnership members and Partnership's Population Health Team contacted members after discharge. Through this intervention, Partnership found that 86% of members that were reached by Population Health attended their appointment that had been scheduled at discharge. The Population Health Team was also able ensure members received education on the importance of well-baby visits, make sure their next appointment was scheduled, and follow up with members that did not attend that appointment to assist them in rescheduling if needed, which was ultimately successful.

Participation in this program continued through December 2023, and at its closure, CMS and DHCS invited Partnership to present their findings at the IWC Affinity.

Launch Participation in DHCS/Institute for Healthcare Improvement (IHI) Collaborative to Improve Pediatric Well-Care Visits

In March of 2024, Partnership engaged in the launch of a one (1)-year, mandated collaborative led by DCHS, intended to improve access, coordination and equity across the communities we serve by initiating a focused effort to improve the completion of pediatric well-care visits, with a specific lens towards equity.

In order to foster learning at the managed-care plan level, the collaborative has required each plan to have an internal project team that meets regularly, as well as attends twice a month collaborative calls led by the Institute for Healthcare Improvement (IHI), and execute the phases of the project.

The front-line project work is conducted in partnership with a primary care organization who have agreed to participate in this program as a pilot partner. Their role is to work with their managed care plan to develop and execute the project phases:

1. Equity and Transparent, Stratified, and Actionable Data (April-May, 2024)
2. Understand Provider and Patient/Caregiver Experiences (June-July, 2024)
3. Reliable and Equitable Scheduling Processes (August-October, 2024)
4. Asset Mapping and Community Partnerships (November-December, 2024)
5. Partnering for Effective Education and Communication (January-March, 2024)

Outcomes from this collaborative will be reported in the 2024-2025 QI Program evaluation.

Women's Health and Perinatal Care

The Women's Health and Perinatal Care workgroup began the year analyzing the MY2022 HEDIS® performance for the 8 measures that are assigned to the group. The group looked at the change from the previous year and compared the performance in each sub region to the benchmarks set by NCQA. This analysis lead the group to prioritize work on the following measures; Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening; and Prenatal and Postpartum care. Later in the year, a large-scale disparity analysis informed the decision to add prenatal care among Native American members as an additional focused effort.

Breast Cancer Screening

Rates for breast cancer screening (BCS) declined in the years of the COVID pandemic (MY2020 and 2021) and were below the minimum performance level (MPL). The Southeast and Southwest sub regions performed above the 50th percentile benchmark in MY2022 and while the Northeast and Northwest regions' performance remained below the 50th percentile benchmark there is a preliminary improvement in the estimated data for MY2023. The major effort to improve BCS performance this year was focused on scheduling mobile mammography event days in our most rural, access challenged areas.

Mobile Mammography started off as a pilot in June 2022 as a strategy to increase PCP QIP breast cancer screening rates across provider organizations falling below the 50th percentile benchmark. Due to its success and positive feedback from providers and members, the Mobile Mammography Pilot officially launched from a pilot to a program in late April 2023. The first event days were set for July 2023. The program engages providers in increasing their BCS measure by inviting their Partnership members to participate in a Mobile Mammography event day to complete their preventative BCS. Mobile mammography events offer an alternative for women ages 50 - 74 who live in rural regions whose only other option for completing a mammogram require significant travel time and expense. The program has provided screening opportunities for women who have never had a mammogram before. Partnership continued to contract with Alinea Medical Imaging, the sole provider of mobile mammography services in Northern California.

BCS are at the provider organization's facilities, indoors using a portable unit or outdoors using full-service, self-contained 34' coach. Each unit type has specific space requirements. The 34' coach requires 8 – 10 uncovered parking spots, conveniently located near the front entrance for easy accessibility to patients and staff. The portable unit requires the provider site to have a private 10' x 10' space inside their clinic, typically an exam room, to conduct the screenings with a separate/private changing area or near a restroom.

Partnership outlined the following eligibility criteria for sponsorship consideration:

- Provider locations below the 50th percentile benchmarks (53.93%).
- Provider locations in imaging center "deserts" defined as areas where patients must travel long and/or difficult lengths to imaging centers.
- Provider locations with lack of access at nearby imaging centers. These are locations that although are near imaging centers, the imaging centers have long wait times for mammograms.
- Provider locations with at least 60 and ideally 90 Partnership members with mammogram care gaps to support a full event day, as Alinea requires a minimum of 30 completed screenings per event day.

These eligibility requirements were implemented in order to get the best return on investment.

Additional requirements of the provider organization for sponsorship included:

- A minimum of 30 patient completed screenings of which a target of 80% of completed screenings must be Partnership members.
- Provider organizations must do the patient outreach, appointment scheduling, appointment reminders and marketing for their event day.

Partnership supports the event days with event coordination support on behalf of the Mobile Mammography Program Management Team, and event attendance by our Population Health Team.

In FY 2023-2024 there were 67 Mobile Mammography event days with 27 provider organizations at 41 geographical sites. These events resulted in 1,528 completed mammograms for Partnership members. There was an overall no-show rate of 26%.

Cervical Cancer Screening

Cervical Cancer Screening performance improved in all sub regions from MY2021 to 2022 except the Northwest. The Southeast and Southwest regions achieved performance above the 50th percentile benchmark. Both the Northeast and Northwest sub regions did not achieve that level of performance.

A Cervical Cancer self-swab pilot launched in January 2024 with five (5) strategically selected primary care clinics in all four (4) sub-regions and of all different sizes. The scale of the pilot was to use 200 kits across the five (5) sites. The objective of the pilot is to develop lessons learned and workflows for allowing patients to collect their own cervical cancer screening swabs in conjunction with clinic staff. Three (3) of the five (5) sites started the pilot in either their street medicine or mobile clinic setting. The pilot was planned to wrap up at the end of May 2024 but is being extended by 12 weeks to allow more time to use all of the 200 kits. The most common barriers to using the test kits reported by the clinics is the process to register the self-swab kit for testing. This process is outside of their normal workflow, thus cumbersome to manage. The equally most common barrier is that patients are still reluctant to be screened, even when they can collect the sample themselves.

Perinatal Care

Performance in the Timely Prenatal Care Measure improved across three (3) of four (4) sub-regions between MY2021 and 2022. Performance in Postpartum Care improved or remained the same in each sub region from MY2021 to MY2022.

Provider Education and Engagement - Presentations with continuing education credits were offered for practices throughout 2023. The intended audience for the educational opportunities were practices that provide perinatal women's health services. Recruitment for this education was focused on practices who had either not participated in a prior year's training or those who expressed an interest in this education event. The objective was to educate providers about the Perinatal and Primary Care Provider Quality Incentive Programs' (PCP QIP) measures and Partnership resources to support members and practices in accessing the Partnership perinatal resources.

Partnership used their Quality Improvement Program and Medical Director newsletters to provide additional venues for provider education.

In Fiscal Year 2023/2024, the Women's Health Perinatal work group identified a need for targeted outreach to Native American/Alaskan Native populations. The complications and poor pregnancy outcomes occur at a significantly higher rate for these communities. Partnership reached out to clinical practices and tribal health systems to encourage them to access new funding for program development that would focus on the perinatal population. With active case management and stronger connections to Community Based Organizations, we anticipate that access to prenatal care will improve and connections to post-partum care will also improve. This program continues to understand, use and develop the resources that will ensure access to quality care for the Native American/Alaskan Native populations.

Access to obstetrical care reduced significantly in Solano County in 2022 and 2023 with a provider shortage. This led to severely constricted access to timely prenatal visits and placed significant burden on the local delivery hospital. A collaborative work group of all prenatal care providers was developed to respond to this urgency. The collaborative identified operational and communication barriers that were impeding access. They developed better systems of care across organizations and improved the standards and methods of patient related and professional communication. The Federally Qualified Health Centers (FQHCs) were able to add additional prenatal providers, one FQHC added new prenatal services which reduced average wait time for new patient appoint from six (6) weeks to one (1) week at most of the practices. With improved access for routine care throughout Solano County, the community hospital system is able to focus on high-risk care, which alleviates other access concerns.

Chlamydia Screening

The Southeast and Southwest sub regions performed above the minimum performance level in MY2022 as they did in MY2021. The Northeast and Northwest regions continue to show low rates of chlamydia screening in MY2022.

Activities to improve this measure in the past year included a new educational session for providers and initial querying of providers about contributing factors to low performance. The educational session included content on screening and treatment best practices and screening disparities by race/ethnicity. Practices indicated that there are complicating factors for chlamydia screening, especially among adolescents. The providers also reported challenges in implementing universal screening for chlamydia that relate to practice work flows and limited provider capacity for soliciting the appropriate history regarding sexual activity. Pilot tests are being planned for the next fiscal year.

New Dashboards in Development

During FY 2022 – 2023, the QI Team developed the Missed Opportunities Dashboard, a dashboard that highlights potential care gaps, with the goal of aiding the Primary Care Provider network in identifying these care gaps and to assist in addressing these gaps in future outreach, especially with focus on established members. For FY 2023-2024, this dashboard was expanded to include logic for all of the clinical measures included in the PCP QIP. This was then reviewed with provider partners to solicit their input and compare what was generated through the dashboard's logic to their provider Electronic Health Records (EHR). Providers identified use cases for this tool, which includes generating outcall lists for their staff or to be reviewed with clinical teams for pre-visit planning.

The QI Team also developed a dashboard to visualize Partnership's membership in the PCP QIP by level of engagement. Engagement on the dashboard is categorized, and ranges from no engagement (no claims over the last two (2) years) to the highest level of engagement (fully compliant for all QIP measures they are in a denominator for). The QI Team has provided demos to internal stakeholders for feedback, and have also begun to review with external providers for feedback. This work is closely aligned with the Reduced Missed Opportunities Dashboard,

and the QI Team is working to integrate these dashboards into a set of analytic tools with the goal of making these provider facing tools in 2025.

Quality Improvement Coaching

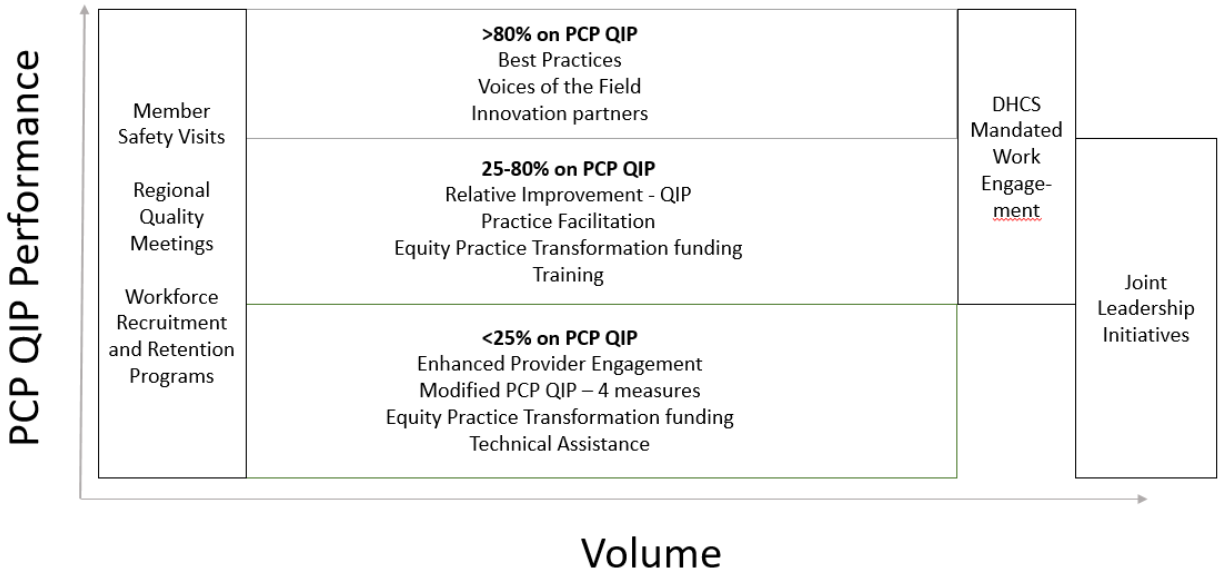
Partnership uses a practice's Primary Care Provider Quality Incentive Program (PCP QIP) scores on clinical measures as a proxy for assessing the strength of a practice's quality program. Each practice is assigned into one (1) of three (3) tiers based on their PCP QIP performance in the previous year, and each tier is associated with coaching and collaborative programs meant to maximize the capacity of the practice for success with the PCP QIP.

The diagram below visualizes the three (3) tiers of PCP practices based on past PCP QIP performance, and the coaching and collaboration programs associated with each tier.

The three (3) PCP practice tiers are:

1. Highest tier: Scoring over 80% of clinical points on previous year's PCP QIP
2. Middle tier: Scoring between 25-80% of clinical points on previous year's PCP QIP
3. Lowest tier: Scoring under 25% of clinical points on previous year's PCP QIP

PCP Practice tiers based on PCP QIP scores, and associated coaching/collaboration programs



Enhanced Provider Engagement and Modified PCP QIP

Enhanced Provider Engagement (EPE) and Modified PCP QIP are two (2) programs centered around Provider Organizations (PO) who are in the Low Performing Tier. These PO's often have significant infrastructure and workforce challenges, and are more likely to be located in rural or frontier areas with inadequate health system infrastructure, and to be serving communities who have historically had less access to healthcare resources. Practices in the Low Performing tier are more likely to have higher rates of leadership and workforce turnover, and a lack of dedicated quality resources and structures. Tribal health organizations are overrepresented in this

tier, partially because these health centers center their quality work around the GPRA, a quality measure set that is not fully aligned with Partnership's QIP.

In 2023, Partnership launched two (2) new tactics to improve the performance of POs who scored less than 25% of possible clinical points in the previous year's PCP QIP:

Enhanced Provider Engagement (EPE): Recognizing that practices who fall into the Low Performing Tier of the QIP often have significant core challenges with infrastructure, leadership, and funding, the EPE coaching methodology centers around the Building Blocks from UCSF's Center for Excellence in Primary Care. The EPE coaching program focuses on interventions that will impact core areas of a practice such as leadership engagement, use of data systems, empanelment, and clinical team formation.

Enhanced Provider Engagement consists of several stages:

- Completion of a Needs Assessment tool and corresponding Supplemental Survey
- Partnership summary and recommendation for impactful quality interventions, based on Needs Assessment and Supplemental Survey
- Coaching with planning and implementation of interventions designed to impact core quality improvement capacity and measure performance

Modified PCP QIP for Low Performing Providers: Partnership developed and implemented consequences for Primary Care Provider Organizations with persistent low performance in Partnership's PCP QIP. Provider Organizations who are assigned more than 1,000 Partnership members and who earned less than 25% of their clinical points for the previous year's PCP QIP are assigned the Modified QIP. The Modified QIP assignment includes several requirements for Provider Organizations qualifying, including:

- Reduction of QIP clinical domain measure set from 11 to 4 measures
- Required Executive meeting with PO's Board
- Required participation in Enhanced Provider Engagement coaching with PI Team
- Demonstrated improvement in QIP measures to 50% or more of clinical measure points to return to fill QIP measure set by next MY

2023 EPE and Modified QIP Goals:

- 80% participation by POs assigned EPE and Modified QIP

2023 EPE and Modified QIP Outcomes: Partnership assigned 11 Provider Organizations to Enhanced Provider Engagement and Modified QIP as the Phase 1 cohort. The 2023 cohort had the following outcomes:

81% of POs assigned EPE and Modified QIP engaged with Partnership and completed at least one (1) of the program activities – GOAL ACHIEVED

- 73% of POs completed a Needs Assessment
- 73% of POs also participated in coaching activities around opportunities identified by their Needs Assessment
- 56% of POs had a Partnership executive or senior leader present on Partnership's quality program to their Board

POs improved their 2023 PCP QIP scores by an average of 11.5%.

- Two (2) POs earned more than 50% of QIP points in 2023 and graduated back to the full PCP QIP in 2024.
- Three (3) POs improved their scores but earned less than 50% of QIP points in 2023, and will stay in the Modified QIP in 2024.
- Four (4) POs participated in Enhanced Provider Engagement coaching and activities but earned no points in 2023, they will stay in the Modified QIP in 2024 and will receive a percentage of their available QIP dollars upfront to support activities that will help them improve their QIP scores in 2024.
- Two (2) POs did not engage in the program at all in 2023. In early 2024 these POs were placed on a Corrective Action Plan (CAP) with Partnership and suspended from the PCP QIP. Partnership has offered these POs extensive engagement and coaching resources to improve their measure performance in 2024. POs that meet a benchmark on one Modified QIP measure in 2024 will be allowed to return to the Modified QIP as a first step to restoring their QIP program.

In addition, 13 POs who scored less than 33% of clinical points on their PCP QIP in 2022, and who are assigned at least 500 Partnership members, were placed in a Phase 2 cohort and were warned in Summer 2023 that they were at risk of being assigned the Modified QIP in 2024. These POs were also assigned Enhanced Provider Engagement activities. The Phase 2 cohort had the following outcomes:

- 75% of POs completed a Needs Assessment
- 66% of POs participated in coaching activities
- POs improved their 2023 PCP QIP scores by an average of 12.8%
- Eight (8) POs scored high enough to avoid placement on the Modified QIP in 2024

The PI Team continued the EPE and Modified QIP Team in 2024. The 2024 Modified QIP cohort consists of:

- Four (4) POs continuing the program
- Seven (7) POs entering the program
- Three (3) POs continuing the program with upfront QIP dollars provided
- Two (2) POs assigned a CAP and continuing Enhanced Provider Engagement coaching activities

In conclusion, PI and QI leadership presented an evaluation of the Enhanced Provider Engagement and Modified QIP program to the Quality Advisory Committee in March 2024 and to the Physician Advisory Committee in April 2024, with the recommendation to adapt and continue the program in 2024-2025.

Equity and Practice Transformation

The Department of Healthcare Services (DHCS) began the Equity and Practice Transformation (EPT) Program in January 2024. It is a one-time $700 million state-wide initiative focused on advancing health equity while reducing COVID-19 driven care disparities. Partnership leveraged this funding opportunity to continue proactively prioritizing organizations with the most need for support of opportunities to improve their core capacities and infrastructure. The funding is divided between three (3) programs; $25M for the Initial Planning Incentives Payments (IPIP), $650M over five (5) years for the Provider Directed Payment Program (PDPP), and $25M over five (5) years for the Statewide Learning Collaborative (SLC).

Partnership awarded $10,000 to 23 qualifying provider organizations through the IPIP, which is geared toward small and medium-sized independent practices to support their planning and application process for the PDPP. 10

of these provider organizations were already engaged under Partnership's Enhanced Provider Engagement (EPE) strategy in 2023. The IPIP funding Partnership received is allocated to support the improvement efforts of tribal health organizations and provider organizations awarded PDPP funding.

A total of 56 provider organizations applied to participate in the PDPP with Partnership, of those, 27 were invited by DHCS to participate. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. The accepted provider organizations are spread across each of Partnership's sub-regions, including five (5) provider organizations recently contracted with Partnership from the 2024 expansion counties, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's EPE program. Based on the funding criteria of the program, there is a possible draw-down of $45M for Partnership's contracted provider organizations upon meeting the practice transformation activities over the program's five-year (5) timeline (January 1, 2024 – December 31, 2028). As of April 2024, all 27 practices have submitted their first EPT milestone deliverable to the Population Health Learning Center (PHLC), who is contracted with DHCS and is responsible for managing EPT program operations and coordinating across provider practices, managed care plans, and other key stakeholders. This deliverable required completion of a Population Health Management Capabilities Assessment Tool (phmCAT). The phmCAT is a self-administered survey assessment that is used to understand the current population health management capabilities of primary care practices. It can help organizations identify strengths and opportunities for improving population health management. Milestone deliverables will be due in May and November of each year and the potential to earn the maximum payment is based on the amount of assigned Medi-Cal members assuming PHLC and DHCS agree on all of the deliverables submitted.

The Statewide Learning Collaborative (SLC) is meant to support practices awarded the PDPP funding in the implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of quality and equity goals stated in their PDPP applications. Participation in the SLC is a requirement for all participants in the PDPP. PHLC is designing and facilitating the Technical Assistance strategy within the SLC for practices. They anticipate launching three (3) forms of Technical Assistance to be available for practices in the Fall of 2024:

- A common curriculum to be provided across all practices through an eLearning module.
- PHLC will group practices into two (2) cohorts (Cohort 1: Health Centers, Tribal Health, and Public Hospitals. Cohort 2: Private Practices) based on practice type, region, and size to support what was learned in the common curriculum, promote peer learning, and sharing of best practices.
- The Coaching Pool is tailored coaching to strengthen the implementation of the EPT curriculum. Unlike the common curriculum and the peer learning, the Coaching Pool is optional and will not be funded by DHCS and PHLC. Practices can purchase a coaching package by funding themselves, using funding from directed payments, or funding from their sponsored managed care plan.

Partnership has a team of coaches dedicated to EPT awardees and may draw on outside experts for specific transformation topics as needed. PHLC and DHCS will be sharing more information regarding the Technical Assistance aspects of the Statewide Learning Collaborative as the EPT Program progresses.

On May 10, 2024, Governor Newsome released the revised budget proposal for California's fiscal year 2024-2025. The revised budget proposal reduces the EPT program from $700 million over five (5) years ($350 million from CA General Fund and $350 million match from CMS), to $140 million ($70 million from CA General Fund, $70 million CMS match). If approved, it will reduce payments available to the EPT practices by about 80%.

While the EPT program is not being eliminated, the reduction in funding, if it remains at the proposed levels, will significantly impact the program structure. Partnership is prepared to continue supporting EPT practices as PHLC and DHCS see fit.

Practice Facilitation and Provider Coaching

Practice Facilitation centers around POs who are in the Mid Performing Tier. These POs have demonstrated engagement and some success with the QIP, but have opportunities to improve their performance on clinical measures, usually within the Pediatric and Cancer Screening measure domains

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

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

In 2023, four (4) provider organizations participated in quality improvement projects with the Improvement Advisors, consisting of one (1) provider in the Southwest Region, and three (3) in the Southeast Region. Each provider organization met with a Practice Facilitator at least once a month, including site-specific QI Team members as well as QI leadership. Multiple provider included team members such as clinicians and clinical support team members in their Practice Facilitation team structure. Providers selected at least one (1) PCP QIP measure to focus on throughout the calendar year.

2024 Engagement in Practice Facilitation

In 2024, there were several changes in the POs participating in Practice Facilitation:

- Two (2) Southeast Region POs decided not to continue Practice Facilitation in 2024 because of competing priorities.
- One Southwest PO that was working with an Improvement Advisor as a Phase 2 Enhanced Provider Engagement provider avoided placement on the Modified QIP and started Practice Facilitation in 2024.
- Five (5) East Region POs that are incoming practices to Partnership have started Practice Facilitation in 2024.

Outcomes for the Practice Facilitation program in 2023:

- All four (4) Practice Facilitation practices set a total of 10 SMART Aims at the beginning of 2023.
- At the end of 2023, 30% of the SMART Aims were met.

Practice	Measure/Sites	SMART Aim Goal	Dec 2023 rate at site(s) of focus	2022 – 2023 rate change at site(s) of focus	SMART Aim met?
Practice A	W15 (2 sites)	61.19%	80.30% (90th)	+19.14%	Goal Met
	CIS-10 (2 sites)	42.09%	21.99% (<25th)	-3.01%	Goal Not Met
Practice B	W15 (1 site)	70.00%	67.93% (90th)	+1.26%	Goal Not Met
	CIS-10 (1 site)	42.09%	24.84% (<25th)	-11.46%	Goal Not Met
	CCS (1 site)	62.53%	59.59% (50th)	+0.11%	Goal Not Met
Practice C	W15 (1 site)	54.92%	59.41% (50th)	+9.86%	Goal Met
	CIS-10 (1 site)	38.20%	34.50% (25th)	+6.72%	Goal Not Met
Practice D	W15 (1 site)	41.50%	45.24% (25th)	+7.74%	Goal Met
	CIS-10 (1 site)	42.09%	35.77% (50th)	-6.65%	Goal Not Met
	IMA-2 (1 site)	41.12%	22.53% (<25th)	-23.94%	Goal Not Met

The SMART Aim outcomes for 2023's Practice Facilitation participants was uneven, and disabuses the idea that success in the W15 measure will lead to success with associated measures, particularly vaccination measures. Not a single SMART Aim around a vaccination measure was met in 2023.

Because of these mixed results, the PI Team recommends **adapting** the Practice Facilitation program going forward, and to consider new approaches around coaching practices around vaccination measures.

Joint Leadership Initiative

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

In FY 2023-2024 the following provider organizations participated in the JLI: Adventist Health, Fairchild Medical Center, Mendocino Community Health Center, Communicare+OLE Health, Open Door Community Health Centers, Shasta Community Health Centers, La Clinica, and Solano County Family Health Services. Santa Rosa Community Health was removed from the JLI program due to high performance in 2022. Collectively these organizations are responsible for the care of approximately 194,000 Partnership members, which is about 29% of the health plan's original 14 county membership. Following the East Region expansion, Ampla Health was identified as a potential JLI provider but has not yet been officially invited until after they are settled and have been fully onboarded to the health plan and the QI Program.

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

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

The FY 2023-2024 QI Work Plan goals for this initiative included:

- Meeting with participating providers in accordance with the tier frequency identified in the prior year, which ranged from a single annual check-in for high performers up to quarterly meetings for lower performers.

- Optimizing the JLI process by combining preparation meetings to develop a standardized process and to reduce the number of meetings required for each JLI provider, and possibly creating more access to engage more practices with the expansion into the East Region.
- Identifying potential JLI providers in the East Region after membership data was available after January 1, 2024.

Overall, the JLI meetings have been well received and have helped improve the relationships with the provider entities. Feedback from participants has also cited that the meetings have allowed focused time to discuss quality issues and provided a platform to discuss provider concerns. It was determined that given the unique needs of each provider organization, using a single prep meeting for all JLIs was not successful. Partnership reverted back to conducting individual prep meetings for each provider for the spring 2024 sessions. When evaluating 2023 QIP performance of JLI providers, it was determined that JLI providers earned 65.49% of possible QIP points on average, which is 11.80% higher than the non-JLI provider average of 53.69%. When reviewing year-over-year data comparing 2022 and 2023 QIP data, JLI providers increased 4.05% more points earned in 2023 compared to non-JLI providers who increased only 0.84%.

Expansion of Regional Quality Meetings

For FY 2023-2024, the QI Team continued to expand regional quality meetings to the Northern Region by including the Northeast Region in quarterly discussions. In FY 2022-2023, the Northwest Region was able to adopt a similar approach to what has been in place in the Southern Regions as a means to address regional quality improvement topics with local stakeholders.

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

- Anderson Medical Associates
- Anderson Walk-In
- Banner Health
- Redding Rancheria
- Fairchild Medical Clinic
- Hill Country Community Clinic
- Karuk Tribal Health
- Lassen Indian Health Center
- Mayers Memorial
- McCloud Healthcare
- Modoc Medical Clinic
- Mountain Communities Healthcare
- Mountain Valleys Health Centers
- Northeastern Rural Health
- Pit River Health Service
- Prime Healthcare
- Quartz Valley Indian Reservation
- Shasta Community Health Center
- Shasta Family Care
- Shasta Regional Medical Group
- Shingletown Medical Center
- Surprise Valley Medical Clinic

The Northeast Region QI Meeting provided a forum to problem-solve issues related to quality improvement, while also sharing and spreading best practices and highlights from organizations within the region. Measures discussed included: Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening, Well-Child Visits in the First 15 Months of Life, Child and Adolescent Well Care Visits and Immunizations. Similar to feedback received the prior year when expanding to the Northwest, the Northeast attendees felt the forum was a useful venue to discuss regional topics and wanted to continue meeting on a quarterly basis.

The Performance Improvement (PI) Team continues to support several regional quality meetings within the Southern Region as well as the incoming East Region in partnership with Regional Leadership:

Solano Quality Improvement Program Initiative (SQIP-I): This monthly meeting is co-sponsored by Partnership and Aliados Health, the Federally Qualified Health Center (FQHC) consortium that is active in Solano County. The SQIP-I Workgroup engages four (4) of the largest PCPs in Solano County as a collaborative forum for collective learning and for partnership on quality measures that are best addressed on a systems level. In 2023-2024, the SQIP-I Workgroup's projects included:

- Planning activities, including root cause analysis activities, around the DHCS assigned Health Equity Performance Improvement Project (PIP) around the Well Child Visits Birth – 15 Months (W30-6) measure. The PIP will be focused on increasing the completion rate for the visit series for African American children in Solano County.
- Sharing of best practices around Lead Screening for Children (LSC) measure.
- Presentation on Cologuard bulk ordering program to increase Colorectal Cancer Screening (COL) rates.
- Focused collaborative work on newborn visit workflows, featuring analysis on newborn transitions of care by Solano County's primary inpatient labor and delivery unit and discussion of newborn Medi-Cal enrollment and PCP assignment.

Southeast Regional Meeting: This quarterly meeting engages all PCPs in the Southeast Region. In 2023-2024, the Southeast Regional Meeting's topics included:

- Voices from the Field presentations by PCP quality teams describing best practices for measures such as Cervical Cancer Screenings (CCS) and Unit of Service measures.
- Overview of Partnership programs such as the transportation benefit, member redetermination tools, and the Electronic Blood Pressure Monitor program.
- Presentations by community partners such as First 5 Yolo, presenting on their Welcome Baby program.

Lake and Mendocino Quality Meeting: This bi-annual meeting engages PCPs in Lake and Mendocino Counties around quality improvement topics. In 2023-2024, the Lake and Mendocino Quality Meeting's topics included:

- Data Spotlights on quality performance by county for all PCP QIP measures. Provider teams were provided with site-level care gaps to benchmarks for each PCP QIP measure.
- Introduction to 2024 eReports features and timelines, including a demo of the Disparity Dashboard added to eReports in 2024.
- Presentations on childhood vaccination measures CIS-10 and IMA-2, including completion rates by vaccine families and strategic recommendations and best practices for completing influenza and rotavirus series, the two (2) vaccine families that are most frequently missed by children who complete nine of ten vaccine families for the CIS-10 measure.

- Presentations on relevant programs and funding opportunities, such as member redetermination tools and resources, the point of care lead screening device awards and the Equity Practice Transformation funding opportunity.

East Region Monthly Office Hours: The PI and QIP Teams held a monthly forum for incoming practices in the East Region beginning in March, 2024. This forum, titled "How to Succeed in the PCP QIP", was meant to engage quality teams from incoming practices and help orient them to Partnership's QIP program and measures, analytic tools, and best practices for success with QIP measures. Topics in 2024 included:

- Gaining access to eReports and understanding the eReports and Partnership Quality Dashboard interface and features.
- Troubleshooting common problems faced by incoming practices, such as member assignment issues and incomplete data issues.
- Understanding the QIP Equity Adjustment and best practices for acuity coding.
- Strategies and best practices for success with QIP measures.

QI Technical Assistance in Partnership with Northern Region Consortia

In prior years HANC and NCCN have worked with Northern Region QI to conduct in-person ABCs of QI sessions. With the onset of COVID-19, Partnership switched to a virtual five (5) webinar series. This allowed Partnership to utilize all Performance Improvement staff to conduct trainings, which allowed HANC and NCCN to focus on supplemental webinars. While Partnership has returned to in-person ABCs of QI sessions, we found the supplemental trainings offered by the consortia partners to be of high value and has elected to keep these trainings in the scope of work. The details of these trainings were noted in the prior section under Quality Improvement Training and Coaching.

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

HANC and NCCN offer great avenues for communicating with the largest Northern Region PCP organizations serving Partnership members. In the past year, Partnership has leveraged the consortia QI and CMO Peer Networks, which each meet monthly, to share key changes in measure sets, HEDIS®/QIP measure education, HEDIS®/QIP performance results, and emerging best practices from ongoing regional performance improvement projects. It is also a forum by which barriers to achieving improved HEDIS® performance can be openly discussed, informing

Partnership's HEDIS® Score Improvement tactical strategies and dialog with DHCS. Historically HANC and NCCN member organizations perform higher than non-members. In 2023, consortia members earned 59.33% of QIP points compared to the Northern Region non-member provider organization average of 38.60%.

Other QI Provider Resource Updates and Changes

The Performance Improvement (PI) Team publishes a set of Measure Best Practices for each PCP QIP measure on an annual basis. 2024 Measure Best Practices feature Partnership programs and tools, and include best practices around data and coding, member care, and health equity best practices for each PCP QIP measure.

Frequently Asked Questions (FAQs) documents were developed by the QIP Team to support newly enhanced dashboards in the Partnership Quality Dashboard (PQD) called Preventive Care Reports. Each dashboard includes supplemental data for three (3) measures included in the PCP QIP core clinical measure set: Immunization for Adolescents, Childhood Immunization Status – Combo 10, and Well Care Visits in support of the Well Child First 15 Months measure. The Preventive Care Report FAQs document provides descriptive highlights of each measure dashboard including guidance on how to use the data in support of measure score improvement. The QIP Team also distributes an educational, bi-monthly email DRIP campaign focusing on helpful tips for using the Preventive Care Reports dashboard and other QIP basics to reinforce on-going performance education provided by the PI Team.

Quality Improvement Training

Improving Measure Outcomes

In conjunction with Partnership medical directors, the Performance Improvement Team offered six (6) virtual Improving Measure Outcomes (IMO) (formerly known as Accelerated Learning) sessions to primary care provider organizations between January - April 2024. The webinars aimed to provide clinical background and best practices related to 2024 Primary Care Provider Quality Incentive Program (PCP QIP) measures. Each session was approved for Continuing Medical Education (CME)/Continuing Education (CE) credits through the American Academy of Family Physicians and the California Board of Registered Nursing for 1.0 contact hours per session.

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

- February 14, 2024 - Preventative Care for 0 - 2 Year Olds
  - 67 attendees, representing 31 unique organizations, seven (7) requests for CME/CEs
    (Webinar covered Well-Child Visits for the First 15 Months of Life, Childhood Immunizations Status, and Blood Lead Screening measures)
- February 28, 2024 - Preventative Care for 3 - 17 Year Olds
  - 62 attendees, representing 30 unique organizations, 14 requests for CME/CEs
    (Webinar covered Child and Adolescent Well-Care Visits and Immunizations for Adolescents measures)
- March 13, 2024 - Chronic Disease
  - 59 attendees, representing 27 unique organizations, seven (7) requests for CME/CEs
    (Webinar covered Controlling High Blood Pressure and Colorectal Cancer Screening measures)
- March 27, 2024 - Diabetes Management

  - 59 attendees, representing 30 unique organizations, four (4) requests for CME/CEs
    (Webinar covered Comprehensive Diabetes Management - HbA1c Good Control, Retinal Eye Exam, and Blood Pressure Control for Patients with Diabetes measures)
- April 10, 2024 - Women's Cancer Screenings
  - 63 attendees, representing 36 unique organizations, five (5) requests for CME/CEs
    (Webinar covered Breast and Cervical Cancer Screening measures)
- April 24, 20240 - Perinatal Care and Chlamydia Screenings
  - 42 attendees, representing 25 unique organizations, six (6) requests for CME/CEs
    (Webinar covered Women and Timely Postpartum Care screening measure)

All six (6) Improving Measure Outcomes trainings featured a leader from a high-performing provider organization as a "Voices from the Field" presenter, allowing these providers to share their best and promising practices with their peers throughout the provider network.

The target audience for Improving Measure Outcomes trainings were quality improvement staff at primary care physician offices within the Partnership geographic footprint. In January 2024, this expanded to include providers in our new Eastern Region counties. Marketing strategies for trainings included the following:

- As a new strategy, rebranding of the Improving Measure Outcomes (IMO) webinar series (formerly Accelerated Learning) was implemented to better reflect educational offering. This involved creating new marketing materials with iconic images that would be included in training promotional flyers, PowerPoint templates as well as an IMO signature banner ad. Members of the Performance Improvement Team added the banner ad to their Outlook signature. The ad touted the webinar series and offered a hyperlink to allow potential attendees to register for the series.
- Targeted eblasts for all trainings were sent using the Primary Care Provider contact list, Improvement Academy contact list, and newly acquired East County provider contact list.
- As a new strategy, QR registration codes were added to training flyers. This offered additional ease for individuals to register. The total number of scans for IMO webinars was 547.
- Event listing on Partnership website for all trainings.
- Distribution of training flyers to Leadership staff.
- Promotional training event slides were sent to internal Quality Teams (QIP, HEDIS® and Improvement Advisors) to incorporate in upcoming provider trainings/meetings.
- Provider Relations fax blast of training flyers.
- Provider Relations Representatives asked to distribute training flyers.
- Training opportunities included in Quality Improvement, Provider Relations, and Medical Director Newsletters.
- The Patient Safety Team was asked to share training flyers when conducting on-site visits with providers. Additionally, IMO training PowerPoints were shared to ensure on-site education by the Patient Safety Team was consistent with educational messaging.
- Local consortia were asked for assistance with promoting trainings.

A new strategy to assess participants' comprehension and application of session concepts was implemented, both after individual session participation and for the IMO sessions as a whole. Initially, during the registration period a pre-session evaluation was implemented to measure participants' baseline knowledge. Additionally, facilitators used this information to adjust content relevant to the learning needs of the participants. Participants' baseline

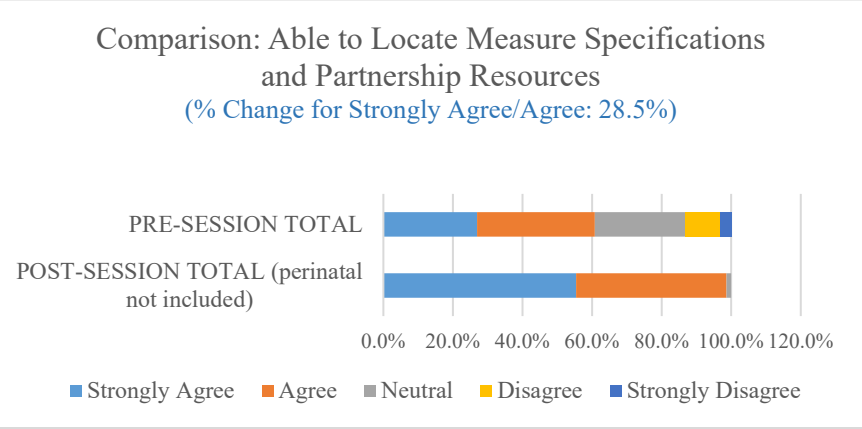
knowledge was compared to post-session evaluation results (excluding the perinatal session) to document any improvements in content knowledge, comprehension or application, which may be attributed to the session content.

Three (3) questions assessed participants' pre-session and post-session knowledge:

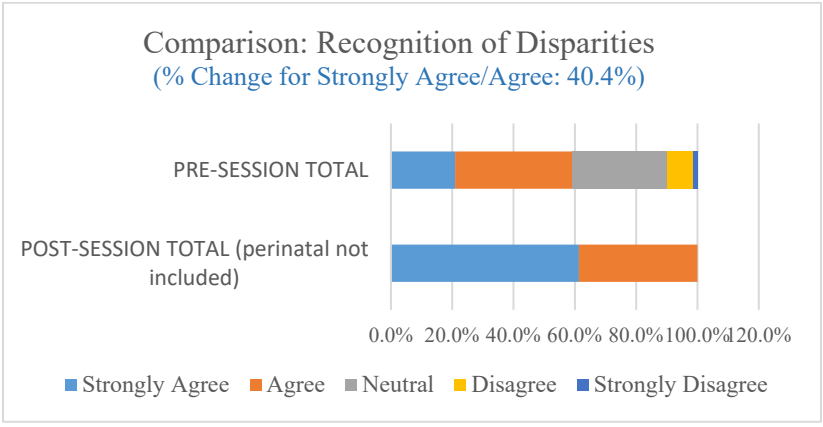
- Question 1: I can locate appropriate Partnership resources that defines measure specification requirements and provides best practices to improve measure performance.
- Question 2: I can recognize disparities in care related to [the measures presented].
- Question 3: I can identify and implement best practices to improve clinical outcomes.

Tables showing the percentage of responses from "strongly agree" to "strongly disagree" for pre-session versus post-session are shown below. Data from all IMO sessions were combined by question.

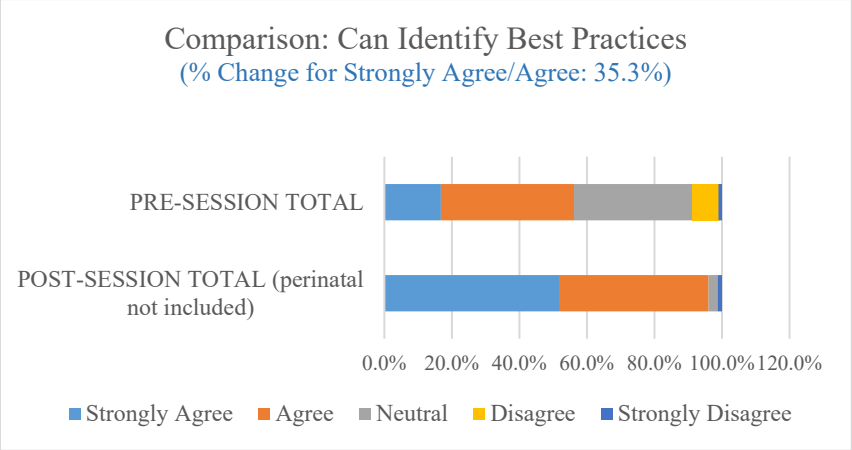
Question 1: I can locate appropriate Partnership resources that defines measure specification requirements and provides best practices to improve measure performance.



Question 2: I can recognize disparities in care related to [the measures presented].



Question 3: I can identify and implement best practices to improve clinical outcomes.



Overall, participants' self-evaluation showed perceived improvements in all three (3) areas with the largest gains reported for "agree" and "strongly agree" responses.

A final IMO series evaluation was sent to participants who attended two (2) or more IMO webinars. The survey was distributed to 77 participants and had a total of 18 responses (23%). The majority of responses to this survey was positive.

Responses were rated on a Likert scale (strongly agree=5, agree=4, neutral=3, disagree=2, and strongly disagree=1). The average for each response was calculated to understand participants' perceived improvements for the following questions. The following table lists each question and Likert score.

Question	Likert Score
I can locate appropriate Partnership resources that define measure specifications for the 2024 Primary Care Provider Quality Incentive Program.	4.7
I can identify and implement best practices to improve clinical outcomes for the specific Improvement Measure Outcomes webinar(s) I attended.	4.4
I can apply specific measure outcome performance strategies to a variety of quality improvement (QI) work in several content areas.	4.4
I am able to develop new measure outcome strategies for my clinic or organization that focus on our patient's specific needs.	4.4
I am able to modify an existing strategy to better suit our patient's needs or our clinical workflow.	4.4
I am able to evaluate our current QI Program and assess future needs or gaps.	4.4
I am able to identify care gaps attributed to health inequities, develop strategies to address those care gaps, and successfully implement those strategies.	4.2
I can communicate to interdisciplinary team members (clinical and non-clinical) about QI best practices to improve measure performance.	4.5
Does offering continuing education credits (CMEs/CEs) influence your attendance.	3.2

Overall, respondents indicated their ability to locate resources for measure best practices, quality improvement strategies, and identify and influence care gaps. Based on participant response, CME/CEs credit options were relevant for approximately 50% of survey respondents. Continued monitoring of the cost/benefit of this option is important moving forward into the next year.

ABCs of Quality Improvement

In FY 2023-2024, Partnership offered five (5) in-person ABCs of Quality Improvement (QI) training series for its provider network. The purpose of the ABCs of QI training is to introduce quality improvement concepts to clinical and non-clinical provider staffs to improve performance in the PCP QIP.

The all-day trainings covered a range of topics, including:

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

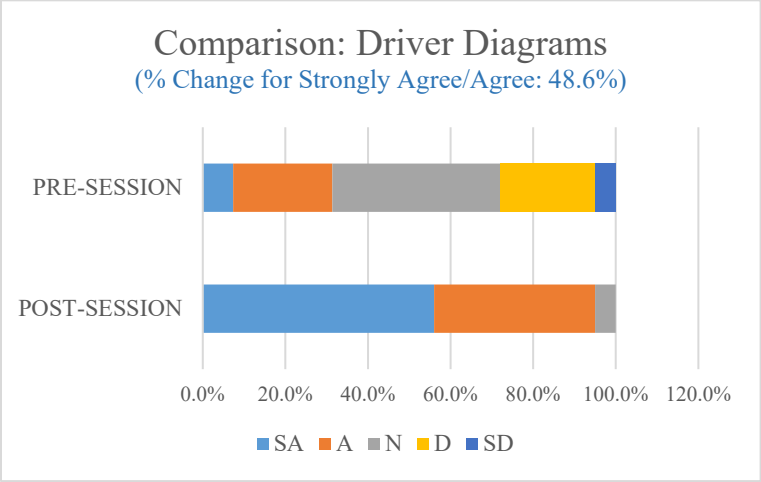
Attendance and overall training satisfaction were as follows:

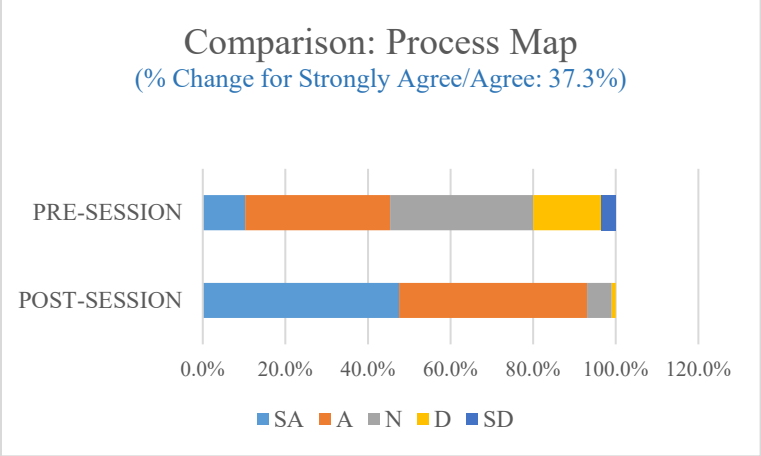
- August 30, 2023 Northwest Region (Eureka) = 42 attendees, representing 10 organizations with 95% of respondents reporting being extremely satisfied/satisfied with this course.
- October 26, 2023 Southwest Region (Redwood Valley) = 23 attendees, representing eight (8) organizations with 100% of respondents reporting being extremely satisfied/satisfied with this course.
- January 30, 2024 Southeast Region (Fairfield) = 79 attendees, representing 26 organizations with 93% of respondents reporting being extremely satisfied/satisfied with this course.
- March 20, 2024 Northeast Region (Redding) = 28 attendees, representing 14 unique organizations with 94% of respondents reporting being extremely satisfied/satisfied with this course.
- May 1, 2024 East Region (Chico) = 27 attendees, representing 12 organizations with 100% of participants reporting being extremely satisfied/satisfied with this course.

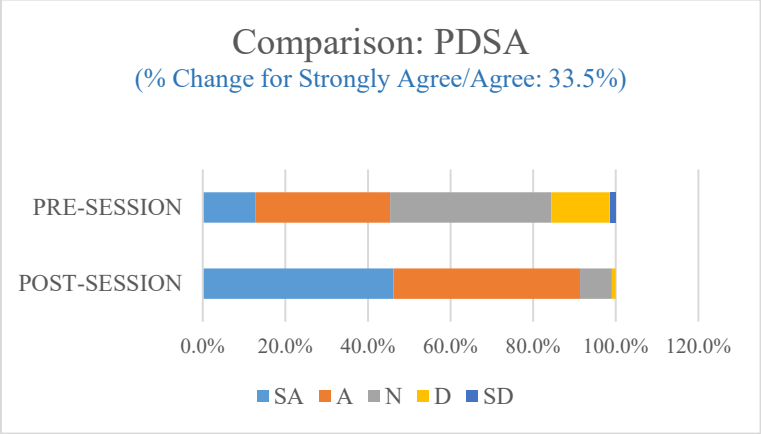
Participants of the trainings included clinicians, front-line staff, quality improvement staff, administrators, and public health professionals. Continuing Medical Education (CME)/Continuing Education (CE) credits through the American Academy of Family Physicians and the California Board of Registered Nursing were offered for each session in the series.

As part of ongoing efforts to improve curriculum and develop meaningful evaluations for our participants and program planners, knowledge check questions were included at pre-registration and compared to post-session evaluations with the use of a QR code when possible. The most significant changes in pre- and post-session knowledge check evaluations were for the following areas (see bar charts below):

- I understand when to use a driver diagram and how it contributes to developing change concepts.
- I am able to develop a process map for a workflow that is commonly used in our practice.
- I am able to design and implement a PDSA cycle.







SA = Strongly Agree; A = Agree; N = Neutral; D = Disagree; SD = Strongly Disagree

Participants were surveyed at the end of each ABC session about their intention of using the course material moving forward in the following areas:

- Expanding QI staff
- Implementing principles of ABCs of QI training
- Starting a new PDSA
- Creating a driver diagram to understand obstacles measuring performance
- Using data sources to drive QI efforts
- Sharing information from this training with clinical and non-clinical staff members

The time for implementation of any of the listed options above is summarized below in the pie chart:

Health Equity Provider Training Series

In FY 2023-2024, the Quality Improvement Department implemented the Health Equity Provider Series as an introduction to health equity concepts and equitable care for Partnership members. The series was a session of three (3) webinars covering the topics: implicit bias, health equity and health equity practices and implementation methods.

Attendance at each event was recorded:

- June 13, 2023 - Session 1 (Implicit Bias) - 33 attendees, representing 24 unique organizations
- July 18, 2023 - Session 2 (Defining Health Equity and Strategies to Improve Organizational Practices) - 32 attendees, representing 21 unique organizations
- August 15, 2023 - Session 3 (Toolkit to Support Health Equity Practices) - 22 attendees, representing 17 unique organizations

CPS HR Consulting facilitated the series with collaboration in content planning with Partnership Subject Matter Experts (SMEs) and stakeholders. The target audience for this training series was organizational leaders who are change facilitators in their system. Each session was approved for CME/CE credits through the American Academy of Family Physicians (AAFP) and the California Board of Registered Nursing for 2.0 contact hours per session. Over the course of the three (3) sessions, there were ten individual requests for CME/CE credit totaling 60 contact hours.

Attendees "agreed" or "strongly agreed" that all learning objectives were met by an average of 91% of respondents in session 1, by an average of 96% of respondents in session 2, and by 100% of respondents in session 3. Over 96% of respondents "agreed" or "strongly agreed" that the content for each session met their expectations. Instructor feedback was positive each session with the majority of survey respondents reporting that the instructors were engaging and well-prepared. The majority of respondents in each session "strongly agreed" that the content was relevant to their professional experience and would encourage others in their organizations to participate in this training.

Attendees were surveyed upon registration and in the post-session evaluation to assess any current health equity efforts in their organization. The health equity efforts were adapted from the California Improvement Network (CIN) document "A Toolkit to Advance Racial Health Equity in Primary Care Improvement". Health equity practices which participants reported the most frequent participation at the time of course registration were:

- Member information delivered through a variety of methods, which are welcoming, person-centered, and delivered in patient's preferred language and format (69.1%)
- External health equity messaging or language through mission or goals statements (66.7%)
- Patient education considers literacy and health literacy barriers and includes alternative methods for dissemination (61.9%)

Health equity practices with the highest response rates in which participants predicted implementation within the 3-6 months following the training series were:

- External health equity messaging or language through equitable hiring practices (28.6%)
- External health equity messaging or language through mission or goals statements (28.6%)
- Patient education considers literacy and health literacy barriers and includes alternative methods for dissemination (28.6%)
- The organization actively addresses barriers to care including hours of operation (28.6%)
- Additionally, respondents were asked to select which organizational changes they would most likely execute in the next 3-6 months. The most prevalent responses were:
- Increasing employee engagement or education to reflect commitment to diversity, equity, inclusion or implicit bias (100%)
- Conducting employee trainings in the area of diversity, equity, inclusion or implicit bias (85.7%)
- Incorporating patient facing changes with reflect diversity, equity, inclusion or implicit bias (85.7%).
- This emphasizes the continued need for ongoing trainings in the area of health equity and implicit bias to expand knowledge, commitment and employee engagement.

HANC and NCCN Consortia Webinars

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

- Advancing Health Equity: Linking Quality and Equity in QI Projects
  - Occurred on 4/18/23 via webinar
  - 159 of registrants, 105 attendees, representing 25 unique organizations

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

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

Value Based Pay-for-Performance Programs

Partnership's Quality Incentive Programs (QIP) provided financial incentives, data reporting and technical assistance to providers for improving in key domains of quality: clinical care, patient experience, access and operations, and resource use. The total pay-out for the MY2022-2023 QIP was approximately $53,279,545.20 across the six (6) QIP programs managed within the Quality Improvement (QI) Department.

Primary Care Provider Quality Incentive Program

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

Program Goals

The PCP program goals and activities outlined in the FY 2023-2024 QI Department Work Plan were completed and highlighted below.

- Development of measures for the 2024 PCP QIP by December 31, 2023.
- Partnership adhered to DHCS guidance regarding this program by including a performance threshold for measures that rewarded providers for conducting activities they may already be compensated for through capitation payments.
- Supported providers enrolled in the program by hosting webinars, sending quarterly newsletters, and responding to provider inquiries via phone and email in timely manner.
- Continued provider engagement and program activities to support quality (HEDIS®) measure score improvement, including monitoring changes to relative improvement methodology, payment methodology, and continuous enrollment requirement.
- Supported provider network and respective sites/clinics in their efforts to use data to improve reporting and performance improvement activities through FY 2023-24.
- Implement process improvement which includes documenting and updating current and new program protocols based on lessons learned.

- Established provider survey satisfaction baseline focused on improving
  - QIP Effectiveness
  - PCP Provider Support/Customer Service

The PCP QIP program performs annual evaluations. The 2022 Measurement Year evaluation was completed during the fiscal year 2023-2024 and is highlighted below.

MY2022 PCP QIP Program Evaluation Summary

The PCP QIP offers pay-for-performance (P4P) financial incentives. The intent of P4P is to improve access and quality of care across all clinical domains. The PCP QIP, designed in collaboration with Partnership providers, offers substantial financial incentives, data resources, and technical assistance to primary care providers who serve our capitated Medi-Cal members so that significant improvements can be made in the following areas: 1) Prevention and Screening, 2) Chronic Disease Management, 3) Appropriate Use of Resources, 4) Primary Care Access and Operations, and 5) Patient Experience. This evaluation is an analysis of the January 1, 2022 – December 31, 2022, Measurement Year.

Program Performance

PCP QIP performance observed incremental year-over-year recovery from September 2021 to 2022 in the following clinical measures:

- Asthma Medication Ratio
- Controlling High Blood Pressure
- Diabetes HbA1c Good Control (<= 9.0%)
- Diabetes Retinal Eye Exam
- Well-Care Visit (First 15 months)
- Child & Adolescent Well Care Visits
- Breast Cancer Screenings
- Immunization for Adolescents

Provider Experience

The PCP provider engagement survey is administered each calendar year. The intent of this survey is to evaluate prior year PCP QIP program experience in the following categories: Program satisfaction, Organization program awareness, Performance measure tools, Program effectiveness, and QIP Team support. Despite the QIP Team's efforts to distribute or publicize this survey, we still had very little participation from our network. We had seven (7) participants out of our total provider network of 264 provider sites. Many of the questions were not answered by all participants. With this low participation rate and results, we did not feel this was an accurate representation of our provider network. These results were excluded from the program evaluation for MY2022 and the survey was retired.

PCP QIP eReports System

The eReports system is an online tool provided to PCP participants in the PCP QIP. It serves as a means for providers to track their performance under the clinical care domain of the Core Measurement set at both an organizational level and individual site level. Under the 2023-2024 QI Work Plan, the eReports system was successfully enhanced to support the 2024 PCP QIP clinical measure set and released to providers on March 1, 2024.

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

In the first quarter of 2024, the PCP QIP Team started to conduct its annual eReports Upload Audit for measurement year 2023. The QIP Team selected to audit the Well Child Visits in the first 15 Months of Life. A random sampling audit was performed and we identified 35 Parent Organizations who submitted W15 uploaded data. This sampling was used to compile the audit list and request supporting medical records. We transitioned our audit approach to focus on provider education based on our results. This approach allowed us to take more time with our analysis because we are no longer removing members from the numerator or denominator counts based on the audit which impacts the final performance scores. Our analysis will be completed by the end of June 2024.

Hospital Quality Incentive Program

The Hospital Quality Incentive Program (HQIP) is a pay-for-performance incentive program that began in 2012 for selected hospitals in the Partnership network. The purpose of the HQIP is twofold: 1) To help improve the health outcomes of Partnership members served by its contracted hospitals and 2) to help participating hospitals assess the quality of care provided to their patients by serving as a guide to their existing quality improvement efforts. To do this, the program offers substantial financial incentives for hospitals that meet specific performance targets, connects HQIP hospitals with regular training opportunities and resources, and hosts an annual Hospital Quality Symposium (HQS). The HQS supports HQIP participants' work in quality by bringing stakeholders together from each hospital entity across two Partnership regions for thoughtful discussion on high-priority, hospital related topics.

Program Goals

All HQIP Goals and activities defined in the FY 2023-24 QI Work Plan were met. Partnership completed development of both the regular 2023/2024 Measurement Set and the 6-month Measurement Set for new hospitals in Partnership's new Expansion Counties. Partnership also provided ongoing technical assistance to providers throughout the year, and conducted an evaluation of the program for the 2022-2023 measurement year which is summarized below, with the number of hospitals participating in this QIP remaining at 26 hospitals.

Partnership conducted ongoing measure performance monitoring on participating hospitals while providing technical support and mid-year performance reports during the 2023-2024 Measurement Year.

Completed Goals

Development of the 2023-2024 measurement set included focus areas in the following domains: readmissions, advanced care planning, clinical quality: maternity care, patient safety and operations & efficiency, and patient experience. Measure development included collaborative efforts with the California Maternal Quality Care Collaborative, Palliative Care Quality Collaborative, California Hospital Patient Safety Organization and Cal Hospital Compare. This resulted in the following 13 quality measures for hospitals large and small, with and without obstetric services on-site:

1. Risk Adjusted Readmissions
2. Palliative Care Capacity
3. Rate of Elective Delivery Before 39 Weeks

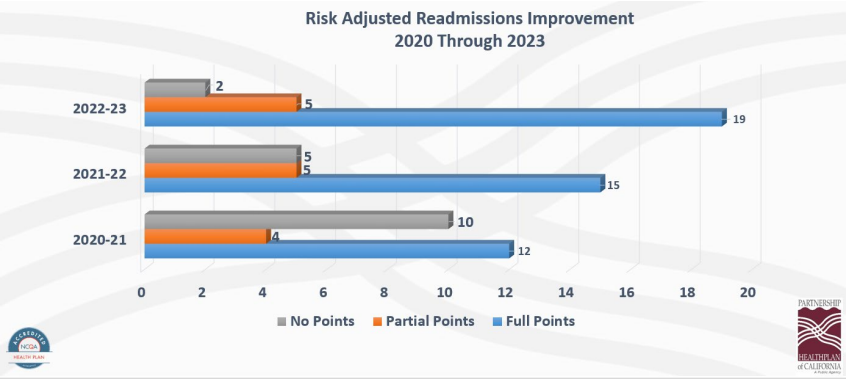
4. Exclusive Breast Mild Feeding Rate
5. Nulliparous, Term, Singleton, Vertex Cesarean Rate
6. Vaginal Birth After Cesarean
7. California Hospital Patient Safety Organization (CHPSO) Patient Safety Organization Participation
8. Substance Use Disorder – Medication Assisted Treatment
9. Hepatitis B Vaccination/CAIR Utilization
10. Quality Improvement Capacity
11. Hospital Quality Incentive Platform
12. Cal Hospital Compare – Patient Experience
13. Health Equity

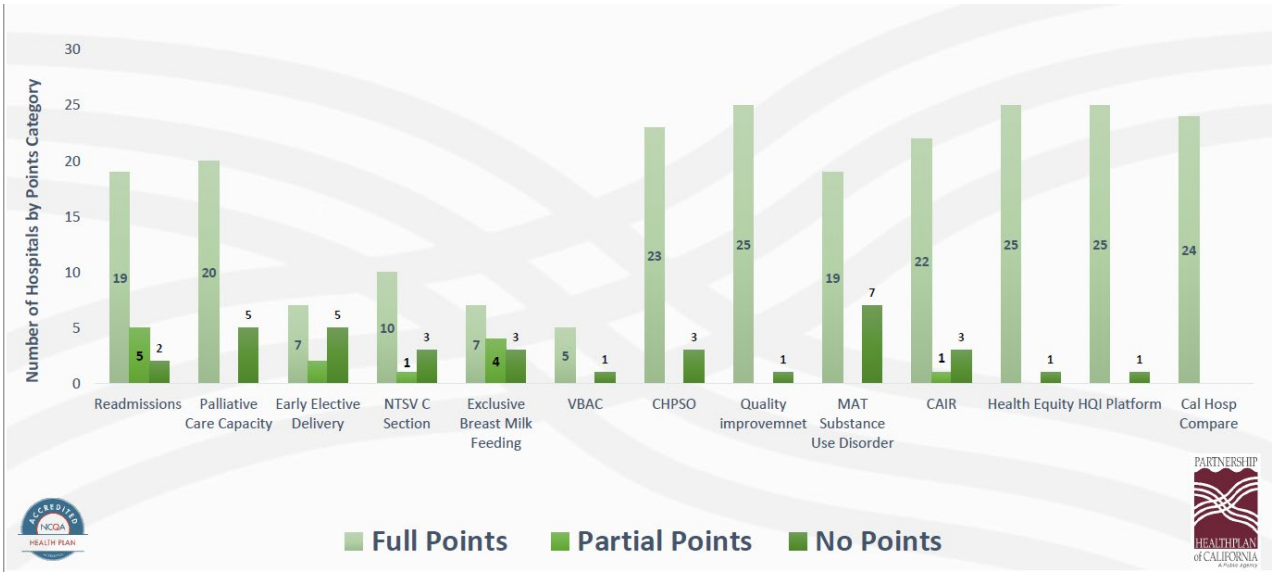
The HQIP also finalized the development of a 6-month measurement set offered to hospitals in the new expansion county regions as an introduction into the HQIP. This measurement set did not include the Risk adjusted Readmissions measure, and it allowed prospective hospitals the ability to earn credit for attending Partnership's Hospital Quality Symposium. These edits along with reducing measure targets, created a measurement set, which allowed hospitals to ease into the program for the second half of the measurement year and prepare them for the full measure set at the start of the new measurement year in July.

The 2023-2024 Hospital Quality Symposium took place on August 8, 2024 and August 10, 2024, with representatives from 25 out of 26 of the HQIP hospitals present. This included representatives from four (4) of the new Expansion County hospitals that started in January 2024. Fifteen different Long Term Care facilities attended the symposia as well. The keynote session explored the important issue of "Risk Management in Perinatal Mental Health," during which the speaker shared her and other women's personal struggle with postpartum depression and psychosis. Other engaging and informative sessions helped attendees learn how to: build a framework for addressing health inequities, maximize QIP performance, understand the new Doula benefit, and effectively work to reduce readmissions.

Annual Program Evaluation Summary

Annually, the Hospital QIP compiles a year-end evaluation utilizing performance relative to targets along with performance points distributed by measure. This year's analysis showed that hospitals have been improving scores in most areas for several years. This is particularly true for the Risk Adjusted Readmissions and Cal Hospital Compare measures. The first table below demonstrates the significant improvement hospitals have made in Risk Adjusted Readmissions scores over the past three (3) measurement years. The second table demonstrates the count of hospitals who fell into each category of achieving full points, partial points and no points for each measure. With the exception of the maternity measures, most measures had very few hospitals earning zero (0) points.





MY2023-2024 Program Focus

Each year, the HQIP Team works to make meaningful measures incentivizing continuous improvement with performance targets considered for adjustment when program-wide performance increases. Our expansion into 10 new counties necessitated the HQIP to focus on engaging our new HQIP participants in a meaningful way. The HQIP Team connected with six (6) new Expansion County hospitals to onboard them into the program. Each hospital participated in an individual deep-dive orientation into the HQIP and the specific 6-month measurement set that was developed specifically for them. The HQIP will continue focusing on fostering forward momentum in quality improvement efforts with a focus on community partnerships, quality improvement education, readmission reduction strategies and a systemic hospital focus on health equity.

Perinatal Quality Incentive Program

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

Program Goals

Perinatal QIP goals and activities in the 2023-2024 QI Department Work Plan encompass a vision of continued/increased provider engagement, HEDIS® measure alignment and the maintenance of an internal dashboard to administratively monitor the performance of postpartum office visits and immunizations.

Completed Goals

- Implemented new "Depression Screening at First Prenatal Visit" measure to incentivize providers for members who screened at prenatal visits at 14 or more weeks of gestation. Providers were educated on differences of the two (2) timely prenatal care measures and the measures' separate attestation templates in email communications, one-on-one meetings and in the PQIP Quarterly Newsletter. Program specifications, submission templates, and onboarding presentation slides for both prenatal time care measures were revised

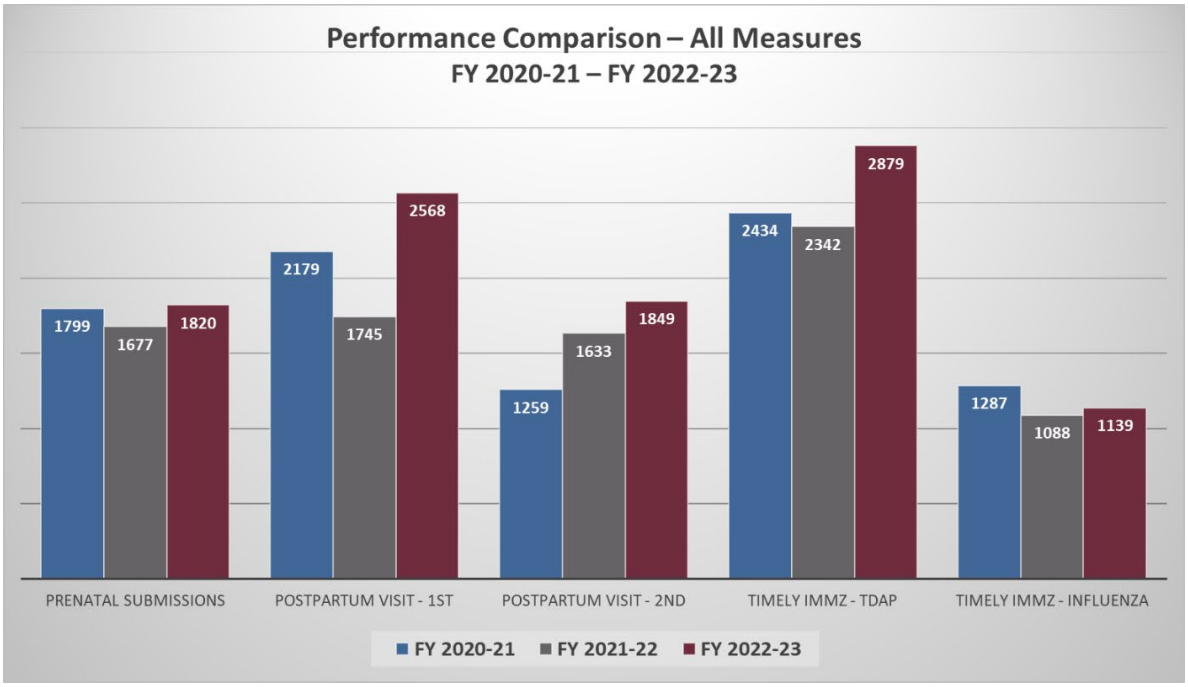
to highlight prenatal visits at "<14 weeks of gestation" or "14 or more weeks of gestation" for better understanding.

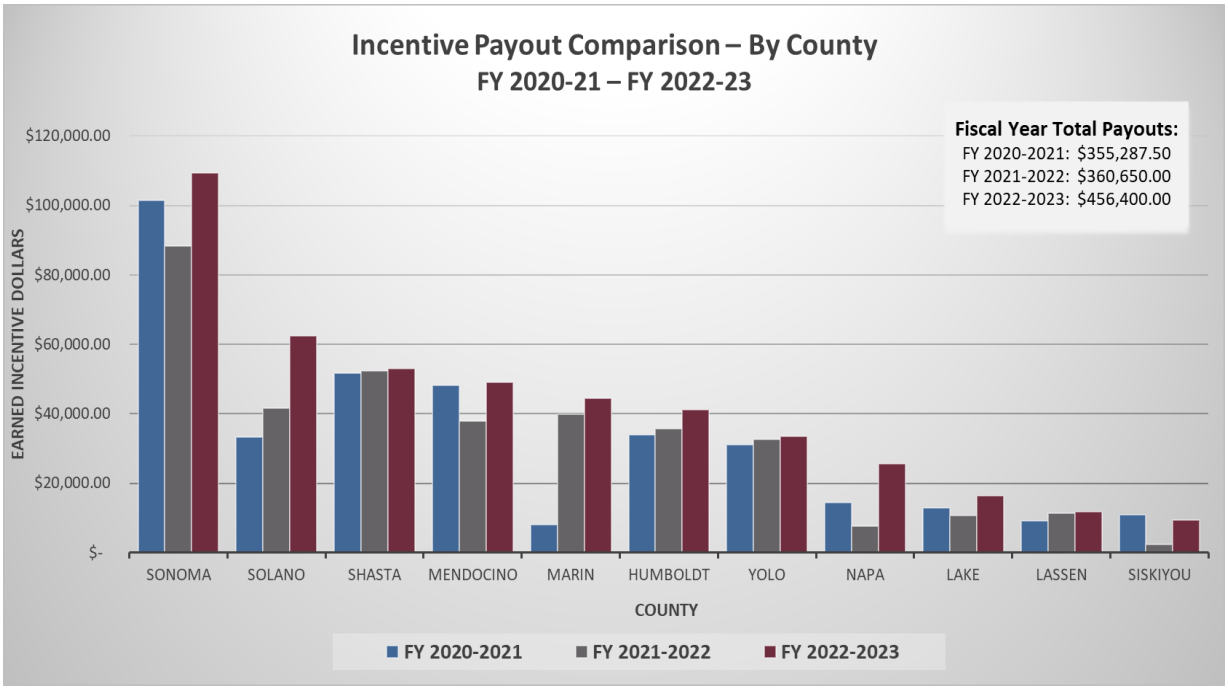
- Continued to support providers through Electronic Clinical Data System (ECDS) implementation to satisfy ECDS measure criteria for the QIP and HEDIS® Managed Care Accountability Set (MCAS). Previously a gateway measure in FY 2022-2023, the ECDS measure changed to a unit-of-service measure for FY 2023-2024. We educated existing and new providers with step-by-step procedures and deadlines shared in the kick-off webinar, all-provider email communications, and one-on-one meetings. We partnered with the HEDIS® Team to ensure notifications to our providers were timely. Because ECDS was dropped as a gateway measure, we updated the goal description. ECDS implementation went smoothly and almost all providers implemented ECDS.

  Because of the change from a gateway measure to a unit-of-service measure, the reporting requirement for the timely prenatal care measures was changed back to using attestation submission templates, leaving several providers confused and continuing to send ECDS data instead of the templates. After contacting each of these providers and educating them of the reporting requirement, all providers are back on track and completed all required submission templates for the Timely Prenatal Care measures.

Annual Program Evaluation Summary

The Perinatal QIP completed its 2022-2023 program evaluation in December 2023, and presented the results at the IQI meeting in January 2024. Program performance continues to strengthen with all Perinatal QIP providers having implemented ECDS. This was a concern due to the shift from gateway measure back to a Unit of Service measure. For this reason, we expected compliance rates for the Timely Prenatal measure to be lower than the prior measurement year; however, the rates were remained stable. This was a result of the strong communication and partnership between Perinatal QIP participants and the Perinatal Program Managers. The first table below compares performance over the last three (3) fiscal years with an increase in performance for almost all of the measures in FY2022-2023 and with a significant increase in postpartum care first visits and Tdap immunizations. The second table compares performance by county with improved performance in all counties and an increase in overall incentive payments for this fiscal year.





Measure Development

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

- Timely Tdap and Influenza Vaccine
- Timely Prenatal Care
- Timely Postpartum Care
- Electronic Clinical Data System (ECDS) Implementation

MY2023-2024 Program Focus

Partnership's expansion into 10 new counties in January 2024 provided the Perinatal QIP Team an opportunity to connect with new perinatal providers and engage them in the Perinatal QIP. In collaboration with our Associate Medical Directors and Population Health, we met with new providers in individual one-on-one meetings to educate them on all aspects of the incentive program measures and requirements as well as Partnership's perinatal care and women's health preventative services and Population Health's Growing Together Program.

Palliative Care Quality Incentive Program

In 2017, Partnership began a pay-for-performance program for Palliative Care Quality Improvement Program (PC QIP) providers. The Palliative Care QIP offers sizeable financial incentives to support and improve the quality of palliative care provided to Partnership members. In collaboration with Palliative Care providers, Partnership has developed a simple, meaningful measurement set to measure quality of care using two (2) measures: Avoiding hospitalization and emergency room visits, and Completion of POLST (Physician Orders for Life-Sustaining Treatment) and use of the Palliative Care Quality Network (PCQN).

Regarding the goals and activities indicated in the 2023-2024 QI Department Work Plan, all intended outcomes were accomplished. Partnership conducted ongoing performance evaluation of the participants, continued to use the most meaningful and feasible measures available, offered technical assistance to providers throughout the year, tracked all submissions, validated them, and gave participants updates on their performance

The Palliative Care QIP runs on a calendar year, from January 1 – December 31. Providers are paid based on their performance during two (2) six-month measurement periods. In 2023, the program had eight (8) participants, and a total payout of $1,805,800. Major program activities during 2023 included: new participant outreach and onboarding; webinars, technical assistance, and program communications; work with providers to coordinate data validation and collection for the Palliative Care Quality Collaborative (PCQC) measure; work with analytics to coordinate data collection and validation for avoiding hospitalization and ED visits measure; and distribution of reports to providers.

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

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

Enhanced Care Management Quality Incentive Program

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

ECM QIP measures are developed based on DHCS directives as well as through collaboration with internal and external stakeholders. Measurement set for the 2023-2024 measurement periods include:

- Timely Reporting (Gateway Measure)
- ECM Care Plans and Shared Consent forms entered into Collective Medical within 60 days of TAR start date
- PHQ-9 Depression Screening
- Blood Pressure Screening.

All intended outcomes were accomplished for the goals and activities indicated in the 2023-2024 QI Work Plan. With contribution of the CalAIM/ECM Team, program activities included:

- Ongoing provider outreach and onboarding through annual kick-off webinar and one-on-one virtual meetings
- Clear and concise program communications to share program changes, best practices and measure deadline reminders
- Quarterly measure auditing and scoring, incentive payment calculation and final payment distribution

- Successful collaboration with the CalAIM/ECM Team

The ECM QIP runs on a calendar year, from January 1 – December 31, and ECM contracted providers are automatically enrolled anytime throughout the measurement year. All ECM providers are paid quarterly. For 2023, Partnership paid out $1.8 million to participating providers.

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

Long-Term Care Quality Incentive Program

In 2016, Partnership began a value-based purchasing program targeting long-term care facilities. The Long-Term Care (LTC) QIP was designed to offer sizeable financial incentives to support and improve the quality of long-term care provided to Partnership members. In collaboration with LTC representatives, a simple, meaningful measurement set containing 10 measures was developed. The LTC QIP, different from the PCP QIP, was offered as an opt-in program to all contracted facilities. In 2023, the LTC QIP had 54 LTC facilities participating in the program. On December 31, 2023, the LTC QIP was sunset due to the implementation of the State's Workforce & Quality Incentive Program (WQIP).

All intended outcomes were accomplished for the LTC QIP sun-setting goals and activities planned for FY 2023-2024. Key activities included sending the LTC provider network communication regarding the sun-setting of the LTC QIP, working with LTCs to provide education on the WQIP transition and how to connect with WQIP contacts. Additionally, the LTC QIP Team partnered with Partnership's Finance Team to create a master Partnership contracted LTC provider list with contact information for distribution of payment and WQIP performance reporting. The 2023 measurement year was the final year for LTCs to participate in the LTC QIP. Each participating LTC provider's measure performance was monitored and the completion of payment processing for the 2023 LTC QIP measurement year was also achieved as a sun-setting goal.

The 2023 LTC QIP measurement year offered 11 measures. Seven (7) of those measures were pay-for-outcome measures that evaluated a facility's performance against a set target. Examples include percentage of high-risk residents with pressure ulcers and percentage of residents who lose too much weight. Since these measures are publicly reported, the QIP Team extracts data from Nursing Home Compare and rewards points accordingly. A Health Equity measure was added to the 2023 LTC QIP measurement set. LTC providers received an incentive for submitting a project plan addressing a health equity issue within their facility. The LTC QIP Team conducted twice yearly good-standing audits. Participating LTC facilities must be in good-standing according to Partnership policy but also must not have citations related to abuse or certain financial sanctions as determined and reported by Nursing Home Compare. LTC facilities are audited for good standing before the start of a new measurement year and mid-way through a measurement year. Any violation of good standing criteria renders the LTC facility incapable of participating in the program and earning incentives, until such time the facility returns to good standing status. In 2023, Partnership paid out ~$2,083,001.86 to 37 out of 54 eligible (in good standing) LTC providers.

Assembly Bill 186 (Chapter 46, Statutes of 2022), Nursing Facility Financing Reform, amended the Medi-Cal Long-Term Reimbursement Act to reform the financing methodology applicable to subacute care facilities and intermediate care facilities. The finance methodology authorized the implementation of three (3) major programs, one (1) of which, was the Workforce & Quality Incentive Program (WQIP). As a part of the implementation of the

State's WQIP, guidance released under **APL 23-004: Skilled Nursing Facilities –LTC Benefit Standardization & Transition of Members to Managed Care** created a requirement for managed care plans (MCPs) to be responsible for maintaining a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided. MCPs must also have a system in place to collect quality assurance and improvement findings from CDPH. MCPs are also required to annually submit QAPI program reports with outcomes and trending data as specified by DHCS.

In 2023, Partnership began research on the requirements needed to create a robust QAPI program. QAPI tools and resources were reviewed on CMS.gov. These tools included, but were not limited to, the QAPI 5 Elements, QAPI at a glance and QAPI Process Tool Framework. Outreach was made to several contracted LTC providers who have worked closely with Partnership to learn about their QAPI programs. Meetings were conducted with Sonoma Post-Acute, Marquis at Shasta Care and Jerold Phelps Community Hospital-SNF. Each LTC provider gave an overview of their QAPI programs, who oversees their QAPI programs, their QAPI committees and who is a part of the committees, processes for collecting and monitoring data for trends, how performance improvement projects (PIPs) are chosen and who participates, and how their PIPs are implemented and monitored. The LTC providers also shared the systems they use to collect data and how observations are used as a part of monitoring a PIPs progress. These LTC providers use tools, such as, PDSA method, the "Fish Bone" diagram or the "5 Whys" to create their PIPs. Each LTC provider shared their QAPI policies and program structures, including, templates of how interventions are documented and tracked.

Utilizing the tools and learnings from each LTC provider's QAPI program, an outline of Partnership's QAPI program structure was created. This outline documented the purpose, guiding principles and scope of the program, and how to develop a QAPI plan. The plan outlines the QAPI goals, data types and methods of collection, governance and leadership, how the QAPI is to be equipped with appropriate resources, communication, monitoring data and tracking trends, and how often the QAPI program will be evaluated. The Partnership QAPI Program is subject to revisions as further guidance on the MCP QAPI Program and quality monitoring requirements are expected to be released by DHCS.

There are five (5) mandatory elements that an MCPs QAPI program must incorporate. Thus far, Partnership is intending to address each element as follows:

- **Contracted SNFs' QAPI programs, which must include five (5) key elements identified by CMS**
  - Partnership will require all contracted LTC providers to submit an attestation confirming they have an QAPI program in place that meets all five (5) key elements identified by CMS
- **Claims data for SNF residents, including but not limited to emergency room visits, health care associated infections requiring hospitalization, and potentially preventable readmissions as well as DHCS supplied WQIP data via a template provided by DHCS on a quarterly basis**
  - Partnership will review data from these resources
    - Partnership's Health Analytics Team
    - Point Click Care
    - Daily Census Reporting
    - DHCS SNF WQIP Quarterly Performance Reports
- **Mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan**

  - The Quality Improvement Team is actively working with its internal stakeholders to continue efforts to develop processes to identify, monitor and assess the quality and appropriateness of care for members using the LTSS.
- **Efforts supporting member community integration**
  - The Quality Improvement Team is working with its internal stakeholders to continue efforts to develop processes to identify, monitor and assess the quality and appropriateness of care for members using the LTSS
- **DHCS and CDPH efforts to prevent, detect, and remediate identified critical incidents**
  - QAPI Program Manager to conduct bi-annual "Provider Good Standing" review
  - Research to be conducted on Nursing Home Compare on the Medicare.gov website where LTC Facility CMS Star and Quality rating results can be viewed
  - CDPH can be reviewed for any site visit findings, abuse related incidents, penalties and monetary fines
  - Results will be presented in an internal stakeholder meeting for approval of the findings
  - The Chief Medical Officer will present the results to the Executive Committee for final approval
  - LTC providers approved for "Not in Good Standing" by the Executive Committee will be added to the "Provider Not in Good Standing" list posted by Provider Relations

Member Safety and Quality Compliance Activities

QI TRILOGY

Member Safety and Quality Compliance Activities

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

Potential Quality Issues

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

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

The top three (3) referral sources were Grievance and Appeals, Utilization Management and referrals from Partnership Medical Directors. The rest of the PQI cases were referred by other sources such as the Care Coordination and Pharmacy departments and external providers.

Table: A

Region-wide Report (Southern and Northern Regions)	2022		Grand Total	2023		Grand Total
PQI Referral Rate, Count and Membership	Q1/Q2	Q3/Q4		Q1/Q2	Q3/Q4	
PQI Count	59	97	156	116	111	227
Members Months	3,499,163	3,930,395	8,109,019	4,944,385	4,216,811	8,493,104
Rate per 1,000 Members	0.20	0.30	0.23	0.28	0.32	0.32

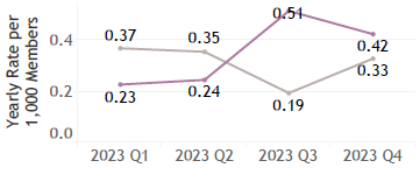
Table: B

Potential Quality Issues
Referral Dates: 2023

PQI Rate, Count and Membership

	2023 Q1		2023 Q2		2023 Q3		2023 Q4		Total
	NORTHERN	SOUTHERN	NORTHERN	SOUTHERN	NORTHERN	SOUTHERN	NORTHERN	SOUTHERN	
Number of PQIs	11	47	12	46	25	25	20	41	227
Yearly Rate per 1,000 Members	0.23	0.37	0.24	0.35	0.51	0.19	0.42	0.33	0.32
Member Months	584,567	1,537,933	590,362	1,563,431	586,300	1,555,059	569,300	1,506,152	8,493,104

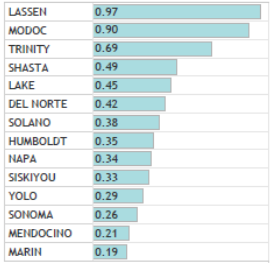
Trend of PQI Rate



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

Mbr County	2023 Q1			2023 Q2			2023 Q3			2023 Q4			Grand Total		
	Member Months	Count of PQIs	Yearly Rate per 1,000 M..	Member Months	Count of PQIs	Yearly Rate per 1,000 Me..	Member Months	Count of PQIs	Yearly Rate per 1,000 Me..	Member Months	Count of PQIs	Yearly Rate per 1,000 Me..	Member Months	Count of PQIs	Yearly Rate per 1,000 Me..
LASSEN				29,132	1	0.41	29,100	2	0.82	28,178	4	1.70	86,410	7	0.97
MODOC							13,282	1	0.90				13,282	1	0.90
TRINITY							17,587	1	0.68	17,129	1	0.70	34,716	2	0.69
SHASTA	227,342	5	0.26	230,339	11	0.57	229,471	11	0.58	223,053	10	0.54	910,205	37	0.49
LAKE	106,843	9	1.01	108,056	1	0.11	107,147	4	0.45	104,022	2	0.23	426,068	16	0.45
DEL NORTE	38,645	1	0.31				38,783	1	0.31	37,712	2	0.64	115,140	4	0.42
SOLANO	447,734	13	0.35	454,744	22	0.58	453,909	10	0.26	443,649	12	0.32	1,800,036	57	0.38
HUMBOLDT	196,854	3	0.18				196,104	6	0.37	190,256	8	0.50	583,214	17	0.35
NAPA	106,598	3	0.34	108,197	4	0.44	107,520	2	0.22	102,883	3	0.35	425,198	12	0.34
SISKIYOU	62,043	3	0.58				61,973	1	0.19	60,176	1	0.20	184,192	5	0.33
YOLO	189,154	6	0.38	192,486	4	0.25	191,135	4	0.25	182,868	4	0.26	755,643	18	0.29
SONOMA	398,056	9	0.27	405,573	13	0.38	402,398	4	0.12	390,381	8	0.25	1,596,408	34	0.26
MENDOCINO	135,887	3	0.26				136,116	2	0.18	131,689	2	0.18	403,692	7	0.21
MARIN	153,661	3	0.23	157,032	2	0.15	156,834	1	0.08	150,660	4	0.32	618,187	10	0.19

PQI Rate per 1,000 Members by County



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

As illustrated in the preceding tables A & B, in 2023, 227 cases were referred for PQI investigation compared to 209 in 2019, 128 in 2020, 113 in 2021, and 156 in 2022. PQI referrals have returned to pre-COVID levels. As expected, when COVID restrictions eased, the number of PQI referrals increased in the latter part of 2022 and significantly in 2023. PQIs are expected to increase as a result of the expansion to 10 additional counties. A total of 235 cases were processed and closed to completion. This number, compared to 177 closed cases in 2019, 151 in 2020, 126 in 2021, and 156 in 2022, reflects the increase in PQI referrals in 2023. Closed cases included four (4) Provider Preventable Conditions (PPC). Providers must report potential PPCs directly via online reporting to the DHCS Audits & Investigation Unit (A&I) after discovery of the event and confirmation that the patient is a Medi-Cal beneficiary.

In accordance with Partnership policy, cases scoring a P2 or P3 or S2 or S3 (refer to the grid below: *Assignment of Practitioner Performance and Systems Scores)* are reviewed by Partnership's Peer Review Committee (PRC) to determine what actions on the part of the health plan are indicated. A total of 19 cases were reviewed by the PRC in 2023. Assignment of practitioner performance and system scores are based on the reviewed medical records, other information submitted by the provider, and additional documentation as needed to fully review the case.

A PQI may involve both a practitioner performance issue and system issue. In addition, some cases involve multiple providers who are scored individually. Physician oversight of the PQI/Peer Review process includes weekly PQI rounds attended by the Medical Director for Quality, Regional Medical Directors, Associate Medical Directors, the Behavioral Health Clinical Director, a Clinical Pharmacist, the Manager of Member Safety Quality Investigations, RN Quality Investigators, RN Clinical Compliance Inspectors, and the team's Project Coordinator. Cases with significant concerns are communicated to the Credentialing Committee at the recommendation of the PRC. Physician and nurse participation in PRC and PQI rounds, inclusive of Partnership medical directors and network providers from diverse specialties was sufficient to meet the requirements for reviewing and making determinations

about PQIs. In January 2024, a Nurse Practitioner from a network provider facility joined the PRC and subsequently, the PRC policy was updated to include Non-Physician Medical Practitioners as voting members.

For the growth and improvement strategy, in 2021-2022, we implemented an outreach program to educate and engage individual providers in identifying potential quality issues to promote member safety. In 2022-2023, we continued this goal with an additional outreach to hospitals regarding Provider Preventable Conditions (PPC). In 2023-2024, our main focus was reaching out to acute care facilities on PPC and reporting requirements to DHCS and Partnership. We conducted four (4) in-service sessions with hospital Quality Staff to ensure they are familiar with the reporting requirements and DHCS PPC website. An article on PPCs was created and published on the Provider Relations Spring 2024 Provider Newsletter. Other improvements include working with the Finance Department on enhancing/refining the Claims PPC monthly report; quarterly meetings with other Managed Care Plan Member Safety/Quality Teams for idea sharing for process improvement; exploring options for upgrading/updating the SugarCRM PQI application (used to catalog and track cases) with IT; and the creation of a PQI flyer for the Member Safety Investigation Team to hand out to providers in the expansion counties. Based on feedback from Partnership's DHCS audit in December 2023, the policy covering PQI resolution (MPQP1016) and the PQI scoring system (see below) were updated to strengthen our efforts at ensuring member safety.

Assignment of Practitioner Performance and Systems Scores

Practitioner Performance Severity Scores		
P Score	**Definition**	**Action/Follow-up**
P0	Care is appropriate.	No action required.
P1	Minor opportunity for improvement. Potential for or actual, minor adverse outcome to member.	The reviewer will send a letter and/or secure email to the provider. Response may or may not be required.
P2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for minor or moderate adverse outcome to member.	Send certified letter and secure email to provider of concern, requiring a response. May impose a CAP and/or other interventions.
P3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for significant adverse outcome to member.	ASAP communication by certified letter, secure email and or direct phone call to provider of concern requires a response. Requires a CAP and/or other interventions. May be referred to Credentials Committee with recommendations from the PRC.
PUTD	Use whenever the PQI cannot be leveled prior to referral to the Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC).	Referral to Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC). If none identified, may be through direct contact with management of the FOC or with oversight of the POC. Refer to the appropriate licensing entity, if indicated.

System Issue Severity Scores		
S Score	**Definition**	**Action/Follow-up**
S0	No system issue.	No action required.
S1	Minor opportunity for improvement. Potential for or actual, minor adverse outcome to member.	The reviewer will send a letter and/or secure email to the provider. Response may or may not be required.
S2	Moderate opportunity for improvement. Potential for or actual minor adverse outcome to member.	Send certified letter and secure email to provider of concern, requiring a response. May impose a CAP and/or other interventions.
S3	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for or actual minor or moderate adverse outcome to member.	ASAP communication to FOC/POC requiring a response. May be by certified letter, email or direct phone call. Requires a CAP and/or other interventions. May be referred to Credentialing Committee with recommendations for PRC.
SUTD	Use whenever the PQI cannot be leveled prior to referral to the Peer Review Organization (PRO) of the Facility of Concern (FOC) or the System of Concern (SOC).	Referral to the PRO of the FOC or the System of Concern (SOC). If none identified, may require direct contact with management of the FOC or with oversight of the SOC. Refer to the appropriate licensing entity, if indicated.

Site Reviews

Partnership conducts Site Reviews to ensure that primary care providers have the capacity to maintain member safety standards and practices. Each PCP site is required to pass an Initial Facility Site Review prior to joining Partnership's network. Site Reviews are conducted, at least every three (3) years. DHCS requires that a DHCS Certified Site Reviewer (Registered Nurse) conduct these reviews. As of April 2024, Partnership has two (2) Master Trainers on the Inspections Team along with eight (8) Certified Site Reviewers (CSR). Partnership follows standards and guidelines outlined in APL 22-017 that was issued on September 2, 2022 and revised September 9, 2022.

DHCS issued updated Facility Site Review (FSR) and Medical Record Review (MRR) Tools that went live on July 1, 2022. Effective July 1, 2022 providers were scored on the newest tools (2022 Version). DHCS later released updated FSR/MRR tools (2024 Version) with additional requirements that were implemented on January 1, 2024 as required. Any additional DHCS updates are disseminated to site review nurses and primary care providers as they are published.

Currently, Partnership continues to educate sites on the 2024 FSR/MRR Tools to assist sites in understanding the new requirements. Best practices are shared with sites to help drive improvement. Education is provided onsite during the exit interview process of site reviews, and is additionally offered as separate educational sessions to all sites. Each site receives an educational packet during the exit interview that consists of information such as: Initial Health Appointment (IHA), Adverse Childhood Experiences (ACES)/Developmental Screening, Blood Lead Testing, Interpretive Services, CalAIM Enhanced Case Management (ECM), Doula Services, Telemed Program, Medical Equipment Distribution, Transportation Benefits, and Potential Quality Issues (PQI).

Certified Site Reviewers address areas identified from the review tool that do not meet the DHCS guidelines at the time of discovery during the Site Review. Partnership nurses also use this time to provide educational feedback to provider staff (i.e., handouts on TB risk assessments, reviewing IHA/Blood Lead Screening [BLS] and any other identified problem areas faced by the provider). For some areas, as required by the Site Review APL, corrective action plans (CAPs) are issued to the provider. If the site is issued a Critical Element corrective action plan (CE CAP), the site is scheduled to have a virtual CE verification with a nurse to validate all CE's were corrected appropriately. An interim assessment is also conducted at the halfway point between periodic reviews. The interim assessment addresses all Critical Elements and any additional CAP criteria from the sites last review (if applicable). Sites are supported throughout the entire CAP process to ensure site success.

Facility Site Reviews

Overall, the Facility Site Review domain scores remained very high in 2023. There are some areas in need of improvement. Through the Facility Site Review process, Partnership identified and communicated to providers where specific improvement is needed, with the following areas commonly cited:

- Access and Safety: Medication dosage chart for all medications is kept with emergency equipment
- Personnel: Disability Rights and Provider Obligations training for all staff
- Clinical Services: All stored and dispensed prescriptions are appropriately labeled
- Preventative Services: Eye Charts (literate and illiterate) and occlude for vision testing

FSR Performance	2022-2023	2023-2024	Difference
Access & Safety	95%	96%	1%
Personnel	92%	94%	2%
Office Management	98%	98%	0%
Clinical Services	97%	98%	1%
Preventive Services	97%	99%	2%
Infection Control	95%	98%	3%

Medical Record Reviews

Format and documentation domain scores for the Medical Record Review (MRR) remained fairly high – within the 90th percentile range. The number of Adult and Pediatric Preventative measures were greatly increased with the release of the 2022 and 2024 MRR Tools. Partnership has been working with sites to understand the new guidelines and where specific improvement is needed.

Pediatric Preventive Health most commonly missed points:

- Fluoride Varnish
- Fluoride Supplementation
- Tuberculosis Screening
- Blood Lead Screening

- Pediatric Immunizations
- Initial Health Appointment
- Sudden Cardiac Death

Adult Preventive Health most commonly missed points:

- Adult Immunizations
- Intimate Partner Violence screening for women of reproductive age
- Skin Cancer Behavioral Counseling
- Folic Acid Supplementation
- Hepatitis B Virus Screening
- Initial Health Appointment

MRR Performance	2022-2023	2023-2024	Difference
Format	97%	98%	1%
Documentation	94%	93%	-1%
Coordination of Care	97%	96%	-1%
Pediatric Preventive	81%	81%	0%
Adult Preventive	77%	76%	-1%
OB Preventive	97%	90%	-7%

Provider Billing Guide

As part of the FY 22/23 Department SMART Goals, the Inspections Team joined with the Claims Team to create a new provider billing guide to assist sites in correctly coding for preventative services. The guide consists of three (3) sections covering Adult, Pediatric and OB preventative services. The billing guide lists the preventative services from the Medical Record Review (MRR) Site Review tool and includes demographics along with the corresponding billing codes. By supporting providers to use the proper billing codes, providers will be able to better demonstrate completion of preventative services required by quality measures and the DHCS Site Review Tools. PCP sites and OB sites are provided with laminated copies of this guide at the Site Review exit interview. (Providers have given us positive feedback and have asked for additional copies of the billing guides to assist their site in better billing practices). Partnership continues to utilize this tool and updates the document quarterly or as needed.

Provider Educational Trainings

Site review measures correspond to priority quality measures defined under the DHCS Managed Care Accountability Set (MCAS) as well as those required for reporting and scoring under NCQA Health Plan Accreditation. Providers are encouraged to engage in educational sessions to drive improvement throughout the communities they serve. Partnership offers educational sessions as needed to our provider network through various forums.

Providers are offered 1:1 educational training sessions with a Certified Site Review Nurse (CSR RN) at every Site Review. Education is provided as requested. Educational offerings are provided through multiple forums such as provider newsletters, the Partnership website and regional meetings. Trainings are tailored to each specific site to assist sites with overcoming barriers and to provide best practices.

In anticipation to the new Site Review tools, Partnership emailed and offered education to PCP offices focusing on the new 2022 and 2024 Site Review Tool changes as well as the Initial Health Appointment (IHA) and Blood Lead Screening. This is in addition to the education provided at every Site Review exit interview. Partnership will continue to offer 1:1 educational sessions to sites to help support our provider network to be successful.

In anticipation for the sunset of the Child Health and Disability Program (CHDP), Partnership has started providing CHDP focused trainings as of May 2024. Training topics offered include hearing and vision testing, anthropometric measurements, BMI, fluoride varnish application, and immunizations, following the DHCS CHDP Transition Plan guidelines. PowerPoint slides were developed in conjunction with CHDP references provided by DHCS and collaboration with CHDP offices throughout Partnership's counties.

Improving Blood Lead Screening

Consistent with APL 20-016, Partnership's Facility Site Review (FSR) and Performance Improvement Teams have regularly educated providers on Blood Lead Screening (BLS) and anticipatory guidance for all children ages 6 months to 6 years. Partnership was able to collaborate with some Partnership network county Public Health offices in order to better support our communities in increasing awareness and testing for Blood Lead. This is an ongoing relationship.

As of May 2023, the Inspections Team (Site Review Team) was able to work with Provider Relations (PR) and join their Operational meetings between Partnership and clinics. These customized meetings with providers and practice staff allow for direct interaction with Partnership staff from multiple departments. They provide a forum for Partnership to present updates on specific topics, review identified gaps in care and to field questions directly from providers about various topics of concern. The Inspections Team is now presenting on BLS and the Initial Health Appointment (IHA) during these meetings.

Blood Lead Screening flyers are given as part of an educational packet at every Site Review. Education is provided 1:1 while on-site during the Site Review exit interview process. Formal education is also offered through various avenues such as provider newsletters, member facing newsletters, webinars, Regional Directors Forums, Partnership's website, etc. Providers receive quarterly lists of members eligible for BLS testing with the expectation they will contact and schedule members to receive the required services they are due for. BLS testing is monitored through the medical record review (MRR) process. Focused audits were also completed as part of our 23/24 Smart goal. We completed 20 focused BLS audits in addition to our normal medical record reviews.

<u>Member Engagement:</u>
Members also receive notifications and reminders through various sources such as member newsletters, Partnership's member website, mailings, community events, etc. Partnership has multiple member programs such as "Growing Together" prenatal and postpartum programs, "Healthy Toddlers and Healthy Kids- Growing Together". These programs help create awareness on multiple topics including blood lead screening.

Physical Accessibility Review Survey

(PARS), aka Part C Review

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

- Basic Access: Indicates that the facility met all 29 critical elements that identify a site's capability of accommodating SPDs
- Limited Access: Indicates that the facility does not meet one (1) or more critical element related to the six (6) indicators listed below:
  - Parking
  - Interior Building
  - Exterior Building
  - Restroom
  - Exam Room
  - Medical Equipment
- Medical Equipment Access: PCP sites only. Demonstrates if a site has a height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient)

PARS Results for PCP and Specialist Offices July 1, 2023-May 23, 2024

Count of PARS-Level	OB	PCP	Spec	Grand Total
Basic	8	51		59
Limited	14	70	2	86
Grand Total	22	121	2	145

Initial Health Appointment

The DHCS contract requires Partnership to cover and ensure the provision of an Initial Health Appointment (IHA) to each new member within 120 days of enrollment in the health plan. DHCS released APL 22-030 on December 27, 2022 with new guidance on the IHA. The IHA includes a history of the member's physical and mental health, an identification of risks, an assessment of needed preventive screens or services and health education, and the diagnosis and treatment plan of any diseases.

Effective January 1, 2024 one additional requirement was added to the Initial Health Assessment. Now, along with the completion of a history and physical within 120 days of enrollment, providers are required to complete a Member Risk Assessment.
The initial Member Risk Assessment is related to health and social needs of members, including cultural, linguistic, and health education needs; health disparities and inequities; lack of coverage/access to care; and social

drivers of health (SDOH) shall be conducted. An assessment of at least one of the following risk assessment domains meets the standard:

- Health Risk Assessment
- Social Determinants of Health (SDOH): The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of SDOH includes housing instability, food insecurity, transportation needs, utility needs, interpersonal safety, etc. Documented assessments of SDOH in the progress notes or use of an SDOH screening tool meet the standard (ex: Social Needs Screening Tool).
- Adverse Childhood Experiences (ACEs) (birth to 64 years old): Potentially traumatic experiences, such as neglect, experiencing or witnessing violence, having a family member attempt or die by suicide, household with substance use problems, mental health problems and other experiences that occur in childhood that can affect individuals for years and impact their life opportunities. Examples of validated screening tools that meet the standards include:
  - The Pediatric ACEs and Related Life-Events Screener (PEARLS), used to screen children and adolescents ages 0-19 for ACEs
  - The ACE Questionnaire for Adults, used to screen adults 18 years and older for ACEs

A Subsequent Risk Assessment shall be completed annually or more frequently if any significant changes in health status are identified. This consists of at least one (1) of the risk assessment domains (HRA, SDOH and ACEs) listed above.

Provider sites are required to document attempts to reach members who missed their scheduled IHA and to ensure that all new members are seen by their provider within the 120day timeframe.

Providers are educated on the IHA through Provider Newsletters, regional meetings and at Site Review visits. Additional educational trainings are offered at every Site Review exit interview and through various forums. Providers are given a monthly list of newly enrolled members, enabling and reminding providers to reach out to these members to schedule their IHA within the 120 days. List are reviewed during the site review process and education/feedback is provided at that time. Members also receive a letter encouraging them to complete their IHA along with their new member packet. IHA has been added to our Wellcare Guide to remind members to schedule their initial appointment. Newly enrolled members are also encouraged to contact their newly assigned PCP to complete their IHA if the member calls Partnership.

Internal and external quality improvement committees review the results of completed Site Reviews, including the review of IHA compliance, at least annually. This allows an opportunity to provide constructive feedback regarding the existing processes.

Partnership is currently working on strengthening our internal data analysis by reviewing coding and reporting procedures. This has proven to be a large task and continues to be a topic of discussion.

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

Improvement Activities

Efforts Made During Site Reviews:

a. A focused audit was completed for 20 sites during FY 23/24. This allowed a great opportunity to educate these sites one on one and answer any questions during the review. This was in addition to the members reviewed in a typical Medical Record Review (MRR). Clinical Compliance Inspectors assessed for a completed IHA for members in their first 120 days. A Corrective Action Plan (CAP) was issued to providers that did not meet APL 22-030 standards. Sites were educated on improvement methods as needed.
b. Sites receive a monthly list of new enrollees and are educated to document their outreach attempts to new members. If they attempted contact two (2) times and documented each attempt, they are compliant for that member. Partnership provides spreadsheets for the sites to document their efforts, as many sites do not wish to open a new chart before the member is actually located and establishes care. These spreadsheets are reviewed and discussed during the Site Reviews.

Miscellaneous Continuous Efforts:

a. A multi departmental collaborative meeting is held biannually to discuss IHA efforts and opportunities. Participating departments include: Claims, Provider Relations, Utilization Management, Care Coordination, Member Services, Population Health, and Regional Directors, as available.
b. Newsletter articles: Information continues to be shared through our Provider and Member Newsletters. These articles are available on the Partnership website.
c. IHA Provider education is available on the Partnership website including a webinar for Providers.
d. Newly credentialed providers are educated on the IHA requirement and a new member packet is sent to members informing them of the importance of an IHA.
e. Member Services mails an initial letter encouraging members to schedule a PCP appointment and will remind members to schedule an IHA if the member calls Partnership.
f. Partnership currently contracts with a vendor to call all newly assigned members to complete Partnership mandated assessments along with recommending an IHA visit (tracked by Care Coordination). Partnership implemented a script change to add the statement “Reminder -Please contact your Primary Care Provider to schedule your important Initial Health Appointment within 90 days of becoming a Partnership member.”
g. Partnership has a “Healthy Growing Together” program and mailers/outreach goes out to babies from birth to 18 months with outbound calls and incentives. This activity particularly focuses on members newly enrolled with the plan, so it provides the opportunity to promote IHAs.
h. IHA is discussed at Operational Meetings with sites along with BLS (see BLS section for further details-page 108.

Delegation Oversight

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

Latent TB Infection – 12 Dose Treatment

The Pharmacy Department led an intervention to track, monitor, and evaluate member adherence to Latent Tuberculosis Infection (LTBI) treatment regimen. The goal was to create a Business Object Report utilizing Magellan pharmacy claims data whereby the health plan clinical pharmacist can timely and proactively identify members who are at risk of becoming non-adherent to their LTBI regimen. Prescribers are notified at Day 16 and Day 20 of members late on their refills and out of medication. The objective is to inform the prescribers so they can reach out to members to refill their medications before the adherence gap exceeds the CDC allowed gap which would requires the member to restart the regimen.

Since July 2023, a total of 148 notification letters were sent for identified treatment gaps from 137 members (11 members had two (2) treatment gap notifications sent to their prescribers). Of the 137 members, 51 members completed a refill of their LTBI medications after the prescriber notification and 32 of the 137 members completed their prescribed LTBI regimen by the recommended timeframe.

For notification timeliness, 82% of notifications were sent by Day 16 and 7% by Day 20. 11% were beyond Day 20 due to claim reversals, delay in confirmed LTBI diagnosis, or missed tracking.

The change from retrospective to concurrent monitoring appears to generate better outcomes in terms of refills and completion of regimen by the recommended timeframe. The Day 16 and Day 20 notifications provide an opportunity for the prescriber to engage the member on continuing their LTBI regimen rather than being informed the member did not complete their regimen and would require a restart. Additionally, the Pharmacy Team expanded the monitoring to cover all LTBI regimens which identified more treatment gaps, as well as provided an opportunity to educate prescribers and pharmacies on the different LTBI regimens and common mistakes that occur with prescribing and dispensing LTBI regimens. Lastly, as we enhance our pharmacy claims data analysis and monitoring, we will be working county public health to share information on instances of LTBI treatment gap and collaborate with public health on improving LTBI treatment completion rates.

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

Quality in Member Experience

QI TRILOGY

Care for Members with Complex Needs and Community Partnerships

Care for Members with Complex Needs

With the goal of improving HEDIS® rates for PPC-Pre, PPC-Post, W15, and to comply with California AB2193 (Maternal Mental Health Screening, 2018), Partnership's Population Health Department decided to review and revise the Growing Together Program by conducting an assessment that asks questions on a variety of topics, including social determinants of health and mental health. Efforts of this revision also consisted of continued focus on HEDIS® measures to support and reinforce maternal participation in prenatal and postpartum appointments, obtaining well-child exams for children within the first 15 months of life, and encourage members to take advantage of mental health services during and after pregnancy. Assessment tools were developed in 2021 to work with women who are progressing with a healthy pregnancy and well babies, and the team worked to improve early identification of pregnant women in 2022. When the team identifies a pregnant, postpartum, or baby that might need additional services, the team will submit a referral into Care Coordination for case management.

Complex Case Management

Partnership's Care Coordination (CC) Department has continued to monitor for any updates in Complex Case Management (CCM) activities to meet DHCS and NCQA requirements and strive for continuous compliance and improvement. The CC Department been using the online NCQA Auditing Tool to keep track of CCM Cases. CCM Cases are being audited continuously to ensure compliance with NCQA standards and identify further training and tools to support staff, primarily Nurse Case Managers or Social Workers who perform the CCM assessment. The CC Department has updated the CCM Assessment on Essette to enhance the assessment's flow and completion process and also made edits to our audit tool to have all auditing and recommendation for each factor in a consolidated document on May 2024 and have provided CC staff training regarding these updates. CC Department has made edits to the CCM Flyer to prevent misunderstanding, increase comprehension, and understand the benefits of enrolling in the CCM program in February 2024. The CC Department has even conducted informational training among other departments in Partnership to increase awareness of different CC programs and provide a better understanding of the CCM program, conducted CC new hire training regarding the CCM program, and conducted refresher training regarding CCM for our current staff on May 2024. The CC Department continues to ensure that they are survey ready with their CCM programs and services and would continuously promote CCM program to the members.

Community Resource Web Pages

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

Services and Patient Experience

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

There were 200 adult members who completed TOC services, and 185 completed Adult TOC Satisfaction Surveys between January 1 and December 31, 2023; a survey completion rate of 93%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Adult TOC Satisfaction Survey. The average score ranged from the lowest at 2.86 to the highest at 2.98, which exceeds the goal average of 2.5. The results of the Adult TOC surveys and the many positive comments left reveal a high satisfaction rate among the members surveyed. Our Adult members report good outcomes with this program and we will continue providing this benefit.

Survey Questions	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my health issues.	2.98	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager)	2.98	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.96	Yes
After working with the case management team, I feel my ability to manage my healthcare needs is better.	2.86	Yes
My health has improved since working with my case management team	2.94	Yes
I was able to safely transition between Providers with the help of my Care Team	2.64	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with my case management team.	2.87	Yes
I was provided the available equipment, medication and/or services that were needed.	2.92	Yes

There were 132 pediatric members who completed TOC interventions, and 98 of them provided responses for the Pediatric TOC Satisfaction Surveys between January 1 and December 31, 2023; a response rate of 74%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Pediatric TOC Satisfaction Survey. The average score ranged from the lowest at 2.85 to the highest at 2.98; well above the goal average of 2.5. The results of the Pediatric TOC surveys and the many positive comments left reveal a high satisfaction rate among the members surveyed. Families report good outcomes with this program for our Pediatric members and we will continue providing this benefit.

Survey Questions	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my child's health issues.	2.98	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	2.99	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.96	Yes
After working with the case management team, I feel my ability to manage my child's healthcare needs is better	2.96	Yes
My child's health has improved since working with our case management team	2.91	Yes
I was able to safely transition my child between Providers with the help of my Care Team.	2.94	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	2.85	Yes
My child and I were provided with the available equipment, medication and/or services that were needed.	2.98	Yes

Housing Grant

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

Many Partnership departments are involved in the HHIP program, including the CalAIM Team, Population Health, IT, PMO and the Regional Directors.

As of May 2024, Partnership has received a total of $63,927,633 of HHIP funds which have been disbursed to counties based on their Local Homeless Plan (LHP) allocation. Partnership has distributed another $640,000 to fund providers through Street Medicine and Outreach grants to build capacity in Street Medicine and Outreach services. During the Street Medicine and Outreach grant year, providers served more than 900 members.

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

- Service Coordination: Partnership worked with the county and the CoCs to identify the CalAIM services that should be reimbursed as well as coordination of both HHIP funding with CalAIM services.
- Permanent Supported Housing Services: Partnership worked with the CoCs and the counties on reviewing current capacity as well as how to expand and build capacity of these services under HHIP, HHAP (Homeless Housing Assistance and Prevention) and federal grant funding.
- Emergency Shelter: The county and CoC continue to analyze ongoing need for emergency shelter investments and the degree to which these needs might be minimized through the expansion of other housing activities and the collaborative focus on prevention of homelessness. HHIP funding was used to the degree that investments were needed. Partnership continues to work with the partners to identify potential grant or other funding sources to sustain these services.
- Rapid Rehousing: While these services are provided to a lesser extent, the CoCs reviewed and evaluated expansion of Rapid Rehousing using HHIP and other sources of funding.
- Interim Shelter Support: CoCs continue to analyze the ongoing need for interim shelter investments and the degree to which these needs might be minimized through the expansion of other housing activities and the collaborative focus on prevention of homelessness.
- Shelter Improvements: HHIP funding was used to support these improvements.
- Street Medicine: Partnership worked with providers to build capacity to provide services to current unsheltered, unhoused members where they live. In June 2023, Partnership used a portion of the HHIP funding to award grants to street medicine providers to help with capacity building. Some counties agreed to match the grant award with their HHIP funding to help support these providers and the street medicine programs. During the grant year, 600 members were served by Street Medicine teams.
- Data Infrastructure/Systems Support: HHIP funds were used to fund data sharing and data infrastructure activities so that Homelessness Management Information Systems (HMIS) data could be shared between Partnership and the CoC/County. Some HHIP funds were used to support updates to county Coordinated Entry Systems (CES). Partnership continues to receive HMIS data from CoC/County partners.

The HHIP grant sunset in March 2024 after receipt of the final HHIP payment from DHCS.

Access to Care

Annually, Partnership collects data from a variety of sources to evaluate all aspects of information related to Network Adequacy to ensure Partnership provides members with adequate network access for needed healthcare services. The provider types covered include primary care clinicians, medical specialists, pharmacies and hospitals. Partnership follows both the DHCS and NCQA requirements. A detailed analysis of access to care data is included

in the Assessment of Access and Availability (NET 3) Grand Analysis Report, included in the Appendix (A). The following provides a preliminary high level summary of the data available to date.

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

The following access to care findings reflect information included for the calendar year 2023 in the 2024 Network Management Grand Analysis Report.

Methodology and Notable Findings

- **Member Grievances**
  For the reporting period of January 1, 2022 through December 31, 2022, Partnership met the goal of less than 1.65 access grievances reported per 1,000 members as compared to the reporting period of January 1, 2023 through December 31, 2023 where Partnership did not meet the goal of 1.82 access grievances reported per 1,000 members. A national shortage of healthcare workers combined with an aging provider population has contributed to access challenges with Partnership experiencing a 28.5% increase in access related grievances from 2022 to 2023.
- **Member Appeals**
  For the reporting period of January 1, 2022 – December 31, 2022, as well as the reporting period of January 1, 2023 – December 2023, Partnership met the threshold of less than or equal to 0.57 per 1,000 members for access to care appeals and second level grievances. Partnership had 73 less total Appeals and Second Level Grievances in 2023 than in 2022 resulting in a decrease of 10%.
- **Out of Network (OON) Requests**
  For the period of January 2023 – December 2023, as a plan, Partnership met the goal of less than 20 per 1,000 members for referrals. Out of 1,674 OON Referral requests submitted, 723 were approved with 55.7% of those being in the Northern region, specifically Modoc, Siskiyou, and Del Norte counties, where access is much harder than the Southern region due to rural terrain and a patient population that is typically too small for a specialist to maintain a viable practice. The three (3) specialties with the highest OON referrals included: Cardiovascular Disease/Internal Medicine with 59.5% of approved referrals used, Gastroenterology with 45.2% of approved referrals used, and Orthopedic Surgery with 46.7% of approved referrals used. Of the 723 approved referrals plan wide, 356 (49.2%) were used.
- **Practitioner Availability (Ratio and Geographic Availability)**
  - *Measured through the 2024 Network Adequacy Report Availability of Practitioners (NET 1, Element B, C).* Primary Care Practitioners overall, Family Practice, and Pediatrics all achieved a "met" score for number of practitioners to members for the reporting period. Although Partnership experienced an 8.2% increase in total membership as compared to 2022, we have been able to maintain access to primary care for all ages by having a stable Family Medicine network. The Provider Recruitment Program provides incentives for Primary Care practitioners to join our network. Partnership is actively recruiting for all categories of Primary Care, specifically in our rural areas that traditionally have a lower number of providers. The six (6) high volume specialties utilized by members remained unchanged from last year (2022). The six (6) specialties include; Obstetrics/Gynecology, Cardiology, General Surgery, Orthopedic, Ophthalmology, and Dermatology. Plan-wide, the provider ratio standards and geographic distribution for all high volume specialist providers were met. No plan-wide interventions are indicated.

- Plan-wide, the provider ratio standards and geographic distribution for all high impact specialist providers were met. No plan-wide interventions are indicated.

- **Practitioner Accessibility (Appointment Time Standard)**
  Measured through the 2023 Third Next Available Appointment Provider Survey
  - Plan-wide, all availability standards were met for all categories of primary care providers.
- As a plan, three (3) high-volume specialties fell below the established median 15-day appointment goal in 2023 as compared to 2022. Cardiology failed in the Northern region, Dermatology failed in the Southern region and Ophthalmology had a slight improvement in the Northern region but continued to fall short of the 2023 goal in both regions.
- **Member Experience**
  The 2022-2023 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Composite Scores taken from the ME7 CAHPS® Results Report revealed the Adult Composite score for Getting Needed Care had a slight increase, and Getting Care Quickly had a slight decrease with both failing to meet the benchmark. In Year 2022-2023, we received eight (8) more completed surveys than in FY 2021-2022, with a negligible higher increase in response rate by 0.2%. However, it is noteworthy that all questions met the 100 sample size criteria for 2022-2023. The Child composite scores for both measures experienced a decrease with a noticeable drop in Getting Care Quickly of 7.8%. Both measures failed to meet the benchmark. In Year 2022-2023, we received 24 more completed surveys than in Year 2021-2022 increasing the response rate by 0.4%. It is also noteworthy that all questions met the 100 sample size criteria.

Member Services Access

The Member Services Department monitors and analyzes internal Call Center performance as well as the performance of our contracted delegates. Performance is based on Partnership's established service level(s) below:

- 80% of Calls Answered within 30 Seconds
- 30 Second Average Speed of Answer
- 10% or less Abandonment Rate

To monitor delegate performance, Partnership requires delegates to submit a monthly performance report in which Partnership tracks and trends results against the established service levels on a quarterly basis. Delegate performance is reported out through our Delegation Oversight Review Subcommittee (DORS). The delegates in Member Services' purview are Kaiser (during this reporting year), Carelon, and Carenet. Additionally, Member Services also track quarterly delegate Call Center performance through inter/intradepartmental collaboration and reporting.

Additionally, the Carenet / Partnership Joint Operations Quarterly meeting provides an open forum for both entities to collaborate and discuss areas of opportunities. Carenet's participation and efforts in this collaborative have led to continued progress around service level standards as they work towards the closure of their outstanding Corrective Action Plan (CAP). Carenet continues to participate in the process around adhering to Partnership's contractual quality standards.

Opportunities for Improvement

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

Activities to Improve Access

Opportunity

Increase the number of contracted primary care and high-volume specialty care practitioners.

- Effectiveness of Prior Actions: Partnership has started a sponsored workforce development program that offers a sign-on bonus for providers when they contract with Medi-Cal for the first time, and if they come from a county outside of the 14 counties that Partnership serves. This updated program is taking place between January 2021 – January 2024 with the bonuses being paid out over multiple payments over a 36-month term for physicians, NP's, and PA's and 12 months for licensed behavioral health clinicians including Substance Use Disorder (SUD) counselors. The strategy is to hold providers in place longer term. To date there has been an increase in accepted offers with 84 the first year and 89 the second with Family Medicine being the majority provider specialty. Partnership was able to recruit 66 new primary care practitioners to the network between May 1, 2023 and December 1, 2023 with 27 of them going to six (6) of our most rural northern counties. Initial retention details look favorable but we may not know completely until the 36-month time period and payments take place.
  - *Planned Action*: Partnership has had success with the sponsored workforce development program to date and will continue the strategy in an effort to continue recruitment of physicians, NP's, PA's, and licensed behavioral health clinicians including SUD counselors.
  - *Planned Action*: Expand efforts to strengthen recruitment of support specialty providers by adding obstetrics providers (physicians, women's health nurse practitioners, certified nurse midwives) whose clinical care focuses on perinatal care, including labor and delivery to the 2024 workforce development program.
  - *Planned Action*: Conduct a retrospective assessment of specialty providers to identify additional opportunities to better use telehealth as a way to increase access to care, particularly in the rural counties.

CAHPS® Program | Member Experience

Overview

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

The National Committee for Quality Assurance (NCQA) requirement for accredited health plans is to conduct an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey designed and governed by Agency of Healthcare Research and Quality (AHRQ).

CAHPS® Survey

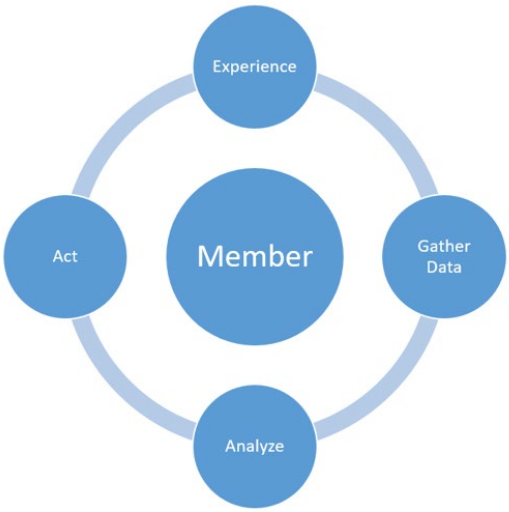
The overall objective of the CAHPS® study is to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which can aid plans in increasing the quality of provided care.

The survey and member experience analysis of Partnership plan delivery and identification of improvement opportunities cover the Measure Year (MY) 2022, and Reporting Year (RY) 2023. The analysis herein will interchangeably reference Partnership as Plan this reporting period as measure year or MY2022-2023. Also included in the evaluation is the 2023 Grievances and Appeals Annual Report, and the continuous monitoring of complaints, grievances, and appeals data through the end of Fiscal Year (FY) 2023-2024.

CAHPS® Program

The CAHPS® programmatic framework is rooted in the discipline of continuous quality improvement (CQI). A combined member-centric and CQI process illustrates continuous purpose (see Diagram A). Action that is focused on listening to member experiences, collecting data, performing analysis, and data-driven improvement targeted to influence the member experience, health outcomes, perception of the health plan, and score performance. The outcome of these improvement activities align with the Partnership mission and vision.

Diagram A



Programmatic Approach to Analysis

The applied methodology includes qualitative and quantitative analysis of current and prior CAHPS® MY2022-2023 survey responses, internal member-reported data, sector trends, and benchmarks.

Medicaid Health Plan Trends

Partnership contracts with NCQA certified vendor and industry leader, PressGaney, with more than 30 years of CAHPS® survey project management and analytic reporting experience. Managing a Health Plan company portfolio book-of-business (BoB) includes more than 89% (160/178) 2022 NCQA Quality Compass All Plans, Medicaid, Managed Care Health Plans (MCP) products.

PressGaney completed a thorough CAHPS® 5.1 H portfolio data analysis of their administered MY2022 Medicaid Adult and Child samples, survey responses include 160 Plans / 38,674 respondents. Their analysis compares the

current Partnership HealthPlan respondent rate and measures performance against our year-over-year performance, HEDIS® and PressGaney BoB benchmarks. The PressGaney BoB is used to monitor health plan trends by comparing side-by-side aggregate scores over the past four (4) years.

MY2022-2023 Trend Highlights

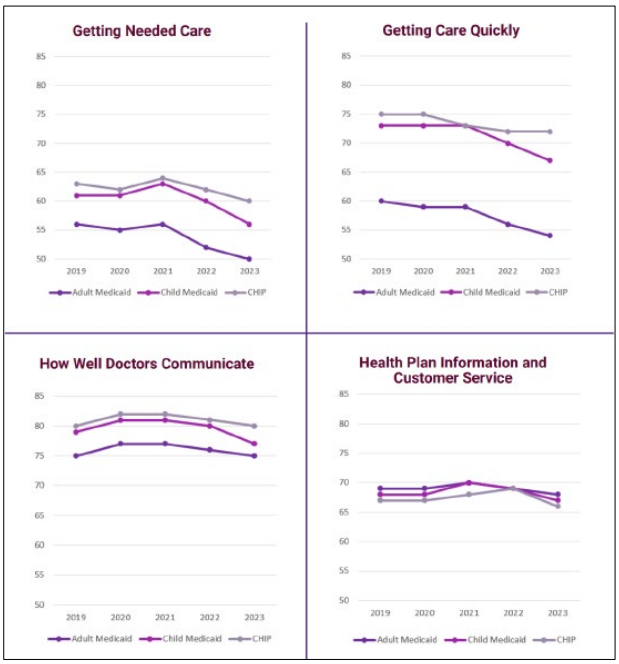
- **Medicaid Adult Population:** Among the Medicaid PressGaney BoB Adult population, one (1) measure declined by more than 1% compared to last year – ***Rating of Specialist,*** while one (1) measure increased – ***Getting Urgent Care.*** Partnership measure performance compared to BoB note trending declines of ***2.3%*** for ***Rating of Specialist*** and ***3.4%*** for ***Getting Care Quickly*** compared to MY2021-2022.
- **Medicaid Child Population:** Among the Medicaid PressGaney BoB Child population, several measures declined by more than 1% compared to last year. The biggest decreases, which continue from 2021, were in ***Rating of Health Care***, ***Getting Specialist Appointments,*** and ***Getting Needed Care***. ***Getting Care Quickly*** is an area of concern, continuing its decline since 2019 seeing a drop of 4.5%. This is primarily due to the ability to get routine care dropping 7.5% since 2020, at the beginning of the pandemic. Partnership measure performance compared to BoB note trending declines of ***1.4% - Rating of Health Care, 2.9% - Getting Special Appointments***, and ***Getting Needed Care***, and ***7.8% of Getting Care Quickly*** compared to MY2021-2022.
- **COVID-19 Impact:** The pandemic caused significant disruption throughout most of 2020. The impact of COVID-19 in some instances continue through today, and is reflected in observed performance scores within the PressGaney BoB and within our local service area.

2023 Agency for Healthcare Research and Quality (AHRQ) Chart Book

Analysis includes the use of the 2023 Health Plan Survey Database, chart book. This external source provides insight into the enrolled nationwide Medicaid population. Infographics and highlights illustrated below.

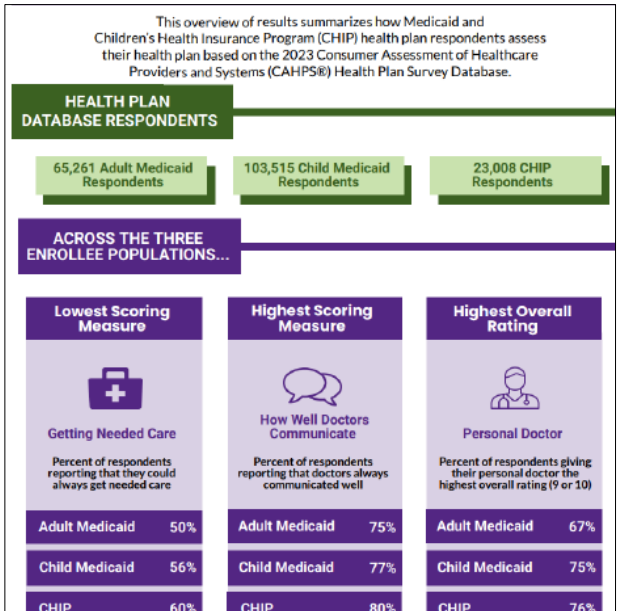
Trends in Health Plan Composite Measure Results by Respondent Population (Adult/Child Medicaid)

Table-1(a)



Top box scores for all composite measures were relatively stable or slightly increasing until 2021. However, Getting Needed Care and Getting Care Quickly showed large declines between 2021-2023. How Well Doctors Communicate and Health Plan Information and Customer Service showed smaller declines between 2021-2023.

Table-1(b)



To view the full 2023 chart book
https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2023-hp-chartbook.pdf

Medicaid Healthcare Notable Findings

The AHRQ-CAHPS® Health Plan Survey Database and 2023 Chart Book continues to indicate a national Medicaid downward trend in all four (4) composite measures Table 1(a). It is significant to recognize the impact of a post-COVID disruption to healthcare delivery, and key to underscore the 2023 US healthcare industry and American Hospital Association (AHA) linkage to severe workforce shortages at every level. The AHA estimates the healthcare industry is likely to experience a shortage of up to 124,000 physicians by the end of 2023. The complexity associated to the workforce crisis is relative to possible factors contributing to national and local impacts and overall how members rate access to care and experience. It should be highlighted that Partnership has a Workforce Development program that incentivizes clinical recruitment and retention through provider network collaboration. Ongoing strategy development to focus on present network gaps and more importantly projected gaps specific to our aging workforce in all clinical disciplines and specialty within Partnership's 24 county service area.

Survey Respondents by State

Among the Medicaid (MediCal) nationwide plan enrollees surveyed, California (MediCal) respondent rates for Adult and Child populations ranked the highest. Adult 18.9% (12,362/65,621), Child 15.7% (16,300/103,515).

AHRQ CAHPS® Chart Book Performance to Partnership Comparison

The Plan outperformed All Health Plan Composite Measures (4) in both populations Adult and Child. The survey questions for each measure (i.e., Getting Needed Care, etc.) only include Always or Usually responses. Conversely, Rating Measures (4) observed underperformance in both populations, Table 2.

Table-2 2023 CAHPS Health Plan Survey Database Medicaid Chart Book to Plan Comparison				
Composite Measures | Rating Measures	All Health Plans		Partnership	
	Adult Medicaid	Child Medicaid	Adult Medi-Cal	Child Medi-Cal
Number of Plans	221	233	1	1
Number of Respondents	65,261	103,515	380	611
Composite Measures				
Getting Needed Care	50%	56%	76%	77%
Getting Care Quickly	54%	67%	70%	76%
How Well Doctors Communicate	75%	77%	93%	93%
Health Plan Information and Customer	68%	67%	89%	90%
Rating Measures				
Rating of Personal Doctor	67%	75%	67%	74%
Rating of Specialist	66%	71%	64%	70%
Rating of Health Care	54%	66%	56%	64%
Rating of Health Plan	60%	69%	57%	68%

All Health Plans / Number of Health Plans increased from 2022

Adult: 221 from 197

Child: 233 from 166

It is worth mentioning that Partnership Adult and Child respondents are included in All Health Plans.

Member Experience Data

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

CAHPS®

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

Grievances and Appeals

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

CAHPS® Regulated Survey Methodology

As illustrated in the table below, the survey applies a mixed-method protocol in English and Spanish language formats to solicit and encourage our members to participate in the CAHPS® survey, including mailers, online survey, QR-code smart device access, reminder (1), and follow up (3) phone calls. Regulated survey cycle occurs between the months of February through May each calendar year.

Letter/Questionnaire • Month One: First Mailer • Month Two: Second Mailer	Reminder and Follow-up calls for non-responders • Month Two: Reminder Call (1) • Month Three: Follow-up Calls (3)	Online Survey English and Spanish Language Formats	QR-Code Smart Device Access for Online Survey

CAHPS® MY2022-2023 Survey Results

The regulated CAHPS® survey for this evaluation includes a six-month lookback period that measures member experiences from July 1 to December 31, 2022. The quantitative and qualitative analysis includes multiple data sources in the measure year/fiscal year, member experience evaluation.

Respondent Rate Trending

Internal stakeholders analyzed the MY2022-2023 CAHPS® survey results for Adult and Child populations. The strategy to oversample in both populations, Adult 100%, and Child 150% yield minimal gains from prior measure ye, and still trending below pre-COVID survey engagement. It's noteworthy to mention survey participation is trending downward within the PressGaney BoB and AHRQ Medicare/Medicaid chart book rates.

ADULT				
PressGaney BoB Survey Responses				
2020	2021	2022	2023	Trend
15.5%	14.8%	12.2%	11.5%	
Partnership Survey Responses				
15.0%	16.0%	14.1%	14.3%	

- Adult: Oversample size of (2,700-34 ineligible) responses, 380 completed 14.3% (380/2,666) compared to prior MY2021-2022, 14.1%.

CHILD				
PressGaney BoB Survey Responses				
2020	2021	2022	2023	Trend
12.6%	12.8%	10.2%	9.9%	
Partnership Survey Responses				
16.5%	17.4%	14.5%	14.9%	

- Child: Oversample size of (4,125-30 ineligible) responses, 611 completed 14.9% (611/4095) compared to prior MY2021-2022, 14.5%.

Respondent Rate Analysis

- ❖ The BoB respondent rates for both populations continue to decline over the past four (4) survey cycles.
- ❖ Relative to Partnership respondent rates, the plan outperformed the average Press Ganey BoB. *For three (3) of the four (4) adult survey cycles, and all four (4) for child.* Keep in mind that PressGaney administers 89% (160/178) 178 Managed Care Plans across the nation.

Performance thresholds used CAHPS® and HEDIS® Quality Compass benchmark targets based on MY2021-2022 performance for FY 2023-2024 performance targets. The rating measures and composite measures Partnership target for measure year MY2022-2023 was set at or above the 25th percentile performance levels. The CAHPS® measure composite, rating, and categories are shown in tables 1^{a}, and 1^{b} below.

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

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

Table 1[b]: CAHPS® survey results are measured against the eight (8) CAHPS® composite categories listed below.

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

The MY2022 CAHPS® survey results and measure performance on Rating and Composite Measures for the Adult and Child Surveys and measures below the 25th percentile are referenced in Tables 2 and 3 below.

Tables 2: Adult CAHPS® Composite - Adult Response rate 14.3%

	ADULT CAHPS Composite	2021-2022 (14.1% Response Rate) Sample Size 2,700 Total Returns 372	2021 Percentile Rate	PHC Benchmark	PHC Benchmark Met?	2022-2023 (14.3% Response Rate) Sample Size 2,700 Total Returns 380	2022 Percentile Rate	PHC Benchmark	PHC Benchmark Met?
Rating Measure	Rating of Health Plan (% 8, 9, 10)	69.9%	<5th	PHC ≥ 25th	No	73.8%	18th	PHC ≥ 25th	No
	Rating of All Health Care (% 8, 9, 10)	70.0%	<5th	PHC ≥ 25th	No	74.9%	40th	PHC ≥ 25th	Yes
	Rating of Personal Doctor (% 8, 9, 10)	77.6%	6th	PHC ≥ 25th	No	81.5%	42nd	PHC ≥ 25th	Yes
	Rating of Specialist Seen Most Often (% 8, 9, 10)	82.3%	34th	PHC ≥ 25th	Yes	81.1%	26th	PHC ≥ 25th	Yes
Composite Measure	Getting Needed Care (% Always or Usually)	76.0%	7th	PHC ≥ 25th	No	76.4%	14th	PHC ≥ 25th	No
	Getting Care Quickly (% Always or Usually)	72.9%	5th	PHC ≥ 25th	No	69.5%	5th	PHC ≥ 25th	No
	Care Coordination (% Always or Usually)	81.3%	15th	PHC ≥ 25th	No	86.6%	73rd	PHC ≥ 25th	Yes
	Customer Service (% Always or Usually)	87.2%	25th	PHC ≥ 25th	Yes	88.6%	38th	PHC ≥ 25th	Yes

Table 2: Measure Performance Comparison

The comparison table shown above illustrates Adult CAHPS® survey composite scores MY2022-2023, and MY2021.

- A noticeable improvement in the Adult MY2022 Rating Measures compared to MY2021. Rating of Health Plan, only one (1) of four (4) measures did not meet or exceed the Partnership 25th percentile target. Noteworthy, is an observed improvement in Rating of Health Plan percentile rating. Although the Rating of Specialist Seen Most Often exceeded the 25th percentile target, there is a decrease in performance.
- Adult Composite Measures compared to MY2021 not meeting or exceeding the Partnership 25th percentile target, are two (2) out of four (4) measures; Getting Needed Care, and Getting Care Quickly. An observed decrease in Getting Care Quickly is noted, which aligns with both industry and Press Ganey BoB composite score trends related to Access to Care.
- Adult oversampling strategy contributed to meeting the reportable threshold of 100 survey responses for each rating and composite measure.

The Adult survey responses relative to Partnership covered members indicate we continue to have dissatisfaction with member access and correlating impact on member experience that influence health plan ratings. Stakeholders determined that continued intervention focused on Getting Needed Care, Getting Care Quickly, and Rating of the Health Plan composite measures and Rating of Health Plan would be in scope for the CAHPS® Score Improvement (CSI) Department Goal for FY 2023-2024.

Table 3: Child CAHPS® Composite - Child Response rate 14.94%

	CHILD CAHPS Composite	2021-2022 (14.5% Response Rate) Sample Size 4,125 Total Returns 587	2021 Percentile Rate	PHC Benchmark	PHC Benchmark Met?	2022-2023 (14.9% Response Rate) Sample Size 4,125 Total Returns 611	2022 Percentile Rate	PHC Benchmark	PHC Benchmark Met?
Rating Measure	Rating of Health Plan (% 8, 9, 10)	82.2%	11th	PHC ≥ 25th	No	84.7%	33rd	PHC ≥ 25th	Yes
	Rating of All Health Care (% 8, 9, 10)	83.7%	<5th	PHC ≥ 25th	No	80.4%	<5th	PHC ≥ 25th	No
	Rating of Personal Doctor (% 8, 9, 10)	89.0%	26th	PHC ≥ 25th	Yes	90.5%	51st	PHC ≥ 25th	Yes
	Rating of Specialist Seen Most Often (% 8, 9, 10)	81.6%	6th	PHC ≥ 25th	No	85.2%	34th	PHC ≥ 25th	Yes
Composite Measure	Getting Needed Care (% Always or Usually)	79.6%	10th	PHC ≥ 25th	No	76.7%	10th	PHC ≥ 25th	No
	Getting Care Quickly (% Always or Usually)	84.1%	25th	PHC ≥ 25th	Yes	76.3%	<5th	PHC ≥ 25th	No
	Care Coordination (% Always or Usually)	85.3%	34th	PHC ≥ 25th	Yes	81.1%	19th	PHC ≥ 25th	No
	Customer Service (% Always or Usually)	89.4%	60th	PHC ≥ 25th	Yes	89.9%	73rd	PHC ≥ 25th	Yes

Table 3: Measure Performance Comparison

The comparison table shown above illustrates Child CAHPS® survey composite scores by MY2022 and MY2021.

- A noticeable improvement in the Child MY2022 Rating Measures compared to MY2021. Rating of All Health Care, only one (1) of four (4) measures did not meet or exceed the Partnership 25th percentile target.
- MY2022 Child Composite Measures compared to MY2021 that did not meet or exceed the Partnership 25th percentile benchmark is three (3) out of four (4) in Getting Needed Care, Getting Care Quickly, and Care Coordination. An observed decrease in both measures align with both industry and Press Ganey BoB trends. As reference Access to Care continues to be a barrier and an area Partnership is focused on improving.
- Child oversampling strategy contributed to meeting the reportable threshold of 100 survey responses for each rating and composite measure.

The Child survey responses relative to Partnership covered members indicate we continue to have dissatisfaction with member access and correlating impact to member experience that influence health plan ratings. Stakeholders determined that continued intervention focused on Getting Needed Care, Getting Care Quickly, and Rating of the Health Plan composite measures would be in scope for the CAHPS® Score Improvement Department Goal for FY 2023-2024.

2023 Grievances and Appeals (G&A) Data

The Member Experience Report tracks increases in case numbers across five (5) specific categories defined by NCQA. The threshold for significant change is set at a 10% increase. This report provides insight into which categories experience fluctuations, reflecting the impact of membership growth and overall case filings.

There were a total of 4,261 closed G&A cases in calendar year 2023, compared to 3,3318 in MY2022. These cases are broken into two (2) groups. Grievances which accounted for 3,572 and Appeals and Second Level Grievances, which accounted for 689. The two (2) case types that comprise the leading filed Grievances were Access at 1,526 (43%) followed by Service and Attitude 1,752 (49%) of 3,572 closed grievance cases.

The G&A performance thresholds are set based on prior year's performance, and targets are set at the level of each NCQA grievance and appeal category. A summary threshold for annual performance was also established (see second column of Tables 4 and 5). This data represents all member filings within the 2023 calendar year. ***For additional details, please reference Appendix H: 2024 Grievance & Appeals Annual Report.***

Table 4: Grievances Only

Grievances Only Reporting Period: Annual 2022 vs. 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Avg PHC Membership	Grievances	Grievances p/1,000	Avg PHC Membership	Grievances	Grievances p/1,000	Threshold	Threshold Met?
Access	638,303	1,055	1.65	678,546	1,526	2.25	1.82	No
Attitude/Service		1,278	2.00		1,752	2.58	2.20	No
Billing/Financial		113	0.18		106	0.16	0.19	Yes
Quality of Care		106	0.17		186	0.27	0.18	No
Quality of Provider Office		4	0.01		2	0.00	0.01	Yes
TOTAL		2,556	4.00		3,572	5.26	4.40	No

Notable Findings

Partnership membership experienced a 6.3% growth, rising from 638,303 members in 2022 to 678,546 members in 2023. Alongside our membership increase, there was a rise in Grievances received in 2023, leading to an increase in Grievances filed per 1,000 members from 4.00 to 5.26 (Table 4). We saw a decrease in the number of Appeals and Second Level Grievances filed in 2023, resulting in a decline in Second Level Grievances filed per 1,000 members from 1.19 to 1.02 (Table 5).

Contributing factors of a 6.3% increase in membership and 28.5% increase in Grievances filed led to three (3) thresholds for Grievances that were not met – Access, Attitude/Service, and Quality of Care. Access issues mainly consisted of long wait times for providers and transportation issues such as the driver arriving late and missed rides. Attitude/Service issues were mostly regarding insufficient communication between the member and the provider's

office. Communication and treatment plan disputes were the most frequently reported Quality of Care concerns. Two (2) categories, Billing/Financial and Quality of Provider Office, did meet the threshold for 2023

Table 5: Appeals & Second-Level Grievances

Appeals & Second Level Grievances Reporting Period: Annual 2022 vs. 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Avg PHC Membership	Appeals & SLG	Appeals & SLGs p/1,000	Avg PHC Membership	Appeals & SLG	Appeals & SLGs p/1,000	Threshold	Threshold Met?
Access	638,303	332	0.52	678,546	350	0.52	0.57	Yes
Attitude/Service		47	0.07		33	0.05	0.08	Yes
Billing/Financial		382	0.60		297	0.44	0.66	Yes
Quality of Care		1	0.00		9	0.01	0.00	No
Quality of Provider Office		0	0.00		0	0.00	0.00	Yes
TOTAL		762	1.19		689	1.02	1.31	Yes

The Appeals and Second Level Grievances saw an overall decrease in numbers. While four (4) categories Access, Attitude/Service, Billing/Financial, and Quality of Provider Office successfully maintained stability by not exceeding the 10% threshold, one (1) category, Quality of Care, saw an increase from one (1) case in 2022 to nine (9) cases in 2023, surpassing the threshold. These cases consisted of treatment plan disputes that caused delay in the care the members received and communications issues such as the provider not returning the member's calls.

CAHPS® Score Improvement (CSI) Interventions

It should be highlighted that through continuous discovery our program has consistently evolved since CAHPS® program inception. To this point, our team placed more emphasis on analyzing existing delivery of services and covered benefits to gain a different perspective of member perception and linkage to satisfied and dissatisfied experiences.

The table below represents potential intervention ideas referenced in the FY 2022-2023 QI Program Evaluation and a status to indicate an influence of change, adoption, or linkage to department goal activities this fiscal year.

Idea	Status
❑ Listen more through all established member engagement channels and determine whether these are adequate. Member focus groups are a potential intervention under evaluation.	✓
❑ Operational awareness of member-supporting activities and internal/external communication. An operational improvement to remove work silos between departments is under review and consideration.	✓
❑ Continue to support Partnership branding and broader member and community awareness of the importance of CAHPS® survey participation.	✓
❑ Partnership Transportation, support, collaborate, and evaluate member experience with the Transportation Services Department and take timely action with what we learn.	✓
❑ Workforce Development, Partner with Workforce Development Associate Director and regional staff to: • Support local activities to bolster residency programs by engaging residents to help improve retention	✓

Idea	Status
• Provide resources to help update and analyze PCP vacancy data and support other Workforce Development tactics linked to improving Access	
❑ Telehealth, where applicable support PMO regional-based telehealth to improve member and provider utilization and the influence of improving access and member experience.	✓
❑ Develop key preventative indicators (KPI) to resolve service line issues quickly. An operational improvement pilot is under review and consideration.	✓
❑ Develop satisfaction thresholds and targets. • G & A complaints to identify member service delivery dissatisfaction themes. • Population Health Management community member engagement survey and call campaign data. • Transportation member satisfaction data collection, analysis and if applicable proposed interventions. • Develop a process to quickly identify service delivery issues through real-time data with the intent to proactively investigate, validate, and implement solutions to improve member satisfaction. • Remove operational barriers, TAR denials, and provider training opportunities.	✓

Drawing on new discoveries and lessons learned in FY 2022-2023, CAHPS® Score Improvement (CSI) goal efforts pivoted in FY 2023-2024 from four (4) distinct workgroups into one (1) collaborative Oversight Workgroup. This change afforded our team the ability to remove cross-department work silos and improve department leader collaboration by linking to external QI Department goal activities that directly and indirectly influence member experiences.

Further, restructuring allowed external departments to adopt or align with the CSI goal. As a result, implementation of new improvement activities and interventions that targeted workforce development, improved access to care, transportation services, direct-to-member activities, and increased Partnership branding and awareness were the focus of this collaborative workgroup. Seven (7) departments officially adopted the CSI goal and three (3) departments closely aligned their goals with CSI.

A summary of each department's activities/interventions, barriers addressed, and outcomes are listed below:

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
HR/Workforce Development QI CSI Department Goal adopted: yes	Intervention: Contract with Third Party Recruiter Impact on CSI: Improve Access with Provider Recruitment	Successfully facilitated the execution of a contingency search firm agreement with CompHealth as wells as creating a contingency search firm Letter of Agreement for partners and provided to sites in Solano County. Five (5) of the six (6) partners (Communicare+Ole, Winters Health, Community Medical Center, LaClinica, and Northbay) signed the agreement. The remaining site is currently in the contracting phase as of the date of this update. Additionally, four (4) sites have provided open position details.

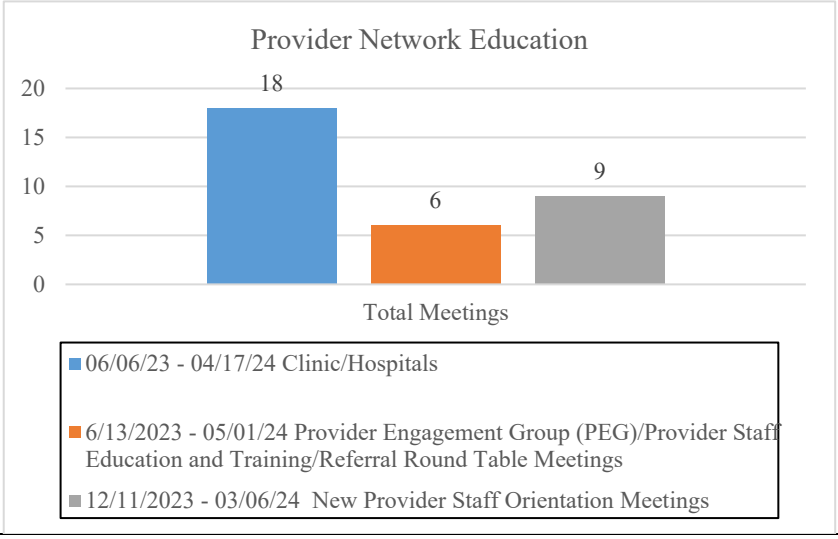
CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Barrier: Access to Care	• Three (3) openings with Community Medical Centers (Family medicine positions in Dixon, Internal Medicine in Vacaville, and a Pediatric opening in Vacaville) • Two (2) openings with La Clinica de La Raza (Family medicine positions in North Vallejo and Vallejo Medical) • Five (5) openings with NorthBay Medical (Family medicine positions in American Canyon, Dixon, Fairfield, Green Valley, and Vacaville) • One (1) opening with Winters Healthcare (Family medicine position in Winters/Esparto) With this information, CompHealth works to market the positions to candidates searching for opportunities. There have been 14 candidates formally introduced by CompHealth to three (3) provider organizations (Community Medical Centers, La Clinica de La Raza, and NorthBay). Four (4) interviews have taken place with candidates in the month of April 2024 (three (3) with Community Medical Centers and one (1) with NorthBay).
	Intervention: Provider Resident Retention Program Impact on CSI: Improve Access with Provider Retention Barrier: Access to Care	Successfully facilitated adding the resident retention bonus to the 2024 Provider Recruitment Program (PRP) Agreement, which launched the first week of January 2024. Of the 65 grant requests submitted to the program as of May 1, 2024, six (6) requests included the additional $20,000 resident retention bonus. To date, one (1) of the offers made, including the $20,000 bonus, has been accepted. There is a possibility that the five (5) remaining requests for program support, including a resident bonus, could be accepted and the resident bonus payment facilitated before graduation. Since the 2024 recruitment program launched in January and physician residents graduate in late June, the opportunity for provider sites to be able to align the bonus successfully may have been difficult. With continued promotion of PRP in the upcoming fiscal year, higher utilization and retention of additional regional residents is expected.
	Improvement Activity: Provider Network Vacancy Survey Impact on CSI: Improve Access with Provider Recruitment	The Provider Network Vacancy survey for Report Year 2024 was successfully launched to partner sites with 500 or more assigned members. The survey was completed between April 1, 2024 and April 19, 2024. Compared to the Measurement Year (MY) 2022/2023 site survey where there was a 74% response rate, initial review of the MY2023/2024 survey results showed nearly an 80% response rate from organizations polled. The increase in response rate can be attributed to initial engagement from the Partnership team with

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Barriers: Access to Care	executives at provider sites as well as multiple follow-ups with clinic managers, Human Resource departments, and recruiters. Final survey results are being compiled.
OpEx/PMO Telehealth Program QI CSI Department Goal Adopted: No	Intervention: Increase DTM utilization by 25% through DTM grant Impact on CSI: Member Experience / Specialty Access / Health Care / Health Plan Ratings Barrier: Access to Care	In FY 2022-2023, Direct-to-Member (DTM) utilization spiked significantly over the prior fiscal year to 1,974 from 543 visits in FY 2021-2022. For FY 2023-2024, the goal was to increase DTM by 25%. Through March, or nine (9) months, DTM utilization has 4,373 completed visits representing a 122% increase. DTM Grant executed with five (5) organizations: Alliance Medical; Redwood Coast Medical Services (RCMS); Redwood Rural Health Center (RRHC); Stallant Health; and Sutter Coast. All five (5) are set to achieve their goals. • Alliance – 143/200 visits completed through March. 117% increase over FY 2022-2023 • RCMS – 63/50 visits completed through March. Did zero (0) visits in FY 2022-2023 • RRHC – 150/100 visits completed through March. 217% increase over FY 2022-2023 • Stallant – 429/150 visits completed through March. 1,489% increase over FY 2022-2023 • Sutter Cost – 127/150 visits completed through March. 75% increase over FY 2022-2023 Collectively these organizations represent 101 completed DTM visits per month over nine (9) months, which is a 290% increase collectively over their collective 26 visits per month in FY 2022-2023.
Communications QI CSI Department Goal Adopted: No	Improvement Activity: Your Partner in Health: Partnership Branding/Awareness Strategy Impact on CSI: Knowing who Partnership is relative to health plan administrator/Managed Care Plan (MCP)	The new Your Partner in Health campaign officially launched on October 1, 2023 in all 24 counties Partnership serves. The goal of the campaign is to reiterate to members that Partnership is here to help them with all their Medi-Cal needs. Your Partner in Health is the organization's slogan and branding campaign/initiative to ultimately raise awareness of who Partnership is and what the organization does for members and the broader community. Strategies included outdoor, radio, social media, streaming, and digital with messaging aimed to target specific populations.

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Barriers: Health Plan Rating / Health Care Rating	
	Improvement Activity: Member Texting Engagement Platform Impact on CSI: Improve member connection with the plan by communicating through preferred channels Barriers: Health Plan Rating / Health Care Rating	Partnership's newly appointed Chief Information Officer is taking the necessary steps to re-evaluate the predecessor's work related to the vendor selection and cyber security considerations. The unforeseen activities affect the ability to execute a contract and submit a texting plan to Department of Healthcare Services (DHCS) for review and approval. In conclusion, the member texting platform is unlikely to launch by June of 2024.
Member Services QI CSI Department Goal Adopted: No	Improvement Activity: Member Texting Engagement Impact on CSI: Improve member connection with the plan by communicating through preferred channels Barriers: Health Plan Rating / Health Care Rating	See Communication's update above.

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Intervention: Optimizing Translation Services Impact on CSI: Member Experience / Health Plan Ratings Barriers: Health Plan Rating / Health Care Rating	Conducted two (2) webinars in November 2023 for providers to engage with AMN vendor to introduce the phone/video remote interpreting (VRI) services and how to utilize. Two (2) additional webinars were completed in January and February 2024. Additionally, covered options of obtaining the AMN platform for video remote interpreting (license [using the provider's owned devices] or securing tablets and stands).
Population Health Management QI CSI Department Goal Adopted: yes	Improvement Activity: Member Texting Engagement Platform Impact on CSI: Improve member connection with the plan by communicating through preferred channels Barriers: Health Plan Rating / Health Care Rating	See Communication's update above.
Transportation Services QI CSI Department Goal Adopted: yes	Improvement Activity: Transportation Gas Mileage Reimbursement Service Recovery Impact on CSI: Member Experience / Health Plan Ratings Barriers: Customer Service / Health Plan Rating	During the course of this fiscal cycle, the Transportation Team worked to automate Gas Mileage Reimbursement payments. Process improvements were identified and implemented, which should increase satisfaction and timely payments moving forward. Out of 40,629 gas mileage reimbursement trips, there were a total of 122 related grievances filed between May 1, 2023 – April 1, 2024. Findings are being reviewed and methods for identifying improvements to increase Customer Service ratings are being developed. One such metric being used to measure improvements in processes is the Gas Mileage Reimbursement Service Recovery Outcall Project. During this pilot project, the Transportation Team will attempt making two (2) calls to members having filed a gas mileage reimbursement grievance to gauge if the member is now satisfied as to receiving timely gas mileage reimbursements. The goal is to achieve successfully connecting with 20% (or 25) members.

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Improvement Activity: Transportation Active Utilizer Survey Impact on CSI: Access to Care / Member Experience / Health Plan Ratings / Health Care Barrier: Access to Care	This activity was abandoned due to Transportation Team being severely understaffed this fiscal year and prioritization of gas mileage reimbursement service recovery efforts.
Grievance & Appeals QI CSI Department Goal Adopted: yes	Improvement Activity: Participate in dialogue channel to provide real-time member satisfaction data and methods to drive key preventive indicators (KPIs). A KPI will have defined risk thresholds, which will provide Partnership more real-time opportunities prior to the survey. G&A will evaluate trends through grievance and appeal data and provide to the workgroup. Impact on CSI: Access to Care / Member Experience / Health Plan Ratings / Health Care / Specialty Care Barriers: Health Plan Rating	Grievance & Appeals (G&A) participated in regular meetings with key stakeholders to discuss intervention ideas and opportunities. Through regular evaluation of trends using G&A data, the team provided the workgroup with analyses to be used for data-driven recommendations. This enabled informed decision-making and targeted interventions.
	Improvement Activity: Participate in analysis activity to better	G&A effectively participated in activities aimed at understanding and improving areas of opportunity within the plan. By actively engaging in the analysis process, the team gained insights into the plan's

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
	understand where the plan's areas of opportunity are. Participate in workgroup to write summaries to track relative milestones G&A participates in. Impact on CSI: Access to Care / Member Experience / Health Plan Ratings / Health Care / Specialty Care Barriers: Health Plan Rating	strengths and areas for improvement. Through collaborative efforts within the workgroup, G&A added valuable contributions to summaries related to CSI.
Provider Relations QI CSI Department Goal Adopted: yes	Improvement Activity: Provider Network Education Impact on CSI: Health Plan Ratings / Member Experience Barriers: Health Plan Rating	Throughout this fiscal cycle, the Provider Relations Team reviewed flyers, PowerPoint presentations, and hosted meetings with providers in support of educating the network on Transportation Services and Benefits and Work Force Development Programs (Provider Recruitment and Provider Retention Initiatives). These meetings included, and not limited to, Operations, Provider Staff Education and Trainings, Provider Engagement, and Referral Roundtables. 

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
Admin – Santa Rosa Office QI CSI Department Goal Adopted: yes	Intervention: Identify primary care providers in the Southwest Region that are providing a significant percent of visits via telehealth (>10% of total); interview providers and summarize the ways telehealth is being used and perceived impact on access to care. Impact on CSI: Member Experience / Specialty Access / Health Care / Health Plan Ratings Barrier: Access to Care	Using Primary Care Tableau Utilization reports, four practices were identified in the Southwest region providing > 25% of primary care visits via telehealth. Organizations included in the study were: West County Health Centers, Long Valley Health Center, Marin Community Clinics, and Alliance Health Centers. A survey was developed and meetings scheduled with leaders from each primary care organization to administer survey and discuss use of primary care telehealth. Information gleaned from surveys was used to create one-page summary documents for each organization. A meeting was scheduled with all participants on May 30, 2024 to share details from each organization and jointly develop primary care telehealth best practices. **Study Participants**: The four (4) health centers in the study provide between 26 – 43% of their primary care visits via telehealth, most often as audio visits rather than video visits. **Common Uses of Primary Care Telehealth**: Telehealth visits are most commonly used for same day appointments and triage and follow-up visits to review imaging and lab results. One provider routinely uses telehealth for Emergency Department and hospital patient follow-up. Follow-up to eConsults also noted as a potential use for primary care telehealth visits. **Telehealth Staffing**: The staffing and structure used to provide primary care telehealth services varies quite a bit from one organization to another. Some rely exclusively on current staff, others contract with remote staff. **Member Satisfaction**: While most organizations have not done a formal telehealth member satisfaction survey, all sites stated that telehealth is well received by their patients, though many still prefer in-office visits, depending on the nature and scope of the visit. For example, one clinic noted patients receiving medication assisted treatment are grateful for the telehealth option, thereby reducing the need for frequent visits to the clinic. **Provider Satisfaction**: Providers appreciate the flexibility afforded by telehealth to work remotely or even with telehealth visits integrated into their daily in-office schedule. One (1) provider sites that telehealth helps with provider satisfaction and retention. **Primary Care Telehealth**: All health centers participating in the study state that primary care telehealth is an important tool to help address access to care. One (1) organization emphasized “Telehealth is here to stay”.

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Intervention: Engage at least two providers in the Southwest Region to implement DTM or increase DTM physician visits to at least 50 visits for FY 2023-24. Impact on CSI: Member Experience / Specialty Access / Health Care / Health Plan Ratings Barrier: Access to Care	The Southwest Direct-to-Member (DTM) workgroup was formed to include staff from the Telehealth Team, Provider Relations, and Regional staff to assess current use of DTM by provider and develop joint outreach and promotional strategies. A dashboard was developed to monitor progress. Specific strategies were reviewed and refreshed at each quarterly meeting. As a result, there was a significant increase in the use of DTM services by provider offices in the Southwest, with an average increase of over 101% from the previous six (6) months. Eight (8) providers met the goal of greater than 50 DTM visits in the goal period.
Office of the CMO – Northern Region QI CSI Department Goal adopted: yes	Intervention: Engagement with Tribal Health Organizations Impact on CSI: Member Experience / Health Care / Health Plan Ratings Barriers: Access to Care / Member Experience	This intervention aimed to support engagement with tribal health providers in an effort to improve the health and well-being of tribal communities. A Tribal Conference was successfully held in October of 2023. 14 tribal health providers were in attendance in addition to representatives from Department of Healthcare Services, Indigenous Pact, Indian Health Organizations, and Partnership leaders. Also occurring in October 2023 were Better Birthing Coalition site visits to K'ima:w Medical Center and ceremony sites on Hoopa Reservation and Sue-Meg village. In February 2024, a successful workshop was led by Indigenous Pact, a tribal healthcare consultant, for key Partnership staff. The intent of the workshop was to increase Partnership staff and leadership's knowledge around tribal history, beliefs and practices, which in turn would improve relationships and communication between organizations. Upcoming meetings, not yet scheduled as of this update, with K'ima:w Medical Center leadership will be centered around CalAIM and quality work.
	Intervention: Work Collaboratively with Telehealth Team and TeleMed2U to Promote DTM Model Impact on CSI: Member Experience / Specialty Access /	Throughout the fiscal year, worked collaboratively with Telehealth Team and provided Subject Matter Expert support for provider outreach to increase use of DTM and other telehealth services.

<table>
<tr><th colspan="3">CSI Goal Oversight Workgroup Participants</th></tr>
<tr><th>Department | Action</th><th>Goal | Milestones</th><th>Accomplishments</th></tr>
<tr><td></td><td>Health Care / Health Plan Ratings

Barriers: Access to Care / Member Experience</td><td></td></tr>
<tr><td rowspan="2">Quality Improvement</td><td>Improvement Activity: Implement CAHPS® Drill Down Survey, and gather all member-centric data points to include but not limited to; community/member-facing engagement activities, and call campaign data points

Impact on CSI: Member Experience / Health Plan Ratings

Barriers: Member Experience / Health Plan Ratings</td><td>Implementation of the non-regulated CAHPS® Drill Down Survey for the Adult population was completed. The purpose of the non-regulated survey was to help identify potential root causes and/or qualitative insight to responses garnered in the regulated Measurement Year 2023 Report Year 2024 CAHPS® survey. To incentivize members to complete the Drill Down survey, a $30 Walmart gift card was offered. The survey timeline and methodology were as follows.

<table><tr><th>Task Name</th><th>Date</th></tr><tr><td>Survey Mailed (First attempt)</td><td>March 18, 2024</td></tr><tr><td>Survey Mailed (Second attempt)</td><td>April 3, 2024</td></tr><tr><td>Telephonic Reminders Begin</td><td>April 17, 2024</td></tr><tr><td>Drill Down Survey Concludes</td><td>May 29, 2024</td></tr></table>
A total of 694 surveys were completed; incentives are in the process of being administered to members. Survey results and analysis are pending and will be outlined in the MY2023-2024 Member Experience Grand Analysis.</td></tr>
<tr><td>Improvement Activity: Analysis and Risk Identification of Grievance and Appeals Data

Impact on CSI: Health Care Rating / Health Plan Rating / Rating of Personal Doctor / How Well Doctors Communicate / Customer Service</td><td>As part of a pilot program, 2023 G&A data and Population Health Management member surveys were reviewed / analyzed. For Population Health Management, themes/requests among members were identified, some of which pointed to third parties (i.e., mental health, dental, etc.) The various grievance and appeals data was categorized and aligned with National Committee for Quality & Assurance's (NCQA) defined categories of Access; Attitude and Service; Billing and Financial; Quality of Care; and Quality of Practitioner Site. The intent was to identify an on-going method to capture member feedback (active listening) that may demonstrate network wide or health plan wide themes requiring adjustments in member-facing communications, branding, and educational activities. This activity would provide active listening in real time as opposed to waiting for yearly CAHPS® survey results. The intent is to effect</td></tr>
</table>

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Barriers: Health Care Rating / Health Plan Rating / Rating of Personal Doctor / How Well Doctors Communicate / Customer Service	change and/or implement steps to address barriers sooner rather than later. Support of the CAHPS® Oversight Workgroup was garnered to move the pilot forward into the next fiscal year and establish a small group of Subject Matter Experts to provide further guidance on what other data sets could be identified pointing to themes of member dissatisfaction; data/interventions to be accessed on a quarterly basis. Ongoing meetings with G&A and other key stakeholders will continue in the next fiscal year.
	Intervention: CG-CAHPS® / Provider Network – Improve Communications Scores Pilot (*Select at least one mid-to-large Parent Organizations, ≥ 1,200 assigned members*) Impact on CSI: Health Care Rating / Health Plan Rating / Rating of Personal Doctor / How Well Doctors Communicate / Customer Service Barriers: Health Care Rating / Health Plan Rating / Rating of Personal Doctor / How Well Doctors Communicate / Customer Service	This intervention was implemented with a provider located in Partnership's Southwest region. Part one involved contracting with the Crossroads Group to establish a system of continuous patient experience surveying and reporting. The Crossroads Group is a well-established company, with extensive experience serving Federally Qualified Health Centers (FQHCs), which offers comprehensive patient experience surveying, data analysis and reporting. The intent was for this provider to use patient experience data provided by the Crossroads group to carry out at least two (2) Quality Improvement Projects addressing patient satisfaction, with specific aims and defined Plan-Do-Study-Act cycles by June 30, 2024. Part two entailed a four-hour, interactive training on patient-centered communication in the primary care setting for all providers and clinical staff. The training would be specifically tailored to strengthen team-based communication techniques to increase patient satisfaction and clinical efficiency. A sustainability plan and training materials for providers and staff who onboard in the future would also be developed. As of the date of this update, this provider successfully launched their post-visit patient experience survey program and collected survey data via live phone interviews from over 1,000 patients in Q1 2024. In addition to receiving an executive summary, the provider also has access to a real-time dashboard displaying up-to-the-minute data, which allows data to be filtered/analyzed in multiple ways.

Additionally, an opportunity presented itself mid-year where the CAHPS® Team was invited to a webinar brainstorming session in order to fulfill Partnership's Northern Region Consortia partners, Health Alliance of Northern California (HANC) and North Coast Clinics Network (NCCN), contractual agreement. The CAHPS® Team suggested a Patient Experience webinar, which stemmed from the team's CG-CAHPS® / Provider Network – Improve Communications Scores Pilot referenced above. The outcome was a webinar entitled *Incorporating Patient Experience in Quality Improvement Projects and Plans,* which was held on May 7, 2024. The learning objectives for participants viewing this webinar were as follows:

- Describe how patient experience impacts clinical outcomes, patient satisfaction, provider/staff satisfaction, and healthcare quality.
- Identify opportunities to assess patient experience data from a Quality Improvement (QI) perspective.
- Apply QI methodology to patient experience improvement activities.
- Discuss strategies for involving patients and their families in the QI process.

There were 53 external individuals, representing 34 unique organizations, who attended this webinar. The webinar recording is posted under "On-Demand" webinars on the Quality page of Partnership's website. An article in the summer 2024 edition of the Partnership Provider Relations newsletter focusing on CAHPS® and Member Experience as a true partnership between the healthplan and providers highlighted this webinar and encouraged providers to view the recording.

Lessons Learned | Move the Dial

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

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

Lessons Learned

❑ Cross-Department Collaboration: Direct dialogue with Senior Leadership this past fiscal year was of particular importance in order to maintain operational awareness of member-supporting activities. We accomplished this through regular attendance at monthly NCQA's Steering Committee meetings. Oversight Workgroup attendees were invited to join on an ad-hoc basis when their Subject Matter Expertise relative to their interventions/activities was needed.

This level of organizational integration helped Partnership:

1) Leverage improvement activities and interventions to meet regulatory requirements
2) Collaborate, strategize, and optimize when and how joint improvement activities were approached
3) Optimize internal allocation of staff to improvement activities

- One example of successful cross-department collaboration was OpEx's intervention of increasing Direct-to-Member (DTM) telehealth utilization and the Admin-Santa Rosa team's efforts, for additional details reference preceding CSI Goal Oversight Workgroup Summary table.
- It is noteworthy to mention that the Admin-Santa Rosa directly targeted their Southwest (SW) Region interventions.
    - Engagement of two (2) SW providers to implement / increase DTM visits to at least 50 visits and identify SW providers utilizing a significant percent of telehealth visits and jointly develop a primary care telehealth best practice document to share among providers experiencing barriers with access.

- At Oversight meetings, the Op/Ex team continually asked for workgroup attendee's partnership in promoting DTM and provided an excellent forum to provide further collaboration on each department's telehealth efforts, all aimed at influencing improving access and member experience.

❑ Oversight Workgroup participants agreed to move the operational improvement pilot aimed at identifying key preventative indicators (KPI) forward into the next fiscal cycle. The intent of the pilot was to identify an on-going method to capture member feedback that may demonstrate network wide or health plan wide themes (KPIs) requiring adjustments in member-facing communications, branding, and educational activities.

- Activity would provide active listening in real time as opposed to waiting for yearly CAHPS® survey results in an effort to implement changes to address barriers sooner rather than later. For the purposes of this pilot, 2023 Grievance and Appeals data and Population Health member engagement surveys were analyzed. The results of the pilot garnered support from the CSI Oversight Workgroup. As a next step, it was agreed upon to move the pilot forward into the next fiscal cycle establishing a small group of Subject Matter Experts to provide further guidance on what other possible data set could be identified pointing to themes of member dissatisfaction.

❑ The CAHPS® Team began attending the 2024 Consumer Advisory Committee (CAC) quarterly meetings. CAC acts as a liaison group between members and Partnership and provides another mechanism to obtain feedback on existing/proposed CAHPS® interventions and activities.

- An example, a small pilot for Partnership branded ID card sleeves is currently taking place. The sleeve would allow members to keep both their state issued Department of Health Care Services (DHCS) Medi-Cal card and their Partnership card together. Results of the pilot will be shared at an upcoming CAC meeting as well as requesting their input before concluding the pilot.

❑ Association for Community Affiliated Plans (ACAP). The CAHPS® Team and several Senior Leaders participated in the first ACAP sponsored CAHPS® Collaborative. We had the opportunity to engage with nine (9) plans in several markets across the nation.

- **Medicaid Child Data Observations**
  - The member respondent population is of similar health status and slightly more diverse than other ACAP collaborative participants
  - Partnership has performance results similar to other plans
  - Rating measures tend relatively to be lower than other measures
  - Those with fair/poor mental health status gave lower scores on the rating measures
- **Medicaid Adult Data Observations**
  - Overall CAHPS® scores are lower than other Medicaid plans
  - Most rates are trending down as well
  - Those with fair/poor mental health status appear to have a much worse care experience
- **Network Management**
  - The Plan must understand provider network coverage and availability. Sometimes time and distance can be adequate while access still is poor
- **Provider Network**
  - Most of the members' experience with health care is going to be with the providers in a care setting; without affecting this, plans have limited ability to move CAHPS® rates overall
- Defining impactful interventions can be difficult to develop based on the results of the CAHPS® survey
- **CAHPS® Response Rates**

- Have decreased and administrative costs have increased, plans are looking for alternative means to assess member experience on a more real-time basis

- **Influencing Member Experience**
  - More complex operationally compared to influencing many clinical measures

Move the Dial

Partnership has experienced a season of change this fiscal year. We had executive level changes to include: new CEO, COO, and CTO, in addition to expanding our Northern California service area by 10 additional counties. We now serve 24 counties in the most rural areas of our state. We have also restructured our department fiscal goal process to organizational goals and targeted metrics. The CAHPS® Program will still maintain our annual programmatic focus but owning the responsibility of delivery is shared among four (4) departments: Communications, Member Services, HR/Workforce Development, and Quality Improvement.

The CAHPS® Program Manager has been appointed to lead ***Goal 4: Access to Care and Member Experience Improvement***. The Access to Care/Member Experience Improvement organizational goal will focus on three (3) main areas:

1. Understanding the landscape of our specialty provider network, identifying gaps, and developing targeted action plans
2. Understanding the landscape of our primary care provider network, identifying gaps, and developing targeted action plans
3. Expanding the "Your Partner in Health" branding campaign and implementing an action plan to improve and increase member awareness

Goal Overview and Impact Summary

Improving access to care and enhancing member experience are pivotal for fostering a healthcare system that prioritizes both quality and member experience.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey measures adult and child (member/patient) experience or perception of key aspects of their care. As an accredited health plan, we may designate which CAHPS® survey we want scored, either adult or child population. Last measure year, we chose child survey results that earned us 2.0 Patient Experience (CAHPS®) rating and an overall NCQA 3.5 Star Health Plan rating. This measure year Partnership designated adult survey results to be included in the scoring.

This fiscal year Partnership aims to achieve or exceed a 2.5 Star NCQA Patient Experience (CAHPS®) rating and achieve or exceed a 4.0 Star NCQA Health Plan rating. The Goal #4 team will continue to build on the prior year's interventions and improvement activities. The established FY 2024-2025 goals are intended to impact or influence positive change on the key focus areas:

Access to Care: Improving access to care serves as the gateway to improve patient/member experience and health outcomes. As an organization, Partnership must plan to navigate through access obstacles linked to ever-changing membership levels, clinical staffing shortages, and economic climate at state, county and federal levels. Over the next fiscal goal period, our plan is to broaden our approach with the stewardship of Workforce Development leadership. In scope is to incorporate the past four (4) years of implemented access improvements and lessons learned through the 5-Star Quality Strategic and Tactical Plans, and, where applicable, adjust them as we develop a comprehensive Access Strategy and Tactical Plan fully dedicated to access moving forward.

Member Experience: Advancing the QI CAHPS® programmatic framework will require implementing interventions rooted in present barriers and before eligible members participate in the regulated CAHPS® survey. Lessons learned through CAHPS® Score Improvement activities over the past two (2) fiscal goal periods has paved the path forward. The plan is to leverage more real time data (i.e., Grievance & Appeals [G&A] and Population Health Management [PHM] community engagement responses) on a quarterly basis to examine and respond timelier to topical themes identified directly from our members, including complaints about the health plan and providers. This enhanced method will provide Goal #4 team more real time opportunity to measure intervention effectiveness against targeted barriers.

Positive Reputation and Brand Identity: Continue to distinguish Partnership as a Managed Care Plan leader that is committed to member-centered care, leading to a positive reputation and member awareness, "our story" within the communities we serve.

Effective Communication: Enhance member communication through texting, email, and Partnership mobile application designed to centralize and simplify all member-facing online websites/tools/platforms. This will help drive usability and value by engaging members through various communication modalities in delivering proactive resources that promote health education, covered benefits literacy, wellness, and preventative care resources.

Member Engagement and Adherence: Empower members with knowledge and resources intended to lead to greater engagement in their own care and increased adherence to treatment plans, resulting in better long-term health outcomes.

Enhanced Digital Experience: Develop a user-friendly mobile app and enhance member portal functionality and methods to empower members to self-serve and inform Partnership how they would prefer to engage with us. The plan is to build upon member demographic collection integration through existing C-Square enhancements.

In summary, improving access to care and member experience is not only essential for meeting the evolving needs of healthcare consumers but also for driving positive outcomes, reducing costs, and maintaining our reputation to deliver high-quality care for our most vulnerable population.

The two (2) groups and focus areas for FY 2024-2025 are listed below.

- **Milestone 1:** The **Access Workgroup** will develop and propose a multi-year Access Strategy plan that is inclusive of: 1) Understanding the landscape of our specialty provider network and identifying gaps 2) Understanding the landscape of our primary care provider network and identifying gaps.
- **Milestone 2:** The Access Workgroup will develop and propose a multi-year Access Tactical plan that outlines targeted actions to drive Milestone 1 objectives.
- **Milestone 3:** The **Member Experience (ME) Workgroup** will drive CAHPS® Score Improvement (CSI) FY 2023-2024 pilot from analysis phase to Strike-Team "action" phase. The enhanced ME improvement strategy is continuous, with the intent to leverage quarterly data (G&A, PHM) sources to drive proactive interventions throughout FY 2024-2025.
- **Milestone 4:** The **Member Experience (ME) Workgroup** will focus on developing and proposing member communication and engagement enhancements through existing platforms or new tool development.

- **Milestone 5:** The **Member Experience (ME) Workgroup** will define and develop Member Informative Session (MIS) program strategy and framework.
- **Milestone 6:** The **Member Experience (ME) Workgroup** will implement Year 1 of the texting program as approved by the monthly texting workgroup.
- **Milestone 7:** The **Member Experience (ME) Workgroup** will continue with Your Partner in Health branding campaign to develop a Partnership Awareness - grassroots communications strategy.
- **Milestone 8:** The **Member Experience (ME) Workgroup** will collaborate with the Quality Improvement Pay-for-Performance Team to explore Unit-of-Service measure development opportunities.

Please see Appendix (E) Member Experience (ME 7) Report for a complete review of the FY 2023-2024 analysis, and interventions implemented and proposed FY 2024-2025 programmatic interventions.

Web Based Member Information Assessment

Purpose and Overview

The Quality and Accuracy of Information Report tracks the quality results of the information provided to Partnership members received during the following:

- Telephonic inquiry call(s) to the Member Services Department
- General inquiry(s) sent electronically (email) to the Member Services Department
- Partnership's website (self-service, Member Portal) online tools at https://member.partnershiphp.org/

Member Services reviews the quality and accuracy of information monthly. On an annual basis, findings are documented through the production of the Quality and Accuracy of Information Report. To provide transparency, the departments and contributors for this report are referenced below:

Title / Department
Senior Director of Member Services and Grievance
Senior Manager of Member Services
Quality and Training Supervisor of Member Services
Director of Grievance and Appeals
Compliance Manager of Grievance and Appeals

Methodology

Telephonic Response

Data Source: *Annual Telephone Quality and Accuracy Evaluation*

Member Services leadership annually tests Member Service Representatives (MSR) on the quality and accuracy of telephone support as it relates to "Referrals and Authorizations", "Eligibility and Benefits", and "Member Financial Responsibilities".

The Member Services Management Team assesses the quality and accuracy of telephonic support provided by an MSR through the administration of the "*Eligibility and Financial Responsibility Knowledge Check"* test. Testing is administered through Partnership's online Learning Management System (LMS) training tool. This tool tracks and trends both individual and overall results. Member Services Supervisors review individual MSR testing results and

provide a departmental summary to be reviewed by the Member Services Management Team. Through this review, the management team addresses any deficiencies identified and determine appropriate next steps.

In terms of performance standards, a minimum score of 90% is required for individual MSR's and a minimum score of 95% for the collective department. If the management team identifies any departmental trend(s) within the deficiencies, they will place the individual(s) and/or the department on a Corrective Action Plan (CAP). Additionally, the management team provides their analysis to the Member Services Quality & Training Supervisor to develop tailored training material that may include, but not limited to:

- Updated desktop procedures/materials
- Instructive and informative email correspondence
- Departmental training classes

In addition, results are summarized annually and documented within the analysis section of the Quality and Accuracy of Information Report. This report is also presented to the Member Experience Sub-Committee for review and approval.

Quality & Accuracy Member Complaints
Data Source: *Member Phone Call/Email*

Member complaints against Partnership staff are documented by Member Services Supervisors. This includes complaints filed due to staff providing misinformation or not enough information related to a member's Financial Responsibility, Referrals, and/or Authorizations. If a supervisor identifies a training opportunity, they provide tailored support and conduct additional training for the staff member.

Partnership's Grievance and Appeals (G&A) Department provides Member Services with an annual report including details on all Partnership staff related complaints. If trend(s) are identified, the Member Services Quality and Training Supervisor may develop tailored training material that include, but not limited to:

- Updated desktop procedures/materials
- Instructive and informative email correspondence
- Departmental training classes

In addition to the annual reporting and analysis, there is an established feedback loop to address any instance of misinformation closer to real time. In the event that the G&A Department note that misinformation was provided, the staff's respective supervisor is notified and shall work with the staff member to provide feedback, coaching, and monitoring.

Website Self-Service Quality
Data Source: *https://www.partnershiphp.org/Pages/PHC.aspx*

10 of Partnership's newest Member Services MSR's audit the functionality and ease of use of Partnership's website. This audit is conducted on an annual basis through the use of a computer-based survey tool. Partnership utilizes new employees as their lack of experience in navigating the Member Portal provide a true gauge of what a member would experience as it relates to the ease of use and the quality of information provided.

Performance is measured on a five-point rating scale, in which one (1) would equate to a poor experience, whereas a five (5) would signify an excellent experience with Member Portal functionality. To adequately measure this metric, there is an established performance threshold of 3.0 for any respective question/activity. Staff members determine the quality and accuracy of the web functionality based on the following:

Changing Primary Care Practitioner:
Was it easy to do?
Was the staff member able to change a PCP?
Was it completed in one attempt?

Determine How/When to obtain Referrals/Authorization:
Was it easy to find?
Was the staff member able to determine how and when to obtain referrals and authorizations for specific services?
Was it completed in one attempt?
Was the information provided useful?

Determine benefits and financial responsibility of a service:
Was it easy to find?
Was the staff member able to find the language that stated that members have no financial responsibility?
Was it completed in one attempt?

Audit findings are summarized and reviewed annually. In the event that the results of a specific question/activity has an average score below 3.0, the Member Services Leadership Team shall engage Partnership's Web Development Team. These efforts will include a robust conversation around potential recommendations and/or enhancements needed for improvement. Similar to the above, the annual report is presented to the Member Experience Sub-Committee for review and approval.

Email

Data Source: Emails submitted via https://www.member.partnershiphp.org

A designated Member Services auditor selects 10% of all email inquiries or a maximum of 10 inquires, whichever is fewer, per month to audit. The auditor determines the quality, accuracy, and timeliness of the email response to the member inquiry through the following categories:

Email Etiquette

- Identified themselves to the member
- Response protects Member(s) Personal Health Information (PHI)
- Response projects professionalism and politeness
- Correct spelling, grammar, and punctuation

Resolution

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

Timeframes and Documentation

- Delivered appropriate acknowledgment or resolution response within one business day of receipt of the Member's request.
- Resolution completed by the end of the following business day
- Member's record is documented according to policy

Audit findings are recorded into the Member Services Department Audit Log, which tracks and trends individual and overall results. Individual audit results are reviewed with the staff member's Supervisor and overall departmental results are reviewed by the Member Services Management Team. Through this review, the department aims to address any deficiencies identified as well as determine appropriate next steps. If the auditor identifies any trends within the deficiencies (meaning an aggregate score that falls below the performance threshold of 95%), they provide their analysis to the Member Services Quality and Training Supervisor to develop tailored training material that may include, but not limited to:

- Updated desktop procedures/materials
- Instructive and informative email correspondence
- Departmental training classes

Annually, the results are summarized in a formal analysis that is presented to the Member Experience Sub-Committee for review and approval.

Results & Analysis

Telephonic

All qualified MSR's were tested on the quality and accuracy of referrals, authorizations, eligibility and benefits, and member's financial responsibilities. Based on the results of this year's testing, the department achieved a 98% (Table 1), which exceeds the established threshold of 95%.

Table 1

	2023	2024
	Quality & Accuracy Question Scores	
Question 1	99%	100%
Question 2	99%	97%
Question 3	100%	100%
Question 4	100%	100%
Question 5	100%	100%
Question 6	100%	100%
Question 7	100%	100%
Question 8	100%	100%
Question 9	100%	97%
Question 10	100%	100%
Question 11	100%	100%
Question 12	98%	77%
Question 13	100%	100%
Question 14	100%	100%
Total:	***100%**	***98%**

*Percentages are rounded

While the department exceeded the threshold, common areas of opportunities were identified in which the Quality and Training Supervisor will collaborate with departmental supervisors on staff level refresher trainings with an emphasis on useful information to provide members who say they need to see a Specialty Provider. This tailored training will address the deficiency illustrated in the results of Question 12 (77%). In addition, the findings below were organized to include a comparison of results, year over year:

- Experienced a decrease of 2% in total score
  - 100% (2023) vs. 98% (2024 -13/14 questions exceeded the 95% threshold)
- Three (3) questions showed a decrease year over year
  - Question 2: -2%
    - 99% (2023) vs. 97% (2024)
  - Question 9: -3%
    - 100% (2023) vs. 97% (2024)
  - Question 12: -21%
    - 98% (2023) vs. 77% (2024)
      - 28/34 or 76% of the participants provided the correct response
    - Results were below the 95% performance standard
- Testing Participation
  - 2023: 32/33 staff tested, 1 leave of absence
  - 2024: 34/35 staff tested, 1 leave of absence
    - Of the staff that tested, 70.5% scored 100% and 29.4% scored a 93%
    - Note that one staff member (newly hired/trained) had to retake the test

Quality and Accuracy Member Complaints

For 2023-2024 evaluation period, Partnership experienced a total of 147 member complaints against Partnership staff (81 previous period). Of the 147, just four (4) were tied to misinformation regarding either "Referrals and Authorizations", "Eligibility and Benefits", and "Member Financial Responsibilities". For the purpose of this report, our G&A Department references these types of complaints as an "RAFR" complaint. When comparing this result to the previous evaluation period (2022 – 2023) in which there were 81 total complaints, non were attributed to an RAFR reasoning. One thing to note is that our G&A Department completed internal process improvement efforts around generating RAFR reporting. These efforts have streamlined our internal efficiencies and provided heightened accuracy when generating RAFR complaint reporting.

Upon further review of the reporting results from this evaluation period, all four (4) complaints were found to have coaching opportunities, which is documented within the Resolution Column in Table 2. When reviewing the departmental breakdown of complaints against staff members, Member Services had two (2) or 50% of the complaints that met the RAFR criteria. G&A and Transportation Departments were associated with the remaining two complaints.

It is also worth noting that the Member Services Department did not exceed the threshold of three (3) complaints in total. The Member Services Leadership Team will continue to monitor member complaints around the RAFR reasoning on an annual basis to ensure that the department continues to perform within the anticipated threshold.

Table 2

2022 - 2023			
Date Received	**Date Closed**	**Issue**	**Resolution**
N/A	N/A	N/A	N/A

2023 - 2024			
Date Received	**Date Closed**	**Issue**	**Resolution**
2/14/2023	2/16/2023	The member is upset because he feels he is receiving conflicting information regarding a TAR from different people at Partnership. The Grievance staff said it was approved and the Care Coordination (CC) person staff said it was denied.	The MSR educated the member regarding the denial of the TAR in question, advised him that his Case Manager (CM) in CC would follow up with him, and offered to file a Grievance. The member declined to file a standard Grievance so an exempt Grievance was filed.
7/31/2023	8/15/2023	Member was unhappy with the Transportation Unit representative who provided her information about the GMR process. Member had a long trip scheduled, which would include a hotel and meal reimbursement. The representative did not specifically tell member that the meal is something they must pay for and request a reimbursement for. Member usually has very little money and she was under the impression Partnership would send meal ticket/vouchers.	Partnership Transportation Unit listened to recorded call and agreed the rep did not explain the process well enough. They provided education and feedback to their staff so that better explanations of the process are given to members. Member asked for help on how to get her receipts to Partnership. She lives in Eureka, so I shared the physical address. Member stated she would drop these off at the office.
9/22/2023	10/17/2023	Member dissatisfied that it took 10 months for billing issue to be resolved. Staff member did not know the correct information.	MS Enrollment unit reviewed the concerns. They have implemented a process to monitor timeframes for billing issues. Staff member has been counseled. The process will be reviewed at

			their department trainings and added to their desktops.
10/6/2023	10/9/2023	The member had communication issues with the Member Services Representative (MSR) who initially assisted her with her referral issue.	The member declined to file a standard Grievance. An exempt Grievance was filed. Supervisor reviewed call, and found training opportunity around referrals / authorizations for palliative care. Feedback was given.

Website Self-Service Quality and Accuracy

When looking at the results of the current reporting period (Table 3), the overall results continue to show perpetual progress above and beyond the established categorical threshold of 3.00. All categories either experienced an increase or remained flat in overall average ratings in comparison to the previous period (Table 4).

Table 3

Year 2024

Changing Primary Care Practitioner:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to do?	5.00	5.00	4.00	3.00	3.00	5.00	5.00	5.00	5.00	3.00	4.30
Was the staff member able to change a PCP?	5.00	5.00	5.00	3.00	5.00	5.00	5.00	4.00	5.00	3.00	4.50
Was it completed in one attempt?	5.00	5.00	4.00	3.00	4.00	5.00	5.00	4.00	4.00	3.00	4.20

Determine How/When to obtain Referrals/Authorization:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to find?	2.00	5.00	4.00	4.00	4.00	5.00	5.00	5.00	5.00	5.00	4.40
Was the staff member able to determine how and when to obtain referrals and authorizations for specific services?	2.00	5.00	4.00	4.00	5.00	5.00	5.00	4.00	5.00	5.00	4.40
Was it completed in one attempt?	1.00	5.00	4.00	4.00	5.00	5.00	5.00	4.00	5.00	5.00	4.30
Was the information provided useful?	4.00	5.00	4.00	4.00	5.00	5.00	5.00	5.00	5.00	5.00	4.70

Determine benefits and financial responsibility of a service:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to find?	1.00	5.00	5.00	4.00	2.00	5.00	5.00	5.00	5.00	5.00	4.20
Was the staff member able to find the language that stated that members have no financial responsibility?	1.00	5.00	4.00	4.00	3.00	5.00	5.00	5.00	5.00	5.00	4.20
Was it completed in one attempt?	1.00	5.00	4.00	1.00	4.00	5.00	5.00	5.00	5.00	5.00	4.00

Table 4

Year 2023

Changing Primary Care Practitioner:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to do?	4.00	3.00	3.00	5.00	5.00	5.00	4.00	5.00	2.00	5.00	4.10
Was the staff member able to change a PCP?	4.00	3.00	4.00	5.00	5.00	5.00	4.00	5.00	1.00	5.00	4.10
Was it completed in one attempt?	1.00	3.00	4.00	5.00	5.00	4.00	3.00	5.00	1.00	5.00	3.60

Determine How/When to obtain Referrals/Authorization:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to find?	2.00	3.00	5.00	5.00	5.00	5.00	5.00	4.00	3.00	4.00	4.10
Was the staff member able to determine how and when to obtain referrals and authorizations for specific services?	4.00	3.00	5.00	5.00	3.00	5.00	5.00	5.00	3.00	4.00	4.20
Was it completed in one attempt?	2.00	3.00	5.00	5.00	5.00	5.00	5.00	3.00	2.00	5.00	4.00
Was the information provided useful?	4.00	3.00	5.00	5.00	4.00	5.00	5.00	5.00	4.00	5.00	4.50

Determine benefits and financial responsibility of a service:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to find?	5.00	5.00	5.00	3.00	3.00	5.00	5.00	4.00	2.00	4.00	4.10
Was the staff member able to find the language that stated that members have no financial responsibility?	5.00	5.00	5.00	4.00	2.00	5.00	4.00	5.00	2.00	5.00	4.20
Was it completed in one attempt?	5.00	5.00	5.00	4.00	2.00	4.00	4.00	3.00	1.00	4.00	3.70

As the granular detail and results for each category and surveyor were reviewed, it was noticed that there was a potential outlier in our surveyor scoring. One (1) surveyor scored 7/10 questions lower than the total surveyor average per question. This same surveyor also scored 2/3 categories lower than the total surveyor average per category. In partnership with the Quality and Training Supervisor, rather than prematurely reacting to this potential outlier in scoring, it was determined that the department will hold course and closely monitor next year's reporting to identify applicable trends. While this potential outlier was not anticipated, it is best to reiterate that the overall scores for each category illustrate positive increases within each category, thus meeting our established thresholds. In addition to the above, we have organized additional year over year comparisons, as shown below:

- Total Average Rating as a whole increased by 6%
  - 4.32 (2024) vs. 4.06 (2023)
- The "Changing Primary Care Practitioner" category experienced a positive increase of 10%, the largest of the three categories
  - 4.33 (2024) vs. 3.93 (2023)
- The "Determine How/When to obtain Referrals/Authorization" (+6%) and "Determine Benefits and Financial Responsibility of a Service" (+3%) categories experienced positive shifts in scoring
- Increased the average rating of the lowest surveyor score by 29% year over year
  - 2.70 (2024) vs. 2.10 (2023)

Email Accuracy and Timeliness

As the intradepartmental workgroup compared the results of the current period against the previous period (Table 6), the total increase in the amount of email inquiries received was glaring. We experienced an increase of 350 total inquiries or +79% over the previous period. As a result of this increase, we conducted 28 additional audits (compared to the previous period). Overall, we audited 11.8% of the total number of email inquiries received.

Additionally, each month of the current period showed a positive increase in total email inquiries received, a larger proportion of the increase in volume occurred between January through April 2024. This increase was attributed to the overall growth in our membership base as our recent geographic expansion added ten additional northern California counties into our service area.

Table 6

		2023								2024				
Email Inquiries	**Goal**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**Total**
Total Email Inquiries Received	N/A	57	41	56	57	55	53	30	35	113	124	67	105	793
# of Submissions Audited Per Month	10 or 10% of # Inquiries Received	5	5	5	5	5	9	9	9	11	12	8	10	93
% of Accuracy of Information	95%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	98%	99.8%
% of Emails Responded to Within 1 Business Day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%

		2022								2023				
Email Inquiries	**Goal**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**Total**
Total Email Inquiries Received	N/A	22	39	28	35	30	26	39	26	46	33	64	55	443
# of Submissions Audited Per Month	10 or 10% of # Inquiries Received	5	5	5	5	5	5	5	5	5	5	10	5	65
% of Accuracy of Information	95%	100%	100%	98%	100%	100%	100%	100%	100%	98%	100%	100%	100%	99.7%
% of Emails Responded to Within 1 Business Day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%

Despite the positive results, the intradepartmental workgroup took a deep dive into the current period results and the overall year over year trend. Through this review, it was determined that our current auditing sample size may not be statistically significant. In an effort to produce reliable results with increased confidence levels, we have decided to adjust our sample size as stated in Table 7 (below):

Table 7

Previous Sample Size	New Sample Size
10% of all email inquiries, at a maximum of ten (10) inquires or whichever is fewer per month to audit.	20% of all email inquiries

Summary

Barriers

Our quality and accuracy results continue to show perpetual progress in which we continue to meet our performance threshold(s). Our intradepartmental workgroup did not identify any barriers nor major challenges to achieving and maintaining our categorical results.

Opportunities for Improvement

While there are no glaring areas of opportunity, we have noted some potential areas to monitor as our focus is now around process improvement and defining sustainability elements to ensure continued success.

When looking at the results of our current period reporting, it is apparent that the heightened focus and effort placed around training and developing our staff has resonated and evidenced through our performance. The department takes great pride in our thorough and exhaustive training curriculum for new and existing employees. As Partnership's membership base continues to grow, our department staff count will mirror that same growth, and with growth comes the hiring of new employees. To address this area, our department shall continue to place an emphasized focus on tailored and timely communication between the leadership team and departmental trainers. We will also continue to solicit new hire feedback, remaining proactive in addressing any potential concerns around training. This communication and foundation will play an instrumental role in ensuring that our quality and accuracy of information results do not waver, regardless of staff count.

At the department level, we remain committed to ensuring a heightened focus on process improvement and shall continue to identify potential avenues of opportunity. Our priorities continue to revolve around realizing increased efficiency and quality standards to ensure the quality and accuracy of all information provided to members is coherent and accurate.

Prioritization and Next Steps

Given the positive results of the current period, there were no visible areas requiring immediate attention or intervention. In an effort to ensure that our year over year results remain consistent, the Member Services Leadership Team will continue to closely monitor individual employee scorecards, new hire training, and process improvement efforts around the quality and accuracy of "Referrals and Authorizations", "Eligibility and Benefits", and "Member Financial Responsibilities".

In terms of next steps, and as mentioned within Section II, our Quality and Training Supervisor will work with our department supervisors to conduct a staff level refresher training. This refresher training will have an emphasized focus on useful information to provide members who say they need to see a Specialty Provider. Through this training, we will also establish a feedback loop providing an open forum for staff members to share their thoughts on the delivery and effectiveness of the refresher. Lastly, attendance for this training will be tracked and compared against future period results.

Quality in Grand Analysis

QI TRILOGY

NCQA - Grand Analyses

Partnership has established a strong foundation and framework to engage and build community partnerships with our members, health providers and organizations that serve the tenets of our organizational mission of ***"To help our members, and the communities we serve, be healthy,"*** and vision of ***"To be the most highly regarded managed care plan in California."*** Our commitment of continuous quality improvement is summarized within the six (6) Grand Analyses herein and in addition the complete analyses are provided in the appendices.

Access and Availability (NET3) Report

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

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

Opportunity

Increase the number of contracted primary care and high-volume specialty care practitioners.

- Effectiveness of Prior Actions: Partnership has started a sponsored workforce development program that offers a sign-on bonus for providers when they contract with Medi-Cal for the first time, and if they come from a county outside of the 14 counties that Partnership serves. This updated program is taking place between January 2021 – January 2024 with the bonuses being paid out over multiple payments over a 36-month term for physicians, NP's, and PA's and 12 months for licensed behavioral health clinicians including Substance Use Disorder (SUD) counselors. The strategy is to hold providers in place longer term. To date there has been an increase in accepted offers with 84 the first year and 89 the second with Family Medicine being the majority provider specialty. Partnership was able to recruit 66 new primary care practitioners to the network between May 1, 2023 and December 1, 2023 with 27 of them going to six (6) of our most rural northern counties. Initial retention details look favorable but we may not know completely until the 36-month time period and payments take place.
    - *Planned Action*: Partnership has had success with the sponsored workforce development program to date and will continue the strategy in an effort to continue recruitment of physicians, NP's, PA's, and licensed behavioral health clinicians including SUD counselors.
    - *Planned Action*: Expand efforts to strengthen recruitment of support specialty providers by adding obstetrics providers (physicians, women's health nurse practitioners, certified nurse midwives) whose clinical care focuses on perinatal care, including labor and delivery to the 2024 workforce development program.
    - *Planned Action*: Conduct a retrospective assessment of specialty providers to identify additional opportunities to better use telehealth as a way to increase access to care, particularly in the rural counties.

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

Continuity and Coordination of Medical Care (QI3) Report:

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

Partnership annually assesses continuity and coordination of medical care opportunities by way of its various Quality Incentive Programs to ensure the providers are getting information needed to facilitate smooth transitions of care when crossing various setting of care. Partnership's QIPs are designed for hospitals, perinatal, and primary care providers. The QIP Team includes members from the Health Analytics, Population Health, Quality Improvement, Care Coordination, and Provider Relations Departments, as well as representation from the Office of the Chief Medical Officer and Partnership's regional leaders.

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

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

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

The Risk Adjusted Readmission measure looks at the rates of member hospital readmissions occurring within 30 days of discharge from hospitals participating in Partnership's Hospital Quality Incentive Program (HQIP). The readmission rate is considered an indicator of appropriate discharges, including adequate re-connection with the patient's primary care office at the time of discharge. Awareness of this set of diagnosis codes provides an opportunity for provider education and improvement. Partnership can work with providers to be aware of members at risk for these diagnoses. Partnership can also assist with care management and coordination to help drive a smooth transition of care and information sharing from the hospital back to the primary care provider. This work will be aided by increased utilization of Sac Valley Med Share, Collective Medical and other record sharing systems by improving awareness of hospitalizations and the sharing of medical information between providers and facilities and between facilities and Partnership. As evidenced in the full “Continuity and Coordination of Medical Care (QI3) Report” (Appendix B), given the continued and significant improvement in this measure over the past few years, and the technical achievement of goals, this measure may not continue to be monitored as part of this report.

The "Emergency Department (ED) to primary care practitioners" measure looks at the rate of assigned members with an "avoidable ED visit" due to any one or more of a specified set of primary diagnoses. ED visits are a high-intensity service and a cost burden on the health care system, as well as on patients. Some ED events may be attributed to preventable or treatable conditions. A high rate of ED utilization may indicate poor care management, inadequate access to care, and/or poor patient choices, resulting in preventable ED visits. Each PCP site (all PCP sites with assigned members are PCP QIP participants) had an Avoidable Emergency Department (ED) Visits/1000 Members per Year target. Partnership will continue to work with providers on improving access (in-office, telephonic, and virtual) to PCPs through actions like patient education, instructions for accessing advice lines (after hours "nurse lines"), and continued financial supports like the Provider Recruitment Program to attract new providers. The PCP QIP will also continue an existing "unit of service measure" incentivizing PCP offices to provide some level of direct member to provider contact (virtual or in office) above normal clinic hours for at least eight (8) hours per week. Partnership also supports and incentivizes practices in achieving Patient Centered Medical Home (PCMH) accreditation. NCQA defines PCMH as, “a model of care that puts patients at the forefront of care. PCMHs build better relationships between patients and their clinical care teams”. One of the foundations of this model is to keep the PCPs involved in all aspects of patients’ care, with the potential benefit of reducing unnecessary services (e.g., ED visits), while improving patient satisfaction. Partnership also maintains an online platform (Provide Online Services) which allows providers ready access to a list of their members who have accessed the ED, and even the option to receive “push notifications” when a patient is seen in an ED. Partnership plans to continue to monitor this measure for this report in the coming year.

The HEDIS® performance measure: Prenatal and Postpartum Care (PPC) - Postpartum rate assesses effective and timely postpartum care following delivery, specifically measuring the rate of members receiving two (2) postpartum care visits, with one (1) occurring within 21 days after delivery and the other occurring between 22 and 84 days after delivery. Effective and timely postpartum care occurs in the first few weeks after delivery. These visits are essential to support maternal-infant bonding and to ensure that birthing patients have access to breast feeding education, screening and treatment for mood disorders, and appropriate family planning options.

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

Furthermore, the Perinatal Work Group will examine the rates of postpartum visits through a race and ethnicity lens to determine how a member engagement initiative can offer education and outreach to populations with lower rates of postpartum visits. Partnership plans to continue to monitor this measure for this report in the coming year.

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

PCP QIP Comprehensive Diabetes Care - Eye Exam measure returned from being a non-incentivized [monitoring] measure in MY2020-2022 to a fully incentivized measure in MY2023.

Prior to the pandemic, many organizations were adopting "tele-optometry" services, which use retinal cameras placed in PCP offices to send digital images of the patients' retinas to optometrists and ophthalmologists for readings and interpretations ("eye specialist services"). Due to the pandemic, with the need for physical distancing and staffing limitations, many organizations were forced to discontinue the use of tele-optometry services. Partnership encourages the revitalization and spread of this practice. Data from MY2022 showed an increase in performance, but only 35.71% of participating sites were able to meet the goal for this measure.

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

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

Continuity and Coordination of Behavioral Health (QI4) Report:

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

Work to analyze, improve and build upon efforts to promote coordination of medical and behavioral health care services across settings, focusing specifically on the performance for two (2) of the measures; Data on the frequency of treatment and follow-up visits following mental health or substance abuse diagnosis and Appropriate Use of Psychotropic Medications. The measures address the sharing of information; promotion of treatment of the whole person, and adherence to standard diagnosis and treatment guidelines.

Data on the frequency of treatment and follow-up visits following mental health or substance abuse diagnosis was a new intervention factor this year. This analysis focused on data on the frequency and follow-up for members diagnosed with a substance use diagnosis. The goal was met with 42% of members with co-occurring diagnosis resulting in a subsequent (Substance Use Disorder) SUD encounter. Of the individuals who connected to treatment, 79% participated in treatment for a minimum of seven (7) days, and 63% remained in treatment for at least 30 days. Members waited to enter treatment an average of 7.71 days after their initial SUD diagnosis. Subsequently, there was an average of 139.22 days in treatment amongst the three (3) most common SUD diagnosis with a median of 14.02 treatment episodes monthly.

Timeliness to first SUD encounter was important to measure whether providers can accommodate subsequent visits after admitting into treatment. While the days to treatment were under the 10-day requirement, hospitals

reported admitted members often have delays in discharge due to lack of capacity within substance use facilities. This led to review of the highest utilized locations of service for newly diagnosed which presented as primary care which aligns with the prescribing of medication for addiction treatment. Outpatient and emergency room visits with new SUD diagnosis had decreased from 33,667 in 2022 and 14,622 in 2023 with the utilization of substance use navigators deemed to be a significant factor. Further review drew attention to inpatient stays with over five (5) claims per utilizing member with co-occurring diagnosis, higher readmission rates, and longer length of stays.

As shared, our work in year primarily focused on the sustainability of the CA Bridge substance use navigation program. While the one (1)-year funding provided by Partnership seems to have improved by decreasing utilization within emergency departments by 57%, a longer term solution needs to be identified and implemented. DHCS has identified community health workers as a new version of substance use navigators and Partnership will partner with hospitals to bridge the two (2) programs.

The analysis presented an opportunity for further review of co-morbidities. Members with dementia averaged 15.2 claims per year, and 11.5 for members with traumatic brain injury (TBI), both substantially lower than plan wide average. Questions loom regarding potential correlations and/or the need to target recruiting of SUD providers who specialize in cognitive behavioral therapy.

Primary or Secondary Prevention Behavioral Healthcare Program Implementation measured the prevalence of eating disorder diagnoses and follow-up treatment within 90 days. Throughout 2020, 2021, and 2022 fewer than 90% of members diagnosed with an eating disorder received follow-up treatment within 90 days; 79.66% in 2020, 78.05% in 2021, and 76.73% in 2022, failing to meet the goal for those years. However, in 2023, 21% less cases were diagnosed in 2023 than in 2022, although still failing to reach the goal of 90% receiving follow-up treatment within 90 days. While it is uncertain the cause of the decrease in number of cases identified in 2023, history has indicated claims lag may influence the measure as Medi-Cal allows for billing up to 365 days' post service. Of the 421 individuals newly diagnosed with an eating disorder in 2023, nine (9) were diagnosed in an acute (emergency room or inpatient) setting, with six (6) receiving follow-up care within 90 days. Primary care and Carelon mental health services resulted in a larger quantity of diagnosis with similar follow-up outcomes with 369 of 412 receiving care within 90 days.

Interventions and associated activities appear to be effective, with a consistent number of members being diagnosed and treated within 90 days. The lack of access and associated barriers were initially identified in 2019, with interventions carried from 2020 through 2023.

Six (6) different projects were leveraged including collaborative meetings with other managed care plans, primary care, and behavioral health clinicians to discuss prevalence and approaches to eating disorders. Partnership hosted trainings by leading experts in the field of eating disorders which have been posted to our website, and referral pathways were modified where opportunities presented themselves. Work appeared to lead to an improvement in the diagnosis and follow up of those with eating disorders, however it did take time for the interventions to show improvement. Partnership plans to continue to offer trainings; recruitment support and an innovative "wrap around" telehealth program. The Plan also continues to identify resources to help providers care for clients with eating disorders.

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

Pharmacy & Utilization Management (UM1B) Report: Utilization Management

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

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

In addition, data for member and practitioner experience with the UM process is evaluated to identify improvement and actionable opportunities. This report does not contain Kaiser Permanente or Carelon Behavioral Health data for evaluation of the UM program. Kaiser Permanente and Carelon Behavioral Health are NCQA accredited, and as such, reports from Kaiser Permanente and Carelon Behavioral Health are reviewed through the delegation oversight process.

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

Member Experience (ME7) Report

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

MY2022-2023 Survey Results

The survey and member experience analysis of Partnership health plan delivery and identification of improvement opportunities cover the Measure Year MY2022, and Reporting Year RY2023. The comparison of NCQA composite measure scores by Adult and Child population includes measure years; MY2022-2023, and MY2021-2022, and notable findings by population are identified below.

CAHPS® Adult

- A noticeable improvement in the Adult MY2022 Rating Measures compared to MY2021. Rating of Health Plan, only one (1) of four (4) measures did not meet or exceed the Partnership 25th percentile target. Noteworthy, is an observed improvement in Rating of Health Plan percentile rating. Although the Rating of Specialist Seen Most Often exceeded the 25th percentile target, there is a decrease in performance.
- Adult Composite Measures compared to MY2021 not meeting or exceeding the Partnership 25th percentile target, are two (2) out of four (4) measures; Getting Needed Care, and Getting Care Quickly. An observed decrease in Getting Care Quickly is noted, which aligns with both industry and Press Ganey BoB composite score trends related to Access to Care.
- Adult oversampling strategy contributed to meeting the reportable threshold of 100 survey responses for each rating and composite measure.

The Adult survey responses relative to Partnership covered members indicate we continue to have dissatisfaction with member access and correlating impact on member experience that influence health plan ratings. Stakeholders determined that continued intervention focused on Getting Needed Care, Getting Care Quickly, and Rating of the Health Plan composite measures and Rating of Health Plan would be in scope for the CAHPS® Score Improvement (CSI) Department Goal for FY 2023-2024.

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

CAHPS® CHILD

- A noticeable improvement in the Child MY2022 Rating Measures compared to MY2021. Rating of All Health Care, only one (1) of four (4) measures did not meet or exceed the Partnership 25th percentile target.
- MY2022 Child Composite Measures compared to MY2021 that did not meet or exceed the Partnership 25th percentile benchmark is three (3) out of four (4) in Getting Needed Care, Getting Care Quickly, and Care Coordination. An observed decrease in both measures align with both industry and Press Ganey BoB trends. As reference Access to Care continues to be a barrier and an area Partnership is focused on improving.
- Child oversampling strategy contributed to meeting the reportable threshold of 100 survey responses for each rating and composite measure.

The Child survey responses relative to Partnership covered members indicate we continue to have dissatisfaction with member access and correlating impact to member experience that influence health plan ratings. Stakeholders determined that continued intervention focused on Getting Needed Care, Getting Care Quickly, and Rating of the Health Plan composite measures would be in scope for the CAHPS® Score Improvement Department Goal for FY 2023-2024.

2023 GRIEVANCES AND APPEALS (G&A) DATA

The Member Experience Report tracks increases in case numbers across five (5) specific categories defined by NCQA. The threshold for significant change is set at a 10% increase. This report provides insight into which categories experience fluctuations, reflecting the impact of membership growth and overall case filings.

There were a total of 4,261 closed G&A cases in calendar year 2023, compared to 3,3318 in MY2022. These cases are broken into two (2) groups. Grievances which accounted for 3,572 and Appeals and Second Level Grievances, which accounted for 689. The two (2) case types that comprise the leading filed Grievances were Access at 1,526 (43%) followed by Service and Attitude 1,752 (49%) of 3,572 closed grievance cases.

The G&A performance thresholds are set based on prior year's performance, and targets are set at the level of each NCQA grievance and appeal category. A summary threshold for annual performance was also established (see second column of Tables 4 and 5). This data represents all member filings within the 2023 calendar year. ***For additional details, please reference Appendix H: 2024 Grievance & Appeals Annual Report.***

QI DEPARTMENT CAHPS® SCORE IMPROVEMENT (CSI) GOAL

Drawing on new discoveries and lessons learned in FY 2022-2023, CAHPS® Score Improvement (CSI) goal efforts pivoted in FY 2023-2024 from four (4) distinct workgroups into one (1) collaborative Oversight Workgroup. This change afforded our team the ability to remove cross-department work silos and improve department leader

collaboration by linking to external QI Department goal activities that directly and indirectly influence member experiences.

Further, restructuring allowed external departments to adopt or align with the CSI goal. As a result, implementation of new improvement activities and interventions that targeted workforce development, improved access to care, transportation services, direct-to-member activities, and increased Partnership branding and awareness were the focus of this collaborative workgroup. Seven (7) departments officially adopted the CSI goal and three (3) departments closely aligned their goals with CSI.

Additionally, an opportunity presented itself mid-year where the CAHPS® Team was invited to a webinar brainstorming session in order to fulfill Partnership's Northern Region consortia partners, Health Alliance of Northern California (HANC) and North Coast Clinics Network (NCCN), contractual agreement. The CAHPS® Team suggested a Patient Experience webinar, which stemmed from the team's CG-CAHPS® / Provider Network – Improve Communications Scores Pilot referenced above. The outcome was a webinar entitled *Incorporating Patient Experience in Quality Improvement Projects and Plans,* which was held on May 7, 2024. The learning objectives for participants viewing this webinar were as follows:

- Describe how patient experience impacts clinical outcomes, patient satisfaction, provider/staff satisfaction, and healthcare quality.
- Identify opportunities to assess patient experience data from a Quality Improvement (QI) perspective.
- Apply QI methodology to patient experience improvement activities.
- Discuss strategies for involving patients and their families in the QI process.

There were 53 external individuals, representing 34 unique organizations, who attended this webinar. The webinar recording is posted under "On-Demand" webinars on the Quality page of Partnership's website. An article in the summer 2024 edition of the Partnership Provider Relations newsletter focusing on CAHPS® and Member Experience as a true partnership between the healthplan and providers highlighted this webinar and encouraged providers to view the recording.

Please see Appendix (E) Member Experience (ME 7) Report for a complete review of the FY 2023-2024 analysis, and interventions implemented and proposed FY 2024-2025 programmatic interventions.

HE-6 Grand Analysis

The HE 6: Reducing Health Care Disparities is an NCQA standard that examines how Partnership stratifies measures by race, ethnicity, language, and sexual orientation, as well as the prioritization and action taken, as necessary, to improve identified inequities. More specifically, the HE 6 report summarizes the work of Partnership to analyze potential disparities within the member population through an analysis of race and ethnicity, language, and gender data, as well as Partnership's effort to implement impactful interventions to reduce inequities and improve any Culturally and Linguistically Appropriate Services (CLAS) identified through the analysis. The measures of focus for the Grand Analysis report are:

1. Controlling High Blood Pressure (CBP)
2. Hemoglobin A1c Control for Patients with Diabetes (HBD)
3. Prenatal and Postpartum Care (PPC)
4. Child and Adolescent Well Care Visits (WCV)

Partnership completed this Grand Analysis for the first time in February 2024 as an element of Health Equity Accreditation (HEA), utilizing MY2022 Health Plan Accreditation (HPA) and MY2022 Managed Care Accountability Set (MCAS) final rates.

After Partnership's assessment for statistically significant inequities for the measures of focus, the following disparity classification system was developed to aid in prioritizing disparities based upon measure findings. This is based upon the Strength of recommendation taxonomy used in various clinical guidelines to stratify recommendations:

Disparity Classification

Strong Disparity (Disparity is clearly present when compared to comparator group or goal)
• Meets at least three (3) of any of following factors below
  ○ HPA Sample Measure
  ▪ Absolute percentage difference (between group or goal) at least 15%
  ▪ One group is performing significantly better than comparator group but at least one (1) group is performing significantly worse per HEA measures
  ○ MCAS Sample Measure
  ▪ One group is performing significantly better than comparator group but at least one (1) group is performing significantly worse per MCAS measures
  ▪ Absolute Average Percentage deficit between specific group and minimum performance level is at least 7% (multiple regions) or 15% in single region in MCAS/HEA measure
  ▪ Absolute Percentage deficit between specific group and minimum performance level is at least 20%
  ▪ Multiple regions (≥2) where specific group falls below 25th percentile per MCAS measure

Moderate Disparity (Disparity is moderately present when compared to comparator group or goal)
• Meets at least two (2) of any of the following factors
  ○ HPA Sample Measure
  ▪ No group is performing significantly better than comparator group yet at least one (1) group is performing significantly worse per HEA measure
  ○ MCAS Sample Measure
  ▪ Absolute Average Percentage deficit between group and comparator (minimum performance level) is at least 5% (multiple regions) or 10% in single region
  ▪ No group is performing significantly better than comparator group yet at least one (1) group is performing significantly worse per MCAS measure
  ▪ Multiple regions (≥2) where group falls below 50th percentile
  ▪ At least one (1) region where group falls below 25th percentile

Weak Disparity (Disparity is uncertain when compared to comparator group or goal)
• Meets at least two (2) of any of the following factors:
  ○ HPA Sample Measure
  ▪ No group is performing significantly better or worse than comparator group but one (1) group is performing at lowest percentile per HEA measure
  ○ MCAS Sample Measure

- No group is performing significantly better or worse than comparator group but one (1) group is performing at lowest percentile per MCAS measure
- Absolute Average Percentage deficit between group and comparator (minimum performance level) is at least 5% (multiple regions) or 7% in single region
- Less than two (2) regions (e.g. one (1) region) where group falls below 50th percentile and no region fall below 25th percentile

No inequities were identified when stratifying the measures of focus by language or gender. After developing this disparity classification system, Partnership identified the following areas of focus:

Health Inequities Areas of Focus

Group	Key Disparity	Sample Findings (N=254 to 397)	MCAS Number of Regions with disparity (below 25th PL)	MCAS Number of additional Regions with disparity (below 50th MPL)	MCAS Absolute Average Percentage Difference between Group and MPL across regions	Estimate Number of Members Engage with to Close Gap	Category of Disparity (S/M/W)
American Indian/ Alaska Native	Controlling Blood Pressure	No significant difference. However, AI/AN performed numerically better than white group (comparator) by 10.39%	3	0	13.18%	1957+	Strong
	Poor HbA1c Control (>9%)	No significant difference and difference and rate of A1c control was above the 90th percentile	0	2	27.42%		Moderate
	Timeliness of Prenatal Care	No significant difference and rate was comparable to other races being above 33rd percentile	1	0	4.32%	642+	Weak
	Well Child Visits (WCV)	No significant difference when compared to white group	2	0	19.70%	2284+	Strong
Black/ African American	Controlling Blood Pressure	No significantly difference. However, African American was in lowest percentile group (10th percentile) and had numerically lower rate of CBP by 10.13% when compared to the white group (comparator)	1	0	2.71%	966+	Moderate
	Hemoglobin A1c Control (<8%)	No significant difference and difference and rate of A1c control was above the 90th percentile	1	0	10.12%	3608+	Weak
	Poor HbA1c Control (>9%)	No significant difference and difference and rate of BP control was above the 67th percentile	0	1	0.10%	36+	Weak
	Timeliness of Prenatal Care	No significant difference when compared to white group.	1	1	25.10%	8950+	Strong
	Timeliness of Postpartum Care	No significant difference when compared to white group.	2	0	9.04%	3223+	Moderate
	Well Child Visits (WCV)	No significant difference when compared to white group.	4	0	8.96%	3195+	Strong
Asian	Well Child Visits (WCV)	No significant difference when compared to white group.	2	0	7.14%	502	Strong

Health Inequities Areas of Focus							
Group	**Key Disparity**	**Sample Findings (N=254 to 397)**	**MCAS Number of Regions with disparity (below 25th PL)**	**MCAS Number of additional Regions with disparity (below 50th MPL)**	**MCAS Absolute Average Percentage Difference between Group and MPL across regions**	**Estimate Number of Members Engage with to Close Gap**	**Category of Disparity (S/M/W)**
Hispanic/ Latino	Hemoglobin A1c Control (<8%)	No significant difference when compared to white group.	0	2	0.52%	1077+	Weak
	Timeliness of Postpartum Care	No significant difference when compared to white group.	1	0	4.64%	9613+	Weak
	Well Child Visits (WCV)	No significant difference when compared to white group.	1	1	4.68%	9696+	Weak
Native Hawaiian/ Pacific Islander	Well Child Visits (WCV)	No significant difference when compared to white group.	2	1	7.62%	536+	Strong
White	Poor HbA1c Control (>9%)	No significant difference when compared to white group.	0	1	4.29	10,946+	Weak
	Well Child Visits (WCV)	Performed significantly worse when compared to Hispanic/Latino and Asian groups.	4	0	9.42%	234,036+	Strong

While all of the above were identified as areas of focus, Partnership prioritized Controlling High Blood Pressure in the American Indian/Alaska Native population to be the first and primary area of focus at this time. Partnership first conducted a barrier and root cause analysis for this measure for the American Indian/Alaska Native population, and also identified opportunities to address. This is highlighted in the table below:

Controlling High Blood Pressure (CBP)	
Group(s) of Focus	American Indian/Alaska Native
Percentage Below Minimum Performance Level (MPL)	*NW Region:* 20% below *SE Region:* 10% below *SW Region:* 10% below *Non-Weighted Average:* 13.18%
Goal for Specific Group	Improve Blood Pressure Control by at least 2.5% across multiple regions or at least 5% in one (1) single region in the American Indian/Alaska Native Population within 12 months.
Root Cause Analysis	The proposed hypothesis of the root cause is that current American Indians/Alaska Natives are more likely to have poor access to traditional or consume a higher amount of processed foods via Western diets. Also, American Indians/Alaska Native members are likely to be in more rural/remote communities. This is based on reviewing tertiary sources and conducting brief interviews with internal and external subject matter experts (SMEs).
Barrier Analysis	Research suggests that there is a positive correlation between traditional food native food consumption and prevention of cardiovascular disease. Nationwide, tribal communities have lost access to various traditional foods—which are historically nutrient dense and unprocessed. Unfortunately, food insecurity and

Controlling High Blood Pressure (CBP)	
	poor nutrition is related to greater risk of hypertension in AI/AN communities (Sinclair et al., 2023). While hypertension (HTN) medications can improve HTN, medications are less likely to address poor nutrition if that is the primary cause of HTN. Within Partnership's service landscape, the region that is experiencing the greatest disparity for this measure is the NW region. Currently, many of Partnership's AI/AN members inhabit this area and likely are experiencing food insecurity, wherein balanced diets are not geographically/financially available. Likely interventions to impact would include ensuring tribal communities can receive medically-tailored groceries or food vouchers for healthy low processed meals. Also, various tribal centers utilize various are held financially accountable to government performance and results act (GPRA) versus HEDIS® measures—which are considered less stringent. Therefore, various tribal centers do not have the financial incentive to be intensive with hypertension treatments versus non-tribal health centers. To improve relations, Manage Care Organizations (MCOs) and Partnership specifically, has explored hiring tribal health center liaisons to improve the collaboration between MCOs and tribal centers. In addition, Parsha et al. (2021) conducted a systematic review of 26 randomized controlled trials and observation studies with 48,187 hypertensive patients to evaluate the impact of Quality Improvement Interventions in improving BP-related outcomes. Overall, researchers found that EMR-Based Interventions, Team-Based Interventions, CHW-Based Interventions, Multicomponent QI Interventions, Patient and Provider Education, and Financial Incentive Interventions were effective in causing at least a 10 mm Hg reduction in BP or achieving defined BP control. The EMR-Based Notification, Team Based Effort, and clinical support system intervention was seen to have the largest effect of blood pressure reduction with patient/provider education following. Therefore, tribal health center engagement should complement integrating one of these validated interventions.
Actions for Direct Clinical/Service Measure Improvement	**<u>Intervention #1: Tribal Health Liaison Hiring and Hosting Tribal Center Event</u>** Partnership has hired a full-time Tribal health liaison to positively impact relationships with tribal health centers, tribal health community members, and provide guidance to help support Tribal member needs. Partnership has recognized partnering with the Tribal community as an organizational initiative, and is working to positively impact all care received by Tribal members through this partnership and communication with Tribal Health Centers within the network at this time. This work has the potential to improve the member experience of American Indian/Alaska Native members, ensure they are receiving culturally appropriate care, and positively impacting the care received by members who identify with this group.

Controlling High Blood Pressure (CBP)	
	Also, the tribal health liaison will be able to conduct various focal group interviews and possibly identify community based organizations to able to provide tele-nutrition counseling sessions, funds for delivery of DASH-diet aligned foods.

In Partnership's assessment of opportunities to improve Culturally and Linguistically Appropriate Services (CLAS), maintaining a member abrasion or dissatisfaction below 1/10th of one percent (0.10%) was identified as an opportunity for improvement. Partnership will be addressing this unmet goal by conducting targeted provider outreach focused on improving CLAS. This will be executed through a pilot project conducted by Partnership's Member Services Department focused on tailored outreach efforts related to Language Assistance Services (Priority 1). Member Services staff will review grievances filed in relation to Language Assistance Services and conduct a root causal analysis. Any findings/conclusions of the analysis may be shared with Partnership's interpreting/translation vendors as well as impacted providers. The intent of this pilot to identify and understand the causal factors linked to CLAS member dissatisfaction. Understanding provider pain points linked to member dissatisfaction is the first step to identifying Health Plan service delivery improvements. This intervention also allows Partnership's Member Services Department with an opportunity to provide direct education and feedback to providers to help eliminate related grievances in the future.

Furthermore, Partnership's Population Health Department will address this unmet goal by addressing the need to provide written materials to members in their choice of format (such as large print, Braille, audio format, or other) to ensure vision-impaired members are able to understand the information Partnership shares. This goal is monitored through the annual C&L Work Plan. This will be done to provide a more proactive approach for language services.

The completed Grand Analysis report will go to Mock Initial Survey in August 2024 to assess Partnership's readiness, address identified gaps, and develop action plans for meeting compliance when preparing for the formal HEA Initial Survey. Partnership will complete a Grand Analysis report utilizing MY2023 final data in September 2024 to be used for HEA Initial Survey, which will take place in June 2025.

Evaluation Conclusion

QI TRILOGY

Evaluation Conclusion

This concludes the FY 2023-2024 Quality Improvement Program Evaluation, which provides an assessment on performance work outlined in the FY 2024-2025 QI Program Description and FY 2023-2024 Work Plan. Partnership's Quality Improvement (QI) Program was successful over the course of fiscal year 2023-2024 in achieving its quality improvement goals and commitments. Partnership successfully renewed its NCQA Health Plan Accreditation in late 2023 and received its first NCQA Health Plan Rating (HPR) as 3.5 Star health plan. Partnership continues to leverage its 5-Star Quality Strategy and corresponding tactical and work plans to demonstrate an increased organizational focus on improving quality measure and CAHPS® scores now and into the future. In 2023-2024, Partnership has been able to engage fully in existing and expanding performance improvement and pay-for-performance strategies and programming, including priorities to advance health equity. While, at the same time, Partnership is working diligently through its QI Program to engage with providers in its 10-county expansion region to help our members in these new communities be healthy. As Partnership moves into 2024-2025, Partnership's QI Program remains committed to striving for its long term goal of achieving a 5-Star HPR, while also preparing short term to implement its new D-SNP and achieve NCQA Health Equity Accreditation by January 2026.

Appendices

QI TRILOGY

NETWORK ADEQUACY REPORT

ASSESSMENT OF NETWORK ADEQUACY

NET 3, ELEMENT A, B: ASSESSMENT OF MEMBER EXPERIENCE ACCESSING THE NETWORK & OPPORTUNITIES TO IMPROVE ACCESS TO NON-BEHAVIORAL HEALTHCARE SERVICES

Table of Contents

Section 1: Objective

The purpose of this report is to evaluate all aspects of data related to Network Adequacy to ensure Partnership HealthPlan of California (PHC) provides members with adequate network access for needed healthcare services. The provider types covered include primary care clinicians, medical specialists, and hospitals. PHC follows the NCQA Network Management Standard requirements and this report will present those findings.

Utilizing access data of our current network, this report evaluates and summarizes the following:

- Member Grievance (Complaints) appeals and member experience about network adequacy for non-behavioral healthcare services from ME7: Element C and D.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results from ME 7 report.
- Utilization of out-of-network services.
- Practitioner Availability summarized results for practitioner ethnicity/race to member ethnicity/race data and provider to member ratio for the top three threshold languages identified in (Net 1 Element A Cultural Needs and Preferences).
- High Volume and High Impact specialty geographic distribution and Practitioner Ratios (NET 1 Practitioner Availability of Services - Elements B and C).
- Routine Primary Care, Urgent Care, Non- Urgent Specialty Care Practitioner (NET 2 - Accessibility of Services - Elements A and C).
- Analysis from factors 1-3 to determine if there are gaps in the network specific to particular geographic areas or types of practitioners or providers.

This report and comprehensive analysis was conducted in collaboration between PHC's Provider Relations Department, Health Analytics, Grievance & Appeals and Office of the Chief Medical Officer. Findings were reviewed with a multi-disciplinary team made up of the Chief Medical Officer, Senior Director of Provider Relations, Manager of Provider Relations Compliance, Senior Director of Member Services & Grievance and Appeals, Director of Grievance and Appeals, Senior Director of Quality and Performance HS Quality Improvement, and Provider Relations Compliance Program Managers

In addition, this team identified opportunities for improvement and approved implementation of appropriate actions.

Section 2: Methodology

The following data sources were used to evaluate Network Adequacy:

***MEMBER GRIEVANCE (COMPLAINTS)*:** From the full volume of member complaints evaluated annually, this analysis includes a subset of those complaints that are specifically focused on network adequacy or access to care. Complaint category used was “access”, which includes all complaints related to appointment access or availability within the network.

MEMBER APPEALS: Member appeals and second level grievances data.

2022-2023 CAHPS: Survey results from ME 7 report for Adult and Child.

***OUT OF NETWORK (OON) REQUESTS*:** Referrals and a prior authorization are required for all OON requests. Data supplied from the Utilization Management system is used to determine number of requests, whether approved or denied. Claims data is pulled to determine how many of the approved referrals were used. Out of network referral, request and claims are analyzed per 1, 000 members. Referral request and claims counts are analyzed at the plan and regional level.

PRACTITIONER AVAILABILITY: (NET 1, ELEMENT A: CULTURAL AND LINGUISTIC NEEDS AND PREFERENCES): PHC collects data every year on language, culture and ethnicity/race of our members and compares the data against practitioners to determine if there is adequate practitioner coverage to meet our members’ needs. Member Ethnicity/Race – all self-reported member race/ethnicity is identified and assessed against provider ethnicity/race. Provider Ethnicity/Race – data from the Medical Board of California's Physician Survey of allopathic physicians and surgeons (licensees) is to analyze practitioner ethnicity/race. Member Grievance Reports: data is collected and analyzed for member concerns regarding discrimination and linguistic needs. Cultural Preference is assessed utilizing the Health Education and Cultural and Linguistic Population Needs Assessment (PNA). The PNA investigates member’s health status and behaviors; cultural and linguistic needs, community health education and cultural and linguistic programs and resources, health disparities, and gaps in services.

PRACTITIONER AVAILABILITY: (NET 1, ELEMENT B, C: PRACTITIONERS PROVIDING PRIMARY CARE & SPECIALTY CARE RATIO, GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS):

PHC obtained data for contracted primary care, high volume, and high impact specialties from our Data Warehouse which then populates Quest Analytics software to evaluate geographic distribution compared to our established geographic standards set forth in policy (MPNET 100) that were in effect at the time of production. Additionally, practitioner ratios were evaluated for primary care, high volume, and high-impact specialty practitioners. The analysis is based on a comparison to our established standards.

PRACTITIONER ACCESSIBILITY: (NET 2 ELEMENT A, C: ACCESS TO PRIMARY CARE & SPECIALTY CARE):

The Third Next Available (3NA) survey is a cross-sectional, one-time call during business hours, to provider offices, to evaluate access. This survey is used to evaluate primary care and high volume/high impact specialty appointment access using the following performance standards:

Routine Primary Care Appointments	**< 10 Business Days of Request**
Prenatal Care Appointments	**< 10 Business Days of Request**
Newborn Appointments	**< 48 hours of Discharge of Request**
Urgent Care Appointments	**< 48 hours of Request of Request**
Non-Urgent Specialty Care Appointments	**< 15 Business Days of Request**

The survey is administered by PHC's provider relations staff annually during the months of February and March and includes all PCP sites and identified high volume/high impact specialist that meet a set threshold of 200 unique member visits a year. The 2022 3NA surveyed 254 primary care provider sites, 255 specialty provider sites, and 110 prenatal provider sites. PHC's Well-managed benchmark analysis to evaluate specialty use trends within our network.

Member Grievances: from the full volume of member grievances evaluated annually, this analysis includes a subset of those grievances that are specifically focused on network adequacy or access to care. The grievance category is used as the "access" category, which includes all grievances related to appointment access for primary care and specialty care providers. Grievance data utilized for the analysis is data from January 1, 2023, through December 31, 2023.

***BEHAVIORAL HEALTH PRACTITIONER AVAILABILITY AND ACCESSIBILITY*:** Behavioral health data is analyzed in the Annual Behavioral Health Report. Additionally, Carelon Health Options is PHC's delegated entities, and are NCQA accredited.

Section 3: Quantitative Analysis:

MEMBER GRIEVANCES:

TOTAL ACCESS MEMBER COMPLAINTS

The trending data includes reporting periods; January 1, 2023 – December 31, 2023, and the previous year, January 1, 2022 – December 31, 2022.

In 2023, there were a total of 3,572 grievances submitted by our members. The analysis attributes 43% of all cases to Access.

In comparison to the 2022 reporting period, there were a total of 2,556 grievances submitted by our members. Similarly, analysis attributes 41% of all cases to Access.

Grievances Only Reporting Period: Annual 2022 vs 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Grievances	Avg PHC Mship	Grievances p/1,000	Grievances	Avg PHC Mship	Grievances p/1,000	Threshold	Threshold Met?
ACCESS	1,055	638,303	1.65	1,526	678,546	2.25	1.82	No

- **Notable Findings:** PHC failed to meet the access grievance threshold in 2023.

MEMBER APPEALS:

The trending data includes reporting periods; January 1, 2023 – December 31, 2023, and the previous year, January 1, 2022 – December 31, 2022.

In 2023, the health plan received 689 Appeals and Second Level Grievance cases, a 10% decrease in case filings from 2022, with Access contributing 50.1% of the total.

In comparison to the 2022 reporting period, the health plan received a total of 762 Appeals and Second Level Grievances cases with Access contributing 43% of the total.

Appeals & Second Level Grievances Reporting Period: Annual 2022 vs 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Appeals & SLG	Avg PHC Mship	Appeals & SLG p/1,000	Appeals & SLG	Avg PHC Mship	Appeals & SLG p/1,000	Threshold	Threshold Met?
ACCESS	332	638,303	0.52	350	678,546	0.52	0.57	Yes

Notable Findings: PHC met the threshold level for Access despite a 5.2% increase in Appeals and Second Level Grievances from 2022.

There were 4,261 Grievances, Second Level Grievances, and Appeals closed in 2023 compared to 3,318 in 2022. These cases are broken into two (2) groups – Grievances accounted for 3,572, and Appeals and Second Level Grievances accounted for 689.

Our membership experienced a 6.3% growth, rising from 638,303 in 2022 to 678,546 members in 2023. Alongside our membership increase, there was a rise in Grievances received in 2023, leading to an increase in Grievances files per 1,000 members from 4.00 to 5.26. We saw a decrease in the number of Appeals and Second Level Grievances files in 2023.

With a 6.3% increase in membership and 28.5% increase in Grievances file, three thresholds for Grievances were not met one of which was Access. Access issues mainly consisted of long wait times for providers and transportation issues such as the driver arriving late and missed rides.

PHC was able to meet the minimum threshold for Appeals & SLGs regardless of a 5.2% increase from 2022. Despite membership growth of 6.3%, the total number of cases filed per 1,000 members decreased from 1.19 to 1.02.

PRIMARY CARE ACCESS MEMBER COMPLAINTS

PHC further analyzes total access complaints by region and practitioner group to determine if there any access trends. Grievance data utilized for the analysis is data from January 1, 2023, through December 31, 2023. The threshold for review is based on the total number of complaints of two or more in any one category and a rate of 4/1000 members.

Primary Care Access Grievance Data Northern Region (January 1, 2023 – December 31, 2023)								
Region	**County**	**Provider Name**	**Appt. Availability**	**Office Availability**	**Telephone Availability**	**Total**	**Total Members Assigned to Provider**	**Rate per 1000 Members**
Northern	Del Norte	Del Norte Community Clinic	1			1	4426	.23
Northern	Shasta	Anderson Family Health	1			1	3914	.26
Northern	Shasta	Anderson Walk In Clinic			1	1	2612	.38
Northern	Shasta	Center of Hope	2			2	2437	.82
Northern	Shasta	Hill Country Community Clinic	2			2	2507	.80
Northern	Shasta	Lassen Medical Center – Red Bluff	1			1	318	3.1
Northern	Shasta	Shasta Community Health Center	3			3	20,930	.14
Northern	Siskiyou	Fairchild Medical Clinic	1			1	5728	.17
Northern	Siskiyou	Karuk Tribal Health Clinic	1			1	441	2.3
Northern	Humboldt	Fortuna Community Health Center	1			1	3464	.29
Northern	Humboldt	North Country Clinic	1			1	4042	.25
Northern	Humboldt	Redwoods Community Health Center	6			6	6956	.86

Northern	Humboldt	WeCare at Scotia Bluffs	1			1	1862	.54
Northern	Lassen	Northeastern Rural Health Clinic	1			1	5073	.20
Northern	Lassen	Lassen Indian Health Cntr	2			2	558	3.6
Northern	Lassen	Westwood Family Practice	1			1	515	1.9
		Northern Region Totals:	**29**	**0**	**1**	**30**		

Member Complaints Primary Care Northern Region (Everest Data, 2023)

- **Notable finding:** The total number of Northern Region member complaints regarding access increased since 2022 from 14 total to 30 in 2023, with appointment availability as the common type of grievance. Despite the over-all increase, the per 1000 member grievances were within the threshold so no opportunities were identified.

- Redwood Community Health Center had the most grievances in appointment availability as well as overall. Despite the number of grievances, the rating per 1000 members was within the standard. No further action is required at this time.

- Lassen Medical Center, Karuk Tribal Health, and Lassen Indian Health Center had the highest per member ratings. Karuk Tribal Health and Lassen Medical Center both had only 1 grievance and Lassen Indian Health Center with two grievances regarding their appointment availability. A trend could not be established due to low member complaints over the course of a year. No further action is required at this time.

Primary Care Access Grievance Data Southern Region (January 1, 2023 – December 31, 2023)								
Region	**County**	**Provider Name**	**Appt. Availability**	**Office Availability**	**Telephone Availability**	**Total**	**Total Members Assigned to Provider**	**Rate per 1000 Members**
Southern	Lake	Lakeview Health Center	2			2	3418	.59
Southern	Marin	Marin Health Medical Network	1			1	1558	.64
Southern	Marin	Marin Community Larkspur Clinic			1	1	1164	.86
Southern	Marin	Marin Community Novato Clinic			1	1	4188	.24
Southern	Marin	Marin Community San Rafael Clinic	3			3	12,404	.24
Southern	Mendocino	Hillside Health Center	3			3	8101	.37
Southern	Mendocino	Baechtel Creek Medical Clinic	1			1	1527	.65
Southern	Napa	Ole Health	1			1	3824	.26
Southern	Napa	Ole Health	2			2	11610	.17
Southern	Solano	Community Medical Center Vacaville	2		1	3	6804	.44
Southern	Solano	La Clinica -North Vallejo	3	1	2	6	8534	.70
Southern	Solano	La Clinica -Vallejo	2			2	6103	.33

Southern	Solano	OLE Health	3			3	4560	.66
Southern	Solano	OLE Health	1			1	4573	.22
Southern	Solano	Solano County Health Services - Vallejo	9			9	12874	.70
Southern	Solano	Solano County Health Services - Fairfield	3			3	4177	.72
Southern	Solano	Solano County Health Services - Fairfield	2			2	3918	.51
Southern	Solano	Solano County Health Services – Vacaville	5			5	4486	1.1
Southern	Solano	Sutter Medical Foundation Dixson	1			1	535	1.9
Southern	Solano	Sutter Medical Group Vacaville			1	1	1170	.85
Southern	Sonoma	Rohnert Park Health Center Clinic	2			2	6289	.32
Southern	Sonoma	Santa Rosa Community Health – Dutton			1	1	8182	.12
Southern	Sonoma	Vista Family Health Ctr	1		1	2	8865	.23
Southern	Yolo	Woodland Clinic	1			1	8589	.12
Southern	Yolo	Sutter Medical Grp –Yolo	1			1	1152	.87
Southern	Yolo	Salud Clinic	1			1	4857	.21
Southern	Yolo	Hansen Family Health	1			1	3067	.33
Southern Region Totals:			**51**	**1**	**8**	**60**		

Member Complaints Primary Care Southern Region (Everest Data, 2023)

- **Notable findings:** The total number of Southern Region member access complaints increased since 2022 from 24 total to 60 in 2023 with appointment availability being most common type of grievance. Despite the over-all increase, the per 1000 member grievances were within the threshold so no opportunities were identified.
  - Solano County Health Services, Vallejo had the most grievances in the appointment category. Despite the number of grievances, the rating per 1000 members was within the standard. No further action is required at this time.
  - La Clinica – North Vallejo had the second highest number of grievances overall. However, the rating per 1000 members was within the standard. No further action is required at this time.

SPECIALTY CARE MEMBER COMPLAINTS:

Specialty Care Access Grievance Data (January 1, 2023 – December 31, 2023)							
Region	**County**	**Provider Name**	**Appt. Availability**	**Office Availability**	**Telephone Availability**	**Total**	**High Volume or High Impact Specialty**
Northern	**Siskiyou**	Nino Pitiuri, MD	**1**			**1**	**High Volume Specialty** OB/GYN
Northern	**Humboldt**	Humboldt Dermatology	**1**			**1**	**High Volume Specialty** Dermatology
Southern	**Marin**	Bay Area Ortho Surgery and Sports Med	**1**			**1**	**High Volume Specialty** Orthopedic Surgery
Southern	**Solano**	Sutter Medical Group Solano	**1**			**1**	**High Volume Specialty** OB/GYN

Specialty Care Access Grievance Data (Everest, 2023)

Notable findings: In 2023, access to specialty care member complaints were low. Four high-volume specialties had one appointment complaint each for the reporting year. A trend could not be established due to low member complaints. No further action is required at this time.

2022- 2023 CAHPS Composite Scores:

CAHPS Results from ME7 Report: Adult Response

Below is a year-by-year comparison of the Composite scores: January 2023– December 31, 2023 and the previous year, January 1, 2022 – December 31, 2022 for the Adult Survey. In Year 2022-2023, we received 8 more completed surveys than in Year FY 2021-2022, with a negligible higher increase in response rate by 0.2%. However, it is noteworthy that all questions met the 100 sample size criteria for 2022-2023.

	ADULT CAHPS Composite	2021-2022 (14.1% Response Rate) Sample Size 2,700 Total Returns 372	2022 Percentile Rate	PHC Benchmark	PHC Benchmark Met?	2022-2023 (14.3% Response Rate) Sample Size 2,700 Total Returns 380	2023 Percentile Rate	PHC Benchmark	PHC Benchmark Met?
Composite Measure	Getting Needed Care (% Always or Usually)	**76.0%**	**7th**	**PHC ≥ 25th**	**No**	**76.4%**	**14th**	**PHC ≥ 25th**	**No**
	Getting Care Quickly (% Always or Usually)	**72.9%**	**5th**	**PHC ≥ 25th**	**No**	**69.5%**	**5th**	**PHC ≥ 25th**	**No**

Notable Findings: The Adult Composite score for getting needed care had a slight increase, and getting care quickly had a slight decrease with both failing to meet the benchmark.

The Adult survey response relative to Partnership covered members indicates we continue to have dissatisfaction with member access which influences health plan ratings. Stakeholders determined that continued intervention focused on; Getting Needed Care and Getting Care Quickly composite measures and Rating of Health Plan would be in scope for the CAHPS® Score Improvement (CSI) Goal for FY 2023-2024.

CAHPS Results from ME7 Report: Child Response

Below is a year by year comparison scores: January 1, 2023 – December 31, 2023 and the previous year, January 1, 2022 and December 31, 2022. In Year 2022-2023, we received 24 more completed surveys than in Year 2021-2022 increasing the response rate by 0.4%. It is also noteworthy that all questions met the 100 sample size criteria.

	CHILD CAHPS Composite	2021-2022 (14.5% Response Rate) Sample Size 4,125 Total Returns 587	2022 Percentile Rate	PHC Benchmark	PHC Benchmark Met?	2022-2023 (14.9% Response Rate) Sample Size 4,125 Total Returns 611	2023 Percentile Rate	PHC Benchmark	PHC Benchmark Met?
Composite Measure	Getting Needed Care (% Always or Usually)	79.6%	10th	PHC ≥ 25th	No	76.7%	10th	PHC ≥ 25th	No
	Getting Care Quickly (% Always or Usually)	84.1%	25th	PHC ≥ 25th	Yes	76.3%	<5th	PHC ≥ 25th	No

- **Notable Findings:** The Child composite scores for both measures experienced a decrease with a noticeable drop in Getting Care Quickly of 7.8%. Both measures failed to meet the benchmark.

  The Child survey responses relative to Partnership covered members indicate we continue to have dissatisfaction with member access and correlating impact to member experience which influences health plan ratings. Stakeholders determined that continued intervention focused on; Getting Needed Care and Getting Care Quickly composite measures would be in scope for the CAHPS® Score Improvement (CSI) Goal for FY 2023-2024.

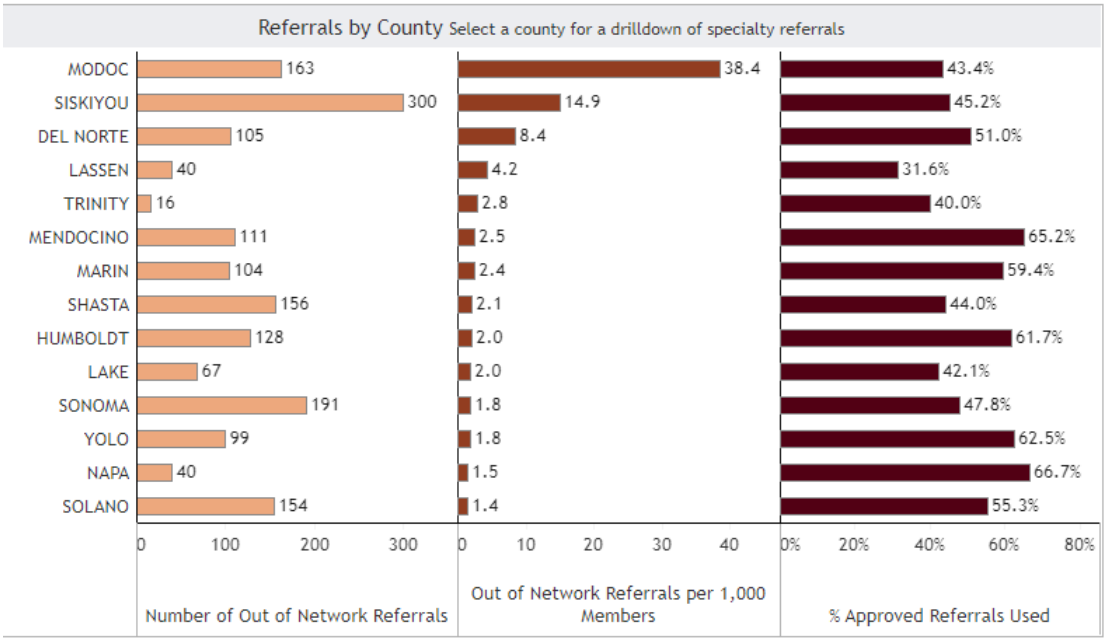
QUALITATIVE ANALYSIS FOR MEMBER SATISFACTION: GRIEVANCE, APPEALS, AND CAHPS

The healthcare system in California and throughout the country has continued to grapple with workforce shortages for both clinical and non-clinical staff. Thus resulting in greater difficulty in obtaining timely appointments. There was an increase in Grievances related to the Quality of Provider Offices in 2023. Members reported 90 concerns against their primary care provider (PCP) or provider's office staff regarding access to appointments in person or by phone, compared to 84 in 2022. The majority of the concerns members reported were in relation to appointment availability, for example, having to wait up to 30 days for an appointment and even longer for specialty appointments and procedures. Partnership continues to work on addressing this challenge by working to support our network and seeking to contract with new providers, predominantly in rural areas.

Out-of-Network Requests:

Out of Network requests and utilization from January 2023 – December 2023. The out of network referrals per 1,000 members' threshold is less than or equal to 20.

	NORTHERN	SOUTHERN	Grand Total
Number OON Referrals	908	766	1,674
Membership	189,248	418,171	607,419
Out of Network Referrals per 1,000 Members	4.8	1.8	2.8
% Referrals Approved	55.7%	28.5%	43.2%
% of Approved Referrals Used	46.6%	55.0%	49.2%
Referrals Serviced	236	120	356



- **Notable findings:** For the period of January 2023 – December 2023, as a plan, PHC met the goal of less than 20 per 1,000 members for referrals. OON referrals for the northern region was 4.8 per 1,000 members and OON referrals for the southern region was 1.8 per 1,000 members.

  Out of 1,674 OON Referral requests submitted, 723 were approved with 55.7% of those being in the northern region, specifically Modoc, Siskiyou, and Del Norte counties, where access is much harder than the southern region due to rural terrain and a patient population that is typically too small for a specialist to maintain a viable practice. The three specialties with the highest OON referrals included: Cardiovascular Disease/Internal Medicine with 59.5% of approved referrals used, Gastroenterology with 45.2% of approved referrals used, and Orthopedic Surgery with 46.7% of approved referrals used. Of the 723 approved referrals plan wide, 356 (49.2%) were used.

PRACTITIONER AVAILABILITY RESULTS: (NET 1, ELEMENT A: CULTURAL AND LINGUISTIC NEEDS AND PREFERENCES)

Availability standards and detailed analysis are provided in the annual Network Adequacy Report Availability of Practitioners reports. For this grand analysis, we have summarized the results for practitioner ethnicity/race to member ethnicity/race data and provider to member ratio for the top three threshold languages identified in 2023. Practitioner to member ratios and geographic distribution data for primary care, high volume specialties, and high impact specialties.

ETHNICITY/RACE COMPARISON:

PHC Member Data Ethnicity/Race Percentages to Physician/Surgeon Ethnicity/Race Percentages and Ratio Report			Goal 1:2000 Physician to Member Ratio
Race/Ethnicity	**PHC Members 686,844**	**Physician 14,283**	
White	**37.5%**	**60.97%**	**1:30**
Hispanic	**30.9%**	**7.62%**	**1:195**
Other	**11.1%**	**2.01%**	**1:265**
Unknown	**8.8%**	**2.01%**	**1:199**
Black	**5.3%**	**4.44%**	**1:50**
Native American	**2.2%**	**1.17%**	**1:90**
Filipino	**1.8%**	**4.52%**	**1:15**
Asian/Pacific Islander	**1.0%**	**1.17%**	**1:27**
Asian Indian	**0.8%**	**6.37%**	**1:6**
Vietnamese	**0.6%**	**1.42%**	**1:21**

PHC Member Data Ethnicity/Race Comparison Analysis to Physician/Surgeon Ethnicity/Race (Amysis Data, April 2023 / Medical Board of California Data, June 2021)

- **Notable Findings:** The self-reported ethnicity/race comparison indications plan wide we met our ratio performance goal of 1:2000 starting from the highest number of member (self-reported) ethnicity/race.

ASSESSING PRACTITIONER AND MEMBER LANGUAGE:

PHC has applied a general standard for PCP to member ratio, which is 1:500 for all threshold languages to establish a point of comparison. The standard is considered compliant if the member to provider ratio is less than 1:500 for each threshold language. For this study, we will look at PHC's top three (3) threshold languages, which are Spanish, Tagalog, and Russian.

Practitioner Language					
Threshold Language	**Provider**	**Member**	**2023 Ratio**	**Performance Goal**	**Goal Met?**
Spanish	360	135,827	1:377	1:500	Met
Tagalog	71	3,269	1:46	1:500	Met
Russian	29	2,205	1:76	1:500	Met

Practitioner Language to Member Language (SUGAR Data, Amisys Data, April 2023)

- **Notable Finding:** As a plan PHC met the overall ratio of 1:500 (provider to member) standard for all three threshold languages (Spanish, Tagalog and Russian).

To further assess how PHC is meeting member language needs, we looked at office staff languages spoken at provider sites as it compares to the top three (3) threshold languages of Spanish, Tagalog, and Russian.

Practitioner Office Staff Language				
Threshold Language	**Provider Sites**	**Member**	**Performance Goal**	**2023 Ratio**
Spanish	326	135,827	1:500	1:416
Tagalog	96	3,269	1:500	1:34
Russian	28	2,205	1:500	1:78

Practitioner Language to Member Language (SUGAR Data, April 2023)

- **Notable Finding:** Provider site language to member language ratios meets the performance goal. Office staff capabilities for threshold languages are sufficient to meet member needs.

GRIEVANCE DATA (MEMBER COMPLAINTS)

PHC looks at network adequacy for issues pertaining to race, ethnicity, and language to ensure practitioners are meeting member needs. This report identifies member-reported grievances which are classified into four discrimination categories which include: Cultural, Ethnic, Racial, and LGBTQ+. For Language grievances, we identify language discrimination and language barriers.

CULTURAL, ETHNIC, RACIAL, LGBTQ+ DISCRIMINATION GRIEVANCES

2023 Discrimination Grievances (January 1, 2023 - December 31, 2023)							
Region	County	Provider	Specialty	Discrimination Grievances			
				CE&R Discrim	Language Discrim	Language Barrier	LGBTQ+ Discrim
South	Mendocino	Adventist Health Ukiah Valley	Nutrition Services	1	0	0	0
South	Solano	DaVita Dialysis - Napa	Renal Dialysis Clinic	1	0	0	0
South	Lake	Elhakim, Samer MD	Family Medicine	0	1	0	0
South	Solano	La Clinica - Vallejo	Pediatrics	1	0	0	0
South	Mendocino	North Coast Family Health Center-Clinic	Pain Management	1	0	0	0
South	Solano	Solano County Health & Social Services	Internal Medicine	1	0	0	0
South	Solano	Sutter Medical Foundation	Orthopedic Surgery	0	1	0	0
South	Sonoma	Sutter Medical Group of the Redwoods	General Surgery	0	1	0	0
South	Solano	Sutter Solano Medical Center	General Medicine	1	0	0	0
South	Marin	Marin Health Network	ENT (Family Practice)	0	1	0	0
South	Solano	Vacaville Urgent Care Medical Group	Urgent Care	1	0	0	0
North	Shasta	Fletscher, Walter Lyle, MD	Cardiovascular Disease/Internal Medicine	0	1	0	0
North	Lassen	Lassen Indian Health Center	Family Practice	2	0	0	0
North	Shasta	Mercy Medical Center-Redding	Emergency Medicine	0	1	0	0
North	Trinity	Meredith, Randall John, MD	Family Medicine	0	0	0	1
North	Shasta	Shasta Regional Medical Center	Psychiatry	0	2	0	0
North	Humboldt	Southern Humboldt Community Clinic	Family Practice	0	0	1	0

Source: 2023 Discrimination Grievances Data: 1Q24 Grievance and Appeals PULSE Report

- **Notable Findings:** The most commonly reported problem was alleged discrimination due to race or ethnicity. The second most common was alleged discrimination due to language. All concerns were addressed by the usual grievance process. Further action is not required.

- An examination of discrimination cases from 2022 to 2023 showed a significant reduction of 21.4%. This decline is particularly noteworthy given the overall year-over-year increase of 39.3% in total grievance cases.

One contributing factor to this decline could be attributed to our comprehensive approach in handling cases of alleged discrimination. Upon identifying instances where discrimination is likely to have occurred by a provider, G&A initiates a proactive measure of implementing a Soft-Warning Letter aimed at fostering awareness and corrective action within the provider community. These letters serve as a formal communication channel providing educational resources that are tailored to assist in understanding and implementing practices that promote inclusivity and prevent discrimination against our members.

LINGUISTIC NEEDS

As a plan, PHC met the overall ratio of 1:500 (provider to member) standard for all three threshold languages (Spanish, Tagalog, and Russian). When comparing our linguistic data to grievances, there was a decrease in language discrimination from ten in 2022 to eight in 2023. Shasta County was the highest reported county however, none of the providers within the county had more than one grievance, and therefore, there is no trend to address.

PHC offers no-cost linguistic services which include, oral interpreters, and sign language interpreters. Many practices have providers and medical staff who speak languages spoken by plan members. Written informing materials are fully translated into the threshold languages upon request.

PRACTITIONER AVAILABILITY RESULTS: (NET 1, ELEMENT B, C: PRACTITIONERS PROVIDING PRIMARY CARE & SPECIALTY CARE RATIO, GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS

PRACTITIONER RATIOS: PRIMARY CARE

The following table summarizes the findings for Primary Care practitioners:

Practitioner Ratios: Primary Care – Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure : Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	**833**	**616,313**	**Primary Care Practitioner to Member (adult and children)**	**1:739**	**1:≤ 2,000**	**MET**
Family or General Practice	**517**	**616,313**	**Family or General Practice Practitioner to Member (adult and children)**	**1:1,192**	**1:≤ 2,000**	**MET**
Pediatrics	**171**	**193,201**	**Pediatricians to Members (children)**	**1:1,129**	**1:≤ 2,000**	**MET**
Internist	**145**	**423,112**	**Internists to Members (adult)**	**1:2,918**	**1:≤ 3,000**	**MET**

Practitioner Ratios: Primary Care (April 1, 2023)

- **Notable findings:** The Plan met the standard for all Primary Care Practitioners. No interventions are indicated at this time.

PHC experienced an 8.2% increase in total membership compared to 2022. We have been able to maintain access to primary care for all ages by having a stable Family Medicine network.

PROVIDER RATIOS: HIGH VOLUME SPECIALISTS

The following table summarizes the findings for High Volume Specialists:

Practitioner Ratios: High Volume Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Obstetrics/Gynecology	479	254,936	OB-GYN to Member	1:287	1:≤ 5,000	MET
Cardiology	574	616,313	Cardiologist to Member	1:1,074	1:≤ 10,000	MET
General Surgery	427	616,313	General Surgery to Member	1:1,443	1:≤ 10,000	MET
Orthopedic	335	616,313	Orthopedic Surgeon to Member	1:1,840	1:≤ 10,000	MET
Ophthalmology	248	616,313	Ophthalmologist to Member	1:2,485	1:≤ 10,000	MET
Dermatology	204	616,313	Dermatologist to Member	1:3,021	1:≤ 15,000	MET

Practitioner Ratios: High Volume Specialist (April 1, 2023)

- **Notable findings:** The six high-volume specialties utilized by members remained unchanged from last year (2022). PHC met the provider ratio standards for all high-volume specialist providers. Interventions are not indicated at this time.

PRACTITIONER RATIO: HIGH IMPACT SPECIALISTS

The following table summarizes the findings for High Impact Specialists.

Practitioner Ratio: High Impact Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Oncology Hematology	**428**	**616,313**	**Oncology Hematology to Member**	**1:1,440**	**1: ≤ 25,000**	**MET**

Practitioner Ratio: High Impact Specialists (April 1, 2023)

- **Notable findings:** Plan-wide, the practitioner to member ratio for Oncology/Hematology practitioners fell comfortably within the performance standard. No plan-wide interventions are indicated at this time.

GEOGRAPHIC DISTRIBUTION: PRIMARY CARE PRACTITIONERS

The following table summarizes the findings for the Primary Care Practitioners.

Geographic Distribution of Primary Care – Standards and Performance Goals				
Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	**1 within 10 miles or 30 minutes from the member's residence**	**97.9%**	**≥ 95%**	**MET**
Family Medicine or General Practitioner	**1 within 10 miles or 30 minutes from the member's residence**	**99.8%**	**≥ 95%**	**MET**
Pediatrics	**1 within 10 miles or 30 minutes from the member's residence**	**97.4%**	**≥ 95%**	**MET**
Internist	**1 within 10 miles or 30 minutes from the member's residence**	**96.6%**	**≥ 95%**	**MET**

Geographic Distribution of Primary Care (Quest Analytics, May 2023)

- **Notable findings:** PHC met the plan-wide geographic distribution of "Primary Care Practitioner Overall" standard and the individual performance standard for each PCP specialty. No interventions are indicated at this time.

Geographic Distribution of Primary Care – Standards and Performance Goals						
Region	**County**	**Specialty Type**	**Standard: Geographic Distribution**	**Result**	**Performance Goal**	**Goal Met?**
Northeast	**Lassen**	**Primary Care**	**1 within 10 miles or 30 minutes from the member's residence**	**88.8%**	**≥ 95%**	**Not MET**

Geographic Distribution of Primary Care Lassen County (Quest Analytics, May 2023)

- **Notable findings:** A breakdown of the data at the county level shows Lassen County as not meeting the time or distance standard for primary care for both children and adults. Out of 8627 PHC members in Lassen County, 968 do not meet the time or distance standard despite the Family Practice to member ratio in Lassen County being 1:663. This is indicative of a rural county where the population is widely dispersed and the providers are located in or near towns and cities.

Rural areas generally have family physicians that serve as primary care physicians, as the population is not sufficient to sustain pediatric and internal medicine specialists. Taking the presence of family physicians into account, there is sufficient access to primary care physicians. Lassen County primary care clinics benefit from PHC's primary care recruitment program that incentivizes practitioners to serve this rural county.

There are no known qualified primary care providers that can be added to the network at this time. Nonetheless, continued general support of the primary care workforce, like our primary care recruitment program and our primary care Quality Incentive Program, are prudent to maintain the primary care network that we have.

PART V: GEOGRAPHIC ACCESS: SPECIALISTS

The following table summarizes the findings for High Volume and High Impact Specialists.

Geographic Distribution of Specialty Care – Standards and Performance Goals				
High Volume Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Cardiology	Standard: % of members whose residence is within a distance (miles) or time (minutes) from a specialist's office. Rural = 60 miles or 90 minutes Small= 45 miles or 75 minutes Medium= 30 miles or 60 minutes	100%	≥90%	MET
Dermatology		100%	≥90%	MET
General Surgery		100%	≥90%	MET
Obstetrics/Gynecology		100%	≥90%	MET
Ophthalmology		98.5%	≥90%	MET
Orthopedics		100%	≥90%	MET
High Impact Practitioner Type		**Results**	**Performance Goal**	**Goal Met?**
Oncology/Hematology		97.8%	≥80%	MET

Geographic Distribution of Specialty Care - High Volume and High Impact (Quest Analytics, May 2023)

- **Notable findings:** All geographic distribution of High Volume and High Impact Specialty standards were met plan wide. Interventions are not indicated at this time.

County Size Categories by Population			
Size Category	**Population Density**	**# of Counties**	**PHC Counties**
Rural	≤50 people per square mile	8	Del Norte, Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Trinity
Small	51 to 200 people per square mile	3	Lake, Napa, and Yolo
Medium	201 to 599 people per square mile	3	Marin, Solano, and Sonoma

County Size Categories by Population (DHCS, Standard for County Size by Population, 2023)

When the data is broken down to the county level, two rural counties did not meet the 60 miles or 90 minutes standard for access to specialists.

Geographic Distribution of Specialty Care – Standards and Performance Goals						
Region	**County**	**Specialty Type**	**Standard: Geographic Distribution**	**Result**	**Performance Goal**	**Goal Met?**
Northern	Lassen	Ophthalmology	Rural standard: % of members' residence is 60 miles or 90 minutes from a specialist's office.	16.0%	≥ 80%	Not MET
	Lassen	Hematology/Oncology		8.3%	≥ 80%	Not MET
	Modoc	Ophthalmology		20.8%	≥ 80%	Not MET
	Modoc	Hematology/Oncology		0.9%	≥ 80%	Not MET
	Modoc	Physical Medicine and Rehabilitation		0.9%	≥ 80%	Not MET
	Modoc	ENT/Otolaryngology		7.2%	≥ 80%	Not MET

Geographic Distribution of Specialty Care - Not Met Score by County (Quest Analytics, May 2023)

Specialty	County	Average Miles	Average Minutes
Ophthalmology	Lassen	84	92
	Modoc	91	99
Hematology/Oncology	Lassen	86	94
	Modoc	116	127
ENT/Otolaryngology	Modoc	98	107
Physical Medicine and Rehabilitation	Modoc	115	126

- **Notable findings:** The average miles or minutes for members outside of the access standard ranges from 1 – 55 miles or 2 – 37 minutes.

PHC contracts with all available high-volume specialists that practice within Modoc and Lassen counties. These areas are sparsely populated and have an insufficient population to sustain a practice for many specialties. Currently, there are no qualified specialists who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. PHC will assist members in making appointments and arrange transportation for the member to see a specialist that is outside of the time or distance standards.

PHC's continues to review all sources of data related to access to specialty care, for monitoring trends and implementing focused strategies on the area of greatest need. This includes a robust telemedicine and e-Consult program. Many telehealth specialties are available to members via video

appointments arranged at primary care offices. In addition, direct-to-member video telehealth between specialist providers and members is available through Partnership's contract with TeleMed2U.

PRACTITIONER ACCESSIBILITY RESULTS: (NET 2 ELEMENT A, C: ACCESS TO PRIMARY CARE & SPECIALTY CARE)

The data for assessing regular and routine care, urgent care, and after-hours care is collected by PHC's Provider Relations staff using the Third Next Available (3NA) methodology for appointment access and the after-business hours' survey for telephone and triage services. All PCPs are surveyed (no sampling). The 2023 3NA surveyed 248 primary care provider sites, 329 specialty provider sites, and 120 prenatal provider sites.

THIRD NEXT AVAILABLE (3NA) SURVEY RESULTS - PRIMARY CARE ROUTINE APPOINTMENT ACCESSIBILITY

Third Next Available (3NA) Survey Findings 2023									
Provider Type	Standard	Median Days for Established PCP Appt.			Percentage of Clinics Meeting PCP Standards			Goal	2023 Goal Met?
		North	South	Plan	North	South	Plan		
Primary Care Adult	Non-urgent care primary care appointments within 10 business days of request	3.0	3.0	3.0	94%	91.7%	92.9%	≥ 90%	Met
Primary Care Pediatrics	Non-urgent care primary care appointments within 10 business days of request	3.0	3.0	3.0	94.4%	90.4%	92.4%	≥ 90%	Met
Newborn Appointments	Newborn appointments within 48 hours of discharge	1.0	1.0	1.0	96.9%	100.0%	98.5%	≥ 90%	Met
Primary Care Urgent Care	Urgent care appointments within 48 hours of request	0.0	0.0	0.0	95.3%	96.9%	96.1%	≥ 90%	Met

Third Next Available (3NA) Primary Care Survey Findings (PR Reps Survey, 2023).

- **Notable findings**: The 3NA survey results show that as a plan we met our 2023 performance goal of 90% across all Primary Care Provider appointments.

THIRD NEXT AVAILABLE (3NA) SURVEY RESULTS - PRIMARY CARE TELEPHONE ACCESSIBILITY:

Third Next Available (3NA) Survey Findings (Primary Care) 2023									
Measurements	Standard	Median Performance Rates			Percentage of Clinics Meeting PCP Standards			Goal	2022 Goal Met?
		North	South	Plan	North	South	Plan		
# Rings before phone answered	≤ 5 rings	2.0	2.0	2.0	100%	100%	100%	≥ 90%	Met
Minutes on hold	≤ 5 minutes	1.0	2.0	1.5	100%	100%	100%	≥ 90%	Met
Average wait time before seeing a provider	≤ 30 minutes	10.0	10.0	10.0	100%	100%	100%	≥ 90%	Met
Return call within 30 minutes	≤ 30 minutes	1.0	2.0	1.5	100%	100%	100%	≥ 90%	Met

Third Next Available (3NA) Primary Care Telephone Accessibility (PR Rep Survey, 2023).

- **Notable findings:** The 3NA survey results show that as a plan we met our 2022 performance goal of 90% telephone accessibility and wait time measurements.

SURVEY RESULTS - PRIMARY CARE AFTER BUSINESS HOURS

After Business Hours Survey Findings Primary Care 2023											
Measurements	Standard	Q1 2023		Q2 2023		Q3 2023		Q4 2023		Goal	Goal Met?
		North	South	North	South	North	South	North	South		
Answering Machine/ Answering Services	100%	100%	100%	100%	100%	100%	100%	100%	100%	≥ 90%	Met
Instructions to call 911/ER	100%	100%	100%	100%	99%	100%	100%	100%	100%	≥ 90%	Met
Instructions to reach MD or Advice Nurse	100%	100%	100%	100%	99%	100%	96%	100%	100%	≥ 90%	Met
Wait times for screening or triage services	≥ 30 minutes	100%	100%	100%	99%	100%	99%	100%	100%	≥ 90%	Met

Survey Results Primary Care After Business Hours (PR Rep Survey, 2023).

- **Notable findings:** The 3NA survey results show that as a plan PHC met 2023 goals for Primary Care After Business Hours Accessibility measurements.

3NA SURVEY RESULTS - ACCESS TO PRIMARY CARE BY COUNTY

The data for assessing access to care by county is pulled from the 3NA survey results. The 2023 3NA findings below summarize the access by county.

PCP 3NA Results by County

% of Clinics Meeting PCP Standards by County

		% Meeting Target - Adult	% Meeting Target - Peds	% Meeting Target - Newborn	% Meeting Target - Urgent	# Clinics
North	Del Norte	86%	100%	100%	100%	7
	Humboldt	96%	95%	100%	96%	27
	Lassen	100%	100%	100%	100%	5
	Modoc	100%	100%	100%	100%	4
	Shasta	85%	81%	94%	90%	21
	Siskiyou	100%	100%	100%	100%	17
	Trinity	100%	100%	75%	75%	4
South	Lake	92%	88%	100%	93%	15
	Marin	84%	100%	100%	91%	23
	Mendocino	89%	87%	100%	100%	20
	Napa	73%	57%	100%	93%	15
	Solano	90%	75%	100%	100%	25
	Sonoma	100%	100%	100%	98%	41
	Yolo	100%	100%	100%	100%	23

3NA Survey Median Number of Business Days for Appointments by County (PR Reps 3NA Survey, 2023)

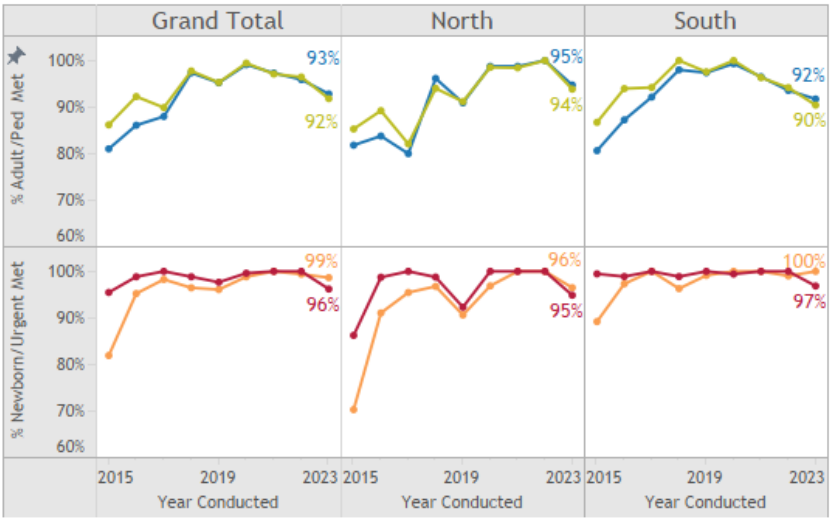
- **Notable Findings:** When the 3NA data is broken down by county we find eight counties had clinics that failed to meet the appointment standards:

  - Del Norte County - seven sites were surveyed and one failed to meet the adult appointment standard.
  - Shasta County - twenty-one sites were surveyed with five failing to meet appointment standards in either adult or pediatric appointment standard and one that failed the newborn standard.
  - Mendocino County - twenty sites were surveyed with two failing to meet either the adult appointment or pediatric standard and one failing both standards.

- Trinity County – four sites were surveyed with one failing to meet the newborn and urgent appointment standard.
- Lake County – fifteen sites were surveyed with one site failing both adult and pediatric appointment standard and one failing the urgent appointment standard.
- Marin County – twenty-three sites were surveyed with three sites failing the adult appointment standard and two failing the urgent standard.
- Napa County – fifteen sites were surveyed with three failing the adult and pediatric standard and one failing the urgent appointment standard.
- Solano County – twenty-five sites were surveyed with two failing pediatric, one failing adult and one failing both adult and pediatric appointment standards.

All sites that fail to meet the standard will be resurveyed and issued a corrective action plan if needed.

Trends for PCP Appointments Meeting Targets



➢ **Notable Finding:** There has been a downward trend for adult and pediatric PCP appointments across both regions since 2020.

3NA SURVEY RESULTS - ACCESS TO PRENATAL CARE[1]

The data for assessing access to prenatal care by county is also pulled from the 3NA survey results.

Third Next Available (3NA) Survey Findings									
Provider Type	Standard	Median Days for Established PCP Appt			% of Clinics Meeting Prenatal Standards			Goal	2023 Goal Met?
		North	South	Plan	North	South	Plan		
Prenatal Care	Appointments within 10 business days of request	2.5	3.9	3.2	87.1%	93.2%	90.2%	≥ 90%	Met

3NA Survey Results Prenatal Care Region and Plan (PR Rep 3NA Survey, 2023)

- **Notable Findings:** The 3NA survey results show that as a plan we are meeting our 2023 performance goal for prenatal care appointments.

Prenatal Appointment Access by County			
Region	County	Service Location	Days to Prenatal Appointment
Northern	Del Norte	Sutter Coast Community Clinic- OB/GYN	12
	Humboldt	K'imaw Medical Center	19
		UIHS-Potawot Health Village	11
	Shasta	Selah Women's Health	12
Southern	Lake	Sutter Lakeside Community Clinic	12
	Mendocino	Adventist Health Physicians Network	26
		Hillside Health Center	15
		Little Lake Health Center	11
	Solano	La Clinica Great Beginnings	20
		SMG Solano OB/GYN	22

- **Notable Findings:** When breaking down the Prenatal Appointment Access by County we find that 10 providers failed to meet the standard within 10 business days. All sites that fail to meet the standard will be resurveyed and issued a corrective action plan if needed.

[1] DHCS requirement-3NA results, Access to Prenatal Care.

ACCESS TO SPECIALTY CARE

The data for assessing access to specialty care is collected by PHC's Provider Relations staff using the 3NA methodology for appointment access and the After Business Hours survey for telephone and triage services. Data results for urgent care and after business hours' survey findings are not required by NCQA, however, they are included in this report to meet DHCS requirements. The 3NA high-volume, high-impact specialists are selected from a list of all specialty offices that served 200 or more unique members in the measurement year. If a county does not meet the 200 unique members seen, the provider with the highest unique members seen is selected to ensure we account for all counties.

The following tables summarize the findings for specialty care providers.

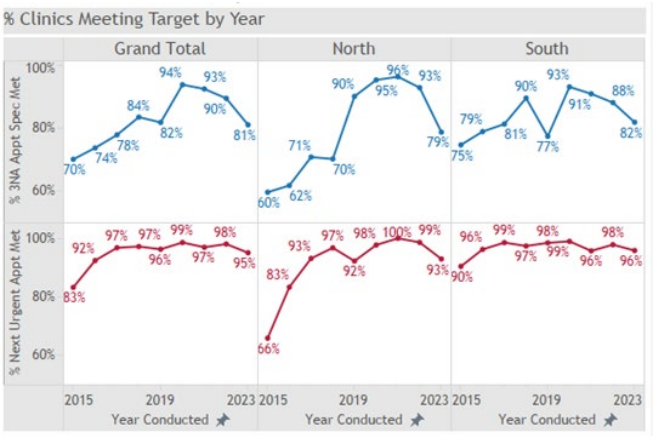
3NA SPECIALTY CARE OVERALL

Third Next Available (3NA) Survey Findings									
Provider Type	Standard	Median Days for Established Specialty Appointment			% of Sites Meeting Specialty Care Standards			Goal	2023 Goal Met?
		North	South	Plan	North	South	Plan		
Specialty Care	Non-urgent specialty care appointments within 15 business days	9.0	8.0	7.0	78.8%	82.0%	80.4%	≥ 80%	Met
Specialty Care	Next urgent appointment ≤ 48 hours	0.0	1.0	1.0	92.9%	95.8%	94.4%	≥ 90%	Met

3NA Survey Specialty Care Overall (PR Rep Survey, 2023)

- **Notable Finding:** As a Plan, we met the 2023 goal for non-urgent and urgent specialty care appointments. However, both regions have suffered an overall decrease in the number of sites meeting both the non-urgent and urgent appointment goal.

Trends for Specialty Appointments Meeting Targets



- **Notable Finding:** There has been a downward trend for routine and urgent specialty care appointments across both regions since 2020. Most notably, the northern region suffered a 14% decrease in sites meeting the non-urgent appointment standard.

3NA SURVEY RESULTS: SPECIALTY CARE ACCESSIBILITY

Specialty Care Accessibility Survey Findings									
Measurements	Standard	Median Performance Rates			% of Sites Meeting Standards			Goal	2023 Goal Met?
		North	South	Plan	North	South	Plan		
# rings before phone answered	≤ 5 rings	2	2	2	100%	100%	100%	≥ 90%	Met
Minutes on hold	≤ 5 minutes	0.0	1.0	1.0	100%	98.9%	99.2	≥ 90%	Met
Average wait time before seeing a provider	≤ 30 minutes	5	10	10	100%	100%	100%	≥ 90%	Met
Return call	≤ 30 minutes	1	1	1	100%	99.5%	99.6%	≥ 90%	Met

3NA Survey Specialty Care Accessibility Survey Results (PR Rep Survey, 2023)

- **Notable Findings:** As a plan, we met our 2023 goal for appointment and telephone access to specialty care providers.

Survey Results: After Business Hours Specialty Care

The after-business hour's survey includes all specialty care providers (no sampling).

After Business Hours Survey Findings Specialty Care 2023											
Measurements	Standard	Q1 2023		Q2 2023		Q3 2023		Q4 2023		Goal	Goal Met?
		North	North	North	North	North	South	North	South		
Answering Machine/ Answering Services	100%	100%	100%	100%	100%	99%	100%	100%	100%	≥ 90%	Met
Instructions to call 911/ER	100%	100%	99%	100%	100%	100%	100%	100%	100%	≥ 90%	Met
Instructions to reach MD or Advice Nurse	100%	100%	99%	100%	100%	94%	99%	100%	99%	≥ 90%	Met
Wait times for screening or triage services	≤ 30 minutes	100%	99%	100%	100%	90%	99%	100%	99%	≥ 90%	Met

Table 1: Survey Results: After Business Hours Specialty Care Accessibility (PR Rep Survey, 2023)

Notable Findings: PHC met the After Business Hours Accessibility Specialty Care goals for each quarter in 2023. No further action is required at this time.

High Volume Specialties Third Next Available Survey Results

3NA Survey Results – Specialty Care: Routine Non-Urgent Care (Standard = 15 Days)								
High Volume Specialties	Median Days for Established Specialist Appointment			% of Clinics Meeting Specialty Care Standards			Goal	2023 Goal Met?
	North	South	Plan	North	South	Plan		
Cardiology	7	8	7	63%	81%	77%	≥ 80.0%	Not Met
Dermatology	9.5	17	12	100%	50%	67%	≥ 80.0%	Not Met
General Surgery	7	5	5	100%	89%	93%	≥ 80.0%	Met
Obstetrics Gynecology	5	6	4	100%	90%	94%	≥ 80.0%	Met
Ophthalmology	18	9	8	60%	78%	73%	≥ 80.0%	Not Met
Orthopedic Surgery	7.5	7.5	7.5	89%	93%	92%	≥ 80.0%	Met

3NA Survey High Volume Specialties (PR Rep Survey, 2023)

- **Notable finding:** As a plan, three high-volume specialties fell below the established median 15-day appointment goal in 2023 as compared to 2022. Ophthalmology had a slight improvement in the northern region but continued to fall short of the 2023 goal.

High Volume: Ophthalmology 3NA Results (Outside Performance Standards)			
Region	County	Service Location	Days to Ophthalmology Appointment
Northern	Humboldt	Humboldt Medical Eye Associates	36
		North Coast Ophthalmology - Eureka	39
	Shasta	Anderson Eye Care	31
Southern	Marin	West Coast Retina Medical Group – Corte Madera	18
	Mendocino	Ukiah Valley Specialist	23
	Solano	Solano Eye Specialist	53
	Sonoma	North Bay Eye Associates – Santa Rosa	43
	Sonoma	North Bay Eye Associates - Sonoma	20

- **Notable finding:** When breaking down the Ophthalmology Appointment Access by County we find that 3 providers in the northern region and five providers in the southern region failed to meet the standard within 15 business days. All sites that failed were resurveyed after 30 days with all 8 having passed. No direct barriers were identified.

High Volume: Dermatology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Ophthalmology Appointment**
Southern	Napa	Brent Loftis, DP	17
	Solano	Solano Dermatology Associates - Vallejo	16
	Sonoma	NorCal Dermatology & Cosmetics	43
		Sutter Medical Group of the Redwoods	70
	Yolo	Woodland Clinic	18

- **Notable finding:** When breaking down the Dermatology Appointment Access by County we find that four providers in the southern region failed to meet the standard within 15 business days. All sites that failed were resurveyed after 30 days with all passing except 2 sites. Corrective Action Plans (CAP) were issued to both providers. NorCal Dermatology & Cosmetics reported a high member demand with appointments being booked out despite being fully staffed. Sutter Medical Group of the Redwoods reported a high number of inappropriate referrals that are impacting their current availability. The CAPs and reported barriers to timely access were shared with the CMO and the information was taken to the PHC Specialty Access Group for discussion.

High Volume: Cardiology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Ophthalmology Appointment**
Northern	Shasta	BV Chandramouli, MD	40
		The Cardiovascular Center	36
Southern	Sonoma	Providence Medical Group	74
	Yolo	Sutter Medical Group	46
	Lake	Adventist Health Clearlake	43
	Mendocino	Adventist Health Ukiah Valley	35

- **Notable finding:** When breaking down the Cardiology Appointment Access by County we find that two providers in the northern region and four in the southern region failed to meet the standard within 15 business days. All sites that failed were resurveyed after 30 days with all passing except one. A CAP was issued to The Providence Medical Group who reported they were not experiencing any staffing issues at the time but were receiving a large number of referrals that were directly impacting their availability. The Provider CAP and reported barrier to timely access was shared with the CMO and the information was taken to the PHC Specialty Access Group for discussion.

HIGH IMPACT SPECIALTY THIRD NEXT AVAILABLE SURVEY RESULTS

3NA Survey Results – Specialty Care: Routine Non-Urgent Care (Standard = 15 Days)								
High Impact Specialty	Median Days for Established Specialist Appointment			% of Clinics Meeting Specialty Care Standards			Goal	2023 Goal Met?
	North	South	Plan	North	South	Plan		
Oncology Hematology	5.5	4.5	4.5	100%	93%	94%	≥ 80%	Met

3NA Survey High Impact Specialty (PR Rep Survey, 2023)

- **Notable finding**: As a plan, we met the appointment standard for our identified high-impact specialty

Section 4: Qualitative Analysis

ACCESS TO PRIMARY CARE

As a plan, PHC met the 90% performance goal for all Primary Care Provider appointments including, adult, pediatrics, newborn, prenatal, and urgent care. When breaking down the primary care access standard 3NA survey data by percentages of clinics in the county that meet the standard we find three counties in the northern region and five in the southern region had lower percentages of appointment compliance. This is an increase from just three counties last year. All sites that fail to meet the standard were resurveyed and issued a corrective action plan if needed.

The total number of member complaints regarding appointment availability increased in both the Northern and Southern regions since 2022 with appointment availability being the most common type of access grievance. The Northern Region experienced a 54% total increase with Redwood Community Health Center having the most grievances in appointment availability as well as overall. The Southern Region experienced a 60% total increase with Solano County Health Services, Vallejo having the most grievances in the appointment category. Despite the number of grievances, the rating per 1000 members was within the standard. No further action is required at this time.

Identified drivers of access challenges continue to be the same as last year, these include:

- An aging physician workforce and a growing, aging population: The COVID-19 Pandemic has exacerbated an existing trending shortage of physicians nationwide. Since 2021 there has been a marked increase in physician retirements prior to the typical age of 65. Additionally, our nation's largest population, the Baby Boomers, are reaching ages where their need for medical care is increasing.
- Practice is closed to new patients: Closing a practice to new patients in one of the ways in which a primary care office can manage their work load in terms of provider to member ratios. A primary care office that is experiencing a shorting in medical care staff cannot continue to accept new patients.

ACCESS TO SPECIALTY CARE

As a Plan, we met our ≥ 80% performance goal for three of the six identified high-volume specialties. Ophthalmology had a slight improvement in the northern region but continued to fall short of the 2023 goal. Both regions continued to fall short of the overall goal upon initial survey. Cardiology failed to meet the goal in the Northern Region but exceeded the goal in the Southern Region at 81%. Dermatology fell short of the goal in the Southern Region but exceeded the goal at 100% in the Northern Region. In 2023, access to specialty care member complaints were low. Two high-volume specialties had one appointment complaint each for the reporting year. A trend could not be established due to low member complaints requiring no action to be taken.

Access to specialty care appointments continues to be an area we must constantly address. The main drivers of access challenges for specialty types that typically fall short of meeting the 15-day accessibility standards are:

- Rural locations where the population is not sufficient to support certain specialty physicians.
- An aging physician workforce and a growing, aging population: The COVID-19 Pandemic has exacerbated an existing trending shortage of physicians nationwide. Since 2021 there has been a marked increase in physician retirements prior to the typical age of 65. Additionally, our nation's largest population, the Baby Boomers, are reaching ages where their need for medical care is increasing.

- Telehealth options not appropriate for all types of specialty care.

Section 5: Summary of Findings

The plan is meeting access standards for primary care (adult/pediatrics, newborn, urgent appointments, and telephone and after-hours accessibility) and three of six specialty care, high-volume and high-impact (urgent, telephone, and after hours), based on data from our provider surveys and additional internal analysis.

PHC has experienced a downward trend for adult and pediatric PCP as well as specialty care appointments meeting the appointment standard across both regions since 2020. This coincides with the start of the pandemic. We are now feeling the effects of a national shortage of providers due to the effects of Covid-19 on health care providers and an aging provider community.

While PHC failed to meet the 15-day appointment standard for Ophthalmology and Cardiology in the northern region, and Dermatology in the southern region, this is not due to a lack of contracting with an available service provider. Currently there are no additional qualified providers who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. Additionally, Ophthalmology is not a specialty that lends itself to the use of telehealth appointments. PHC monitors appointment access each quarter and works with individual providers who fail to meet the standard to identify strategies for improvement.

The 2023 CAHPS data from the ME7 (Member Experience) report indicates performance below the twenty-fifth percentile benchmark for getting care quickly and getting care needed for Adult. The Child survey indicates PHC was below the twenty-fifth percentile benchmark for getting care needed and getting care quickly. This is a decrease from 2022 when getting care quickly for child performance met the benchmark. The response rate for Adult was 14.3% and Child was 14.9%. In comparison to last year, the impacts to staffing have seemingly become worse while the demand for in person care is growing. Residual impacts from COVID have only exacerbated the issue. From this impact the most frequently reported Access-related concern was regarding provider services, which accounted for 48.4% of the cases. Issues reported in this category included providers unable to see members due to staffing shortages, providers not letting members know about changes to their scheduled appointments, and members having a hard time reaching their provider by phone.

Within the Access category in the Appeals and 2nd Level Grievances, Members raised 125 concerns regarding appointment delays with their primary care provider (PCP) or provider's office staff with the primary focus of reported concerns revolving around appointment availability. Notably, members expressed dissatisfaction with prolonged appointment wait times and challenges securing appointments with specialist in a timely manner, hindering their ability to promptly address their urgent needs. Partnership continues to work on addressing this challenge by working to support our network and seeking to contract with new providers, predominantly in rural areas.

There were no identified gaps in the provider ratios overall. PHC experienced an 8.2% increase in total membership compared to 2022. We have been able to maintain access to primary care for all ages by having a stable Family Medicine network. The Provider Recruitment Program provides incentives for Primary Care practitioners to join our network and PHC is actively recruiting for all categories of Primary Care, specifically in those rural areas that traditionally have low numbers of Internal Medicine providers.

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

Section 5: Opportunities for Improvement

Partnership operates in a broad service area encompassing urban, suburban, and rural settings. Partnership's provider network is challenged by a national shortage of providers, combined with an aging provider community. Because of this, Partnership has developed a multi-pronged approach to recruit and retain providers.

Opportunity: Increase the number of contracted primary care and high-volume specialty care practitioners.

- Effectiveness of Prior Actions: Partnership has started a sponsored workforce development program that offers a sign-on bonus for providers when they contract

with Medi-Cal for the first time, and if they come from a county outside of the 14 counties that Partnership serves. This updated program is taking place between January 2021 – January 2024 with the bonuses being paid out over multiple payments over a 36-month term for physicians, NP's, and PA's and 12 months for licensed behavioral health clinicians including SUD counselors. The strategy is to hold providers in place longer term. To date there has been an increase in accepted offers with 84 the first year and 89 the second with Family Medicine being the majority provider specialty. PHC was able to recruit 66 new primary care practitioners to the network between May 1 2023 and December 1, 2023 with 27 of them going to 6 of our most rural northern counties. Initial retention details look favorable but we may not know completely until the 36-month time period and payments take place.

- *Planned Action*: Partnership has had success with the sponsored workforce development program to date and will continue the strategy in an effort to continue recruitment of physicians, NP's, PA's, and licensed behavioral health clinicians including SUD counselors.
- *Planned Action*: Expand efforts to strengthen recruitment of support specialty providers by adding obstetrics providers (physicians, women's health nurse practitioners, certified nurse midwives) whose clinical care focuses on perinatal care, including labor and delivery to the 2024 workforce development program
- *Planned Action*: Conduct a retrospective assessment of specialty providers to identify additional opportunities to better use telehealth as a way to increase access to care, particularly in the rural counties.

Continuity and Coordination of Medical Care

July 2023

QI 3 Element A Factors 1,2, and 3

QI 3 – FY2022/2023

Overview

Partnership HealthPlan of California (Partnership) annually assesses continuity and opportunities to coordinate medical care by way of its Quality Improvement Programs (QIP), ensuring plan network providers can easily access needed information across various settings of care. This helps to facilitate smooth transitions of care from setting to setting. Partnership has QIPs for Primary Care Providers (PCPs), hospitals, perinatal providers, and long-term care (LTC) facilities. The QIP team includes members from the Health Analytics, Population Health, Quality Improvement, Care Coordination, and Provider Relations departments, as well as representation from the Office of the Chief Medical Officer and Partnership's regional leaders.

The QI 3 team was built by drawing from the larger QIP Team. The primary QI 3 team members include:

1. Robert Moore, MD MPH MBA, Chief Medical Officer
2. Mark Netherda, MD, Medical Director for Quality
3. Dorian Roberts, Senior Project Manager, Performance Improvement
4. Amy McCune, Manager of Quality Incentive Programs
5. Colleen Townsend, MD, Regional Medical Director
6. Margarita Garcia-Hernandez, Director of Health Analytics
7. Athena Beltran-Nampraseut, CPhT, Program Manager, Primary Care Provider Quality Improvement Program
8. Amber Newell, CPhT, Program Manager, Primary Care Provider Quality Improvement Program
9. Jessica Delaney, PMP, Program Manager, Hospital and Perinatal Quality Improvement programs
10. Staci Vercellotti, Program Manager, Hospital and Perinatal Quality Improvement programs

Partnership's QI 3 focus includes measures collecting data for:

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

QI 3, Element A, Factor 2,
Continued on next page

Opportunity 1: Movement across settings -Plan All-Cause Readmissions (PCR)

Description

For assigned members 18 to 64 years of age, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

- Count of Index Hospital Stays* (denominator)
- Observed Readmissions: Count of 30-Day readmissions (numerator)
- Expected Readmissions: Sum of adjusted readmission risk (numerator)
- Ratio of Observed/Expected Readmissions

*An acute inpatient stay with a discharge during the first 11 months of the measurement year (i.e., July 1, 2022 – June 1, 2023). The 11-month period was chosen to ensure a member remained enrolled in the plan a full 30 days after discharge. Otherwise, a readmission might go uncounted.

Relevance

According to the Centers for Medicare and Medicaid (CMS, 2021), research shows that hospital readmission rates differ across the nation leading to an opportunity to improve the quality of care, improve patient safety and save taxpayer dollars by incentivizing providers to reduce excess readmissions. Data from the California Department of Public Health ongoing statewide collaborative "Let's Get Healthy California" shows that in 2015, the readmission rate for privately insured individuals was 10.4%, but 15.7% for patients with Medi-Cal, with a statewide rate of 13.5% (the statewide target rate is 11.9%). This disparity is targeted as part of the Department of Healthcare Services' (DHCS) ambitious California Advancing and Innovating Medi-Cal (CalAIM) program. One of the primary goals of CalAIM is to improve care coordination efforts and communication between hospitals, primary care providers, patients and payers (health plans), in both discharge planning and post-discharge provision of care and housing, all aimed at patient well-being, safety and reduced readmission rates. Partnership's efforts to improve readmission rates and improve members' health experiences include incentivizing hospitals to improve communication and care coordination efforts to better engage patients and caregivers on post-discharge planning.

Partnership's Hospital Quality Improvement Program (HQIP) and Primary Care Provider Quality Improvement Program (PCP QIP) include performance measures for "Risk Adjusted Readmissions". This quality measurement increases awareness and transparency to the issue of hospital readmissions, with the goal towards measure improvement through value-based payments in the inpatient care setting.

Goal for this measurement

Fiscal year 2022/2023 HQIP participants consisted of 26 hospital participants that vary in contract type – "fee-for-service" or capitated rate, size - large (≥ 50 licensed general acute beds) or small (<50 licensed general acute beds), and geography- rural or urban. The goal is to have at least 60% earn full points, at least 30% earn partial points, and less than 10% earn zero points across all HQIP participants for the readmission measure.

Each participant hospital site had a readmission rate goal of:

QI 3, Element A, Factor 2

- <1.0 (full points)
- ≥1.0 - 1.2 (partial points)
- >1.2 (zero points)

Methodology

The measurement period is the fiscal year July 1, 2022 to June 30, 2023.

Denominator: The number of acute inpatient or observation stays (Index Hospital Stay) on or between July 1st and June 1st of the measurement year by members 18 to 64 years of age continuously enrolled for at least 90 days prior to the admission date and for at least 30 days after admission date.

Numerator: Observed 30-Day Readmission: The number of acute unplanned readmissions for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay on or between July 3rd and June 30th of the measurement year by Partnership members included in the denominator.

Calculation:

$$\text{Observed 30 Day Readmissions Rate} = \frac{\text{Observed 30 Day Readmissions}}{\text{Total Count of Index Hospital Stays}}$$

Note: Inpatient stays where the discharge date from the first setting and admission date to the second setting must be two or more days apart and considered distinct inpatient stays (hence, the July 3rd numerator start date).

Expected 30-Day Readmission

An Expected Readmission applies stratified risk adjustment weighting. Risk adjusted weighting is based on the stays for surgeries, discharge condition, co-morbidities, age, and gender.

Calculation:

$$\text{Expected 30 Day Readmissions Rate} = \frac{\text{Expected 30 Day Readmissions}}{\text{Total Count of Index Hospital Stays}}$$

Final Measure Calculation:

$$\text{Ratio of Observed/Expected Readmissions} = \frac{\text{Observed 30 Day Readmissions}}{\text{Expected 30 Day Readmissions}}$$

Exclusions:

- Exclusions for Numerator and Denominator:
    - Discharges for death
    - Pregnancy condition
    - Perinatal condition
    - Stays by members with 4 or more index admissions in the measurement year
- Exclusions for Numerator:
    - Planned admission using any of the following:
        - Chemotherapy
        - Rehabilitation
        - Organ Transplant

QI 3, Element A, Factor 2

- Planned procedure without a principal acute diagnosis

Resource: Partnership Hospital QIP 2022 Specifications for Large and Small Hospitals, both page 15.

Quantitative Analysis

The readmission data is shared with HQIP participants bi-annually during the program year as readmission data from Partnership that contains their rates, see the data table below sorted by the Observed/Expected Ratio from highest to lowest, along with the member/patient drill down report.

Hospital QIP Readmissions Rates, July 2022 – June 2023, Run Date: July 05, 2023

Contacts: Margarita Garcia, Director of Health Analytics

HOSPITAL NAME	*DENOMINATOR (IHS CNT)*	*OBSERVED READMISSION CNT*	*OBSERVED READMISSION RATE (%)*	*EXPECTED READMISSION CNT*	*EXPECTED READMISSION RATE (%)*	*VARIANCE*	*OBSERVED EXPECTED RATIO*
MEDICAL CENTER NORTHBAY	1015	75	7.39	77.26	7.61	70.98	0.97
HOSPITAL VACAVALLEY	189	17	8.99	14.88	7.87	13.65	1.14
CENTER MODOC MEDICAL	24	1	4.17	1.77	7.37	1.64	0.57
ST HELENA ADVENTIST HLTH	271	20	7.38	21.85	8.06	19.99	0.92
MEMORIAL HOSP WOODLAND	326	23	7.06	24.03	7.37	22.15	0.96
QVMA MED CTR PROVIDENCE	572	28	4.90	42.03	7.35	38.74	0.67
HEALDSBURG DISTRICT HOSP	59	1	1.69	4.54	7.69	4.18	0.22
COMMUNITY HOSP MAD RIVER	116	5	4.31	8.35	7.20	7.72	0.60
HOWARD MEM ADVENTIST HLTH	209	11	5.26	15.41	7.37	14.21	0.71
UKIAH VALLEY ADVENTIST HLTH	342	24	7.02	26.47	7.74	24.26	0.91
CENTER REDDING MERCY MEDICAL	1201	81	6.74	89.85	7.48	82.77	0.90
MEDICAL CENTER MARINHEALTH	604	45	7.45	47.02	7.78	43.09	0.96
MEMORIAL HOSP PROVIDENCE SR	1079	58	5.38	84.06	7.79	77.01	0.69
WOOD MEM HOSP PROVIDENCE RED	93	6	6.45	7.45	8.01	6.81	0.81
VALLEY HOSP PETALUMA	204	13	6.37	15.41	7.55	14.17	0.84
JOSEPH HOSP PROVIDENCE ST	756	61	8.07	60.05	7.94	54.94	1.02
HOSPITAL TRINITY	13	0	0.00	0.89	6.85	0.83	0.00
MENDO COAST ADVENTIST HLTH	71	6	8.45	5.79	8.15	5.28	1.04
CLEARLAKE ADVENTIST HLTH	162	17	10.49	12.59	7.77	11.56	1.35
SONOMA VALLEY HOSPITAL	79	3	3.80	5.25	6.65	4.89	0.57
MEDICAL CENTER FAIRCHILD	128	8	6.25	9.21	7.20	8.53	0.87
MEMORIAL HOSP MAYERS	17	1	5.88	1.23	7.21	1.13	0.82
CTR MT SHASTA MERCY MEDICAL	49	3	6.12	3.47	7.09	3.22	0.86
COMMUNITY HOSP ST ELIZABETH	37	1	2.70	2.55	6.89	2.36	0.39
COMMUNITY HOSP JEROLD PHELPS	3	1	33.33	0.20	6.60	0.18	5.05
MEDICAL CENTER BANNER LASSEN	58	5	8.62	4.27	7.36	3.94	1.17
COMMUNITY HOSP SURPRISE VLY	1	0	0.00	0.06	5.82	0.05	0.00

QI 3, Element A, Factor 3
Continued on next page

QI 3, Element A, Factor 3
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Below are the top 10 primary diagnosis descriptions (admissions and readmissions) for the data:

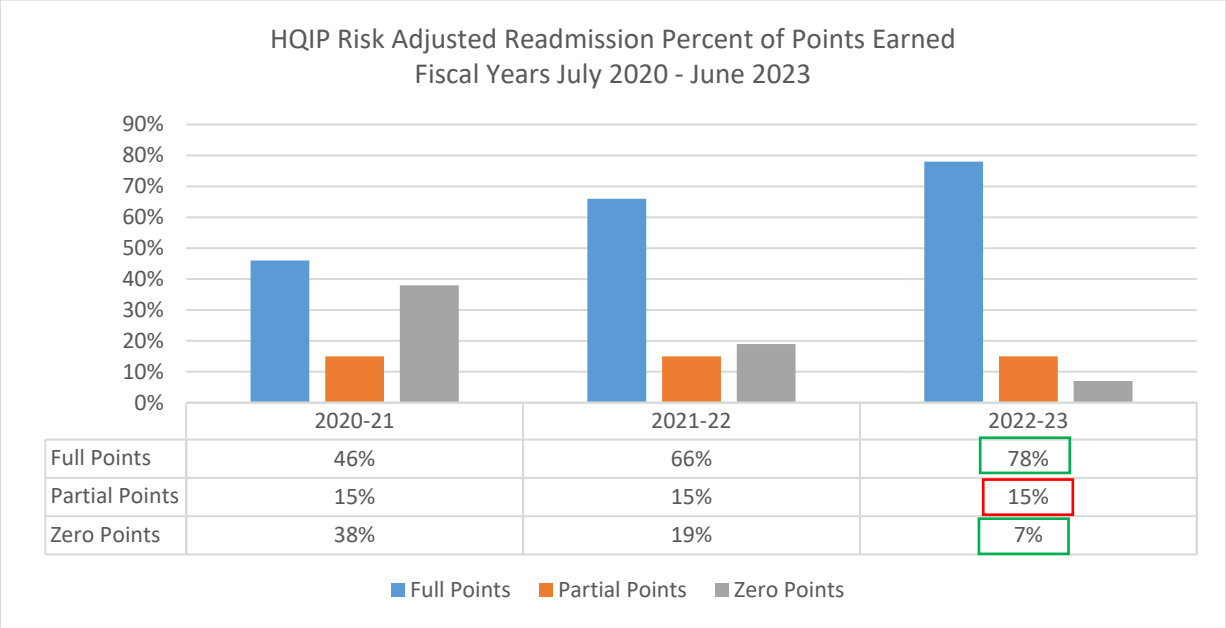
Top 10 Primary Diagnosis Descriptions, Fiscal Year 2022/2023	Count of Primary Diagnosis Description
SEPSIS, UNSPECIFIED ORGANISM	898
MORBID (SEVERE) OBESITY DUE TO EXCESS CALORIES	178
HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	157
ACUTE KIDNEY FAILURE, UNSPECIFIED	138
ALCOHOL DEPENDENCE WITH WITHDRAWAL, UNSPECIFIED	133
SEPSIS DUE TO ESCHERICHIA COLI [E. COLI]	94
PNEUMONIA, UNSPECIFIED ORGANISM	91
NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	91
TYPE 1 DIABETES MELLITUS WITH KETOACIDOSIS WITHOUT COMA	86
ALCOHOL INDUCED ACUTE PANCREATITIS WITHOUT NECROSIS OR INFECTION	82

Below are the data elements in the member/patient drill down report:

- Admit ID
- CIN
- Member Name
- Date of Birth
- Age
- Sex
- Admit Date
- Discharge Date
- Discharge Code
- Primary Diagnosis Code and Description
- Hospital Name
- Readmission ID
- Days Between Admissions
- Readmit Denominator Flag
- Observed Numerator Flag
- Observed Numerator Flag Originating Hospital
- Variance
- Expected Readmission Risk

QI 3, Element A, Factor 3

Below is the breakdown of the percent of points earned in the Hospital QIP per fiscal/ measurement year for the included risk adjusted readmissions measure.



	2020-21	2021-22	2022-23
Full Points	46%	66%	78%
Partial Points	15%	15%	15%
Zero Points	38%	19%	7%

The goal is to have at least 60% earn full points, at least 30% earn partial points, and less than 10% earn zero points across all HQIP participants by the close of the fiscal year. The data revealed the following about the goal:

- At least 60% earn full points – Met – 78% earned full points
- At least 30% earn partial points – Not Met – 15% earned partial points
- Less than 10% earn zero points – Met – 7% earned zero points

Qualitative

Two of the three specific target percentages were met – the "Zero Points" and the "Full Points" goals. The strong showing among facilities reaching the "Full Points" goal (78%) made achieving the "at least 30%" "Partial Points" goal mathematically impossible. (Although, as the goal was written as "at least" rather than "30-59%", the goal is technically met).

This measurement year saw a 12% increase in the percentage of hospitals achieving "Full Points" for this measure. The results document significant improvement over MY2021-22 and dramatic improvement over MY2020-21, particularly in the percentage of facilities achieving "Zero Points" (down 31% from MY2020-21).

The improvement in this measure is likely driven by several factors. Most obvious is the dramatic decrease in COVID-19 related hospital cases in the MY2022-23. The previous year's report on "the top 10 primary diagnosis descriptions (admissions and readmissions)" for MY2021-22 showed 409 readmissions with COVID-19 Respiratory Infection listed as the primary diagnosis resulting in readmission, whereas COVID-19 did not rise high enough to be included in the "top 10" list for MY2022-23. This is likely due to improvements and availability of treatments for COVID-19 in both the inpatient and outpatient settings and to the tremendous and sustained reduction of cases in the community.

QI 3, Element A, Factor 3
QI 3, Element C, Factor 1
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QI 3, Element A Factor 3
QI 3, Element C, Factor 1
Continued

Additional improvement in the readmission rate may be because of the development of services directed at housing and transitional care, as directed by and made available through the CalAIM benefit. See additional discussion of this in the "Acting on Opportunities" section below.

Acting on Opportunities

As of November 2, 2021, Partnership received confirmation of qualifying for the NCQA Recognition program Partners in Quality. On May 30, 2023, Partnership received confirmation of continuing as a "Partner in Quality". With this designation, Partnership is exercising the automatic credit opportunity for Opportunity 1, Factor 2 - movement across settings, Plan All-Cause Readmissions (PCR).

Partnership will include a presentation addressing "Reducing Hospital Readmissions Rates", with a focus on CalAIM driven services, at the scheduled 2023 Hospital Quality Symposium. The symposium is an annual educational event exploring and discussing many quality based issues, such as patient care topics, patient safety, equity, managing and using data, and staff satisfaction. Invited attendees are network hospital staff involved in Quality Improvement and policy decision making. Attendees have the opportunity to ask questions of our presenters and learn with and from their peers, regarding the HQIP and HEDIS measures, including identified best practices.

The preponderance of readmissions are for the primary diagnosis of "SEPSIS, UNSPECIFIED ORGANISM". Investigation into why that particular diagnosis is by far the most prevalent is warranted. Analysis of at least a subset of these 898 cases could help identify points of intervention and potentially decrease such readmissions.

Furthermore, Partnership utilized services provided through the CalAIM benefit to help decrease readmissions in 2022 through the placement of between 1,500 and 2,000 members in either recuperative care or short-term care post- hospitalization with allowed placement stays of between 90 days and 6 months. While Partnership believes this practice is helping to reduce readmissions and ED visits, likely contributing to the improved rates noted above, Partnership will evaluate the effectiveness of this practice to ensure it provides a sustainable reduction in readmissions and benefits members while accounting for claims lag.

The continued and significant improvement in this measure over the past few years, and the technical achievement of the three point levels goals draws into question whether or not this measure should continue to be monitored as part of this report.

Appendix 1: Partners in Quality (PIQ) 2023 Welcome/ Continuance Letter.

Appendix 2: NCQA Resource Directory of Incentives for NCQA Recognition, Updated March 2021, https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/benefits-support/payer-support/directory/

Appendix 3: PCP QIP Specifications, Unit of Service Measure 3: Patient Centered Medical Home Recognition (PCMH), 2022

QI 3, Element A, Factor 4
QI 3, Element B, Factor 1

QI 3, Element A, Factor 2
Continued on next page

Opportunity 2: Movement across settings – Primary Care Practitioners (PCPs) to Emergency Departments (ED)

Description

The rate of assigned members with an "avoidable ED visit" with a primary diagnosis that matches the diagnosis codes selected by Partnership HealthPlan of California (Partnership).

Relevance

ED visits are a high-intensity service and a cost burden on the health care system, as well as on patients (Measures of Care Coordination, 2015). Some ED events may be attributed to preventable or treatable conditions (Measures of Care Coordination, 2015). A high rate of ED utilization may indicate poor care management, inadequate access to care or poor patient choices, resulting in ED visits that could be prevented (Dowd, et al., 2014).

Direct provider contact decreases ED use for non-emergent problems. (Chou, S., Gondi, S., Weiner, S., Schuur, J., Sommers, B. 2020). Improving access (in-office, telephonic, and virtual) to PCPs would likely decrease ED use. Patient education and instructions for accessing advice lines (e.g., after hours "nurse lines") could also help reduce ED visits. Partnership is trying to assist with access through financial supports like its Provider Recruitment Program to attract new providers to Partnership PCP sites. Partnership's Primary Care Provider Quality Improvement Program (PCP QIP) includes a "unit of service measure" for Extended Office Hours. This measure incentivizes PCP offices at a rate of 10% of their capitation rate to provide some level of direct member to provider contact (virtual or in office) for at least 8 hours per week over and above normal clinic hours to improve patients' access to their PCPs.

More directly, Partnership's PCP QIP includes the "Avoidable Emergency Department (ED) Visits/1000 Members per Year" measure, which incentivizes practices for low rates of assigned member ED visits for conditions or issues that could have been taken care of out of the ED setting.

Goal for this measurement

For Calendar year 2022, Partnership's PCP QIP consisted of 263 individual PCP sites, defined as "capitated" or the assigned medical home for Medi-Cal/ Partnership members. These sites have diverse membership sizes and are located in both rural and urban communities throughout Partnership's large geographic coverage area. All contracted PCPs are automatically enrolled in the PCP QIP, and the Avoidable ED Visits measure is tracked for all practices. The goal for this measurement is to have at least 60% of PCP sites earn full points, at least 30% earn partial points, and less than 10% earn zero points across all PCP QIP participants. The percentages of PCP QIP participants meeting target goals provides a way to discover gaps in access to primary care for "avoidable ED visits" with primary diagnoses that match identified diagnosis codes and in overall network performance (Continuum, n.d.).

Each PCP site has an Avoidable Emergency Department (ED) Visits/1000 Members per Year target based on 2019 PCP QIP plan wide Avoidable Emergency Department (ED) Visits/1000 Members per Year (as taken from the "2019 Primary Care Utilization Measure" which was renamed "Avoidable Emergency Department (ED) Visits/1000 Members per Year" in 2020 and onward):

- 60th percentile (9.18) (full points)
- 70th percentile (9.19 - 11.44) (partial points)

QI 3, Element A, Factor 2

- >70th percentile (>11.44) (zero points)

Methodology

The measurement period is the calendar year January 1, 2022 to December 31, 2022.

Denominator: The number of assigned members 1 year of age or older with an emergency department visit anytime during the measurement year.

Numerator: The number of assigned members 1 year of age or older with "avoidable ED visits" with a primary diagnosis that matches the diagnosis codes selected by Partnership.

Calculation:

$$Avoidable\ ED\ Visits\ per\ Member\ per\ Year\ X\ 1000 = \frac{\text{Avoidable ED Visits}}{(\text{Sum of Member Months}) * 12{,}000}$$

Exclusion: This measure excludes member who are less than 1 year of age. ED claims with at least one diagnosis code not considered avoidable will deem the visit as not avoidable (Partnership PCP QIP 2022 Specifications Manual, Detailed Version, page 50).

Quantitative

The dataset used comes from Partnership's claims data from January 1, 2022 to December 31, 2022 with a 90-day claims lag period to ensure the data set is as complete as possible. ED data was shared monthly via Partnership's Partnership Quality Dashboard (PQD) to all PCP QIP participants.

Partnership's Partnership Quality Dashboard (PQD) is a Tableau® dashboard that displays Primary Care Provider Quality Improvement Program (PCP QIP) data. PQD dashboards are designed to inform, prioritize, and evaluate quality improvement efforts. Dashboard elements and performance metrics built into the PQD provide the ability to track and trend QIP data. Performance data in PQD can be rolled up in executive summary views and drilled-down to the patient demographic level. PQD is actionable, informative, and supportive in pursuit of a site's QI goals.

The year over year trend in the monthly Avoidable Emergency Department (ED) Visits/1000 Members per Year is presented here:

QI 3, Element A, Factor 3
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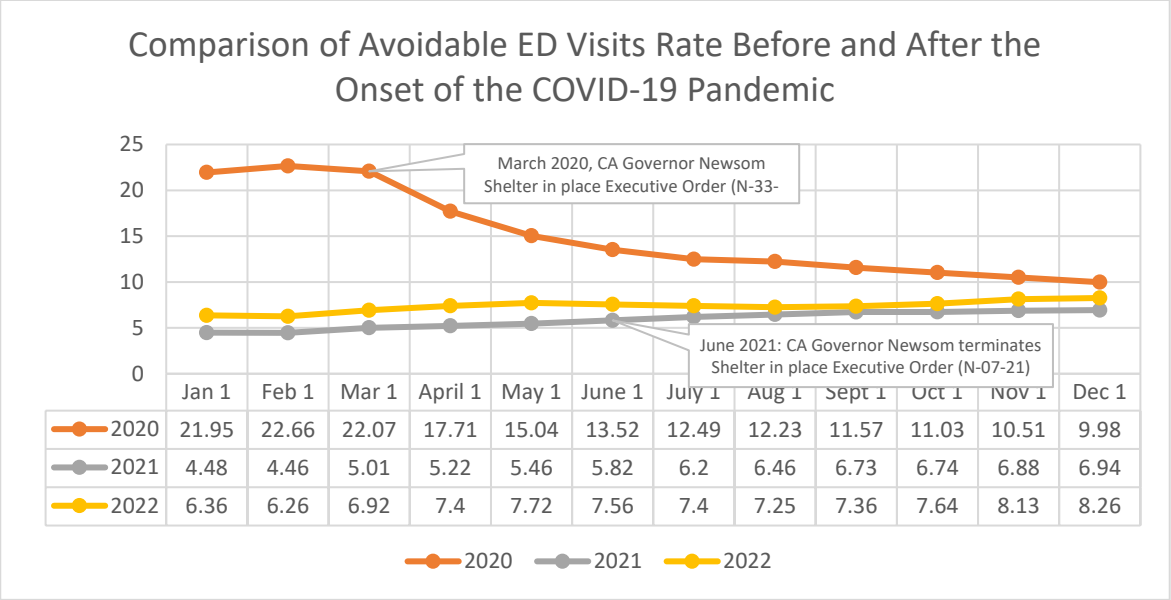
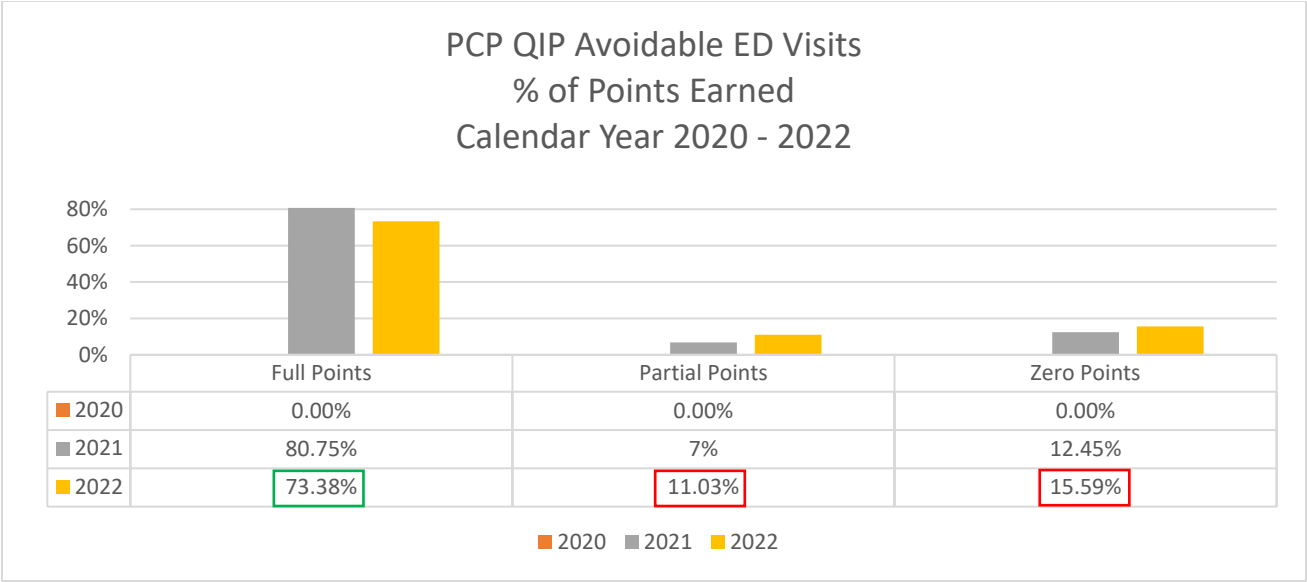
QI 3, Element A, Factor 3 continued next page
QI 3, Element C, Factor 2



It is important to note, on March 4, 2020, California's Governor Newsom Shelter in place Executive Order (N-33-20) took effect and remained in effect until June 11, 2021. This undoubtedly affected the rate of ED visits in most of 2020 and in at least the first half of 2021.

The implementation of the shelter in place order prompted Partnership to convert the incentivized PCP QIP Avoidable Emergency Department (ED) Visits/1000 Members per Year to a non-incentivized (monitoring) measure in measurement year 2020. For Measurement Year 2021, Partnership reinstated the Avoidable Emergency Department (ED) Visits/1000 Members per Year as an incentivized measure. Below is the year over year breakdown of full, partial or zero points earned from 2020 – 2022.



The goal to have at least 60% of sites earn full points, at least 30% earn partial points, and less than 10% earn zero points across all 2022 PCP QIP participants was partially met

The data revealed the following results:

QI 3, Element A, Factor 3

- At least 60% earn full points: Met – 73.38% earned full points
- At least 30% earn partial points: Not Met – 11.03% earned partial points
- Less than 10% earn zero points: Not Met – 15.59% earned no points

Qualitative

The ongoing COVID-19 pandemic affected the Avoidable ED Visits measure results. To fully appreciate the pandemic effect, data from the last pre-pandemic year, 2019 (not graphed here), should be considered. In 2019, the percentage of practices earning "full points" was only 58.49%, a stark contrast to the percentage earning full points in 2021, an outcome continuing to a lesser extent in 2022. At least one 2020 study, (Friedman, A., et al. 2021) documents a dramatic decline in hospital visit rates following "stay-at-home" orders. It is likely this effect persisted even after the June 11, 2021 lifting of stay-at-home orders, as individuals continued to avoid trips to the ED. This persisting decrease in avoidable ED visits could be due to patient fear of long wait times, fear of exposure to COVID-19, or not wanting to add to an already overburdened system with problems that were not serious. Additionally, it is likely some of the noted effect derives from pandemic driven increased access to and improvements in telephonic and virtual instructions from PCP offices and other "medical advice lines", educating patients about when to access the ED. The tremendous increase in virtual visits across the healthcare system also likely contributed to improved ED use. Some combination of these effects likely explains the dramatic increase in the percentage of sites meeting the 60% goal (making achievement of the partial points 30% goal impossible). It is unlikely that an improvement in access to PCP office visits was the cause, as Partnership data shows that PCP in-office visits were down across all Partnership geographic regions in 2021 and 2022 compared to pre-pandemic years.

Following this measure for at least another year is indicated. The pandemic effect, while not gone (the healthcare workforce was seriously diminished during the pandemic and a return to pre-pandemic levels has been slow to occur), is easing and ED rates may be level setting. Perhaps any effects of improved triage technics and improved virtual care access will persist and spread, and avoidable ED visit rates will remain low. Moreover, despite the overall high percentage of practices earning full or partial points (84.41%), the 3rd goal of <10% of sites earning zero points was not met and worsened compared to MY2021. This deserves further examination to determine why some practices are struggling with this measure when so many others are doing well. If the percentage of practices achieving "full points" remains high, Partnership may need to consider setting higher goals or retiring this measure in future years.

QI 3, Element A, Factor 3 and 5
QI 3, Element C, Factor 2

Acting on Opportunities

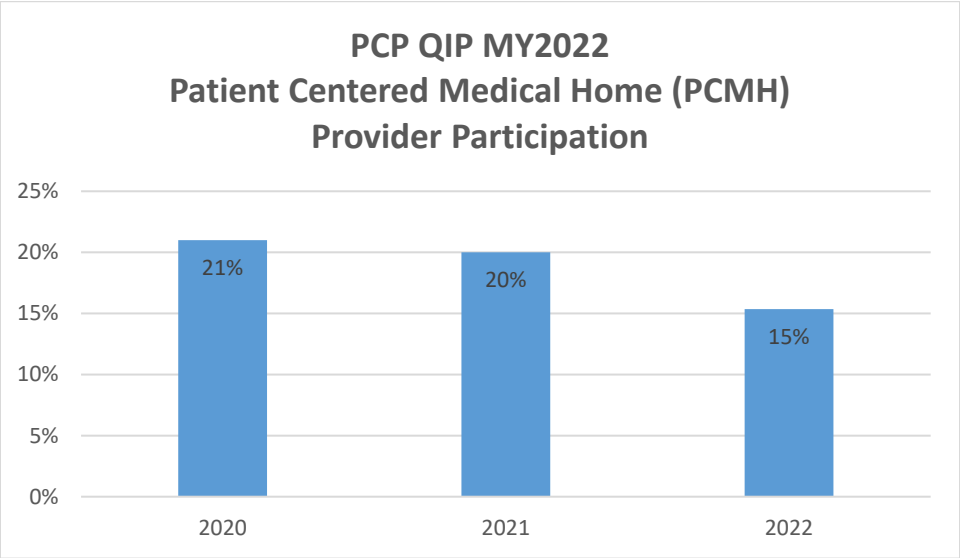
Processes and systems that support key capabilities for the Patient Centered Medical Home (PCMH) may require real upfront investment and ongoing costs to primary care providers (Philip, Govier, and Pantely, 2019). PCMH often prepares PCPs for alignment with value-based payment arrangements and success. In an attempt to address equity, Partnership offers an annual incentive of $1,000.00 to participating providers via a PCMH unit of service measure in the Primary Care Provider Quality Improvement Program (PCP QIP) for each site achieving or maintaining PCMH accreditation from NCQA, or the equivalent from AAAHC or JCAHO.

QI 3, Element A, Factor 5
QI 3 Element B, Factor 2,
Continued on next page

QI 3, Element A, Factor 5
QI 3 Element B, Factor 2
QI 3 Element C Factor 2

Participating PCP sites must receive accreditation, maintain accreditation, or re-certify within the measurement year. Documentation of PCMH recognition, accreditation maintenance, or re-certification from NCQA, AAAHC, or JCAHO must be faxed or emailed to QIP@partnershiphp.org by January 31, 2023.

Below is a year over year chart of the PCP participation in the PCMH unit of service measure:



Opportunities for improvement

On November 2, 2021, Partnership was confirmed as an NCQA Recognition program PIQ. On May 30, 2023, Partnership received confirmation of continuing as a "Partner in Quality". Partnership shares the PIQ discount code broadly across all PCP organizations in an effort to further increase the number of PCMH sites in the PCP network.

Furthermore, providers in the network have access to an online platform (Provider Online Services) which allows them access to a list of their members that have presented in the ED as well as the ability to receive ED notifications to receive this list without having to log in to access. Partnership's Behavioral Health workgroup will evaluate which providers within the network are utilizing this tool as well as "push-notifications" from the EDs, and how they are utilizing these tools actionably.

QI 3, Element A, Factor 2

Opportunity 3: Movement Across Settings – HEDIS® Performance Measure Data: Prenatal and Postpartum Care (PPC) – Postpartum Rate

Description

Two timely postpartum care services rendered to Partnership members with one occurring within 21 days after delivery and the other occurring between 22 and 84 days after delivery.

Relevance

Timely postpartum care is a measure of quality care and can contribute to healthier outcomes for women after delivery. The postpartum visit is an important opportunity to educate new mothers on expectations about motherhood, address concerns, and reinforce the importance of routine preventive health care. The American College of Obstetricians and Gynecologists (ACOG) recommends that a timely postpartum visit should assess the health of the infant, the mother's medical and psychological condition, breastfeeding, and contraception plan.

Effective and timely postpartum care occurs in the first few weeks after delivery. These visits are essential to support maternal-infant bonding and to ensure that birthing patients have access to breast feeding education, screening and treatment for mood disorders, and appropriate family planning options. While the benefits of these visits is well established, the timing of these visits presents a number of challenges that can be difficult to overcome. As the timing of deliveries cannot be predicted, these visits are typically scheduled after the birth. Most birthing patients leave the hospital within 1-5 days after delivery. Ideally, postpartum obstetrical visits should be scheduled before or at the time of discharge from labor and delivery.

Barriers

Timely postpartum care can be hindered by any one of several elements or a by combination of several, resulting in failure of the delivering mother to transition from the hospital back to the obstetrics provider. The timing of the discharge (e.g., after office hours or on weekends) might further impede scheduling the postpartum visits before discharge. Under staffing at the hospital, especially during the pandemic, might make this less of a priority, instead resorting to instructing the patient to call to schedule the follow up. Even when scheduled, patients can "no show" for appointments for a number of reasons including failure to understand the need, being busy with the new baby/ work/ other children, and failure to prioritize personal healthcare (Henderson, V. et al., 2016). Geography can be an additional barrier, as some patients in rural settings live very long distances from their obstetrics providers, making the trip (especially for a "check-up") a hardship.

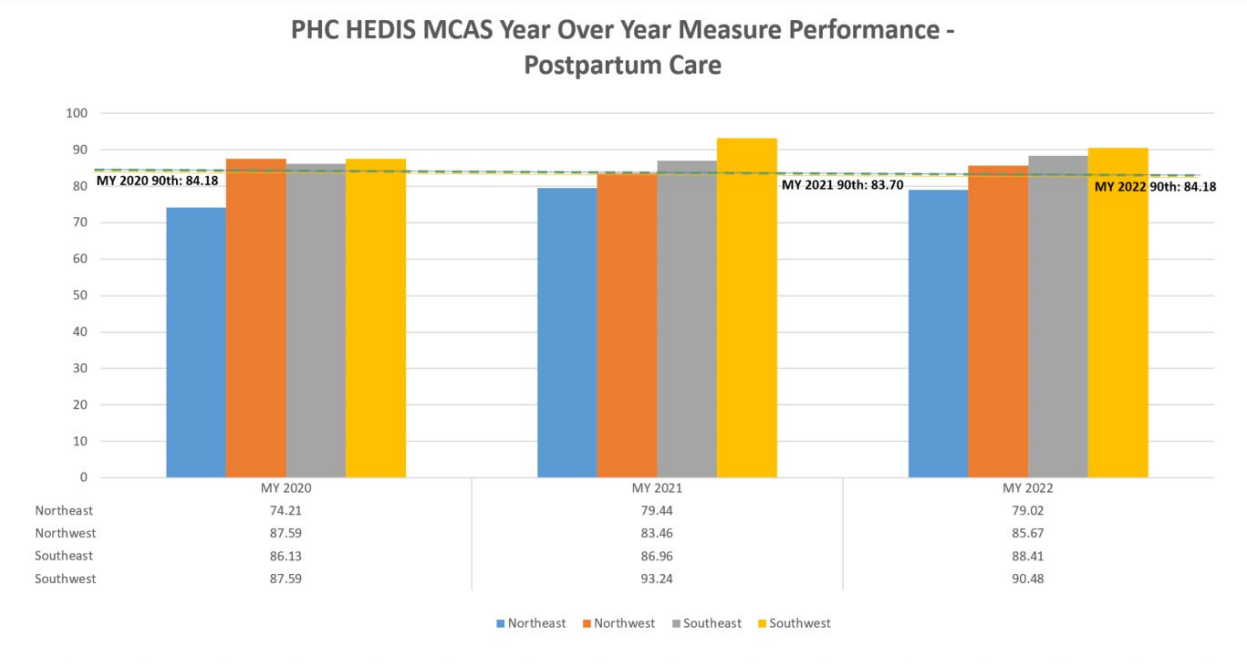
Goal

The High Performance Level (HPL) 90th percentile rate was met across ALL Partnership regions for the HEDIS® MCAS Measure for Prenatal and Postpartum Care (PPC) – Postpartum Care in pre-pandemic 2019. The goal for this measure was to regain that HPL across all regions in 2022.

Quantitative

QI 3, Element A, Factor 3
QI 3, Element C, Factor 3

The table below shows HEDIS® MCAS performance rates for the Prenatal and Postpartum Care (PPC) – Postpartum Care measure for each of Partnership's four regions in Measurement Years 2020, 2021, and 2022. Data for postpartum visits is collected via claims data for the time-period of 7-84 days after delivery that occurs on or between Oct 8th of the year prior to the Measurement Year and Oct 7th of the Measurement Year. Deliveries of live births are the denominator indicators for this measure. The high performance level (HPL) 90th percentile target for this measure changed year over year, as displayed in the table, but the goal was to reach the HPL for each region each year.



The goal to "Regain the High Performance Level (HPL) 90th percentile rates across all Partnership regions for the HEDIS® MCAS Measure for Prenatal and Postpartum Care (PPC) – Postpartum Care" was not met for ALL of the Partnership regions in the measurement year 2022. The Northeast Region was not at goal.

Qualitative

Effective and timely postpartum care occurs as two visits in the first three months after delivery. The first occurs within 21 days, and the second from 22-84 days after delivery. While the benefits of these visits is well established, the timing of these visits presents a number of challenges that can be difficult for patients and health systems to overcome.

For patients, the home environment after delivery is fraught with challenges to scheduling and keeping appointments. Once home, new parents are coping with recovering from delivery while managing the erratic schedules of a newborn, other children and other family members. All of this can interfere with less pressing tasks, such as scheduling and keeping postpartum visits. Transportation is also a significant factor for the Medi-Cal population. While Partnership has a transportation benefit, many individuals and families are not comfortable using this benefit. As noted above, geography is another barrier, particularly in the rural and "frontier" counties of Partnership's Northeast Region. Some patients have to travel a hundred miles or more for care, often on poorly maintained roads, which can be impassable in inclement weather or fire season. Patients in these areas often struggle with getting to and from appointments in the same day and may not prioritize follow-up care if they are not having a specific

QI 3, Element A Factor 3 and 6
QI 3, Element C, Factor 3,
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QI 3, Element A, Factor 3 and 6
QI 3, Element C, Factor 3

problem. This geographic barrier likely contributes to the continued poor performance in the Northeast Region. Partnership's Perinatal QIP program also noted an OB provider in the Northeast region closed, and therefore is no longer of service to members in the area exacerbating the barriers mentioned and impacting access to timely appointments within the region.

Furthermore, Partnership has seen eight hospitals in eight years within the 24 services areas close their maternity units, which adds up to about 25% of hospitals, or a 3% loss per year. The closure of maternity units is part of a nationwide trend, and one study showed maternity deserts where there are no maternity services in 50% of rural counties throughout the United States. Looking at each of Partnership's current counties and expansion counties, there used to be maternity services in each with the exception of Sierra County (supported by Trinity County). Now those counties, along with Modoc and Plumas Counties, have no hospitals offering maternity services. This is a concerning trend, and without addressing the issue, it is one likely to continue. Six more hospitals in the 2024 Partnership region are at risk of closing (those with fewer than 300 deliveries per year).

Large geographic areas in the Partnership service area, with thousands of residents, are currently more than one hour away from the nearest hospital providing OB services. Women must now travel farther, potentially when in labor or with a complication, due to this lack of access. There are worse outcomes for newborns and mothers when they are more than an hour from a hospital with a maternity ward. The loss of OB access disproportionately affects lower income, rural and non-white ethnicity populations. Lack of maternity care also increases maternal mortality rates, which have been rising in the United States. They initially fell in California, but have been steadily rising in part due to association with hospitals closing OB units in rural areas and also due to increased opioid use in pregnancy.

Acting on Opportunities

The Perinatal Quality Improvement Program

The Perinatal Quality Improvement Program (PQIP) is a pay-for-performance program that offers financial incentives to participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP practitioners that provide quality and timely prenatal and postpartum care to Partnership members. The PQIP is developed and designed with primary care providers PCPs (PCP) and OB/GYN providers in mind to drive measurable health outcomes through a concise and meaningful measurement set. The PQIP focuses on the following measures: (1) Timely TDaP and Influenza Vaccinations, (2) Timely Prenatal Care, (3) Timely Postpartum Care, and (4) Electronic Clinical Data System (ECDS) use.

Provider participation is by invitation. Participating CPSP and select non-CPSP perinatal providers with more than 50 deliveries per year may be invited to participate in the PQIP. Adding the incentive payment for timely postpartum care visits was done in part to reward those providers doing this well and in part to encourage providers to improve in this area. Provider participation in this program stayed consistent from Fiscal Year (FY) 2020-21 to FY2021-22, with 25 participating Parent Organizations. In FY2020-21, 54 Provider Sites, representing 25 parent organizations, participated. In FY 2021-22, participation increased to 58 Provider Sites, representing 25 Parent Organizations. In FY2022-23, program participation was reduced by one (1) Parent Organization to 24 following the closure of one clinic (Women's Healthcare Associates of Redding), leaving 57 participating Provider Sites. Although the PQIP measurement year is fiscal, while the HEDIS® measurement year is annual, the effect of the QIP to drive improvement, if any, should be continuous across both measurement periods. Starting in FY2020-

QI 3, Element B, Factor 3
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QI 3, Element B, Factor 3
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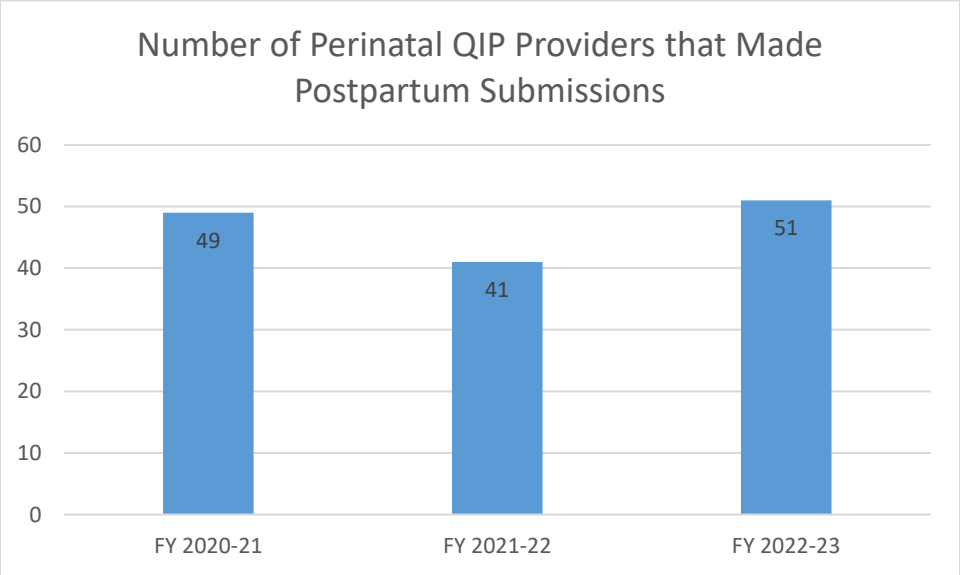
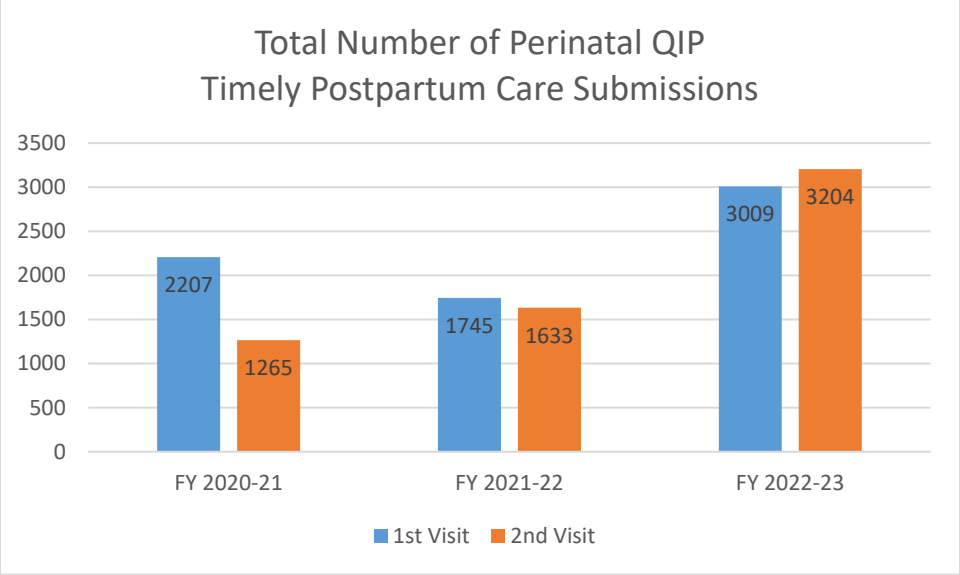
21, the PQIP program allowed one visit to occur via telehealth, but requires at least one in person postpartum visit.

Although the number of Parent Organizations and participating Provider Sites decreased in FY2022-23, the number of providers submitting postpartum submission increased from 49 submitting providers in FY2020-21, 41 in FY2021-22, to 51 providers in 2022-23. The total number of timely postpartum submissions in the program also increased from 2,207 timely first visit submissions and 1,265 timely second visit submissions in FY2020-21, to 1,745 timely first visit submissions and 1,633 timely second visit submissions in FY2021-22, to 3,009 timely first visit submissions and 3,204 timely second visit submissions in FY2022-23.





The Perinatal Quality Improvement Program Team will continue to assess the effectiveness of the program in encouraging the network to improve on the timeliness of postpartum care they are providing and ensuring timely capture of these visits.

QI 3, Element B, Factor 3
Continued on next page

Perinatal Provider Engagement

Partnership staff identified high volume perinatal providers (at least 50 deliveries per year) to offer targeted educational sessions highlighting the importance of quality, timely postpartum visits and to share best practices to achieve higher rates of visits. The presentations, entitled "Raising the Quality of Outcomes in Perinatal Services", were customized for each targeted provider. The presentations included staff from a variety of Partnership departments and teams: the Perinatal Quality Incentive Program (PQIP), Population Health, Regional Medical Directors, Care Coordination, and Provider Relations.

Each presentation included an overview of standard guidelines related to perinatal care and shared state, regional and, where possible, practice specific data related to perinatal care. Also, descriptions of the PQIP measurement specifications were shared to ensure clinical and quality staff were aware of the details of the incentive program and how the PQIP mirrored current practice guidelines. The presentations highlighted the best practices to engage patients in postpartum care, such as scheduling postpartum visits prior to discharging a patient from the hospital, the practice of calling patients who deliver/ discharge on the weekend, developing a relationship with the delivery practices and the prenatal/ postpartum care providers to share information about deliveries in a timely fashion.

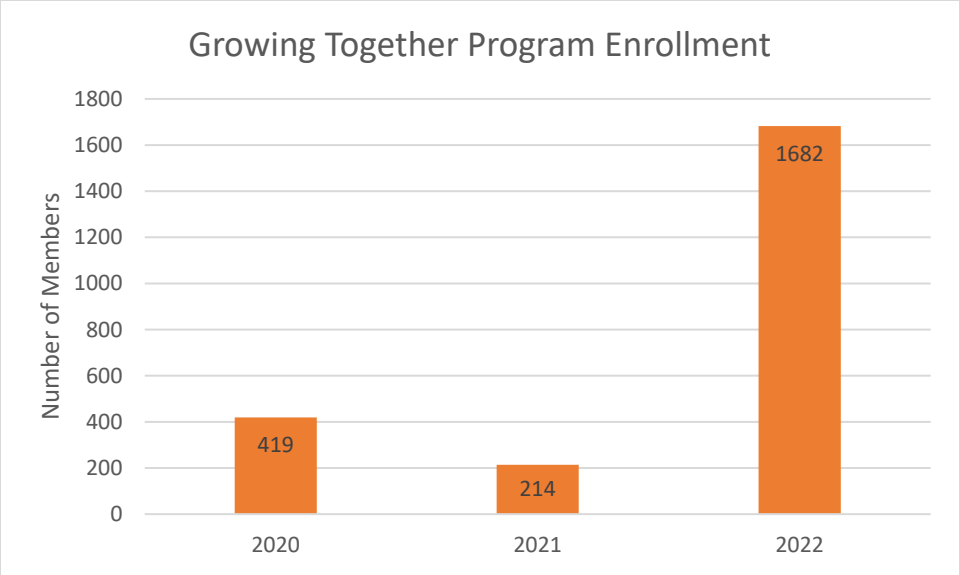
To schedule these educational sessions, the practices were sent an email letter from the Partnership Regional Medical Director at the beginning of the measurement year (July/August) inviting the practice to schedule an onsite or virtual presentation. After three months if there was no response, the Regional Medical Director contacted the practices' clinical and operational managers and the Perinatal QIP staff contacted the quality staff at the site to offer practice specific presentations. In 2021, there were 21 Perinatal Provider Engagement presentations across the Partnership network. In 2022, there were 12 presentations, with 9 providers who attended a presentation previously requesting another presentation in 2023. Partnership continues outreach to the network to schedule presentations for 2023, with four already scheduled.

Growing Together Program

The Perinatal Provider Engagement sessions detail the clinical evidence for timely perinatal care, the provider incentives to support implementation of operational steps that support success in ensuring postpartum follow up after delivery, and **member incentives** that encourage close follow up. Concurrent to developing the PQIP, Partnership developed the "Growing Together Program" in which pregnant members were offered incentives for completing the perinatal care visits, as well as enrolling and engaging in primary care with their infants. Members were contacted by Partnership during the 3rd trimester to provide education related to prenatal and postpartum visits. These members were also called after delivery as a reminder to ensure postpartum visits were scheduled and completed.

In 2020, The Growing Together Program contacted 1,373 members eligible for enrollment in the program, and saw 419 (30.52%) members enrolled. In 2022, the Growing Together Program team reached out to 4,003 postpartum members after identifying their delivery to offer them an incentive for enrollment in the program, and 963 (24.06%) agreed to participate. 719 members were enrolled in the program during their prenatal period, and continued through the postpartum period (total 1682). Year over year enrollment in the program can be seen below:

QI 3, Element B, Factor 3



Opportunities for improvement

Going forward, the perinatal provider presentations will emphasize a format that effectively shares best and promising practices while discussing each practice's challenges. The presentations will focus less on the measure specifications in order to identify barriers noted by practices for scheduling and achieving the visits. Where applicable, the health plan will work with the hospital and outpatient staff to develop systems and work flows that favor ease in scheduling appointments. The health plan will explore messaging and outreach to align with the hospitals and OB practices for scheduling appointments.

Many of the obstetric providers in the Partnership network are part of an FQHC practice or multispecialty group. The provider engagement presentations for 2022 aimed to include non-perinatal primary care providers who may have clinical contact with postpartum patients and can encourage or facilitate follow up care. For instance, family medicine providers who evaluate a newborn, can support postpartum patients to follow up with the obstetrics provider. In the setting of an "urgent care" visit for a non-perinatal issue (e.g., a URI), a primary care provider can reinforce or facilitate scheduling a postpartum visit.

While the number of members enrolled in the Growing Together Program has increased significantly since it began, the team will continue to explore ways to further increase the number of perinatal members engaged through member outreach, as well as those enrolled in the program, receiving education and incentives that support postpartum visits.

The perinatal work group is examining the rates of postpartum visits with a race and ethnicity lens to determine how a member engagement initiative can offer education and outreach to populations that have lower rates of postpartum visits. The group has also analyzed racial and ethnic disparities for members receiving perinatal care, and have not only included this analysis in their presentations but are working to address disparities as well.

Appendix 4: Raising the Quality of Outcomes in Perinatal Services PPT presentation
Appendix 5: Improving Women's Health Measures Workgroup Charter (draft)

QI 3, Element A, Factor 6

QI 3, Element A, Factor 1
Continued in next page

Opportunity 4: Movement Between Practitioners - HEDIS® Performance Measure Data: Comprehensive Diabetes Care (CDC) – Eye Exam rate.

Description

The percentage of members 18-75 years of age who had a diagnosis of diabetes (type 1 and type 2) who had an eye exam (retinal) performed.

Relevance

According to the CDC, diabetes is the leading cause of blindness in adults. For this reason, regular eye exams are recommended for all people with diabetes, to detect early changes that can lead to interventions to prevent blindness. Scheduling and tracking the results of these exams can be difficult. Lack of communication between eye specialists and primary care practitioners often means that the communication is reliant on patient self-report to determine whether and when diabetic eye screening was completed, as well as the date when screening is next due (Liu and Swearingen, 2019). Communication barriers are further compounded by lack of access to records from eye care providers (Liu and Swearingen, 2019). Lastly, from the eye care provider perspective, there is difficulty in scheduling an eye care appointment (e.g., long eye appointment wait times) because the current eye care provider workforce is insufficient to meet the growing demand for diabetic eye screening (Holley and Lee, 2009, and Liu and Swearingen, 2019).

Partnership HealthPlan of California's (Partnership's) Primary Care Provider Quality Improvement Program (PCP QIP) includes the Comprehensive Diabetes Care (CDC) – Eye Exam rate as a means to add quality measurement, transparency, and improvement to value-based payment in the primary care setting (CMS, 2021).

Partnership uses its eReports system to communicate which members 18-75 years of age with a diagnosis of diabetes (type 1 or type 2) completed or still need to complete retinal eye exams. (eReports is an online system built by Partnership's Web team for the PCP QIP Clinical measures; it is the mechanism by which providers can monitor their performance and submit supplemental medical record data to Partnership to enhance their performance).

Goal for this measurement

In calendar year 2022, the PCP QIP consisted of 263 PCP parent organizations defined as capitated or assigned medical homes for Medi-Cal (Partnership) members. Of the 263 PCP organizations, 238 had a practice type of Family Medicine (member age range 0-99+ years of age) or Internal Medicine (member age range 18+ years of age), making those PCP organizations eligible for including the Comprehensive Diabetes Care (CDC) – Eye Exam measure in their monitoring (non-incentivized) measurement set. Partnership's Pediatric Medicine practice type (member age range 0-18 years of age) is excluded from the Comprehensive Diabetes Care (CDC) – Eye Exam measure.

The goal for this measurement was for PCP QIP participants to achieve the HEDIS® 2020 50th percentile, minimum performance level or MPL, target of 51.36% for the Comprehensive Diabetes Care (CDC) – Eye Exam measure.

It is important to note, on March 4, 2020, California's Governor Newsom Shelter in place Executive Order (N-33-20) took effect. The PCP QIP Comprehensive Diabetes Care (CDC) – Eye Exam measure was

QI 3, Element A, Factor 1

converted to a non-incentivized (monitoring) measure in measurement year 2020 and that continued in measurement years 2021 and 2022.

Methodology

Denominator: The number of assigned members 18-75 years of age by the end of the measurement year with a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Numerator: The number of assigned members in the eligible population who received an eye screening for diabetic retinal disease. This includes people with diabetes who had the following:

- a retinal or dilated eye exam by an eye care professional (optometrist, ophthalmologist, or approved tele-optometry service) in the measurement year OR
- a negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year OR
- bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year

Exclusions include assigned members who:

- A diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
- Have a current lab value indicating no diabetes that is less than 12 months old and more recent than the last diabetic triggering event. (Partnership PCP QIP 2022 Specifications Manual).

Quantitative

Comprehensive Diabetes Care (CDC) – Eye Exam rate is shared daily with the PCP QIP participants who access eReports from March 1 of the measurement year through the measurement year grace period that concludes on January 31 following the measurement year.

Partnership's eReports, is an online system built for the PCP QIP Clinical measures, and is the mechanism by which providers can monitor their performance and submit supplemental data to enhance their performance. eReports offers the following functionality to its user base:

- Access to a web based portal 24 hours/7 days a week
- Tracking of clinical performance in real time
- Download patient reports for each of the clinical measures
- Bi-weekly data refreshes on Tuesday and Thursday with five data sources: (1) claims data, (2) California Immunization Registry (CAIR) data, (3) pharmacy data, (4) Lab data, and (5) data from eReports users who upload supplemental data for their patients and Partnership members.

Although providers were not incentivized for their performance in the Retinal Eye measure, the 2022 final score data found 67 out of 226 (29.64%) PCP sites were able to achieve the 2020 HEDIS® 50th MPL (51.36%) for Comprehensive Diabetes Care (CDC) – Eye Exam rate. Of the 67 sites achieving the goal, the average denominator for measure was 103 members, with a max of 659 members and minimum of 1 member. Below is the 2022 Comprehensive Diabetes Care (CDC) – Eye Exam rate score table sorted from highest to lowest rate:

QI 3, Element A, Factor 3
Continued on next page

QI 3, Element A, Factor 3
Continued on next page

PCP	County	Members in Measure	Score
St. Joseph Heritage Healthcare	NAPA	3	100.00
Full Circle Center For Integrative Medicine	HUMBOLDT	2	100.00
Paul Farley, MD	LAKE	2	100.00
Sutter Pacific Medical Foundation	SONOMA	2	100.00
O'Connor, William T.	SOLANO	1	100.00
St. Joseph Heritage Healthcare	SONOMA	1	100.00
Shasta Community Health Centers	SHASTA	59	81.36
Anderson Valley Health Center	MENDOCINO	19	78.95
Sutter Medical Foundation-West	YOLO	32	75.00
Campos And Tran Medical Assoc., Inc	NAPA	4	75.00
Sutter Medical Foundation-West	YOLO	4	75.00
Sutter Pacific Medical Foundation	SONOMA	4	75.00
Voltaire Velarde, Md	SOLANO	4	75.00
Chua, Gabriel S.	SOLANO	13	69.23
Karuk Tribal Health & Human Srvcs.	SISKIYOU	51	68.63
Sonoma Valley Comm Health Center	SONOMA	208	68.27
Sutter Medical Foundation-West	YOLO	24	66.67
Marin Community Clinics	MARIN	6	66.67
St. Joseph Heritage Healthcare	HUMBOLDT	3	66.67
Voltaire Velarde, Md	SOLANO	3	66.67
Mountain Valley Health Centers	SISKIYOU	49	65.31
Northeastern Rural Health	LASSEN	20	65.00
Sutter Medical Foundation-West	SOLANO	51	64.71
MAYERS MEMORIAL HOSPITAL DISTRICT	SHASTA	11	63.64
Northbay Healthcare	SOLANO	79	63.29
Ole Health	NAPA	54	62.96
Hill Country Community Clinic Inc.	SHASTA	16	62.50
Sutter Medical Foundation-West	SOLANO	16	62.50
Santa Rosa Community Health Centers	SONOMA	406	62.32
Modoc Medical Clinic	MODOC	53	62.26
Northbay Healthcare	SOLANO	143	62.24
Adventist Health	LAKE	475	61.68
Santa Rosa Community Health Centers	SONOMA	530	60.75
Shasta Community Health Centers	SHASTA	659	60.39
Adventist Health	LAKE	15	60.00
Shasta Family Care	SISKIYOU	10	60.00
Sutter Medical Foundation-West	YOLO	10	60.00
Communicare	YOLO	210	59.52
Santa Rosa Community Health Centers	SONOMA	415	59.52
Northern Valley Indian Health	YOLO	37	59.46
Community Medical Centers	YOLO	17	58.82

QI 3, Element A, Factor 3
Continued on next page

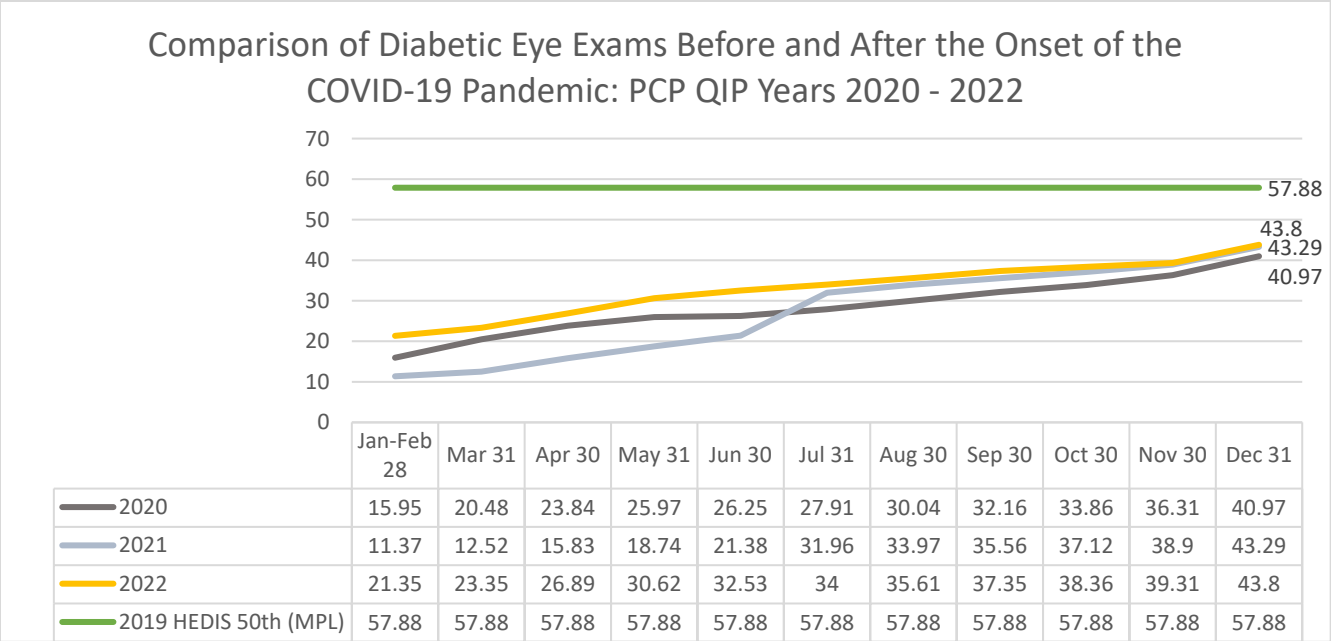
Northeastern Rural Health	LASSEN	140	58.57
Sutter Medical Foundation-West	SOLANO	70	58.57
Shasta Community Health Centers	SHASTA	113	58.41
Ole Health	NAPA	40	57.50
West County Health Centers	SONOMA	40	57.50
Healdsburg Primary Care	SONOMA	7	57.14
Medical Offices Of Robert Rushton, Inc.	MENDOCINO	7	57.14
Sutter Pacific Medical Foundation	SONOMA	7	57.14
Northbay Healthcare	SOLANO	92	56.52
Modoc Medical Clinic	MODOC	23	56.52
Sonoma County Indian Health Project	SONOMA	114	56.14
West County Health Centers	SONOMA	43	55.81
Dignity Health	SHASTA	9	55.56
Fairchild Medical Clinic	SISKIYOU	209	55.50
Sutter Medical Foundation-West	SOLANO	29	55.17
Dignity Health	SHASTA	55	54.55
St. Joseph Heritage Healthcare	SONOMA	11	54.55
Mendocino Coast Clinics	MENDOCINO	118	54.24
Shasta Community Health Centers	SHASTA	183	53.01
Ole Health	NAPA	155	52.90
Ole Health	NAPA	577	52.86
Pit River Health Service, Inc.	SHASTA	36	52.78
Solano County Health & Social Services	SOLANO	558	52.51
Solano County Health & Social Services	SOLANO	252	51.59
Mendocino Community Health	MENDOCINO	101	51.49
Churn Creek Healthcare-Redding Rancheria	SHASTA	237	51.48

Partnership also analyzed the 2022 PCP QIP scores of organizations with 100 or more members in the denominator. The 2022 final score data identified 28 out of 92 (30.43%) PCP organizations with 100 or more members in the denominator in measurement year 2022. The membership size average was 202 members per PCP organization with a max of 1434 members and minimum of 116 member in the denominator per PCP organization. Of these 28 sites with larger denominators, only 10 (35.71%) were able to achieve the 2020 HEDIS® 50th MPL (57.88%) for Comprehensive Diabetes Care (CDC) – Eye Exam rate in measurement year 2021.

Parent Org	Members in Measure	Score
Santa Rosa Community Health Centers	1434	59.76
Shasta Community Health Centers	1014	60.06
Adventist Health	914	51.53
Northbay Healthcare	314	60.83
Sutter Medical Foundation-West	267	61.05
Fairchild Medical Clinic	228	54.39
Sonoma Valley Community Health Center	208	68.27

QI 3, Element A, Factor 3

Northeastern Rural Health	160	59.38
Mendocino Coast Clinics	118	54.24
Sonoma County Indian Health Project	116	55.17



	Jan-Feb 28	Mar 31	Apr 30	May 31	Jun 30	Jul 31	Aug 30	Sep 30	Oct 30	Nov 30	Dec 31
2020	15.95	20.48	23.84	25.97	26.25	27.91	30.04	32.16	33.86	36.31	40.97
2021	11.37	12.52	15.83	18.74	21.38	31.96	33.97	35.56	37.12	38.9	43.29
2022	21.35	23.35	26.89	30.62	32.53	34	35.61	37.35	38.36	39.31	43.8
2019 HEDIS 50th (MPL)	57.88	57.88	57.88	57.88	57.88	57.88	57.88	57.88	57.88	57.88	57.88

Qualitative

The COVID-19 pandemic imposed unprecedented challenges on the medical system, especially in services that require close proximity (i.e., less than six feet between patient and provider), like retinal eye exams. On March 18, 2020, at the onset of the COVID-19 pandemic in the USA, the American Academy of Ophthalmology recommended, "all ophthalmologists cease providing any treatment other than urgent or emergent care immediately."(Ahmed and Liu, 2021). This greatly decreased access to non-urgent diabetic retinal exams. In response to the pandemic and understandably limited access to eye exams, Partnership changed its PCP QIP diabetic eye exam measure from incentivized to a non-incentivized, but monitored measure. Partnership's historic data indicates that the combination of the sudden onset of the COVID-19 pandemic and the change from an incentivized to a non-incentivized measure resulted in steep declines in measure performance, as evidenced by the 2019 final plan-wide performance rate of 63.63 (not graphed here).

Despite the lingering effects of the pandemic, however, some providers, including ten of the larger organizations were able to achieve the MPL goal. Partnership will investigate what practices enabled these sites to be successful despite identified barriers. Partnership will determine if the activities at the successful clinics represent "best practices" that can be duplicated and spread to other sites.

Prior to the pandemic, many organizations were adopting a "tele-optometry" service to perform diabetic screenings in PCP offices. Tele-optometry services place or provide retinal cameras in PCP offices. PCP staff are trained to use these cameras for the purposes of screening exams for diabetic patients. The cameras then send digital images of the patients' retinas to optometrists and ophthalmologists for readings and interpretations. Any patients with "positive" screening results are

QI 3, Element A, Factor 7
Continued on next page

QI 3, Element A, Factor 7

referred for full examinations to the specialist provider. Adoption of this service was gaining momentum among Partnership PCP organizations just prior to the pandemic, in part due to the introduction of new tele-optometry service providers to the Partnership network. Several Partnership PCP organizations were outspoken regarding the ease of use and positive effect this service provided to their patients, encouraging other colleagues to consider the service. Due to the pandemic, with the need for physical distancing and staffing limitations, many organizations were forced to discontinue the use of tele-optometry services. Partnership will encourage the revitalization of this practice. Partnership will also encourage the adoption of tele-optometry by other PCP organizations, using testimonies from PCP organization "tele-optometry advocates" who recognize the benefits of these services.

Acting on Opportunities

Partnership members are provided vision benefits through their regular medical coverage and with Vision Service Plan (VSP). The member's general vision coverage includes one eye examination with refraction every 24 months (Partnership Policy MCUP 3102 Vision Care, 2021). A second eye examination with refraction will be covered if the member has a sign or symptom indicating medical necessity (Partnership Policy MCUP 3102 Vision Care, 2021).

Given the current trend in eye care and the vision care benefits available to Partnership members, Partnership has partnered with VSP to share data on members who are identified as diabetic and are still in need of a retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year. In 2021, VSP sent 14,179 reminders to Partnership members and 1,306 retinal eye exams took place within 180 days of the reminder being sent. In 2022, VSP sent 24,316 reminders to Partnership members, and 1,394 retinal eye exams took place with VSP within 180 days of the reminder being sent. Partnership plans to continue collaborating with VSP on this intervention for now. Based on the apparent return rate, however, this intervention may need to be reevaluated to determine if continuing the current process is worthwhile.

Opportunities for improvement

Partnership will provide a list of members diagnosed with diabetes to VSP, so they may be flagged in VSP's system. Partnership Quality Improvement (QI) Senior Project Manager works with a Partnership QI Data Analyst to pull a member list that is shared and sent to VSP.

This will trigger two primary actions:

1. Will enroll the member in their established 'reminder' program where the member receives an eye exam reminder in the mail AND
2. When a member presents at a VSP provider, the provider will know to ask about their condition and provide a dilated eye exam AND
3. Send the primary care provider the exam findings and follow-up recommendations via the VSP Primary Care Physician Communication Form

For the MY2023 PCP QIP, Comprehensive Diabetes Management – Retinal Eye Exam is restored as a fully incentivized measure. This is expected to improve the completion rates for this measure.

Appendix 6: VSP Primary Care Physician Communication Form

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May 30, 2023

Sarah Molteni-Casper
Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534

Dear Sarah,

This letter confirms that Partnership HealthPlan of California is an NCQA Partner in Quality. We appreciate your continued support and dedication to healthcare quality. This letter confirms your Partner in Quality status through December 31, 2023.

Please let me know if I can be of further assistance and we look forward to continuing to work together.

Best regards,

Adam O'Neill
Vice President, Sales & Marketing
National Committee for Quality Assurance (NCQA)

Appendix 1 (pages 28-31) - PHC is a PIQ organization. Auto-credit request for the following requirements:
QI 3, Element A, Factor 4
QI 3, Element B, Factor 1
QI 3, Element C, Factor 1
Continued on next page

Appendix 1 (pages 28-31) - PHC is a PIQ organization. Auto-credit request for the following requirements:
QI 3, Element A, Factor 4
QI 3, Element B, Factor 1
QI 3, Element C, Factor 1
Continued on next page

November 2, 2021

Sarah Molteni-Casper
Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534

Dear Sarah,

This letter is to confirm that Partnership HealthPlan of California is an NCQA Recognition program Partner in Quality.

NCQA is pleased to acknowledge current Partners in Quality in our online Resource Directory of Incentives for NCQA Recognition. We update this information as changes occur. The directory allows you to easily filter by organization type, state, program supported and type of support provided, and is an important resource for practices seeking information on organizations that can assist them on their Recognition journey—whether in the form of financial incentives, technical assistance or other means.

NCQA offers provider quality data to organizations seeking to integrate validated quality ratings into their information tools. Partners in Quality are eligible for 50% off data extracts with information on Recognized practices in their state. Data are available via NCQA's Recognition Data License for each Recognition program and are updated each month. Pricing depends on the type of data feed (e.g., one-time, monthly), the type of organization seeking the feed and requests for custom data outside the standard fields. NCQA-Accredited health plans receive monthly data feeds at no cost. Visit our RP Data License page for more information.

Your discount code is **CCAPHC**. Practices supported by your organization may use this code* for a 20% discount for NCQA Recognition. The discount code may be used for all practices identified in the program survey. Please share it with eligible practices/clinicians *before they submit payment to NCQA.* NCQA does not reimburse practices/clinicians after submission of the application and final payment for processing.

*The discount code applies only to *initial Recognition program fees*; it does not apply to annual reporting, education sessions, survey tools or NCQA publications.

NCQA thanks you for the support your organization provides to practices seeking NCQA Recognition. Please consider me a resource for all information regarding the Partner in Quality program. I look forward to speaking with you soon!

Best regards,

Adam O'Neill
AVP, Business Development & Marketing

Appendix 1 (pages 28-31)
QI 3, Element A, Factor 4
QI 3, Element B, Factor 1
QI 3, Element C, Factor 1
Continued on next page

Partners in Quality Program FAQs

Which Practices Are Eligible to Use the Discount Code?

PCMH 2017 Practice Eligibility. Both single-site and multi-site practices are eligible to use the Partners in Quality discount code and receive 20% off program fees on Initial Recognition. *(Discount cannot be applied to annual reporting fees.)*

PCSP Practice Eligibility.

- Multi-site practices with three or more independent sites are eligible for a 50% per-clinician discount on application fees and are not eligible for an additional discount through this sponsorship.
- Practices with three or more sites that share the same EHR or registry (i.e., tracks patient and billing data the same way) and can submit under the same program agreement are eligible for the multi-site discount.
- Practices that have not been approved as multi-site are eligible for the 20% discount on Initial Survey and Renewal Survey submissions.
- Single-site practices, practices with fewer than three locations and practices that do not meet multi-site criteria may use the 20% discount through support of NCQA Partner in Quality status.

Where Do Practices Enter the Discount Code?

PCMH 2017: Enter the Discount Code in Q-PASS. The Discount Code field is located on the Organization Dashboard under the **Make Payments** tile of your Q-PASS account. Refer to the attached document for step-by-step instructions.

PCSP: Enter the Discount Code in the Survey Tool. The Discount Code field is located on the Online Application under the Practice Site tab. Click the site name and enter the code in the Discount Code field. The code may be added any time before the application is submitted.

Where Can We Find Answers to Our Questions?

NCQA's online My NCQA portal lets practices submit questions and receive answers electronically. Questions are triaged to NCQA staff. After you create an account, simply log in and submit questions or view previous submissions.

How Can we Promote Our Partner-in-Quality Status?

NCQA encourages organizations to share their status and discount-code information. All Partners in Quality should reference our Recognition Program Marketing and Advertising guidelines for appropriate language to incorporate in marketing and advertising materials you may create. There is no specific section for Partners in Quality; use the general information about Recognition program language.

Appendix 1 (pages 28-31)
QI 3, Element A, Factor 4
QI 3, Element B, Factor 1
QI 3, Element C, Factor 1

Is There a Partner in Quality Seal?

There is no seal, but there is a Partner in Quality “stamp” that can be used to promote the program on an organization’s website or in communication materials.

Collaborative Marketing Opportunities

NCQA is interested in your work helping practices seek Recognition. We often collaborate with Partners in Quality to promote their initiatives and events or to share successes.

Is there an upcoming event you’d like us to tweet about? Are you launching a new quality initiative for our PCMH, PCSP or clinical programs? We’d be happy to assist you by providing a quote for a press release or discussing other ways we can collaborate.

Appendix 2
QI 3, Element A, Factor 4
QI 3, Element B, Factor 1
QI 3, Element C, Factor 1

Resource Directory of Incentives for NCQA Recognition

Updated March 2021

Reset Filters/Sorting

Refine By

ORGANIZATION TYPE
- Federal Government
- State/Local Payer
- Commercial Payer
- Medical Board
- Association
- Other
- Medicaid Payer
- State Initiative

STATE
California

PROGRAM SUPPORTED
- Patient-Centered Medical Home
- Patient-Centered Connected Care
- Patient-Centered Specialty Practice Recognition (PCSP)
- Diabetes Recognition Program (DRP)
- Oncology Medical Home
- Heart/Stroke

Save | Email | Print | Share

Americares	Patient-Centered Medical Home	$	Supports free, charitable, hybrid and look-alike clinics. Application process annually
Blue Shield of California Promise Health Plan	Patient-Centered Medical Home	$	Provides $1.50 PMPM every 6 months (April and October) for primary care practices who have a practice size of at least 100 Medi-Cal members. Geographic region is Southern California, specifically Los Angeles and San Diego counties.
California Primary Care Association	Patient-Centered Medical Home		Provides training and technical assistance to member clinics; practice transformation coaching for PCMH available. Also offers PCMH + educational program for NCQA PCMH transformation process. For more info contact pdy@cpca.org
Central California Alliance for Health	Patient-Centered Medical Home	$	Financially supports initial PCMH recognition and Behavioral Health Integration
Health Resources Services Administration	Patient-Centered Medical Home	$	Financial support for the cost of NCQA PCMH Recognition
Partnership HealthPlan of California	Patient-Centered Medical Home	$	Provides lump sum payments to NCQA-Recognized PCMH practices, as well as assistance to help identify areas to focus transformation. For more information, contact qip@partnershiphp.org.

QI 3, Element B, Factor 2
Continued on next page

VIII. Unit of Service **$1,000 per site**

Measure 3. Patient-Centered Medical Home Recognition (PCMH)

(Page 48 of 2023 PCP QIP Measure Specifications)

Description

This measure encourages PCP sites to create a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand (What is Patient-Centered Medical Home, n.d.).

Primary care provider sites with a minimum of 50 assigned Partnership members.

Thresholds

$1000 yearly incentive for achieving or maintaining PCMH accreditation from NCQA, or equivalent from AAAHC or JCAHO.

Measure Requirements

PCP sites must receive accreditation, maintain accreditation, or re-certify within the measurement year from NCQA, or equivalent from AAAHC or JCAHO.

Submission Process

All documentation must be submitted on the Patient-Centered Medical Home Recognition template (Appendix I) by January 31, 2024 via email to qip@partnershiphp.org or fax to (707) 863-4316.

Exclusions

Submission(s) received after the close of the “grace period” that ends on January 15 following the close of the measurement year.

Measure Rationale and Source

According to the American College of Physicians (ACP), the objective of PCMH is to have a centralized setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family (What is Patient-Centered Medical Home, n.d.). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner (What is Patient-Centered Medical Home, n.d.).

QI 3, Element B, Factor 2

IX. Appendices

Appendix I. Patient-Centered Medical Home Documentation Template

(Page 59 of 2023 PCP QIP Measure Specifications)

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

4665 Business Center Dr.
Fairfield, CA 94534

Please complete all of the following fields on this form by **January 31 following the measurement year** and send to:

- Email: QIP@partnershiphp.org
- Fax: 707-863-4316
- Mail: Attention: Quality Improvement, 4665 Business Center Dr. Fairfield, CA 94534

1. **Name of Recognition entity (NCQA, JCAHO or AAAHC):**
2. **Recognition status (First time, Maintenance or Re-certification):**
3. **Date of recognition received:**
4. **Level accomplished (if applicable):**
5. **How often is recognition obtained?**
6. **Attach a copy of PCMH recognition documentation provided by the recognizing entity (must contain a date of recognition within the measurement year).**

Additional Notes/Comments:

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

Raising Quality and Improving Outcomes in Women's Health and Perinatal Care

CommuniCare Health Centers
April 3, 2023

An Overview of Quality and Equity through Perinatal and Women's Health Measures

Colleen Townsend, MD

Regional Medical Director

Appendix 4 (pages 34-73)
QI 3, Element B, Factor 3
Continued next page

Staci Vercelloti

QIP Program Manager

Nicole Curreri

Manager of Population Health

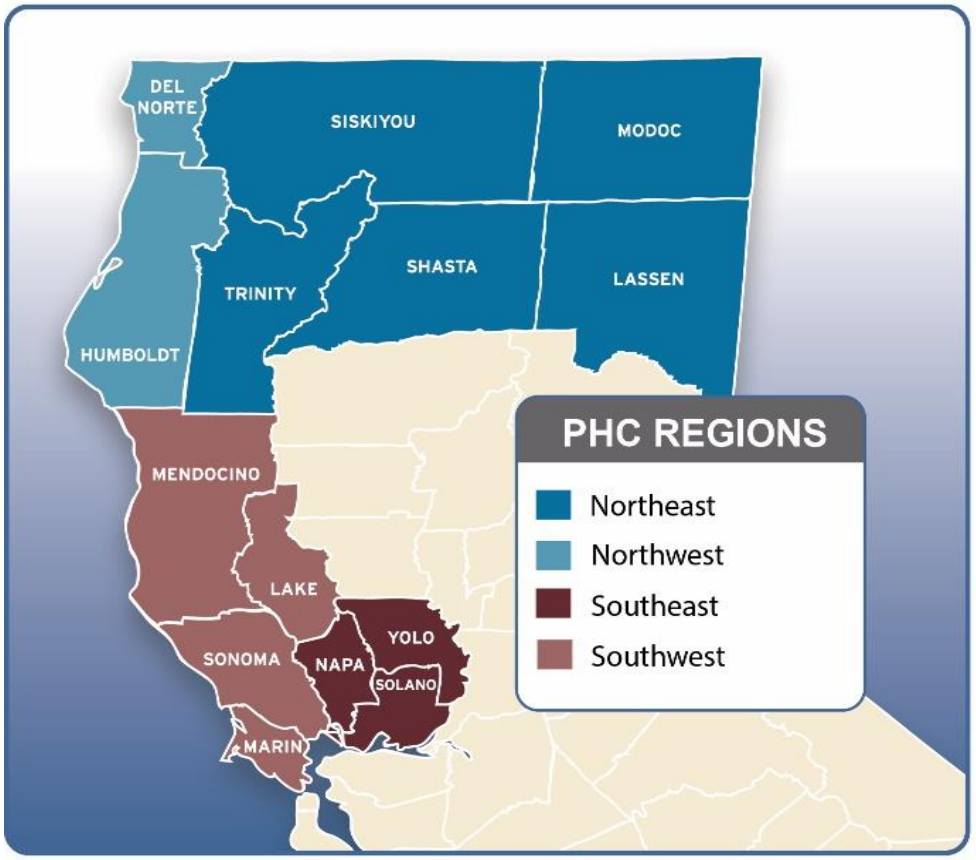
All presenters have signed a conflict of interest form and have declared that there is no conflict of interest and nothing to disclose for this presentation.

Please complete an evaluation to give us feedback about our presentation also required for CME certificate

Please unmute to ask questions or share comments OR use the chat to ask questions or share comments

Partnership HealthPlan of California (PHC)

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page



Mission

To help our members, and the communities we serve, be healthy

Vision

To be the most highly regarded managed care plan in California

Focus

1. Quality in everything we do
2. Operational excellence
3. Financial stewardship

Learning Objectives

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

At the end of this activity, you will be able to:

- ✓ Identify the key elements and standards in Perinatal care, Chlamydia screening, Breast and Cervical Cancer screening.
- ✓ Describe PHC's Growing Together and Care Coordination program services and referral process.
- ✓ Describe the clinical background, and performance data for Perinatal care, Chlamydia, Breast and Cervical Cancer screening for your county and organization.
- ✓ Provide promising and best practices to improve perinatal and women's health preventative services that address clinical process, interpersonal communication, member and staff education, and outreach.
- ✓ Share resources for education and trainings on implicit bias, health and racial equity.

Health Equity

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

The Construct of Equity

EVERYONE has a fair and just opportunity to be as healthy as possible

- **No one** is denied the resources they need to achieve optimal health outcomes
- **No** population or group in need of health care is disadvantaged due to physical, economic, social, or psychological factors
- Birth and health outcomes are **not** predicted by race/ethnicity, age, education, income level, geographic location

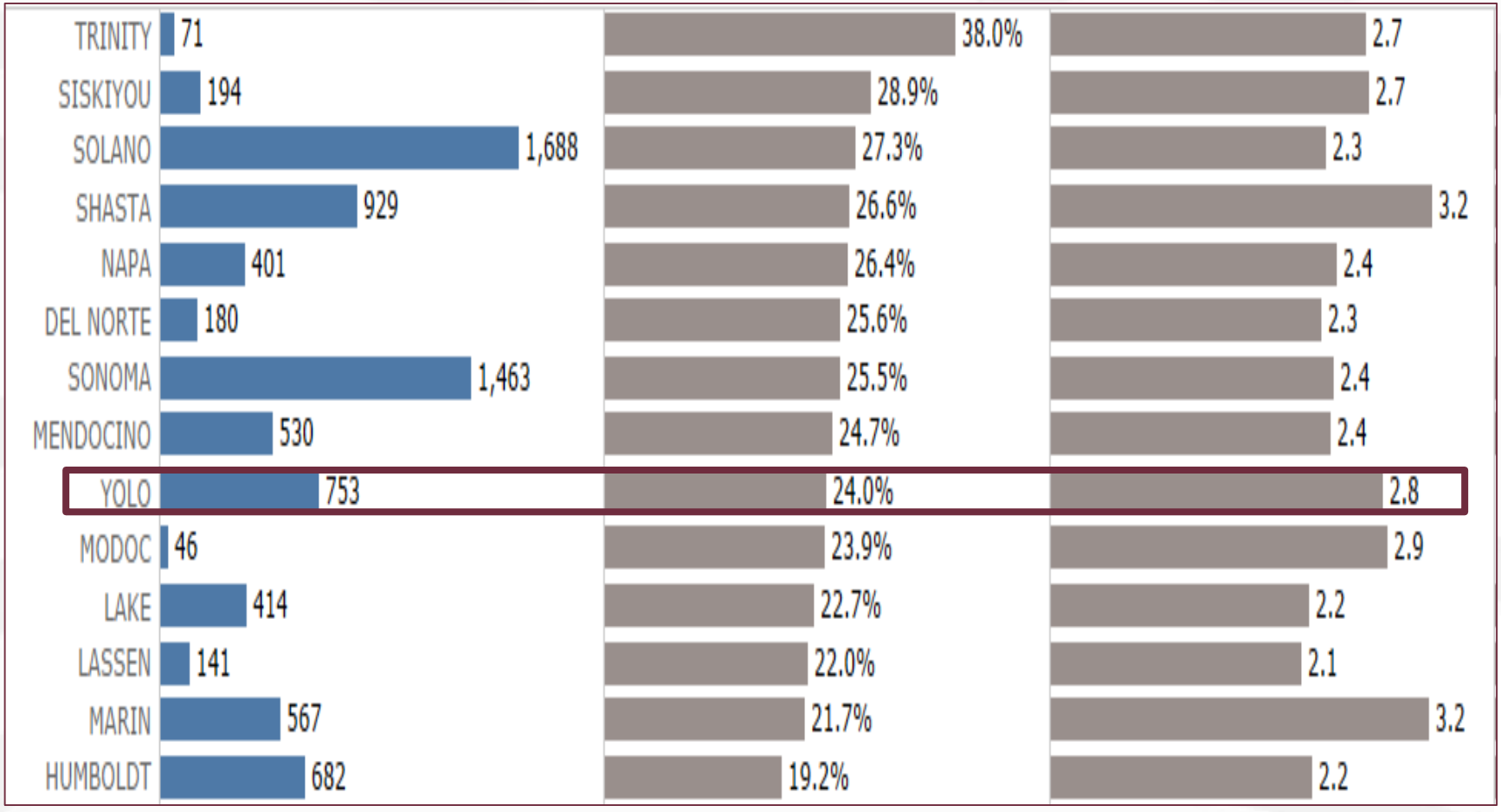
Striving toward Equity

- Treatment and resources ensure different population groups have the access to health services
- Eliminate inequitable policies, practices, attitudes, and cultural messages that measurably disadvantage some population groups relative to others
- Address root causes that lead to inequities, such as racism
- Practice social justice in health care

Deliveries For PHC Members: Plan wide and by County 2022

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

	Deliveries	C-Section Rate	ALOS
PHC	8059	25%	2.6



PARTNERSHIP HEALTHPLAN of CALIFORNIA

Recommendations for Perinatal Care

CT

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

Prenatal Visits

- First visit in first trimester
- Identify behavioral health and substance use disorders
- Screening for high risk medical conditions
- Breast feeding & family planning discussions
- Vaccinations: TDaP, Influenza and COVID19
- Develop relationship with patient

Post Partum Visits

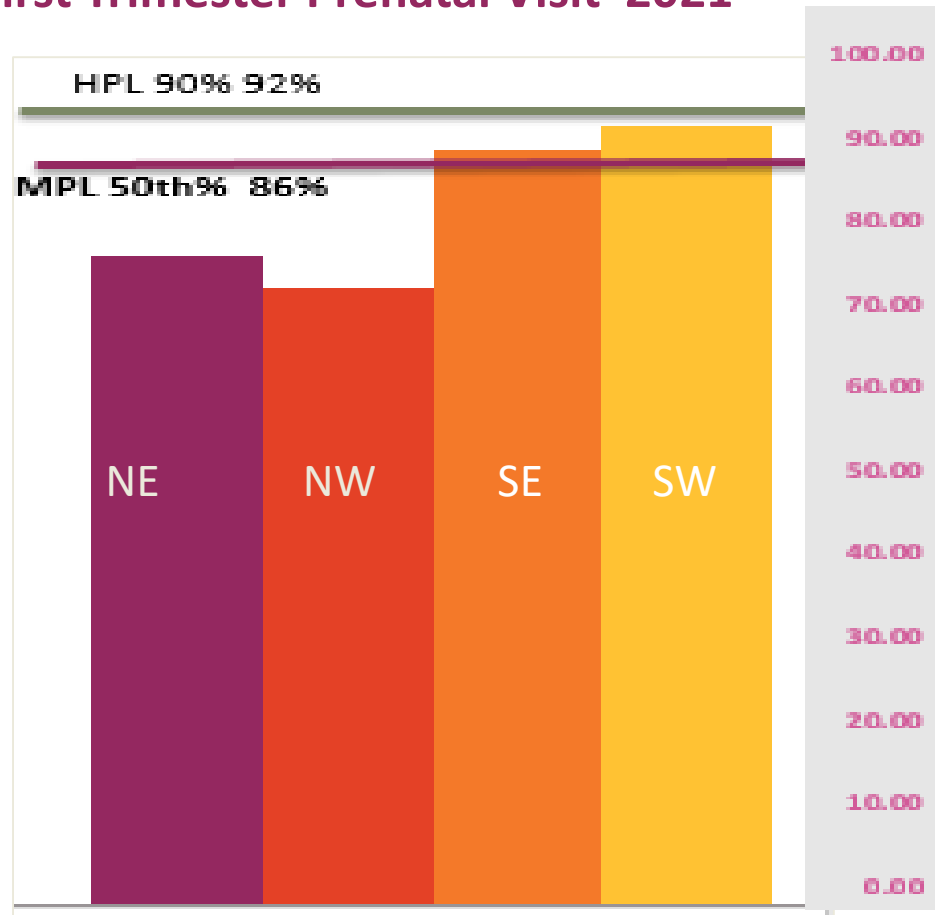
- 2 visits: first within 3 weeks and follow up by 12 weeks
- Screening for post partum depression
- Lactation support
- Implement family planning
- Address conditions or risks identified in pregnancy
- Connection to healthcare systems

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Percent of PHC Members Accessing Perinatal Visits (HEDIS 2021)

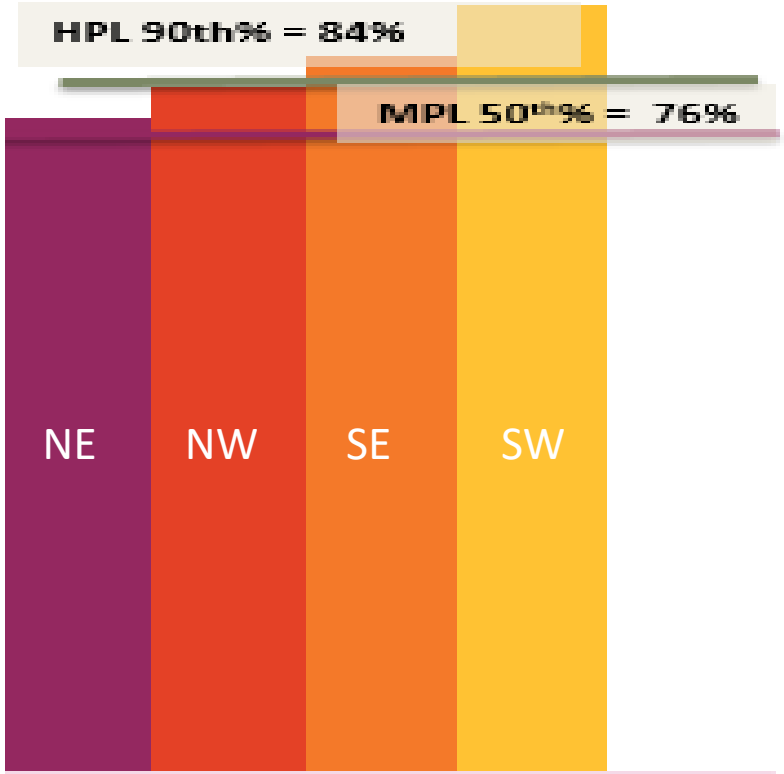
Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

First Trimester Prenatal Visit 2021



	MY 2021
NE	76.01
NW	72.31
SE	88.41
SW	91.30

Two Post Partum Visits 2021



	MY 2021
NE	79.44
NW	83.46
SE	86.96
SW	93.24

Racial Disparities in Perinatal Care in the PHC Network 2021 HEDIS

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

Yellow Boxes ≤ MPL
Blue ≥ MPL
Red Small Population

PHC Region	Percent with First Trimester Prenatal Care MPL 86% HPL 92%				Percent with Two Post Partum Visits MPL 76% HPL 84%			
	NE	NW	SE	SW	NE	NW	SE	SW
	76	72	88	91	79	84	87	93
American Indian Alaska Native	60	17		25	87	42		75
Asian/Pacific Islander	79	69	82	100	93	92	94	100
Black	80	75	85	75	80	100	92	100
Hispanic	89	74	87	92	84	79	90	96
Other/Unknown	59	84	93	93	82	92	86	91
White	76	79	89	94	77	89	71	92

California Dignity in Pregnancy and Childbirth Act

CT/MK/JR

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

CA Senate Bill 646

- **Requires that Perinatal Care providers implement an implicit bias program that includes:**
  - Initial training of perinatal providers followed by additional training every 2 years and more often if needed based on changing demographics of the population
  - Focusses on identifying previous or current individual and institutional biases and barriers to inclusion (previous and current)
  - Develops a corrective measure to decrease bias individual and institutional
  - Informs on the effects of current and historical exclusion and oppression of minority communities
  - Provides information abut cultural identity across racial or ethnic groups
  - Effective communication strategies across identities
  - Discussion of health inequities within perinatal care and maternal infant outcomes

Dignity in Pregnancy and the Child Birth Project

Perinatal Health Equity Training

CT

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

1 hour e-learning course for perinatal providers

Each **15-30 minute section** will provide evidence-based learning on:

- Understanding bias in perinatal care
- Reproductive justice and maternal health
- Strategies to protect yourself and your patients from bias

Resources for equity in perinatal care

A **toolkit** for organizational leaders and change agents:

- Facilitation guides for engaging staff
- Toolkit for leadership teams
- Activities to deepen understanding and learning

Learn more

Visit **www.diversityscience.org/perinatal** for more information

- Evidence-based and developed with stakeholders
- Materials are fully responsive to California Senate Bill 464
- Free for perinatal providers and CA-based healthcare organizations

This course is accredited for 1 hour of CME or CEU credits.

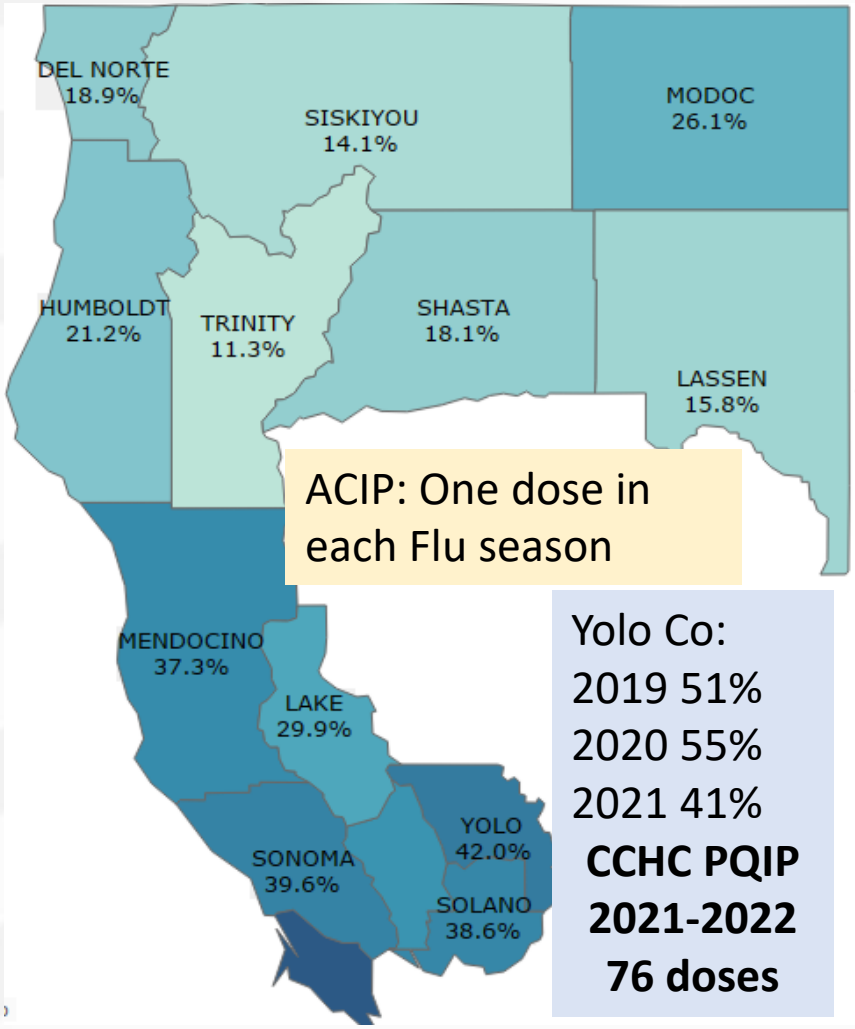
equalcare@diversityscience.org **www.diversityscience.org/perinatal** phone: (612) 584 8214

Perinatal Vaccination 2022 PHC Claims Data

MK/
CT

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

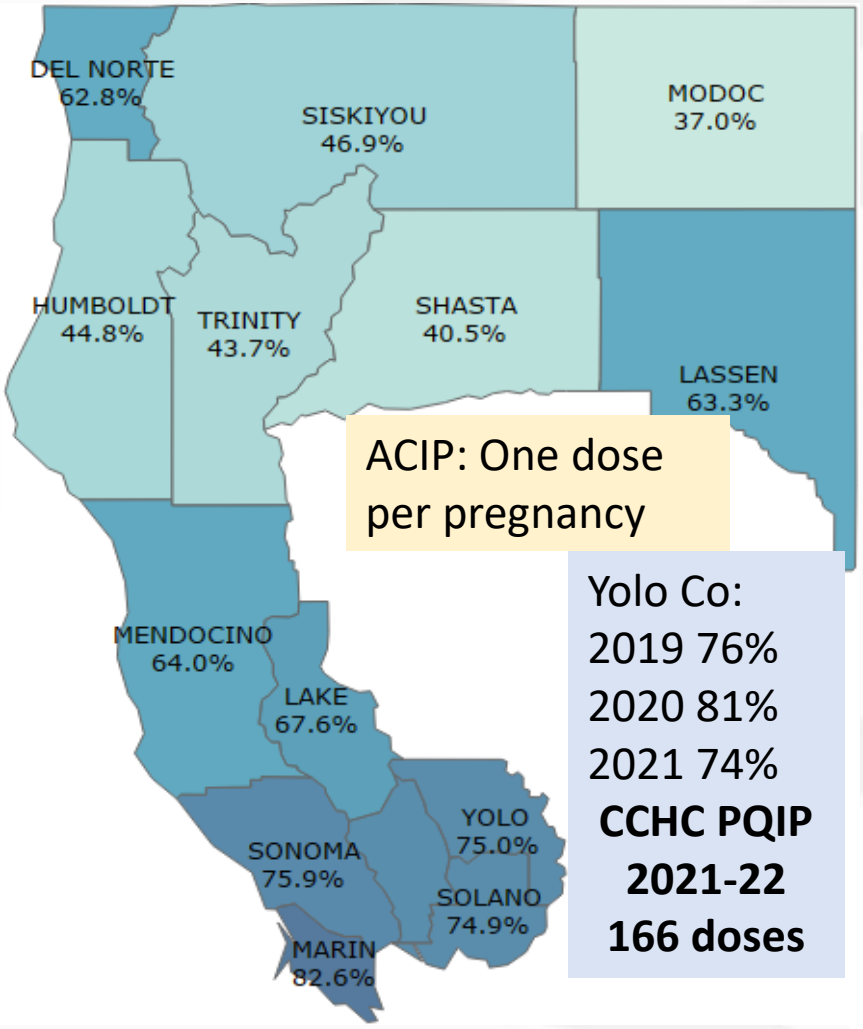
Influenza 34% Goal 70%



ACIP: One dose in each Flu season

Yolo Co:
2019 51%
2020 55%
2021 41%
CCHC PQIP 2021-2022 76 doses

TDaP 66 % Goal 90%



ACIP: One dose per pregnancy

Yolo Co:
2019 76%
2020 81%
2021 74%
CCHC PQIP 2021-22 166 doses

PARTNERSHIP HEALTHPLAN of CALIFORNIA

COVID19 and the Perinatal Period

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

Maternal Impacts

- High Mortality Risk
  - 22 times more likely to die than non pregnant individuals with COVID19
- Higher rates of Pregnancy Complications
  - Labor Induction
  - Csection,
  - Preterm delivery

Newborn Impacts

Higher rates of:

- COVID19 infections
- NICU admission > 7days
- Neonatal death

Vaccination Mitigates the Risks

COVID19 vaccination **STRONGLY** recommended for pregnant and lactating individuals – Complete minimum of 2 dose series + Boosters with mRNAs preferred

PARTNERSHIP HEALTHPLAN of CALIFORNIA

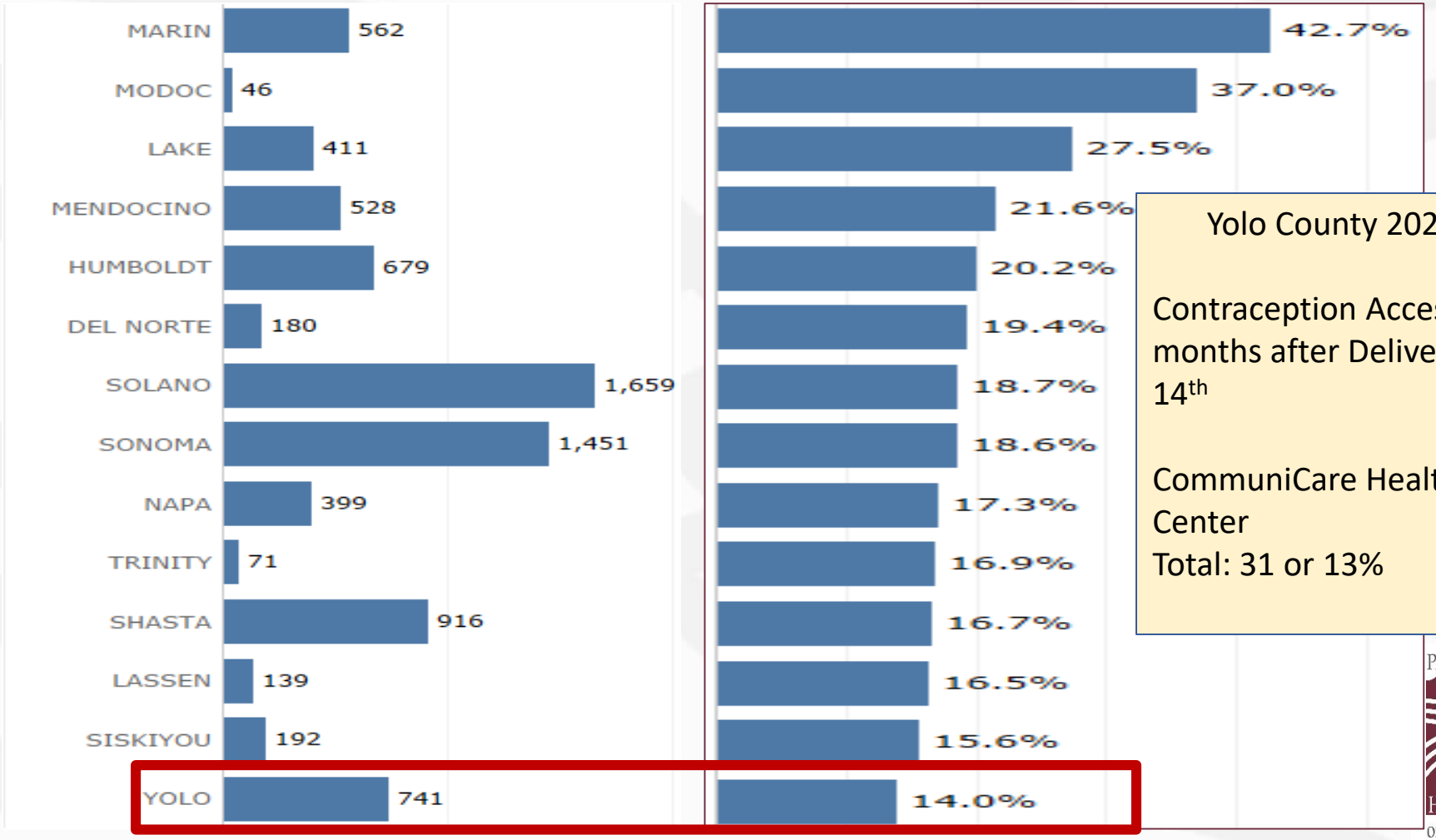
Highly Effective Family Planning After Delivery by County

CT

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

Total PHC Deliveries 2022 6,882

Members with Post Partum Contraception by 180 days of Delivery



Yolo County 2022

Contraception Access Six months after Delivery: 14th

CommuniCare Health Center
Total: 31 or 13%

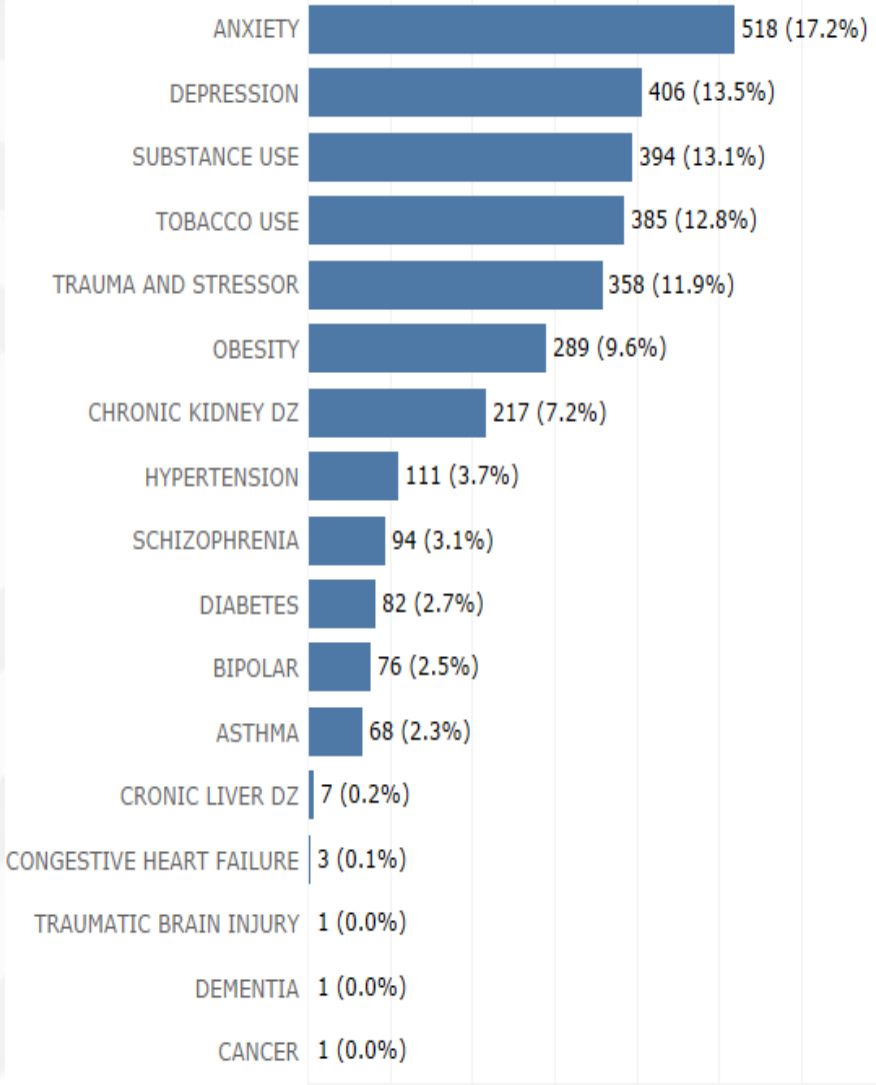
PARTNERSHIP HEALTHPLAN of CALIFORNIA

Chronic Conditions in Pregnancy For PHC Members 2022 Claims Data

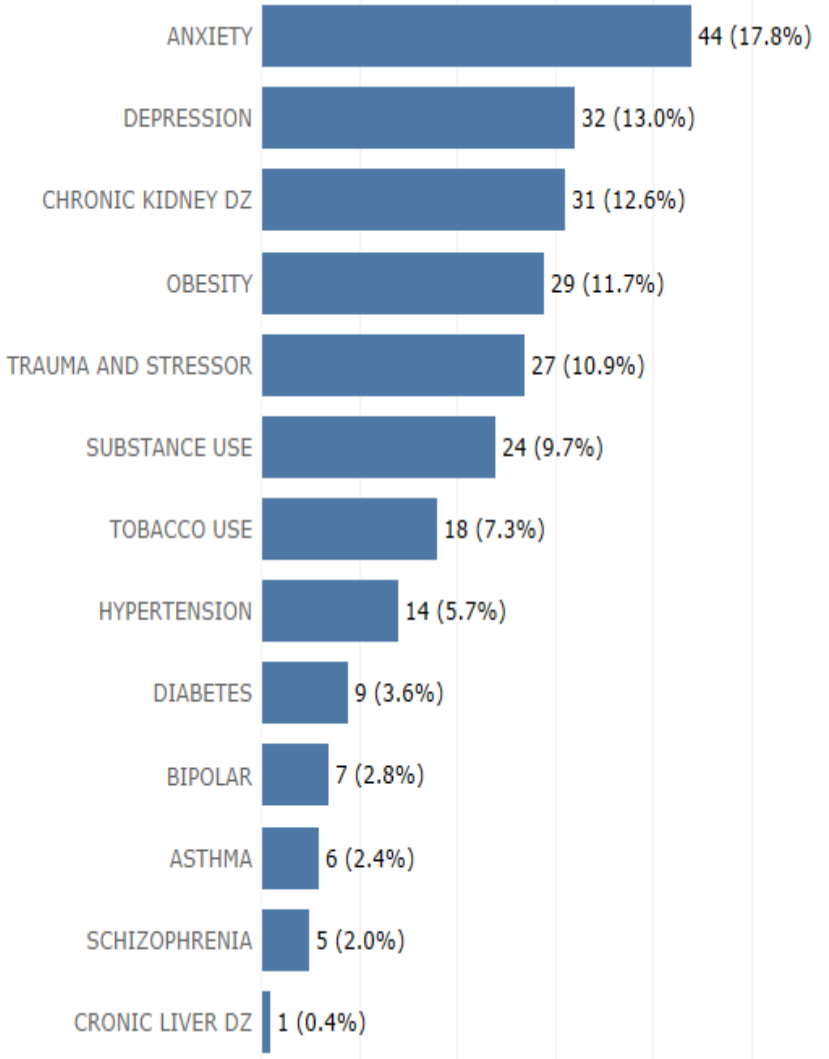
MK/CT/JR

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

PHC wide 7442 Deliveries



Yolo County



PARTNERSHIP HEALTHPLAN of CALIFORNIA

Interventions to Stem Impact of Perinatal Depression and Risk for Depression

CT

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

At Risk or Moderate Depression

Behavioral Health Therapy

and Supportive Services:

- Cognitive behavioral or interpersonal therapy
- Refer to PHC Growing Together program
- Consider PHC Care Coordination

Refer To:

- Beacon Health Perinatal **Services phone number**

Severe Depression

Medication Management + Behavioral Therapy

- SSRI and SSNRI safe and effective
- Reassess every 1-2 weeks after starting Rx, titrate if no change after 4-6 weeks
- Treat at least 6 months

Refer To:

- Beacon Health Perinatal Services, PHC Care Coordination and Growing Together programs

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Screen All Pregnant Patients and Refer for Treatment for Substance Use Disorder

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

Yolo Co: 4.5% with SUD code
PHC Claims Data: 14% lower rate of post partum visits for those with SUD diagnosis

Tools for Screening

SBIRT and 4P+

https://nastoolkit.org/explore-the-toolkit#screening **Provides your team with tools to build practices for SUD screening and Treatment**

Opioid Use Disorder Prevention & Treatment Strategies

- **Reduce risk** of Opiate Use Disorder by limiting opiates prescribed for delivery and post partum and non specific chronic pain disorders
- **Increase** access to Medication Assisted Treatment before, during and after pregnancy
- **Optimize** care of opiate exposed infants by improving maternal engagement in newborn care – Hugs NOT Drugs after delivery

New Doula Benefit

CT

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

- PHC Doula Benefit
  - Supportive pregnancy services to PHC pregnant or post partum members
- Prenatal, Intrapartum and Post Partum Care
  - During Pregnancy labor and delivery, miscarriage, still birth and abortion
  - Physical, emotional and non medical care
  - Services can be provided up to 12 months from the end of pregnancy
  - Do not require supervision of clinical provider
  - **Requires a recommendation from: Physician licensed practitioner of the healing arts**
- Covered Services Include:
  - One initial visit
  - 8 additional visits (pre and /or post partum)
  - Labor Support
  - Up to 2 extended 3 –hour post partum visits
  - Addition visits (≤9) may be considered if needed
- Contracted doulas will be added toe the provider Directory
- Interested Doulas can contact PHC: doulaservices@partnershiphp.org

Extended CPSP Services

CT

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

- Comprehensive Perinatal Program
  - Perinatal services provided during and after pregnancy:
    - Nutrition
    - Psychosocial services
    - Health Education and Case Management
- Benefits
  - Services from first trimester and up to 1 year after delivery
- PHC will cover CPSP services up to 365 days post partum
  - Up to 80 units (20 hours) for each of the 3 domains (Z6208, Z6308 and Z6414)

Population Health

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

Growing Together Program

PHC Growing Together Program:
Member Education and Engagement though targeted outreach

NC/
SA

Member Education

Packet with information on:

- Prenatal Immunizations
- Post-Partum Care
- Perinatal Mood Disorder (PMD)
- Well-Baby Visits
- Well-Baby Immunizations
  - Diseases Prevented
- Family Planning
- Medi-Cal Enrollment for Baby

Pharmacist Collaboration

- Phone call outreach for vaccination education

Member Engagement

Phone call check ins

- Prenatal x 3
- Postpartum x 2
- Healthy Babies up to 7

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

$25 incentives x 4

- Tdap vaccine (recommended between 26 wks & delivery)
- Postpartum exam before 84 days
- Well Child visits with shots before 3 months
- Well Child visits with shots between 4-6 months

Case Management follow-up

- At-Risk Members
- At-Risk Babies

PARTNERSHIP HEALTHPLAN of CALIFORNIA

PHC Growing Together and Care Coordination

NC
SA

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

Growing Together Program (GTP)

- Prenatal & Post Partum Outreach from PHC to members
- Focus: Health Education and Access to services for all members
- Case Management follow up for at risk families

855-798-8764

PHC Care Coordination

- Health Care Guides and Nurse Case Manager offer care management
- Refer patients with care coordination needs

1-800-809-1350

PARTNERSHIP HEALTHPLAN of CALIFORNIA

JH

Referring PHC Members to GTP

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

- PQIP patients will be automatically enrolled into the Growing Together Program
- Best practice – mention the program and notify patients that someone will be contacting them
- If patient does NOT want to be enrolled, send an email to Population Health letting us know the member is opting out

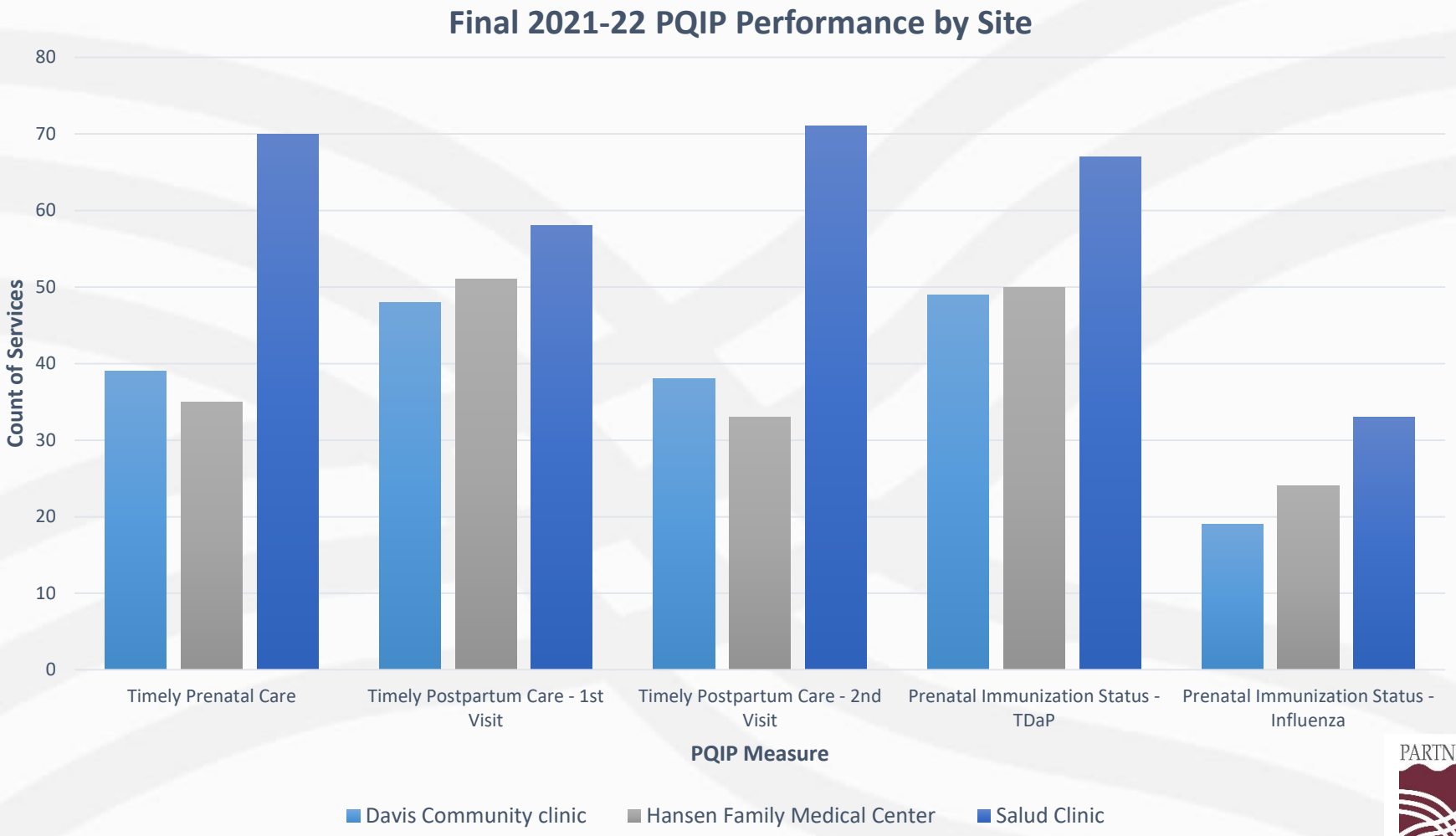
PopHealthOutreach@partnershiphp.org

1 (855) 798-8764

Communicare Perinatal QIP Status

SV

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page



Communicare Perinatal 2021/22QIP Earnings

SV

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

Communicare
Perinatal QIP Summary
July 1, 2021 - June 30, 2022
FINAL PAYMENT Report

Measure Name	Incentive Amount/Unit	Site Number	Site Name	Number Received	Dollars Earned
Prenatal Immunization Status – Influenza	$12.50	2426	Davis Community Clinic	19	$237.50
		4860	Hansen Family Medical Center - 4860	24	$300.00
		6930	Salud Clinic	33	$412.50
Prenatal Immunization Status – TDaP	$37.50	2426	Davis Community Clinic	49	$1,837.50
		4860	Hansen Family Medical Center - 4860	50	$1,875.00
		6930	Salud Clinic	67	$2,512.50
Timely Postpartum Care – 1 Visit	$25.00	2426	Davis Community Clinic	48	$1,200.00
		4860	Hansen Family Medical Center - 4860	51	$1,275.00
		6930	Salud Clinic	58	$1,450.00
Timely Postpartum Care – 2 Visit	$75.00	2426	Davis Community Clinic	38	$2,850.00
		4860	Hansen Family Medical Center - 4860	33	$2,475.00
		6930	Salud Clinic	71	$5,325.00
Total Earned					**$21,750.00**

Measure Name	Incentive Amount/Unit	Site Number	Site Name	Number Received	Dollars Earned
Timely Prenatal Care	$75.00	**2426**	Davis Community Clinic	**39**	**$2,925.00**
		4860	Hansen Family Medical Center - 4860	**35**	**$2,625.00**
		6930	Salud Clinic	70	$5,250.00
Electronic Clinical Data Systems (ECDS) Implem	$5,000.00	**2426**	Davis Community Clinic	-	$0.00
		4860	Hansen Family Medical Center - 4860	-	$0.00
		6930	Salud Clinic	-	$0.00
Total Earned					**$10,800.00**

Total PQIP Incentive: $32,550.00

Women's Health

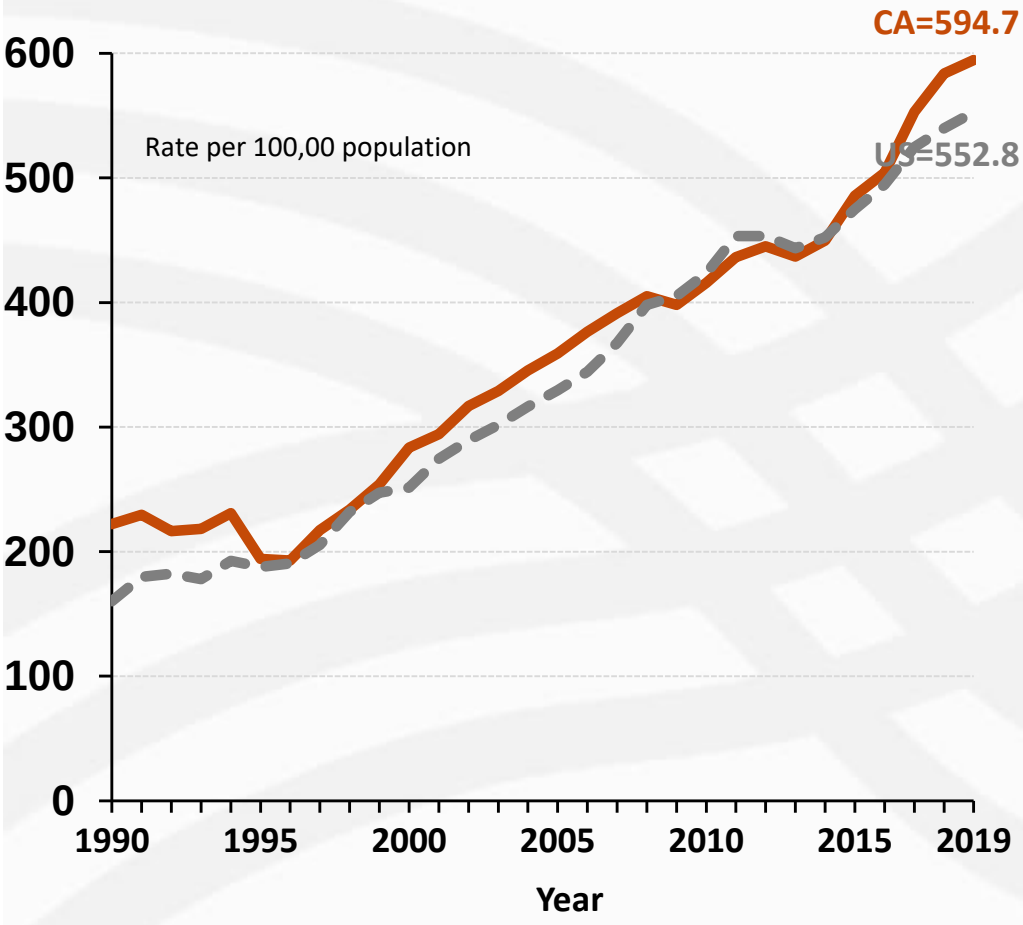
Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

Chlamydia incidence Rates California vs United States

CT

Trends In CA vs USA



CDPH STD Control Branch (revised 11/2020)

PHC 2021 Chlamydia Screening Rates

MPL 55% /HPL 66%

Screening Rate by Region	NE	NW	SE	SW
	47	54	63	58
American Indian /Alaska Native	45	50	44	52
Asian/ Pacific Islander	49	52	62	58
Black	49	66	71	70
Hispanic	49	56	62	50
Other/unknown	42	55	65	61
White	47	53	59	51

Yolo Co 2021 Chlamydia Screening 68%

CDC Chlamydia Screening and Treatment Guidelines for Women

Appendix 4 (pages 35-87)
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- **Annually** for sexually active women under 25 years of age
  - HEDIS Measure: the proportion of sexually active females between 15 – 24 who were screened for chlamydia annually captured administratively
- Pregnant Women
  - **ALL** under 25 yo and over 25 yo with risk factors
    - AND repeat in third trimester
  - Test of Cure 4 weeks after treatment and Retest within 3 months after treatment
- Sexually active women 25 years of age and older if at increased risk:
  - new sex partner,
  - more than one sex partner,
  - sex partner with concurrent partners,
  - sex partner who has an STI
- Treat with Antibiotics + Abstinence for 7 days from start of treatment
  - Treat Partners
  - Retest after treatment ~ 3 months after treatment

Screening Recommendations and Consideration for Women CDC

Chlamydia Screening Successful Strategies

Appendix 4 (pages 35-87)
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- Incorporate standardized sexual history into the History and Physical and at regular intervals
- Develop work flows to screen all sexually active members assigned female at birth for chlamydia through age 25
- Include chlamydia screening as part any visit women 25 years and younger
- Members older than 24 who are at increased risk and for men at increased risk
- Educate patients about STIs including signs, symptoms and treatment and prevention
- Standardized staff communication by using scripts for staff to take sexual history and for education on the recommendations for screening

Cervical Cancer Screening (CCS)

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Cervical Cancer in California

CT

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- **Sixty percent** of Cervical Cancer diagnosis occur in women with no history of a Pap test or no screening in the past five years

- In CA 51% cases are diagnosed at a Late Stage (regional or distant metastasis)

- Highest **incidence rate** is among Hispanic women – 8.8 new cases per 100,000 per year (CA all rate 3.7/100K) (NIH Cancer Profiles)

- **Highest Mortality Rate is in African-American women - 3.0 deaths per 100,000 per year (CA rate 2.2 /100K per year)**

PHC Cervical Cancer Screening Trends HEDIS

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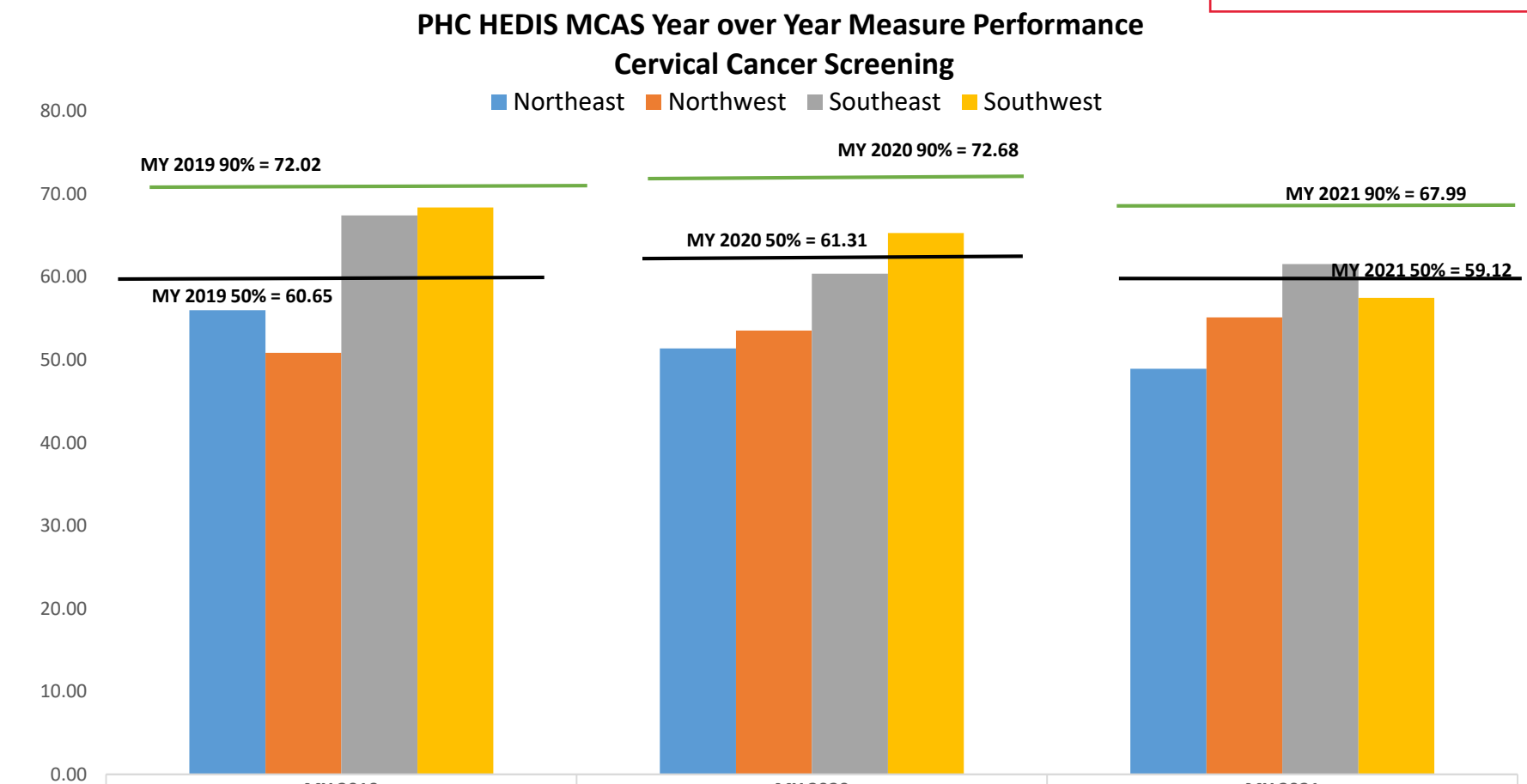

	MY 2019	MY 2020	MY 2021
Northeast	55.96	51.35	48.91
Northwest	50.85	53.53	55.12
Southeast	67.40	60.38	61.52
Southwest	68.37	65.28	57.45

Race and Regional Impacts in Cervical Cancer Screening Rates

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PHC 2021 HEDIS Scores

Yolo 67% MPL 59% HPL 68%

	NE	NW	SE	SW
Screening Rates by Region	49	55	62	58
American Indian Alaska Native	20	55	25	64
Asian/Pacific Islander	79	70	62	44
Black	75	67	63	73
Hispanic	37	51	61	66
Other/Unknown	39	44	62	63
White	51	58	63	49

Yellow Boxes ≤ MPL
Blue Boxes ≥ MPL
Red Small Population

PCP QIP CommuniCare Health

Cervical Cancer Screening
Estimated 2022

Score: 68.83

Earnings: $109,696

Remaining: 0

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Cervical Cancer Screening - Successful Strategies

Appendix 4 (pages 35-87)
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CT

- ✓ Take advantage of “pap-ortunities”
- ✓ Phrasing “if you haven’t prepped it’s not a big deal. Let’s just get it done so you don’t have to come back”
- ✓ Fully stocked rooms w/ setup speculums/swabs
- ✓ Pap specific clinical sessions highlighting women’s health
- ✓ Partner w/ PCP who DOES paps
- ✓ Unhoused individuals- pair with shower clinic & fem hygiene gift bag
- ✓ ROI to get records from external providers

Breast Cancer Screening

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CT

Breast Cancer in California

CT

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Breast cancer is the **most commonly** diagnosed cancer among women in California regardless of race/ethnicity

- 122/100k per year new cases
  - about 1/3 are Late Stage Diagnosis
  - Non-Hispanic white women have highest rate at 140/100K per year

Second leading cause of cancer deaths among women in California: CA *Mortality Rate 18.5 /100k per year*

- Significant Racial Disparities in mortality
  - African-American / Non Hispanic Black 29.5 /100K
  - American Indian/Alaska Native 36.8/ 100K

California Cancer Registry
Breast Cancer in California

CT

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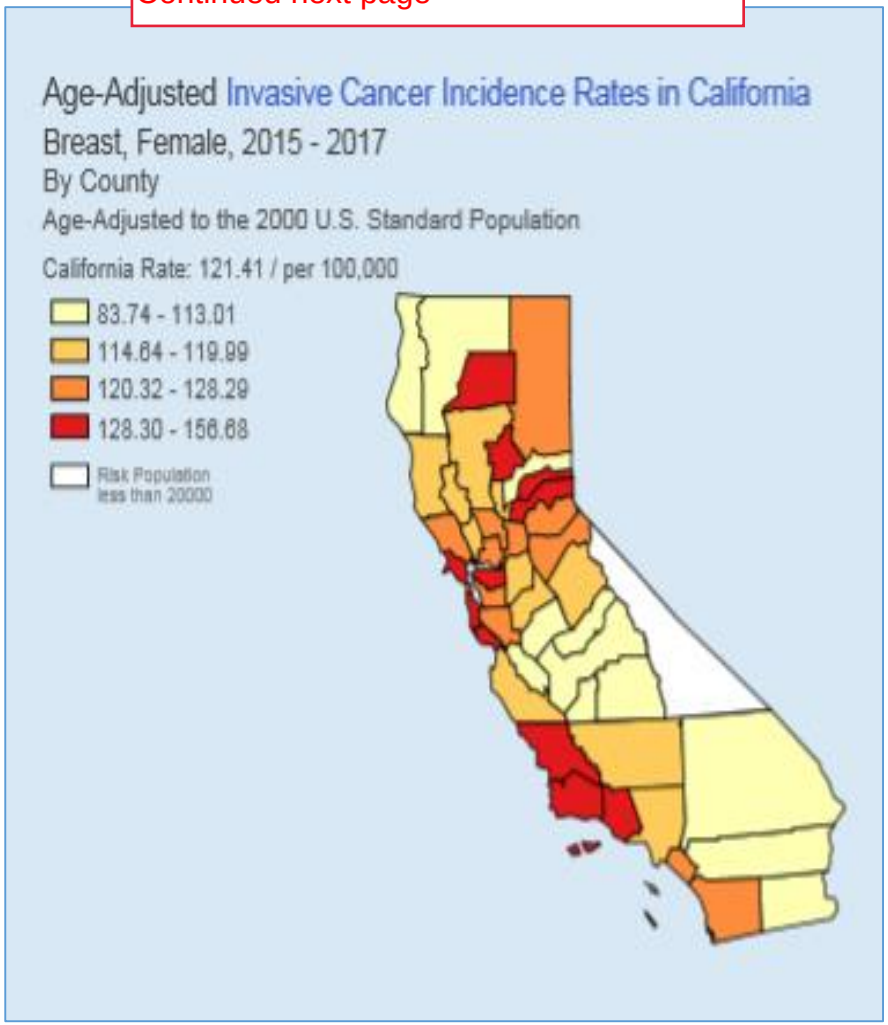

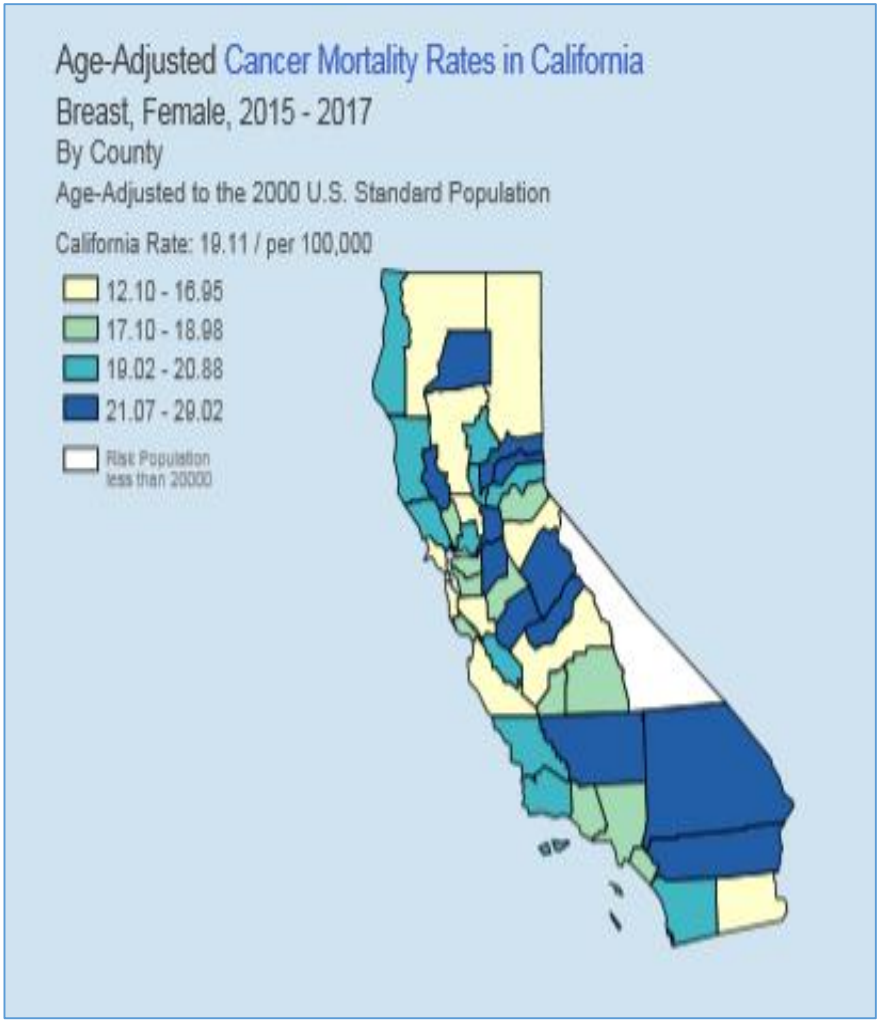

Trends in PHC Breast Cancer Screening

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Appendix 4 (pages 35-87)
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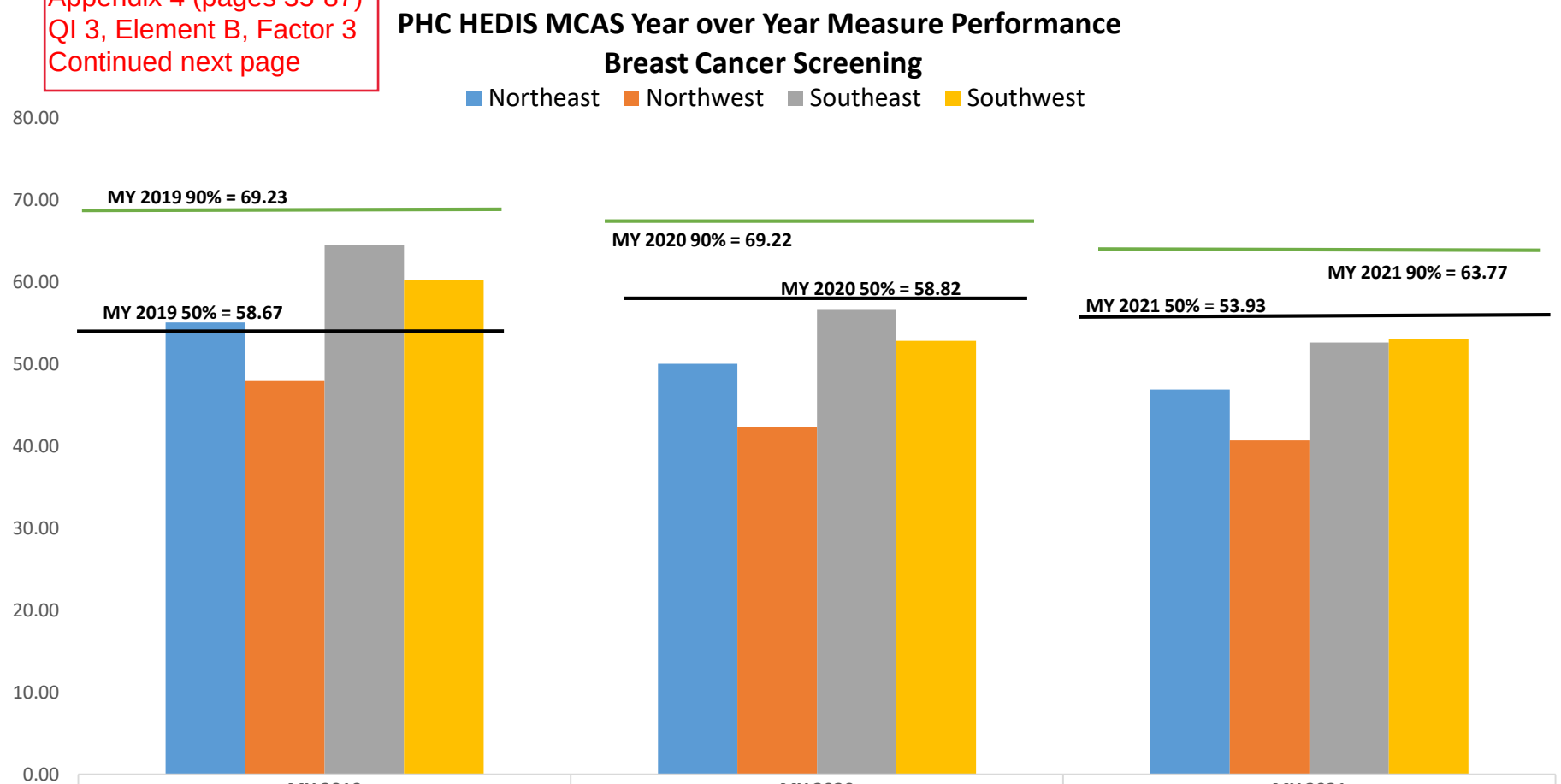

	MY 2019	MY 2020	MY 2021
Northeast	55.13	50.09	46.93
Northwest	47.96	42.41	40.73
Southeast	64.54	56.64	52.67
Southwest	60.26	52.88	53.14

Race and Region Impacts Breast Cancer Screening

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PHC Breast Cancer Screening Rates HEDIS 2021

Yolo 61% MPL 54% HPL 64

Rates by Race and Region	NE	NW	SE	SW
Plan Wide	47	41	53	53
American Indian	38	24	46	42
Asian/Pacific Islander	54	41	54	52
Black	53	41	50	43
Hispanic	59	52	62	70
Other/Unknown	41	39	49	51
White	47	42	45	47

PCP QIP CommuniCare Health Center

Estimated 2022

- Score: 63.44
- Earnings:$109,696
- Remaining $: 0

Mammography- Successful Strategies

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
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CT

- ✓ Collaborate with the referral mammography imaging center/facility - meet with imaging managers; Ask for a day you can schedule (so patient leaves w/appt card)
  - Reminder calls for mammo appts, specify location of appt, assist with transportation arrangement
- ✓ When able, assist with scheduling
- ✓ Create report of referrals for mammography – close the loop with entering results and report into EMR
- ✓ Depending on location, consider mobile mammography services

Moving from Disparities Toward Health Equity and Building Health Justice

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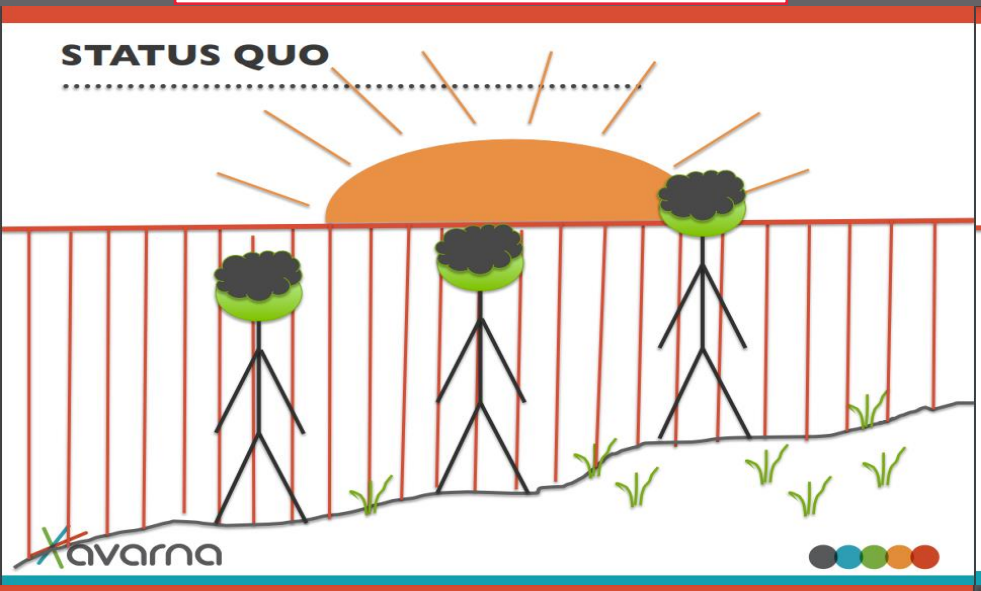

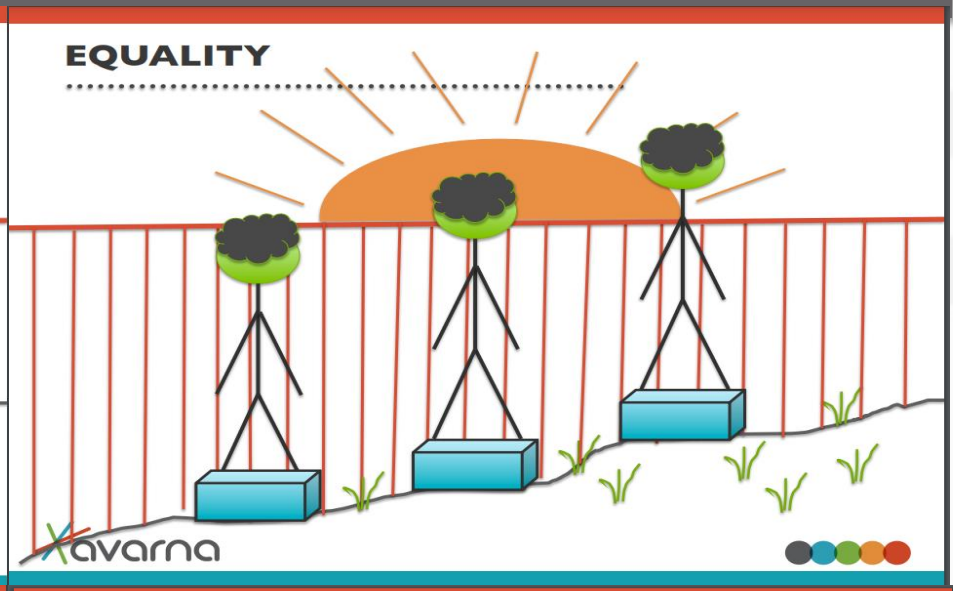

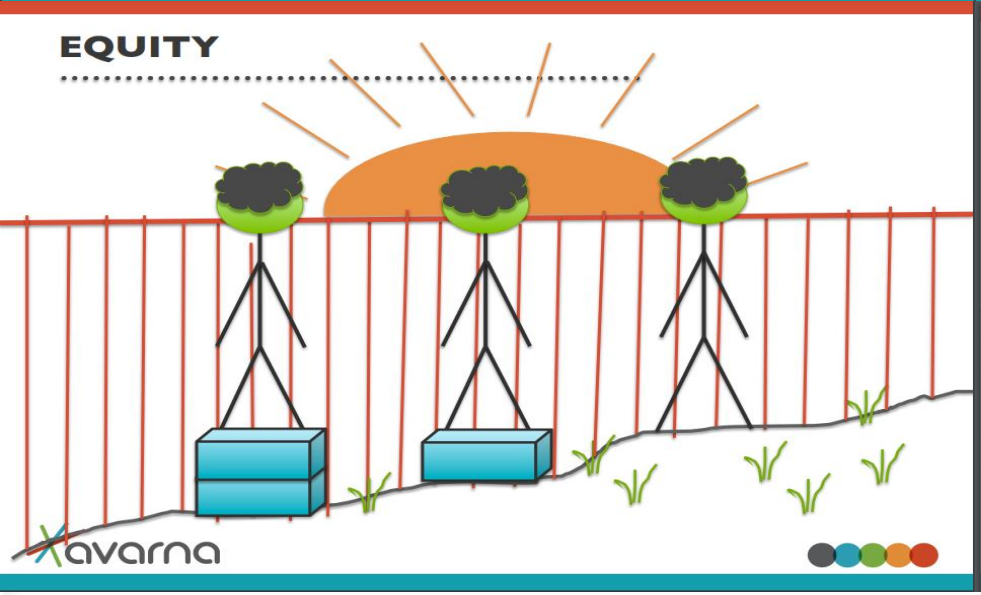

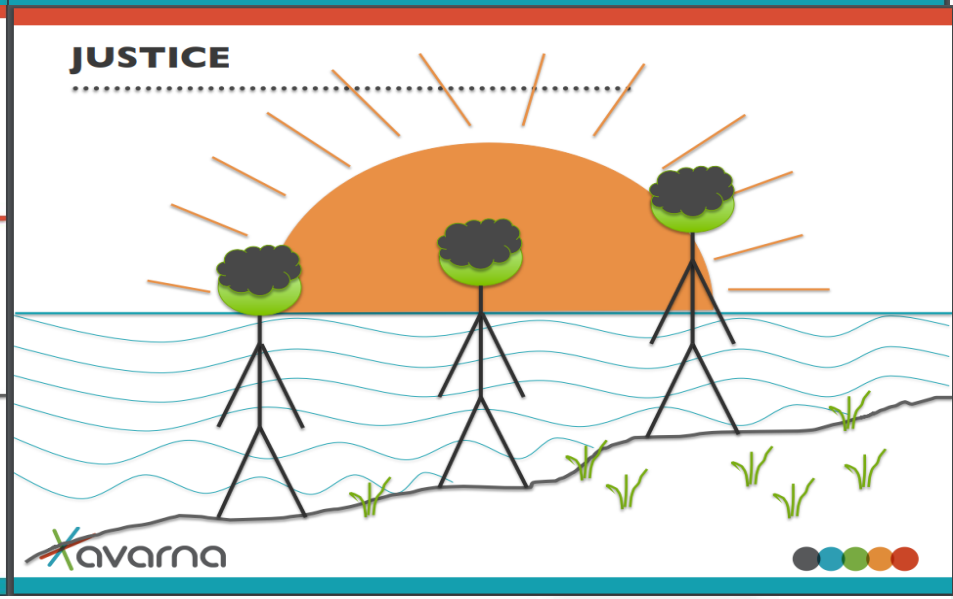

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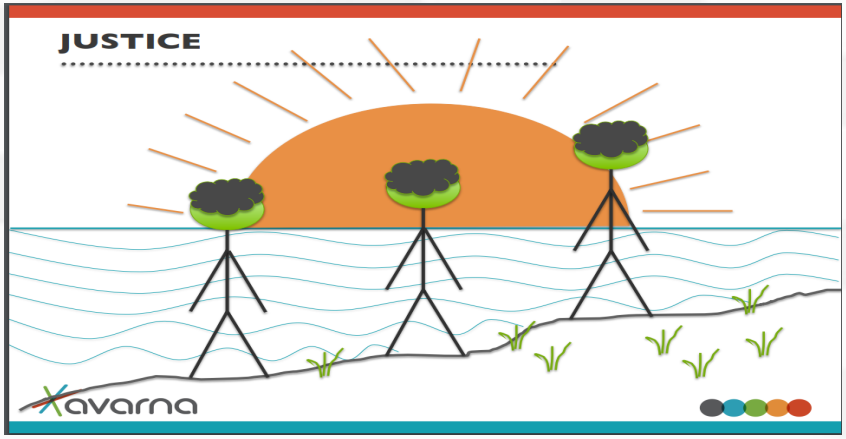
High Quality Care for All - Steps to Take toward Health Equity and Health Justice

- Use stratified data to identify care gaps for different populations
- Address the root causes of inequities such as, such as racism that contribute to care gaps
- Review organizational policies, workflows and cultural messages to eliminate structural barriers to care
- Include topics on equity, racism, unconscious bias into staff training
- Resources for Health Equity trainings and further information are included in the slides at the end of this presentation



Evaluations

CT

Appendix 4 (pages 35-87)
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Please complete your evaluation. Your feedback is important to us!

Questions

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The End

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Trends in PHC Perinatal Services
First Trimester Prenatal Care

Appendix 4 (pages 35-87)
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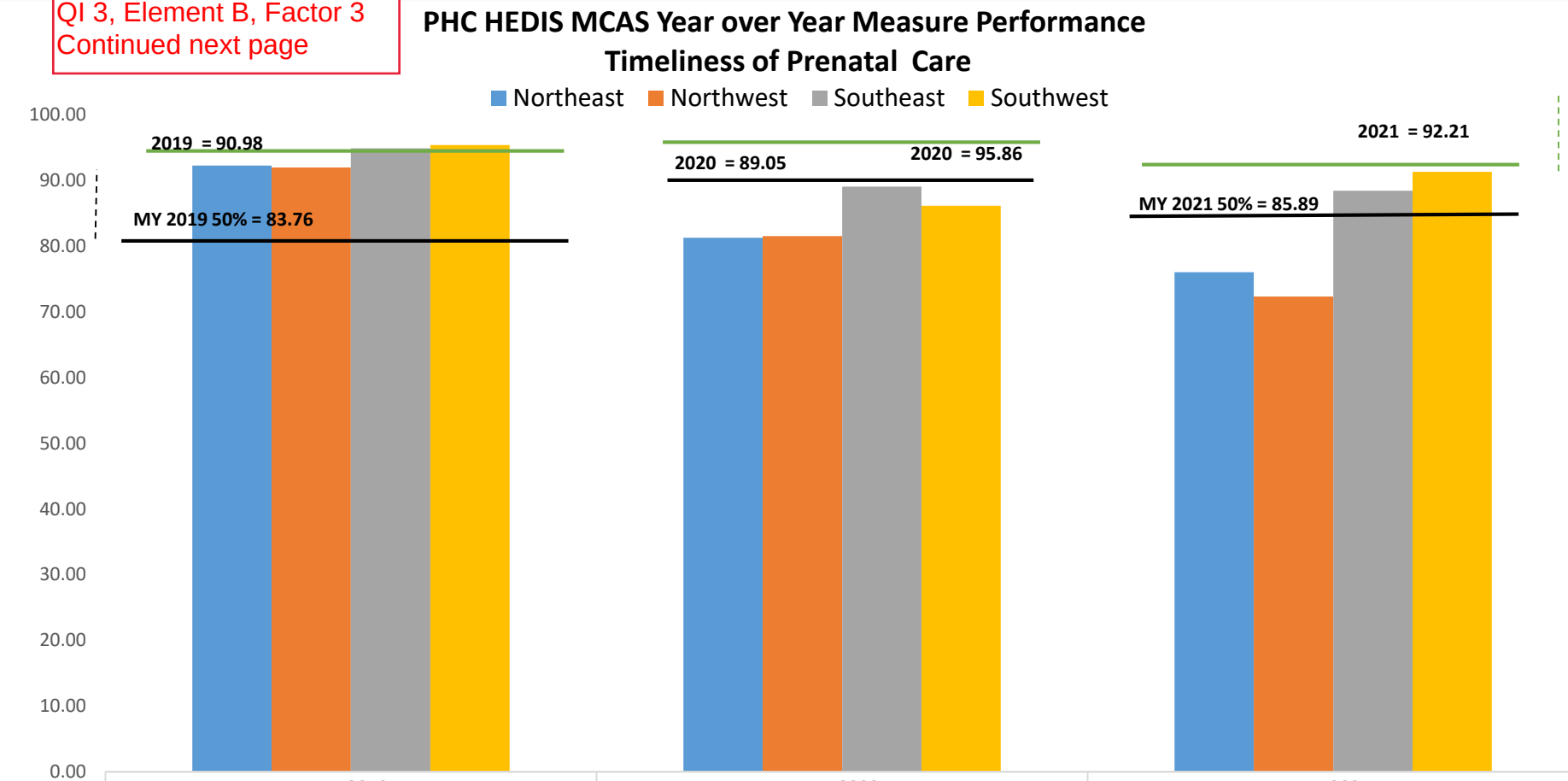

	MY 2019	MY 2020	MY 2021
Northeast	92.24	81.27	76.01
Northwest	91.97	81.51	72.31
Southeast	94.89	89.05	88.41
Southwest	95.38	86.13	91.30

MPL 50%

HPL 90%

Trends in PHC Perinatal Services Post Partum Visits

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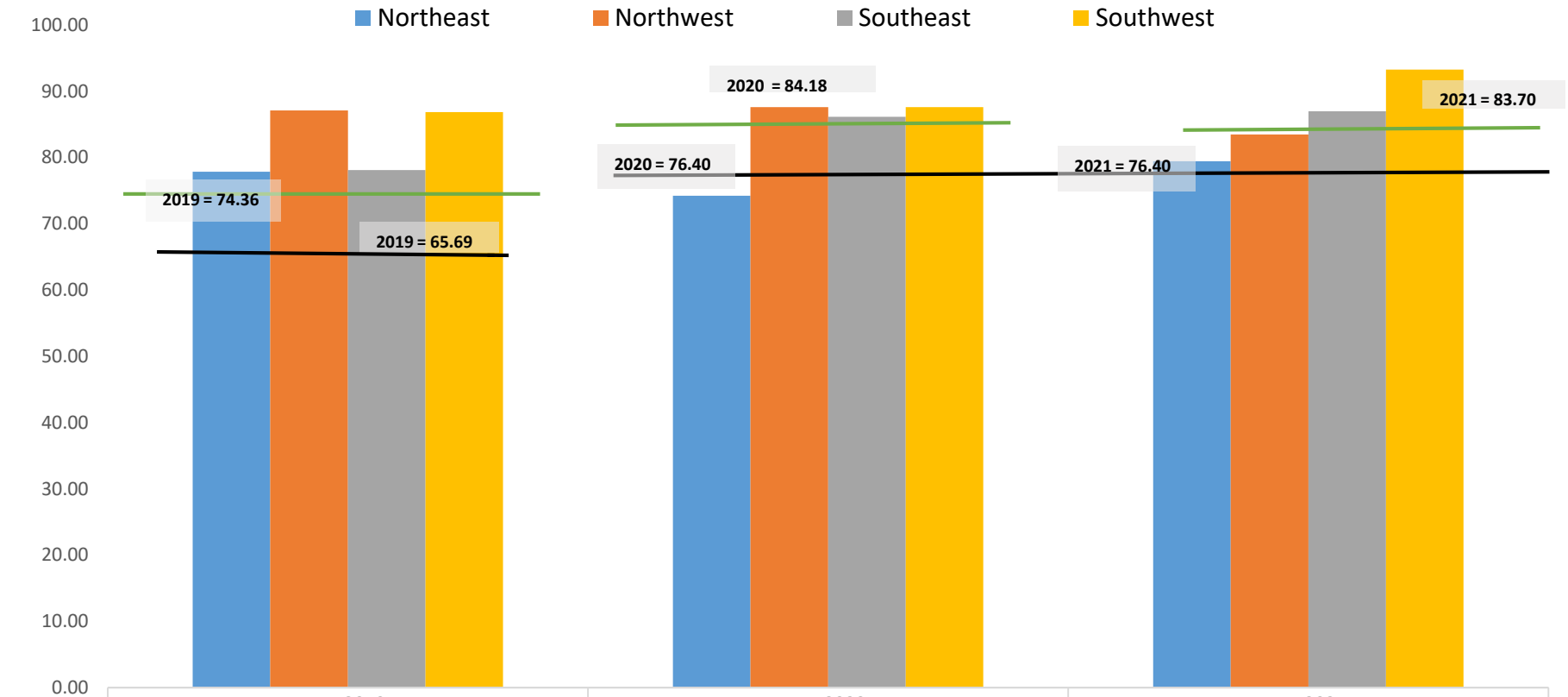

	MY 2019	MY 2020	MY 2021
Northeast	77.86	74.21	79.44
Northwest	87.10	87.59	83.46
Southeast	78.10	86.13	86.96
Southwest	86.86	87.59	93.24

MPL 50%

HPL 90%

Impacts of Perinatal Depression: Bad for Mom and Bad for Baby

CT

Appendix 4 (pages 35-87)
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Maternal Impacts

Pregnancy Effects

- Preterm Delivery
- Small for Gestational Age
- Low Birth Weight Infant

Post Partum Effects

- Negatively impacts parenting and interactions with infant/children

Infant /Child Impacts

- Early cessation of Breast Feeding
- Fewer preventative visits
- Fewer vaccinations
- Increased behavioral and cognitive issues
- Increased risk for psychiatric disease

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Screen for Mood Disorder Diagnosis and **RISK** for Perinatal Depression **and** Refer for Treatment

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3
Continued next page

CT

Highly predictive factors

- Personal history
- Current symptoms but not meeting criteria
- Current intimate partner abuse
- Low socio-economic status
- Single or teen Parent

Refer for treatment when at least ONE risk factor present

Additional Associated Factors

- History of physical or sexual abuse
- Medical complications to pregnancy
- Family history of depression
- Poor social /financial support
- Current stressful life
- Unplanned/undesired pregnancy

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Breast Cancer Screening Guidelines for Average Risk Individuals

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Age based

- Expert groups and guidelines have different recommendations
  - Most “individualize” the decision age 40-49
  - Some start at 45
  - Most stop at 74
- US Preventive Services Task Force (USPSTF)
  - All age 50 - 74
  - Age 75+ continue if healthy and life expectancy >10 years

Frequency

- No consensus
- USPSTF – every 2 years

Breast Cancer Screening Tools

Appendix 4 (pages 35-87)
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- Mammogram is the GOLD standard test for screening for Breast Cancer in average and high risk individuals
  - **Breast exams and are NOT substitutes for mammograms**
- MRI for screening may be recommended for high risk individual when family or personal history shows Lifetime Risk of ≥ 20%
- Ultrasound is **NOT** recommended for Breast Cancer Screening
  - Used for **diagnostic evaluation** when symptoms (lump or mass) or after abnormal mammogram

Resources

Appendix 4 (pages 35-87)
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- Growing Together Program (GTP):

PopHealthOutreach@partnershiphp.org 1 (855) 798-8764

- PHC Website: Routine Mammography Screening- Member Information:

http://www.partnershiphp.org/Members/Medi-Cal/Pages/Health%20Education/Routine-Mammogram-Screenings.aspx

Resources on Health and Racial Equity

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California Improvement Network (CIN): https://www.chcf.org

Toolkit to Advance Racial Health Equity in Primary Care Improvement https://www.chcf.org/publication/toolkit-racial-equity-primary-care-improvement/

American Medical Association: https://www.ama-assn.org/about/ama-center-health-equity AMA Center for Health Equity: The AMA Center for Health Equity works to embed health equity across the AMA organization so that health equity becomes part of the practice, process, action, innovation, and organizational performance and outcomes. Also jointly released with Association of American Medical Colleges, led by its Center for Health Justice, a new health equity guide to language, narrative, and concepts entitled, "Advancing Health Equity: A Guide to Language, Narrative, and Concepts."

Center for Health Care Strategies : https://www.chcs.org/

Diversifying Medicaid's Leaders to Better Address Health Equity - Highlights strategies for ensuring a robust pipeline of strong and diverse Medicaid leaders. See also a related **infographic**.

Words Matter: How Language Used in Health Care Settings Can Impact the Quality of Pediatric Care - This webinar featured perspectives on the impact of language used during care and in medical records, and how provider interactions rooted in respect can support health and well-being. This is not exclusive to pediatric delivery.

Health Begins: https://healthbegins.org

Health Equity Strategies from the AHC Model: Working with Mathematica on behalf of the Centers for Medicare & Medicaid Services (CMS), Health Begins has this tip sheet provides a multi-level framework for understanding health equity, including actionable strategies related to social needs interventions that organizations such as health systems, payers, and community service providers can leverage to improve health equity.

Resources on Health and Racial Equity

Appendix 4 (pages 35-87)
QI 3, Element B, Factor 3

Implicit Bias Association Test https://implicit.harvard.edu/implicit/takeatest.html.

Tool for showing bias and how our unconscious drives our day to day decision making. This tool was developed by a group of researchers from Harvard University and has proven validity. The test is free and results are kept confidential, but tagged for research purposes. Please refer to the disclaimer.

Diversity Science: https://www.diversityscience.org/equal-perinatal-care/

Developed an interactive training courses and resources for perinatal providers focused on implicit bias and reproductive justice. These resources are developed in accordance with the training requirements outlined in the California Dignity in Pregnancy and Childbirth Act (Senate Bill 464).

Project Charter ~~7.22.22 – 7.27.22~~ ~~Updated 8.1.22~~ Updated 9.18.22

Organizational Initiative: Quality, Access and Equity

Focus Area: Quality Measure Score Improvement (QMSI) De

Project: Women's Health and Perinatal Work Group (WHaP),

Appendix 5, QI 3, Element B Factor 3 (pages 89-91)
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Chief Sponsor and Executive Sponsor	Robert Moore, MD	**Workgroup Leads Project Resource**	Colleen Townsend, MD; Flora Maiki Liezel Lago	Quality Measure Score Improvement Focus Area	Nancy Steffen, Sr. Director of Quality

Problem Statement	Perinatal Measure have improved with the targeted outreach to providers and quality incentive programs. PHC data before and after COVID19 show that non-perinatal quality measures related to women's health lag behind benchmark targets. PHC needs to engage perinatal and primary care providers and members to optimize performance on perinatal and women's health measures.	**Objective**	Restore and improve Quality performance over the women's health and perinatal measures in the measurement years of 2022- 2023 under the DHCS Managed Care Accountability Measure Set as well as additional HEDIS measures. To continue collaboration and initiate work within PHC participating departments to adopt the QMSI goals. To integrate the measure- focused WHaP workgroup project charter and activities for 22/23 into their departmental work. And, to identify leaders/ staff who can actively participate in the implementation of the WHaP joint improvement activities.

Scope – In	Categories:
	• Provider Engagement
	  ○ Engagement through updated education with provider practices that includes women's health measures.
	  ○ Continue with Accelerated Learning –Early Cancer Detection.
	  ○ Explore the creation of a Women's Health and Perinatal (WhaP) Provider Advisory Group.
	• Member Engagement
	  ○ Strategic discussion of direct member outreach for women's health and perinatal measures with analysis of equity gaps.
	  ○ Identify health equity gaps (race, ethnic, geographic, language) and develop member focused outreach and communication plan.
	  ○ Increase engagement in the Perinatal Growing Together Program.
	• Identify and Address Gaps in Care
	  ○ Identify and address equity driven gaps.
	  ○ Share specific local/practice /equity resources through provider presentations.
	  ○ Explore a new intervention: self-collection for cervical cancer screening.
	  ○ Explore member engagement inclusion in WHaP workgroup structure.
	• Communication to providers and PHC members
	  ○ Submit articles in the PCP QIP, and Perinatal newsletters.
	  ○ Submit articles in the Member newsletter.

Continued next page

	• Participate in the DHCS mandated work and related NCQA opportunities based on HEDIS 2021 measure results. Continue to lead the DHCS mandated Health Equity Performance Improvement Project with SE Region on Breast Cancer Screening.
Scope-Out	• Details of the Perinatal QIP (separate workgroup) and PCP QIP (separate work groups). • Execution of direct member outreach (Population Health operationalizes).

Critical Activities	• Complete a data repository of WHaP related measures. *X • Complete a repository of PHC initiatives / activities that support WHaP measure improvement. *X • Complete an intervention/project/PDSA on Breast Cancer Screening using mobile mammography services with two providers in the SW Region.* X • Complete an evaluation of the mobile mammography project to include all the PHC supported events. **X • Complete the Well Woman Birthday Club Intervention and an evaluation of the Pilot. ** • Provider Education- presentations to 80% of practices in the Perinatal Program, inclusion of women's health measures. **X 50%) • Develop a focused Member Engagement outreach utilizing identified heath equity gaps. ** • Increase Member engagement in Growing Together (GTP) by 50%. ** • Support/lead DHCS mandated work that pertains to WHaP.** (Existing Performance Improvement Plan (PIP). Breast CA Screening with CCHCX • Contribute and develop communication articles and educational sessions (Accelerated Learning Education Seminar) on specific measures. ** X *Indicates required activity/deliverable: ** Indicates workgroup choice of the required minimum two activities/deliverables

Major Milestones	**Qtr 1 / July - Sept. 2022**	**Qtr 2 / Oct – Dec 2022**	**Qtr 3 / Jan – Mar 2023**	**Qtr 4 / April – June 2023**
	1) Define at least 5 major activities for each measure-specific workgroup 2) Complete Project Charter 3) Provider Engagement/Education Presentation: Review existing Perinatal and Women's Health measure materials, Draft updated slides; Include provider health equity resources (Sept) 4) Provider Engagement/ Education: Complete all documents including new evaluation and cultural competency documents for CME/CE and submit (Sept)	1) Identify gaps: Create and review data repository for WHaP identify gaps (regional/practice type/race) review for equity related gaps X 2) Member Engagement/Education: Identify a Population for which there is low performance in Women's Health Measures and /or Perinatal measure (equity gap) that would benefit from targeted member education, engagement and/or communication (Oct) 3) Addressing Gaps: Develop an internal tool for tracking data by region for WHaP	1) Member Engagement: Develop member engagement and education material that addresses the identified equity gap and create outreach/ communication plan X 2) Addressing Gaps: Complete repository of information that details PHC initiatives /activities that address Women's Health and Perinatal Health across all regions (Jan 2023) 3) Provider Engagement: Continue presentation to practices X 4) Identify gaps: Review and update as needed data repository (PQIP and / PCP QIP)	**Complete all required activities by June 30, 2022** 1) Provider Engagement /Education: Provide one Accelerated Learning Education included in Early Cancer Detection 2) Complete WHaP provider presentations for 80% of identified practices (April 2023) 3) Provider Engagement: Conduct follow up survey, compile responses - Present data to WHaP MSI work group (May 2023) 4) Member Engagement: Finalize an outreach/ communication plan for member education and

	5) Provider Engagement/Education: Identify and prioritize practices for 2022-23 (Sept) X 6) Intervention/Project /PDSA: Breast Cancer Screening Mobile mammography events. Planning and complete 1 three day events with two providers in the SW Region. X 7) Outreach to Providers in GTP. Report bi-monthly X 8) Draft articles in Perinatal newsletters X 9) Operations: Send invites for all workgroup meetings/huddles (Aug) X 10/ Participation in new DHCS mandated work (pending)	measures and identifies the data resources (Nov) 4) Provider Engagement/Education: Begin WHaP presentations with practices (Oct) 5) Develop survey questions to follow- up for participating providers (Oct) X 6) Reach out to providers conducting pilots on self – screening HPV based cervical screening (Oct) Aliados Health/SR CH 7) Draft article in Perinatal Newsletter X 8) Present to the Team Goal Workgroup *and* Executive Quality Measure Score Improvement/EQMS meetings (Oct/Nov) X	5) Addressing Gaps: Identify options for self-swab cervical cancer screening; Write up findings – Aliados Health WG 6) Write article in Perinatal NewsletterX 7) Write an article in the PHC member newsletter on a women's health topic X 8) Explore the creation of a Women's Health and Perinatal Provider Advisory Group.	engagement related to equity gap (See Q2 #1) 5) Draft article in Perinatal NewsletterX 6) Complete and submit the Health Equity PIP (BCS) to DHCS - 7) Present to Team Goal Workgroup *and* Executive Quality Measure Score Improvement/EQMS meetings (May/June)

Potential Risks or Barriers	• Provider hesitance to schedule educational sessions • Continued difficulty with access for members for care due to COVID19 • Increasing barriers in accessing mobile mammography services

QI 3, Element A, Factor 7

PRIMARY CARE PHYSICIAN COMMUNICATION FORM

Date _____ PCP Name _____

PCP Fax Number _____ PCP Address _____

The following patient received an eye health exam in my office on _____
In an effort to ensure coordination of care, I am including my exam findings and follow-up recommendations.
Please contact me if you have questions or would like additional information.

Patient Name _____ DOB _____

VSP Doctor Name _____ Phone _____

VSP Doctor Signature _____ VSP Doctor Credentials _____

FINDINGS

- ❑ Diabetes with no diabetic retinopathy found in either eye
- ❑ Retinal exam abnormalities detected, as follows:
  - Non-proliferative diabetic retinopathy only ❑ Right ❑ Left
  - Clinically significant macular edema ❑ Right ❑ Left
- ❑ Proliferative changes detected, as follows:
  - Neovascularization ❑ Right ❑ Left
  - Pre-retinal hemorrhage ❑ Right ❑ Left
  - Vitreous hemorrhage ❑ Right ❑ Left
- ❑ Other conditions:
  - ❑ High cholesterol ❑ Ocular surface disease ❑ Hypertension
  - ❑ Cataracts ❑ Elevated intra-ocular pressure ❑ Macular degeneration
  - ❑ Corneal dystrophies ❑ Glaucoma ❑ Other_____

RECOMMENDED FOLLOW-UP

- ❑ Follow-up exam is scheduled in my office on _____
- ❑ Follow-up of abnormalities in my office is recommended in _____
- ❑ Recommended consultation with Dr. _____
  Phone _____ within _____

Attachments _____

Comments _____

Continuity and Coordination between Medical Care and Behavioral Healthcare

April 2024

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Objective

This report summarizes Partnership HealthPlan (PHC) work to analyze, improve and build upon efforts to promote the continuity and coordination of medical and behavioral health care services. This work uses established goals for the range of measures and applied interventions and evaluations of effectiveness to improve Plan performance for two of the measures. The measures address the sharing of information; promotion of treatment of the whole person, and adherence to standard diagnosis and treatment guidelines.

In 2019 PHC convened a multidisciplinary team to identify appropriate measures for this analysis, to gather and review the data, recommend interventions and select opportunities for improvement, which is then reported to PHC's Quality & Utilization Advisory Committee. The focus and membership of the team was subsequently narrowed as the specifications, measures and interventions were identified. The current team has members represented from the following departments: Behavioral Health, Health Analytics, the Office of the Chief Medical Officer, Pharmacy, and Carelon Behavioral Health, the Plan's delegated administrator of mental health services. See appendix for further detail on participation. See appendix for list of participants and applicable licensure.

Data sources included in this analysis are:

Data Type	*Data Source*
Medi-Cal Rx pharmaceutical claims data	State data exchange
Medical claims and encounter data	Amisys
PHC HEDIS scores	HEDIS Team
National Incidence Data	Evidence Based Research
Annual Provider Survey	PHC Annual Provider Survey
Annual Provider Survey	Carelon Annual Provider Survey
Meeting minutes	Behavioral Health and other PHC documentation (Appendix)

Results and Analysis

Factor 1: Exchange of Information between Primary Care and Behavioral Health Providers

Measurement

Determination of the extent of effective exchange of information between primary care and behavioral health providers will be determined by a provider survey with a goal of at least 50% of providers will routinely share information that confirms referral is addressing the patient's needs, and that information sharing is bidirectional. Surveys were sent to 274 primary care providers and to 1250 behavioral health providers, encompassing all primary care providers (PCPs) and Behavioral Health (BH) provider sites.

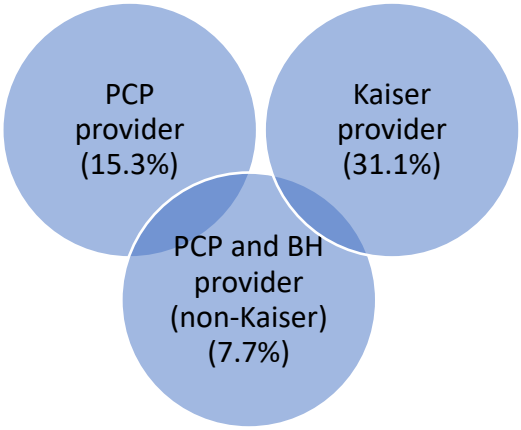
Note that the definition of this factor changed in the HPA 2021 Standards and Guidelines, so the data cannot be trended from years prior to 2021.

Relevance

PHC members receive primary care treatment from a range of primary care site types including federally funded clinics (Federally Qualified Health Centers, Indian Health Service Centers, Rural Health Clinics), from clinics associated with hospital networks, and from private practitioners. Many members address their mental health needs with both a mental health practitioner and with their PCP, emphasizing the need for effective coordination among behavioral and primary care providers.

In 2023, about 15.3% of primary care visits included a mental health diagnosis indicating that the members' mental health was addressed during the visit. This was down 7% from calendar year 2022. During the same period of 2023, 44,845 of non-Kaiser PHC members had at least one visit with a mental health practitioner, which was nearly half, and 6.06% of those who had a mental health-related visit with their PCP also saw a mild-to-moderate mental health practitioner[1].

Sources of Mental Health Care for PHC Members, 2023



In other words, coordination among providers could be an important element of health care for many members; there is a significant need for PCPs and mental health providers to effectively exchange information to ensure the coordination of care and effectively work collaboratively to address patient needs.

Goal

[1] In 2023, 89,249 unique members, or 15.3%% of the average non-Kaiser membership of 580,857 members had a PCP visit that involved a mental health diagnosis. 44,845 unique members, or 6.7% had a visit with a mental health practitioner for mild to moderate treatment needs. Additionally, 12,920 or 2.2% of PHC members were treated in the county-administered mental health system for those with severe and persistent mental health needs. 39,209 members had both a PCP visit for mental health needs *and* a visit with a mild-to-moderate mental health practitioner.

At least 50% of providers will routinely share information that is sufficient; accurate and clear; provided on a timely basis and with sufficient frequency.

Methodology

Primary care providers in particular are asked to participate in a large number of surveys, many of them required by regulations. PHC Provider Relations and other staff often hear concerns regarding the clinic resources needed to respond to these surveys. PHC opted to survey providers through three surveys; directly to providers through a focused survey link, through the Carelon Annual Provider Survey as well as the PHC Annual Provider Survey. By modifying the mode and combining with the annual provider surveys, the pool of respondents grew from 96 in 2022 to 1057 in 2023.

Consequently, the survey was distributed to all PCP sites (274) and to all Carelon[2] mental health provider sites (1250) via a multi-mode survey approach, allowing respondents to complete via email or web. The large disparity in the number of sites for each area of practice is because most PCP sites have a number of clinicians providing care at a site, while a large number of mental health providers are solo practitioners with one provider per site.

Results

929 providers (847 behavioral health providers and 82 primary care providers) responded to the surveys, acknowledging duplication could not be linked as a unique identifier such as a Tax ID or NPI was not included. Overall behavioral health providers had a response rate of 67.76% while PCPs had a 29.9% rate.

Sharing of Information- PHC Independent Survey Responses (10 total responses):

Sharing Information with Other Providers of 10 total responses: Primary care providers reported that they are more likely to routinely share patient information:	BH Providers	PCPs	Total
Info routinely shared	33.3% (2 of 6)	25% (1 of 4)	33.3% (3 of 10)
Info routinely shared w/ release of information	33.3% (2 of 6)	25% (1 of 4)	33.3% (3 of 10)
Information not routinely shared	66.67% (4 of 6)	75% (3 of 4)	70% (7 of 10)

Reported Problems with Receiving Information from Other Providers When Information is Shared (10 total responses):

[2] PHC mental health services are administered by Carelon Behavioral Health, which contracts directly with the providers on PHC's behalf.

	BH Providers	PCPs	Total
Info not generally sufficient	66.7% (4 of 6)	50% (2 of 4)	66.7% (6 of 10)
Info not generally accurate/clear	33.3% (2 of 6)	25% (1 of 4)	33.3% (3 of 10)
Info not timely or provided with sufficient frequency	66.67% (4 of 6)	75% (3 of 4)	70% (7 of 10)
Info was generally sufficient, accurate/clear, timely and sufficiently frequent	33.3% (1 of 6)	25% (0 of 4)	10% (1 of 10)

Sharing of Information- PHC PCP Responses (250 total responses):

Sharing Information with Other Providers of 208 total responses: Primary care providers reported that they are more likely to routinely share patient information:	PCPs
I routinely receive reports after my PHC patients have accessed Mental Health Care and Services	44% (110 of 205)
Once a referral has been issued to Carelon, I routinely receive confirmation that my patient's mental health referral is being addressed	43% (107 of 250)

Sharing of Information- Carelon Mental Health Responses (847 Total responses):

	BH Providers
If my patient has a Primary Care Physician: I communicate (verbal and/or written) about our mutual patient's care	28.8% (244 of 846)
If my patient has a Primary Care Physician: I receive communication (verbal and/or written) about our mutual patient's care	18.5% (157 of 847)
If my patient is currently treated by another behavioral health practitioner: I communicate (verbal and/or written) about our mutual patient's care	44.9% (315 of 701)
If my patient is currently treated by another behavioral health practitioner: I receive communication (verbal and/or written) about our mutual patient's care	29.9% (180 of 607)

Quantitative Analysis

The goal was not met as less than 50% of providers expressed they receive or share information regarding mutual patient's care.

Qualitative Analysis

When examining the quality of the data shared, the 50% goal was not met. Overall, 33.3% of respondents reported they share or communicate regarding the mutual patients are receiving. Previously PCPs had been more likely to answer the survey, indicating a potential need to modify the

communication strategy used to retrieve this information as only 10 of 106 (9.4%) of the survey #1 recipients responding to the survey questions regarding the sufficiency, accuracy, or timeliness of the information.

The survey demonstrated that 33.3% of behavioral health providers feel they receive verbal or written information from primary care providers, indicating information sharing is often one sided. Consequently, PCPs indicated mental health referrals are only addressed 25% of the time, indicating the need to address closed loop referrals.

Appropriate Diagnosis, Treatment, and Referral of Behavioral Disorders Commonly Seen in Primary Care

Measurement

Primary care providers are required to screen/diagnose and provide brief treatment or referral to services for individuals with alcohol use disorder[3]. For several years, PHC's value based incentive program for PCPs, the PCP Quality Improvement Program (QIP) has included alcohol screening and brief intervention among the factors that will allow for PCP-QIP payments to the site. Specifically, primary care sites with at least 50 assigned members will have screened 5% of their assigned members over 18 years of age, and billed or provided encounter data for this screening which can take place every six months.

Analysis through 2020 showed the need to persuade PCPs to more aggressively screen adults and provide brief interventions for those with excessive alcohol use, and to report these activities. It is unclear if the data supports conclusions regarding the prevalence of excessive alcohol use among PHC members or even the prevalence of screenings for these conditions that may occur during a visit. PHC sought to improve this rate in 2021, partnering with regional staff to promote the use of Screening, Brief Intervention, and Referral to Treatment (SABIRT) in primary care settings.

Relevance

Excessive use of alcohol is associated with a range of poor health conditions as well as a variety of adverse social outcomes.

According to the Centers for Disease Control and Prevention January 2014 Vital Signs Report:

- At least 38 million adults (15.5% of the total population)[4] in the US drink too much although most are not alcoholics;
- Only 1 in 6 adults talk with their doctor, nurse, or other health professional about their drinking; and
- Alcohol screening and brief intervention has been shown to reduce drinking by as much as 25% for those who drink too much. (CDC Vital Signs, 2014).

[3] See California Department of Health Services All Plan Letter 18-014, in the Appendix.
[4] According to the U.S. Census there were 244.7 million adults over 18 in 2014

Drinking too much causes about 88,000 deaths in the US each year, and costs the economy about $224 billion (CDC Vital Signs, 2014). These numbers may be significantly higher for recent years; data show increased unhealthy alcohol use in 2020 associated with the Covid-19 pandemic and related social and economic effects.[5]

Information regarding excessive alcohol use is especially important in the primary care setting; as noted, many conditions are associated with or exacerbated by excessive alcohol use and primary care providers are in the best position to identify this problem early.

Talking with a patient about their drinking is part of the screening and brief counseling process, which involves:

- Using a set of questions to screen all patients for how much and how often they drink; counseling patients about the health dangers of drinking too much, including women who are (or might be) pregnant; and
- Providing a brief intervention/counseling; and
- Referring some patients to specialized treatment.

Goal

As noted above, it is estimated that nationally about 15.5 % of those 18 and older drink too much. Ideally, PHC providers will identify all of the individuals who drink too much and provide them with a brief intervention. Thus, the goal is that PHC providers will screen and identify excessive alcohol use in 15% of their adult patients.

Methodology

PHC members receiving services during measurement year 2022 will be screened and connected to treatment for unhealthy alcohol use.

Data Source	Claims data
Denominator	SABIRT screenings conducted as identified by claims with H0049
Numerator	SABIRT screenings found to require follow-up for excessive alcohol use as identified by claims with H0050
Measurement Period	CY 2021-2023

Results

Adult Members Screened for Alcohol Misuse

2021	2022	2023

[5] See for instance, Pollard MS, Tucker JS, Gree HD, Changes in Adult Alcohol Use and Consequences During the Covid-19 Pandemic in the US, JAMA Netw Open 2020;3(9):e2022942.doi:10.1001/jamanetworkopen.2020.2294

Members Screened	# Found to have excessive alcohol use	% of those screened and determined to have excessive alcohol use	Members Screened	# Found to have excessive alcohol use	% of those screened and determined to have excessive alcohol use	Members Screened	# Found to have excessive alcohol use	% of those screened and determined to have excessive alcohol use
785	331	42%	989	605	61%	1695	597	35%

Quantitative Analysis

In 2021 over 40% of those screened were determined to have excessive alcohol use, well above the expectation. Conversely in 2022 further increase in excessive use was apparent with 61% of those screened requiring intervention. In 2023 the goal was met with 706 more screenings than the previous year, with only 35% positive for excessive use of alcohol.

Qualitative Analysis

The data shows that while previously only a small proportion of PHC adult members are reported as being screened, incentive has influenced the integration of behavioral health screenings and referrals within non-behavioral health settings. While the study indicates the presence of need for screening and intervention for alcohol misuse in members being seen in primary care settings the opportunity remains to further study the efficacy of the intervention.

Appropriate Use of Psychotropic Medications

Measurement

This analysis used the HEDIS measure, Follow Up Care for Children Prescribed ADHD Medication – Initiation Phase indicator: members 6-12 years of age with a newly prescribed and dispensed attention-deficit/hyperactivity disorder (ADHD) medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.

Relevance

Children who require medication to treat attention deficit disorder (with or without hyperactivity) have varying responses to treatment. While some respond well to first-line drug choices, there are many who may either require additional medication therapies or completely different therapeutic modalities. To improve the coordination and efficacy of the care to these children, PHC sought to improve PCPs' understanding and application of these medications and to promote timely follow-up after the initial diagnosis and prescription. Follow-up visits are an essential part of an effective treatment plan in order to assess the efficacy of the medications and to modify the interventions according to the child's needs. The HEDIS measure Follow-Up Care for Children Prescribed ADHD Medication tracks the success of these efforts.

Goal

Each of PHC's four regions will be at or above the 50th percentile of the National Medicaid Benchmark for the ADD-Initiation Phase HEDIS measure indicator.

Methodology

HEDIS measure description	Follow Up Care for Children Prescribed ADHD Medication (ADD); Initiation Phase indicator: Percent of members ages 6 to 12 prescribed ADHD medication with a follow-up visit to a prescribing provider 30 days after initiating treatment.
Measurement Periods	Measurement Year (MY) 2022

Results

Follow-Up Care for Children Prescribed ADHD Medication (ADD) – Initiation Phase

Region	MY 2020 Performance	Num/Denom	Percentile Ranking	National Medicaid Benchmarks			
				25th	50th	75th	90th
Northwest	33.62%	39/116	<25th	36.56	42.95	48.05	55.33
Northeast	28.99%	60/207	<25th				
Southwest	29.08%	114/392	<25th				
Southeast	24.84%	118/475	<25th				
Composite	27.82%	331/1190	<25th				

Region	MY 2021 Performance	Num/Denom	Percentile Ranking	National Medicaid Benchmarks			
				25th	50th	75th	90th
Northwest	33.79%	49/145	<25th	36.56	42.95	48.05	55.33
Northeast	33.33%	75/225	<25th				
Southwest	39.44%	127/322	<50th				
Southeast	34.29%	120/350	<25th				
Composite	35.61%	371/1042	<25th				

Region	MY 2022 Performance	Num/Denom	Percentile Ranking	National Medicaid Benchmarks				Goal Met?
				25th	50th	75th	90th	>50th
Northwest	36.92%	48/130	<25th	38.37	44.51	49.12	55.99	No
Northeast	31.67%	70/221	<25th					No
Southwest	45.37%	147/324	<75th					Yes
Southeast	41.58%	158/380	<50th					No
Composite	40.09%	423/1055	<50th					No

Quantitative Analysis

The goal was not met. The Plan continues to rank below the 50th percentile. However, there is improvement seen in MY 2022 performance in comparison to both preceding measurement years. The Southwest region showed a marked improvement, meeting the 50th percentile goal. There is a slight increase in the ADD measure denominator (eligible population) compared to MY 2021.

Qualitative Analysis

The ADD measure is designed to monitor the follow-up care that children receive over the first 10 months of starting their ADHD medication. Members are included in the ADD eligible population based on their follow-up care timeframe rather than their medication start date; therefore, they are included in the measure 10 months after starting their medication. The ADD measure MY 2022 population reflects members who began their medications between March 1, 2021 and February 28, 2022.

The slight increase in total number of children who started a new ADHD medication in MY 2022 may be attributed to the return of in-person instruction in schools. Notable trends include a slight decrease in children newly started on ADHD medication in the Northern Region while there is an uptick in children newly started on ADHD medication in the Southern Region. The Northern Region continues to perform lower when compared to the Southern Region. Some barriers to care may include access to fewer health care providers and transportation challenges in rural communities.

Collaborative Activities

This was one of the two measures selected for further study and engagement. In 2020, several PHC departments (Pharmacy, Quality Improvement, Behavioral Health, and Health Analytics) developed a process to send prescribers letters to alert them of their patient filling a new ADHD medication at the

pharmacy, and to inform them of the importance of follow-up care when initiating ADHD treatment for pediatric patients between the ages of 6-12 years. This intervention began in July 2020 and continued through 2021.

Methodology

From March 2021 through December 2021, letters were sent to individual prescribers with a patient (6-12 years of age) whom first filled an ADHD medication within the preceding week. The letter included member-specific details, such as medication name and prescription fill date. The letter reminded the prescriber to have a follow-up appointment within 30 days of starting ADHD medication treatment based on the pharmacy prescription claim record.

A total of 188 letters were sent on behalf of individual members newly starting ADHD medication. All 188 members count toward MY 2022 because they started their ADHD medication between March 1, 2021 through February 28, 2022 (the end of the Index period for the ADD measure).

Measuring Effectiveness

Measurement Year	Cohort	Denominator	Numerator	ADD-Initiation Phase Score
2021 (IPSD 03/01/2020 – 02/28/2021)	ADD Composite	1,042	371	35.61%
	Control (i.e. no letter) (control = ADD composite – intervention group)	995	348	34.97%
	Intervention (letter recipients)	47	23	48.94%
2022 (IPSD 03/01/2021 – 02/28/2022)	ADD Composite	1,055	423	40.09%
	Control (i.e. no letter) (control = ADD composite – intervention group)	867	333	38.41%
	Intervention (letter recipients)	188	90	47.87%

IPSD = Index Prescription State Date, date of newly starting ADHD medication

After allowing sufficient time for the members to receive appropriate follow-up care (i.e. 10 months), letter recipient members were identified in the ADD measure MY 2022 eligible population and scores were extracted from the ADD measure data accordingly. The letter recipient cohort included 188 individual members, with 90 of those members receiving appropriate follow-up care with their prescriber within 30 days of starting their new ADHD medication, which translates to an ADD-Initiation Phase score of 47.87% for the intervention group. With a contrasting score of 38.41% for the ADD

eligible population who received no intervention, the results suggest that continual communications with providers through these letters may be beneficial in ensuring appropriate and timely follow-up care for these children.

The 188 letters impacting MY 2022 were sent to 98 individual prescribers. Unfortunately, the ADD measure is not stratified by prescriber, therefore further details or conclusions regarding prescribing habits of individual providers in relation to the impact of these letters cannot be drawn.

Next Steps

As the Plan still has not reached the >50th percentile goal, there is significant room for improvement with the ADD measure – Initiation Phase indicator. This intervention began MY 2021 and based on the continued increase in ADD – Initiation Phase score each year it appears that the prescriber letter notification has had a positive impact. Based on these findings, it is favorable to continue the prescriber letter intervention. Continuing this intervention may open doors to collaborate with prescribers we communicate with, and perhaps identify additional opportunities to improve access to appropriate care for these children.

Due to the transition of pharmacy services from Partnership HealthPlan to Medi-Cal Rx, timely pharmacy data availability was disrupted after December 2021. As a result of this transition combined with the late Q1/Q2 2022 PHC system outage, there was a prolonged delay in receiving timely weekly ADHD new start reports. Timely pharmacy claim data reports were not made available until August 2022. Due to time constraints and competing priorities, the intervention was put on hold until March 2023. To build upon the current intervention, Pharmacy planned the following changes to the intervention:

- Sending individual prescribers faxes instead of U.S. mail for faster turnaround.
- Providing the date that the follow-up appointment must be completed by based on the pharmacy prescription claim record (30 days from fill date).
- Targeting lower performing providers: Providers that had at least five members that newly started ADHD medication within a 6-month lookback period (7/2022-1/2023) and performed below the MPL based on claims data.
- Performing follow-up calls to confirm fax receipt.

Fax communications to providers began March 2023 and the impact of the changes to the intervention will not be fully realized until MY 2024 results are reported.

Data on the frequency of treatment and follow-up visits following mental health or substance abuse diagnosis

Measurement

This analysis focused on data on the frequency and follow-up for members diagnosed with a substance use diagnosis.

Relevance

According to the 2020 National Survey on Drug Use and Health (NSDUH), 40.3 million Americans, aged 12 or older, had a substance use disorder (SUD) in the past year.[6] Further, nine percent of Californians met the criteria for a substance use disorder (SUD) in the last year. The health care system is moving toward acknowledging substance use disorders as chronic illnesses, yet only about 10% of people with an SUD in the last year received treatment.[7]

Goal

At least 50% of members with a co-occurring diagnosis (medical and SUD) will be connected to SUD treatment within 10 days, and at least 50% will remain in treatment for 30 days.

Methodology

Data Source:	Claims and encounter data
Denominator:	Members diagnosed with an substance use disorder for the first time within the calendar year, who initially presented with a medical diagnosis
Numerator:	Of those diagnosed, number of days between new diagnosis and first SUD encounter
Numerator #2:	Of those diagnosed, number of days between first and last SUD encounter
Measurement Period:	2021-2023 Calendar Years

Results

2021		2022		2023	
Region	Days from new diagnosis to first SUD encounter	Region	Days from new diagnosis to first SUD encounter	Region	Days from new diagnosis to first SUD encounter

[6] Substance Use Disorders (SUDs) | Feature Topics | Drug Overdose (cdc.gov)
[7] https://www.chcf.org/wp-content/uploads/2022/01/SubstanceUseDisorderAlmanac2022.pdf

Northeast	15.73	Northeast	34.41	Northeast	8.54
Northwest	14	Northwest	35.69	Northwest	8.53
Southeast	13.47	Southeast	28.83	Southeast	6.82
Southwest	11.57	Southwest	28.83	Southwest	6.97

Region	SUD Diagnosis	Average Days Remaining in Treatment
Northeast	Alcohol use and dependency	131.94
	Opioid Use	148.9
	Stimulant use and dependency	148.95
Northwest	Alcohol use and dependency	139.27
	Opioid Use	95.84
	Stimulant use and dependency	91.29
Southeast	Alcohol use and dependency	136.33
	Opioid Use	147.42
	Stimulant use and dependency	151.75
Southwest	Alcohol use and dependency	63.88
	Opioid Use	302
	Stimulant use and dependency	113.07

Service location	Claims PMPY	Member Count
Outpatient	2.6	3109
ER	3.9	11513
Inpatient Hosp	5.5	5666
Office Visit	6.3	18366

Quantitative Analysis

The goal was met with 42% of members with co-occurring diagnosis resulting in a subsequent SUD encounter. Of the individuals who connected to treatment, 79% participated in treatment for a minimum of 7 days, and 63% remained in treatment for at least 30 days.

Members waited to enter treatment an average of 7.71 days after their initial SUD diagnosis. Subsequently, there was an average of 139.22 days in treatment amongst the 3 most common SUD diagnosis with a median of 14.02 treatment episodes monthly.

Qualitative Analysis

Timeliness to first SUD encounter was important to measure whether providers can accommodate subsequent visits after admitting into treatment. While the days to treatment were under the 10-day requirement, hospitals reported admitted members often have delays in discharge due to lack of capacity within substance use facilities. This led to review of the highest utilized locations of service for newly diagnosed which presented as primary care which aligns with the prescribing of medication for addiction treatment. Outpatient and emergency room visits with new SUD diagnosis had decreased from 33,667 in 2022 and 14,622 in 2023 with the utilization of substance use navigators deemed to be a significant factor. Further review drew attention to inpatient stays with over 5 claims per utilizing member with co-occurring diagnosis, higher readmission rates, and longer length of stays.

Collaborative Activities

Throughout the analysis it was apparent substance use navigation supports members in connecting to treatment. With the sun-setting of funding, sustainability of the program with hospitals became a priority.

- Barriers:
    - CA Bridge projects ended July 2023 and many existing substance use navigator (SUN) positions embedded within hospitals were going to be lost or repurposed due to lack of funding.
- Actions:
    - PHC included a substance use disorder referral metric into the Hospital Quality Improvement Program (HQIP) intended to incentivize hospitals for including dedicated staff and/ or referring members for substance use disorder services. Many hospitals have utilized the incentive funding for on-going employment of their SUNs. In 2023, 26 hospitals opted into the HQIP and 19 met the measurement target of at least 10 members referred from larger hospitals and 3 within small hospitals.
- Barriers:
    - Hospitals have expressed a need for SUD screenings to be conducted prior to members discharging from an acute facility.
- Actions:
    - Partnered with Shasta Regional Medical Center to support with discharging members in need of SUD connections from acute setting through offering of screenings and care coordination to support the transition of care.
    - Mercy Medical Center was connected to a local SUD provider to participate in joint discharge planning for those requiring a transition to a SUD setting.
- Barriers:
    - Hospitals report wait listing amongst substance providers due to capacity issues, leading to lengthy time between diagnosis and engagement.
- Actions:
    - Efforts were made to recruit additional SUD providers to accommodate need within service areas. Seven providers have agreed to contract and 3 have executed agreements.
- Barriers:

    - Members and community partners have shared SUD providers rarely answer the phone, resulting in an inability to schedule or participate in treatment.
- Actions:
    - Developed a process for sharing of data to identify individuals who have failed to connect to a provider. As a result, 217 members were connected to treatment after failing during initial engagement.
- Barriers:
    - In July of 2023 DHCS implemented the Behavioral Health Quality Improvement Program, incentivizing counties for meeting deliverables intended to improve HEDIS measures. Counties expressed an inability to identify when a member is admitted into an acute setting therefore limiting the ability to conduct screenings and interventions for multiple measures.
- Actions:
    - PHC and counties executed data sharing agreements and partnered to implement SacValley HIE, prioritizing real time exchange of behavioral health encounters in acute settings. To date 12 of 24 counties have signed participation agreements with Sac Valley, while 4 others are in early participation phases.

Measuring Effectiveness

As shared, our work in year primarily focused on the sustainability of the CA Bridge substance use navigation program. While the one-year funding provided by PHC seems to have improved by decreasing utilization within emergency departments by 57%, a longer term solution needs to be identified and implemented. DHCS has identified community health workers as a new version of substance use navigators and PHC will partner with hospitals to bridge the two programs.

The analysis presented an opportunity for further review of co-morbidities. Members with dementia averaged 15.2 claims per year, and 11.5 for members with TBI, both substantially lower than plan wide average. Questions loom regarding potential correlations and/ or the need to target recruiting of SUD providers who specialize in cognitive behavioral therapy.

Next Steps

- Implement new community health worker program within hospitals
- Gather additional data regarding admissions, readmissions, and acute length of stay, specifically with alcohol use disorder diagnosis
- Partner with counties to identify operational strategies for the use of data provided through SacValley HIE
- Continue work to identify and implement opportunities to bring services to the beneficiary whenever possible as to decrease limitations in engagement

Primary or Secondary Prevention Behavioral Healthcare Program Implementation

Measurement

The prevalence of eating disorder diagnoses and follow-up treatment within 90 days.

Relevance

Eating disorders are among the most difficult behavioral health disorders, with significant healthcare consequences and potential lifelong struggles. Without effective diagnosis and treatment of eating disorders:

- There is a demonstrated adverse effect on the quality of life that is greater, in many cases, than the effects of other severe behavioral health disorders such as schizophrenia or bipolar disorder.
- Anorexia nervosa has been linked to severe cardiac complications, with a mortality rate of 10%. These effects "include profound bradycardia, hypotension, decreased size of the cardiac silhouette and decreased left ventricular mass associated with abnormal systolic function. Patients with anorexia report fatigue and attenuated blood pressure response to exercise and reduction in maximal work capacity. An increased incidence of mitral valve prolapse without significant mitral regurgitation is also observed. Low potassium-dependent QT prolongation increases the risk of ventricular arrhythmia". (Facchini, 2006).
- "Malnutrition subsequent to self-starvation leads to protein deficiency and disruption of multiple organ systems, including the cardiovascular, renal, gastrointestinal, neurologic, endocrine, integumentary, hematologic, and reproductive systems". (Facchini, 2006).
- The physical consequences of bulimia nervosa are myriad, including loss of dental enamel and bowel irregularities, fertility problems, esophageal rupture, dehydration and metabolic disarray, heart failure and cardia dysrhythmias.
- National data shows that 95% of eating disorders start in individuals from 12 to 25. (In 2021, PHC had 161,572 members in this age range, representing 81,244 women and 80,329 men).
- Of those with an eating disorder, 50% have a co-occurring major depressive episode; there are also close associations with substance use disorders and substance misuse and other issues. Suicide and suicidal behaviors are also highly prevalent in populations of individuals with eating disorders.
- While the prevalence of eating disorders is lower in males versus females, the incidence in men is growing rapidly. Different screening and diagnostic tools may be required for men.

Goal

90% of those diagnosed with an eating disorder for the first time in 12 months will have a follow-up visit within 90 days.

Methodology

Data Source:	Claims and encounter data from both PHC and Carelon providers
Denominator:	Number of unique members diagnosed with an eating disorder for the first time in 12 months
Numerator:	Of those diagnosed, number of members who have a follow-up visit within 90 days of the diagnosis.
Measurement Period:	2020-2023 Calendar Years

Results

Timely Follow-up for those Diagnosed with an Eating Disorder for the First Time in 12 Months

Calendar 2020			Calendar 2021		
% Follow Up	# w/ follow-up w/in 90 days	# Diagnosed	% Follow Up	# w/ follow-up w/in 90 days	# Diagnosed
79.66%	376	472	78.05%	441	565
Calendar 2022			Calendar 2023		
% Follow Up	# w/ follow-up w/in 90 days	# Diagnosed	% Follow Up	# w/ follow-up w/in 90 days	# Diagnosed
76.73%	409	533	89.07%	375	421

Quantitative Analysis

Throughout 2020, 2021, and 2022 fewer than 90% of members diagnosed with an eating disorder received follow-up treatment within 90 days; 79.66% in 2020, 78.05% in 2021, and 76.73% in 2022, failing to meet the goal for those years. However, in 2023, 21% less cases were diagnosed in 2023 than in 2022, although still failing to reach the goal of 90% receiving follow-up treatment within 90 days. While it is uncertain the cause of the decrease in number of cases identified in 2023, history has indicated claims lag may influence the measure as Medi-Cal allows for billing up to 365 days' post service.

Of the 421 individuals newly diagnosed with an eating disorder in 2023, 9 were diagnosed in an acute (emergency room or inpatient) setting, with 6 receiving follow-up care within 90 days. Primary care and Carelon mental health services resulted in a larger quantity of diagnosis with similar follow-up outcomes with 369 of 412 receiving care within 90 days.

Qualitative Analysis

The intervention and associated activities appear to be effective, with a consistent number of members being diagnosed and treated within 90 days. The lack of access and associated barriers were initially identified in 2019, with interventions carried from 2020 through 2023.

Collaborative Activities

This was one of the two measures selected for further study and engagement. Activities and efforts to collaborate with counties and providers on this measure, and to address the various challenges associated with care for eating disorders.

In discussions with counties, providers and others (see Appendix for sample minutes) a variety of challenges were identified, including the providers' and plans' inexperience with this disorder due to the relative infrequency of its occurrence and the complexity of its diagnosis; the absence of a clear Medi-Cal provider structure to address the problem; and confusion due to the differing responsibilities to address eating disorders. The issue of eating disorders involves a range of providers, counties, and Medi-Cal health plans. Clients may be diagnosed in the primary care or outpatient behavioral health setting, but also in the hospital and in specialty mental health clinics. Over previous years providers from throughout PHC's networks and from each of our 14 County (specialty) Mental Health Plans reported their lack of familiarity with this disorder and difficulties in arranging for effective care.

In 2022 the Plan continued collaborative activities with providers and counties to break down barriers and identify opportunities for improvement for eating disorder services. This partnership has allowed for the following:

- Barrier:
    - Widespread knowledge of the detection, diagnosis, and treatment of eating disorders lacks throughout the region, and often county staff do not specialize in the disorder.
- Actions:
    - A series of meetings with other Medi-Cal managed care plans, with County Mental Health Plans, with eating disorder experts, and with primary care and behavioral health providers to discuss the prevalence and approaches to eating disorders.
    - Presentation of a series of webinars focused on the handling of eating disorders. The webinars have remained accessible to all via PHC's website.
    - Annual targeted trainings for PHC and county mental health plan staff presented by Dr. Erin Accurso, an eating disorder expert at UCSF, with the most recent hosted on February 28, 2024.
- Barriers:

    - Bottlenecks in access to care exist due to resistance from providers in accepting Medi-Cal clients due to rates, lengthy enrollment processes, and significant administrative oversight. Lack of access contributes to significant wait times from initiation to treatment often allowing for disengagement.
- Actions:
    - Strategies were identified to leverage Letter of Agreements (LOAs) with PHC for providers unwilling to enroll in Medi-Cal, ultimately building a "trust first" pathway to contracting. This process has allowed for a regional approach where providers have the opportunity to work with one entity (PHC) rather than 14 (individual counties).
- Barriers:
    - Referral pathways between and to PHC and counties were unclear, often causing confusion amongst the provider network as to who to coordinate treatment with.
- Actions:
    - Continued allocation of a single point of contact for providers and counties allowing PHC to identify more ED cases and address them sooner. This has allowed for added trust within the provider network throughout the coordination efforts. By now being engaged in all eating disorders requiring specialty services we have been able to improve tracking which allows assurance that beneficiaries are not slipping through the cracks.
- Barriers
    - Often the diagnosis and treatment of eating disorders is managed by PCPs due to lack of access to additional options, especially in rural communities.
- Actions:
    - PHC has continued to build the relationship with telehealth intensive outpatient programs intended to provide an alternative for higher acuity cases where transportation or access may be a barrier.

Measuring Effectiveness

As was discussed, our work appeared to lead to an improvement in the diagnosis and follow up of those with eating disorders, however it did take time for the interventions to show improvement. PHC plans to continue to offer trainings; recruitment support and an innovative "wrap around" telehealth program. The Plan also continues to identify resources to help providers care for clients with eating disorders, including as noted above, the use of an expert agency to review cases and help determine the appropriate level of care; providing incentives to providers to hire staff with eating disorder treatment experience; and working to add specialist providers to the network to help address this issue.

However, a total of 1991 PHC members have been diagnosed with any type of eating disorder in during our intervention period between 2020-2023. As was noted, 0.67% to 1.2% of women would be expected to develop anorexia nervosa (reflecting potentially between 544 to 975 female PHC members between 12-25 years of age in 2023) and about 0.1% of men (potentially 80 male PHC members between 12-25 years of age in 2023.). 0.6% of women aged 12 to 25 are predicted to have bulimia nervosa (upwards of 487 PHC members in 2023). While follow-up percentages near the goal of 90%, it is recognized the rate of new diagnosis is comparable to national data. PHC will focus on the early and

correct diagnosis of eating disorders, as well as the timeliness of the treatment after this diagnosis through collaborative activities with counties and community partners, providing tools to help providers diagnose eating disorders at early stages, provide specialists available for PCP consultation, more trainings for providers and encouraging continued outreach and prevention activities aimed at adolescents.

Next Steps

While existing interventions appear to be working, a period of sustainability and efficacy measurement will continue. PHC will strive to improve our work on behavioral and medical care coordination, focusing more closely on the diagnosis, treatment, and follow-up of substance use disorder and eating disorders. The upcoming work for each of these two factors will continue to involve data gathering and analysis with individual providers to supplement our understanding of the issues and barriers they face and how to address them most effectively.

Annual Utilization Management (UM) Program Evaluation

NCQA UM Standard 1 Element B

Evaluation Period
January 1, 2023 – December 31, 2023

Production Date: March 29, 2024

Prepared by: Tony Hightower, CPhT, Associate Director of UM Regulations
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Table of Contents

Related Reports:

1. Consistency in Applying Criteria Report – NCQA UM Standard 2 Element C
2. UM Timeliness Report – NCQA UM Standard 5 Element D
3. Provider Satisfaction Survey
4. Member Grievance and Appeals (G&A) PULSE Report

Executive Summary:

The Annual Utilization Management (UM) Program Evaluation analyzes all aspects of data related to the UM program, identifies gaps and opportunities for improvement, and updates the program as necessary to ensure the program remains current and appropriate. Key elements in this annual evaluation include program structure, program scope, processes, and information sources, as well as level of involvement of senior-level physicians and designated behavioral healthcare practitioners in the UM program. In addition, data for member and practitioner experience with the UM process is evaluated to identify improvement and actionable opportunities. This report does not contain Kaiser Permanente or Carelon Behavioral Health data for evaluation of the UM program. Kaiser Permanente and Carelon Behavioral Health are NCQA accredited, and as such, reports from Kaiser Permanente and Carelon Behavioral Health will be reviewed through delegation oversight.

Methodology / Data:

As outlined below, Partnership HealthPlan of California (PHC) collects all aspects of data related to the UM program and evaluates key elements and performance indicators of the UM program against its established goals and thresholds. From this evaluation, PHC determines if any gaps exist in particular program activities or structure, identifies opportunities for improvement, prioritizes those opportunities, and takes actions that will improve the UM program in order to better serve our members. The evaluation was conducted as a collaboration between UM, Pharmacy, Quality Improvement, Provider Relations, Member Services, and Grievances and Appeals.

Program Structure

- Physician to Nurse ratio
- Physician to Behavioral Health Nurse ratio
- Physician to Pharmacist ratio
- Staff to Treatment Authorization Request (TAR) ratio

Program scope, processes, and information sources used to determine benefit coverage and medical necessity

- Monitoring and evaluation of services and updates to policies and procedures (P&P), as appropriate, but at least annually
- Utilization Management activities to ensure appropriate care
- TAR timeliness
- Inter-Rater Reliability (IRR)
- Level of care

Level of involvement of senior level physician in the UM determination

- Advisory committee structure and participation

Member and Practitioner experience with the UM program

- Member Grievance and Appeals Pulse Report
- Provider Satisfaction Survey

I. PROGRAM EVALUATION

A. PROGRAM STRUCTURE

1. STAFFING OVERSIGHT

Physician to Nurse, Physician to Pharmacist, and Physician to Behavioral Health (BH) Nurse ratios are measured annually to evaluate the level of involvement of senior level physicians in the UM program. PHC establishes a minimum threshold of Medical Directors to Nurses at 1:5 (0.20) and Medical Directors to Pharmacists at 1:5 (0.20). PHC establishes a minimum threshold of Behavioral Health Clinical Directors to BH Nurse staff at 1:5 (0.20). A ratio falling below PHC's established threshold will require an evaluation of the current staffing structure and UM processes to determine if changes will be implemented. Staff count is an average of the total number of FTEs in each staff category at the end of each month.

Staffing Oversight												
2023	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Nurses	44	44	44	44	44	43	40	40	37	41	46	44
Pharmacists[1]	7	7	7	7	7	7	5	5	5	5	5	5
MDs	**11**	**11**	**11**	**11**	**11**	**11**	**11**	**11**	**11**	**12**	**12**	**12**
MD: Nurse Ratio	0.25	0.25	0.25	0.25	0.25	0.26	0.28	0.28	0.30	0.29	0.26	0.27
MD: Pharmacist Ratio	1.57	1.57	1.57	1.57	1.57	1.57	2.20	2.20	2.20	2.40	2.40	2.40
BH Nurse	1	1	1	1	1	1	1	1	1	1	2	2
BH Clinical Director	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
BH MD: BH Nurse Ratio	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0.50	0.50

[1]Includes only Pharmacists who perform TAR reviews.

PHC's Physician to Nurse, Physician to Pharmacist, and Physician to BH Nurse ratios all met the threshold goal of 1:5 (0.20) in 2023.

2. STAFFING WORKLOAD

Staff-to-TAR ratios are measured and monitored monthly to evaluate the level of staffing to ensure PHC has adequate and appropriate staffing to meet the daily workload demands and comply with standards and requirements set forth by PHC policy and procedure.

The UM and Pharmacy departments monitor and evaluate TAR to FTE ratios to assess staffing adequacy. A 20% change in the month-over-month ratio is established as the UM and Pharmacy Departments' threshold for further assessment of staffing model and to determine if an intervention is necessary. Calculation used is the month to month difference between TARs/staff/day divided by TARs/staff/day from the preceding month. Example below is inpatient number for TARs/Nurse/day in June = 10.5 and July = 12.5. The month to month change is 2/10.5 = 0.19 or 19%.

NOTE: Due to the relatively low volume of Wellness & Recovery (Behavioral Health) TARs and small number of reviewers, that category of reviews is excepted from the 20% threshold standard.

Utilization Management:

Inpatient TARs – All Regions												
2023	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Nurse FTE (Inpatient)	13	13	14	14	14	14	13	11	10	12	14	15
Total TARs	3463	3090	3413	3114	3469	3229	3258	3387	3263	3399	3393	3275
Working days	20	19	23	20	22	22	20	23	20	22	20	19
TARs per nurse per day	**13.3**	**12.5**	**10.6**	**11.1**	**11.3**	**10.5**	**12.5**	**13.4**	**16.3**	**12.9**	**12.1**	**11.5**

Outpatient TARs – All Regions												
2023	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Nurse FTE (Outpatient)	24	24	23	23	23	23	22	23	23	24	27	23
Total TARs	15069	14584	17336	14729	17287	15884	15326	17852	15225	17144	15568	14468
Working days	20	19	23	20	22	22	20	23	20	22	20	19
TARs per nurse per day	**31.4**	**32.0**	**32.8**	**32.0**	**34.2**	**31.4**	**34.8**	**33.7**	**33.1**	**32.5**	**28.8**	**33.1**

SNF/LTC TARs – All Regions												
2023	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Nurse FTE (SNF/LTC)	7	7	7	7	7	6	5	6	4	5	5	6
Total TARs	1450	1185	1346	1058	1324	1245	1109	1291	1119	1231	1092	1076
Working days	20	19	23	20	22	22	20	23	20	22	20	19
TARs per nurse per day	**10.4**	**8.9**	**8.4**	**7.6**	**8.6**	**9.4**	**11.1**	**9.4**	**14.0**	**11.2**	**10.9**	**9.4**

Wellness & Recovery (Behavioral Health) TARs – All Regions												
2023	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
BH RN FTE (SUD)	1	1	1	1	1	1	1	1	1	1	2	2
Total TARs	114	110	115	100	115	123	146	141	118	150	130	121
Working days	20	19	23	20	22	22	20	23	20	22	20	19
TARs per RN per day	**5.7**	**5.8**	**5.0**	**5.0**	**5.2**	**5.6**	**7.3**	**6.1**	**5.9**	**6.8**	**3.3**	**3.2**

For calendar year (CY) 2023, the UM department processed a total of 246,234 Treatment Authorization Requests (TARs) that included requests for outpatient settings, inpatient acute hospital settings, durable medical equipment, skilled nursing/long term care facilities, and residential treatment for substance use disorders (SUD). This is a 10.74% increase in total TAR volume compared to CY 2022. On a business daily average, PHC's UM department processed 985 TARs. Nurse and BH Nurse full-time employees (FTEs) are defined by the total number of FTEs at the end of the month. Partial FTEs are the result of leave of absence and/or cross-coverage of staffing over different review types. TARs per staff ratios are expressed as the daily average of TARs per nurse FTE.

For UM staffing adequacy, a month-to-month TAR to FTE ratio outside of the 20% variance threshold was identified for the months of July through October for both Inpatient TARs and SNF/ LTC TARs. For Inpatient TARs, the variance was driven by a decline in staff from July to September due to leaves of absence, followed by an increase in staff for October. For SNF/LTC TARs, the variances were driven by a combination of fluctuations in TAR volume coupled with staff leaves of absence. Interventions by the UM team in addressing these variances have included continuing a multi-year effort of cross-training UM nursing staff for timely coverage across review categories, the hiring of temporary staff, as well as requisitioning permanent positions to address staffing gaps.

Pharmacy:

Pharmacy TARs – All Regions												
2023	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Total TARs	653	582	740	613	649	649	577	647	536	679	623	554
Working days	20	19	23	20	22	22	20	23	20	22	20	19
Tech FTE[1]	5	5	5	5	5	5	5	5	4	4	4	5
TARs per Tech per day	**6.5**	**6.1**	**6.4**	**6.1**	**5.9**	**5.9**	**5.8**	**5.6**	**6.7**	**7.7**	**7.8**	**5.8**
RPh FTE[1]	7	7	7	7	7	7	5	5	5	5	5	5
TARs per RPh per day	**4.7**	**4.4**	**4.6**	**4.4**	**4.2**	**4.2**	**5.8**	**5.6**	**5.4**	**6.2**	**6.2**	**5.8**

[1]Includes only staff who perform TAR reviews.

Pharmacy Technician and Clinical Pharmacist full-time employees (FTEs) are defined by the total number of respective FTEs at the end of the month. TARs per staff ratios are expressed as the daily average of TARs per Technician and Pharmacist FTE.

For CY 2023, PHC's Pharmacy department processed a total of 7,502 TARs, which includes requests for Physician Administered Drugs (PADs). This is a 3.21% decrease in total TAR volume compared to CY 2022. On a business daily average, PHC's Pharmacy department processed 30 TARs.

For Pharmacy staffing adequacy, a month-to-month TAR to RPh FTE ratio outside of the 20% variance threshold was identified from June to July. In July, there was a significant decrease in RPh staffing which accounts for this variance. A month-to-month TAR to Tech FTE ratio outside of the 20% variance threshold was identified from November to December. The variance was driven by decreased TAR volume in December as well as hiring of new Technician staff. Department leadership continued to monitor timeliness and inter-rater reliability (IRR) on a quarterly basis to ensure the Pharmacy department had adequate staffing levels to meet daily workload demands.

3. EVALUATION OF THE PHC ADVISORY COMMITTEE STRUCTURE

Physician Advisory Committee (PAC)

The PAC is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to PHC members. The PAC reviews the activities of the Quality/Utilization Advisory Committee (Q/UAC), Pharmacy and Therapeutics (P&T) Committee, the Quality Improvement Program (QIP) Advisory Group, the Pediatric Quality Committee (PQC), and the Credentials Committee. The PAC then makes recommendations and assists PHC in other ways as defined in PHC's policies and procedures. The PAC meets at least ten (10) times a year, and may not convene in the months of July or December, with the option to add additional meetings if needed. Only committee members who are not PHC staff may vote. The Chief Medical Officer (CMO) serves in a tie breaking capacity as necessary. A quorum is the majority of members of the committee or subcommittee, as described in the PHC by-laws. Committee attendees include practicing physicians from Kaiser Health Systems, NorthBay Healthcare, and other medical centers. PHC monitors and evaluates meeting the quorum to ensure the UM program and policies are reviewed and approved by this PHC advisory committee in compliance with PHC policies and procedures.

2023	JAN	FEB	MAR	APR	MAY	JUN	AUG	SEPT	OCT	NOV
Total voting members in attendance	12	11	9	10	11	9	10	11	12	12
Total voting members	13	13	13	13	13	13	13	13	13	16
Quorum	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

A total of 10 PAC meetings were held in 2023. Quorum requirements were met for all 10 meetings. Review of the committee's activities confirm it executed the responsibilities of its functions. No further action or change to this aspect of the program was deemed necessary.

Quality/Utilization Advisory Committee (Q/UAC)

The Q/UAC is responsible for monitoring the quality of medical care and services provided to PHC members. The Q/UAC annually reviews, recommends, and approves the UM Program Description submitted by the UM section of the Health Services (HS) Department and provides recommendations to the PAC. The Q/UAC meets at least 10 times a year and may convene in the months of July or December if needed. The Q/UAC is chaired by the PHC Chief Medical Officer (CMO) and is comprised of formal voting representatives from community primary and specialty care practices, as well as consumer representative(s). The physician members represent licensed providers from hospitals, medical groups, and practice sites in geographic sections of PHC's service area. The consumer representative(s) must be a consumer from one of the counties served by PHC. A quorum is the majority of members of the committee or subcommittee as described in the PHC by-laws. Voting members with annual attendance of less than 50 percent are evaluated for termination from the Q/UAC. PHC monitors and evaluates meeting quorum to ensure the UM program and policies are reviewed and approved by this PHC advisory committee in compliance with PHC policies and procedures.

2023	JAN	FEB	MAR	APR	MAY	JUN	AUG	SEP	OCT	NOV
Total voting members in attendance	11	7	11	11	8	9	9	10	10	9
Total voting members	12	12	12	12	12	12	12	11	9	9
Quorum	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

A total of 10 Q/UAC meetings were held in 2023. Quorum requirements were met for all 10 meetings. Review of the committee's activities confirms it executed the responsibilities of its functions. No further action or change to this aspect of the program was deemed necessary.

Pharmacy & Therapeutics Committee (P&T)

The P&T Committee is chaired by PHC's Chief Medical Officer (CMO), or designee such as the Director of Pharmacy, and is comprised of PHC's Pharmacy Director, Associate and Regional Medical Directors, PHC staff, and practicing members from the community including pharmacists, primary care physicians, behavioral health and other specialists. P&T makes decisions and recommendations on development and review of Physician Administered Drugs (PADs) provided under the medical drug benefit, medication policy and procedures, and drug approval criteria. P&T Committee also serves as PHC's Drug Utilization Review (DUR) Board to review PHC's DUR program and activities and make recommendations where necessary to improve PHC's drug utilization. The P&T meets quarterly, providing regular activity reports and recommendations to the PAC, the approval authority for P&T related activities. A quorum, defined by one-third of the practicing members from the community, must be present in order to conduct the P&T Committee meeting. A consensus recommendation is made on drug coverage changes and drug/benefit policies. If no consensus is established, the issue is voted on with the decision determined by majority vote of the voting membership. Voting membership includes the practicing members from the community, PHC CMO, PHC Medical Directors, PHC Director of Pharmacy, PHC Manager of Clinical Pharmacy and PHC Clinical Pharmacists.

2023	January	April	July	October
Total # of Practicing Members in Attendance	4	2	4	3
Total # of Practicing Members	8	6	6	7
Quorum	Yes	Yes	Yes	Yes

A total of four P&T meetings were held in 2023. Quorum requirements were met for all four meetings. Review of the committee's activities confirms it executed the responsibilities of its functions. No further action or change to this aspect of the program was deemed necessary.

B. PROGRAM SCOPE

1. POLICY REVIEW

The UM and Pharmacy Departments review each policy at least annually and are therefore compliant with PHC policy and regulatory requirements. No additional actions needed at this time.

For 2023, the UM Department had 80 policies which encompass both behavioral and non-behavioral healthcare. Of those 80 policies, 51 policies did not have substantive revisions and were approved as consent. 29 polices had substantive revisions that were reviewed and approved by the respective external advisory committee.

For 2023, the Pharmacy Department had seven policies. Of those seven policies, five policies did not have substantive revisions and were approved as consent. The remaining two polices had substantive revisions that were reviewed and approved by the respective external advisory committee.

Department	Policies	Policies reviewed for consent	Policy revisions approved
UM	80	51	29
Rx	7	5	2

C. PROGRAM PROCESS

1. UM TIMELINESS FOR NON-BEHAVIORAL AND BEHAVIORAL DECISIONS AND PHARMACY TIMELINESS

(Reference*: NCQA Utilization Management Standard 5 Element D report*)**

UM and Pharmacy monitored timeliness compliance on a quarterly basis to evaluate performance and identify opportunities for operation and reporting improvements. Below are the 2023 results, interventions and ongoing activities by UM and pharmacy to address identified gaps and opportunities.

Summary of Results:

- UM non-behavioral health achieved 87.89% annual compliance toward NCQA notification timeliness standards.
- UM behavioral health had no denial decisions for 2023 and scored N/A toward NCQA notification timeliness standards.
- Pharmacy achieved 99.04% annual compliance toward NCQA notification timeliness standards.

UM: UM did not meet the 95% timeliness goal for non-urgent pre-service and post-service requests in 2023. Timeliness goals were met for urgent concurrent and urgent pre-service requests.

In 2023, the UM department experienced staffing and leadership turnover challenges for Q2-Q4. These challenges primarily impacted UM's ability to comply with the timeliness goal for non-urgent pre-service requests, which is UM's largest review category by volume and the chief overall driver for timeliness compliance in 2023. UM has pursued, and continues to pursue, the following remedies in order to mitigate risk to overall timeliness:

- Hiring of permanent nursing staff in order to address work volume in excess of budgetary projections.
- Hiring of temporary staff to address staffing gaps created by leaves of absences.
- Adjustments to UM workflows to remove barriers created by nurses working only in specific review categories and provide cross-training across the review continuum. This will allow nursing staff to effectively respond to fluctuations in TAR volume and staffing levels on a daily basis.

Pharmacy:
Pharmacy did not meet the 95% timeliness goal for urgent pre-service requests in 2023. Timeliness goals were met for non-urgent pre-service and post-service requests. No urgent concurrent requests were reviewed in 2023.

In 2023, the Pharmacy department experienced a high turnover of experienced staff and leadership. In Q3, there was a significant reduction in Pharmacist staffing primarily as a result of the carve-out of the pharmacy benefit to Medi-Cal Rx in January 2022. To mitigate risk to timeliness, the Pharmacy department implemented the following changes to the TAR review workflow process:

- During periods of high TAR volume, the Pharmacy Technician assigned to manage the queue screened TARs for any requests that may require medical necessity review and send these TARs directly to the pharmacists' queue for review.
- Queue management technician assigned TARs to technicians based on order of urgency.
- The list of medication(s) to be reviewed for each TAR are included in the M2 technician email to allow for more efficient queue management.

Both the UM and Pharmacy departments plan to continue to closely monitor and evaluate timeliness performance and data integrity, and will provide quarterly reports to leadership for update and review.

2. CONSISTENCY OF APPLYING UM CRITERIA

(Reference*: NCQA Utilization Management Standard 2 Element C Report*)**

The organization uses a methodology of 5% or 50 TARS, whichever is less, for each staff member to test inter-rater reliability (IRR). For 2023, 50 TARs per reviewer pursuant to PHC Policy MPUP3026 (including appeal cases where indicated on PHC's P&P) were reviewed by each nurse coordinator, pharmacy technician, pharmacist, and physician for IRR.
The IRR concurrence rate by reviewer type is as follows:

- Nurse Reviewers: 2,217 TAR cases were reviewed with a total concurrence rate of 95.44%.
- Behavioral Health Nurse Reviewers: 70 TAR cases were reviewed with a total concurrence rate of 97.14%.
- Physician Reviewers: 674 TAR cases were reviewed with a total concurrence rate of 97.48%.
- Pharmacist Reviewers: 306 TAR cases were reviewed with a total concurrence rate of 99.35%.
- Pharmacy Technician Reviewers: 218 TAR cases were reviewed with a total concurrence rate of 98.62%.

2023 Results:
PHC met the 90% concurrence score goal for all reviewer types. No additional action is required.

3. APPROPRIATE CARE: MONITORING FOR OVER/UNDERUTILIZATION

2023 Summary of Over-/Underutilization Workgroup Activities

February, 2024

Summarized by Robert Moore, CMO

Overview:

PHC has systematic processes for monitoring for over-utilization and under-utilization of services (see Appropriate Service and Coverage Policy MPUP3006 and UM Program Description MPUD3001 for details). Evaluation and analysis of the availability of primary care and specialty care providers and accessibility of primary care and specialty care services are evaluated as part of the network adequacy and availability section of the QI evaluation, following DHCS and NCQA standards. The Over-/Under-utilization Workgroup evaluates available data on PCP utilization to determine if any apparent under-utilization is associated with capitation of providers (versus due to data incompleteness). Specialty utilization patterns are addressed in the Access and Availability Grand Analysis (part of the annual QI evaluation), and as a separate report on follow-ups for specialty referral, presented to IQI and Q/UAC each January.

The under-utilization of preventive care is initially identified in two ways: results of annual quality data reporting (HEDIS® measures and some others); and medical record reviews conducted periodically at each PCP and prenatal care sites. HEDIS® results are reviewed by the quality committees (IQI and Q/UAC) and governance committees (PAC and Board). The HEDIS® Measure Improvement Workgroup prioritizes interventions to improve HEDIS® measures and monitors these interventions and the NCQA Steering Committee oversees these efforts. Preventive healthcare deficiencies identified through the site review process are addressed with corrective action plans, or other actions as detailed in the Site Review Requirements and Guidelines Policy MPQP1022. Additional analysis of selected preventive care measures that are under-utilized is also presented at each Over-/Under-utilization Workgroup meeting.

Over-utilization of clinical activities/procedures may be prevented through the overall prior authorization process for Pharmacy, inpatient hospital, long-term care, skilled nursing, durable medical equipment etc. The potential and propensity of health care providers to over-utilize a service is a factor for deciding which services/medications etc. are subject to prior authorization; cost is the other major factor that is considered. The policies and standards which define prior authorization criteria are designed to assure medically necessary use without overuse. Surveillance for over-utilization of medications/services/equipment that do **not** require prior authorization is conducted by the Medical Directors, Nurses and Pharmacists when reviewing clinical records for other purposes (in the UM/Pharmacy prior authorization, peer review, HEDIS® data abstraction, medical record review, fraud/waste/abuse (FWA) reporting and grievance processes). Individual instances of potential over-utilization are noted and potentially addressed with the individual clinician (depending on the certainty of over-utilization by the reviewer and the implications of the over-utilization). If a systematic or more global over-utilization is suspected, the CMO or designee is consulted. Based on the review by the CMO or designee, data analysis related to the potential over-utilization will be conducted and the results presented at the Over-/Under-utilization Workgroup. In addition, systematic reviews of hospital-based care metrics are reviewed for patterns of potential overuse. Actions based on the over-

utilization depend on the circumstances but may include referral to the FWA, Peer Review, Credentialing, and/or quality committees.

Summary of Over-/Under-utilization Workgroup Analyses for January 2023 through December 2023.

Meeting dates in 2023: January 30, May 8, July 26 and October 31.

Analysis of PCP visits for under-utilization is conducted at each meeting. The average number of billed visits per capitated member per year is calculated for each PCP site and is evaluated from different perspectives at different meetings.

The January meeting looked at overall trends in PCP visit patterns as affected by the COVID pandemic. Average PCP visit rates in 2022 remain lower than in 2019, but improved from 2021. The rates may also be depressed artificially by the pause in redetermination, which would inflate the denominator.

The May and July meetings broke out the year end 2022 data by individual PCP site. Outliers with low visits per member recorded were Sutter Medical Group, Solano (repeat from last year), likely due to under-reporting, not true under-utilization. Other outliers with low visits are Solano County Health Services, Lake County Tribal Health both due to low utilization due to access challenges mainly due to a shortage of Primary care providers. These are both FQHCs have no financial motivation to avoid providing care due to the PPS system. Both are part of the Quality department's Leadership Engagement process.

Effects of COVID-19.

The COVID-19 Pandemic had a significant effect on the supply and demand for PCP visits through 2022, with an increase in virtual visits (largely telephonic), which varies by providers. This has led to a notable decrease in well child visits, vaccination visits, lead screening rates and most quality parameters. This global under-utilization due to COVID-19 is mediated in a variety of ways: decreased staff, offices closed or with decreased availability of in-person visits. One notable exception: use of mental health services increased for PHC during the pandemic, reflective of national trends.

Telemedicine utilization in 2022 was summarized in the May Meeting, with the highest rates in Napa and Sonoma Counties (rates 29.7% of PCP visits ad 27.1% respectively), and the lowest rates were in Trinity and Modoc Counties at 2% and 2.9% respectively. Telemedicine utilization fell over the course of 2022.

Specialty Office visit rates were reviewed in the May meeting, with overall use of specialists falling in 2022, from a high in 2021. Compared to a well-managed benchmark, rates of specialist under-utilization were lowest in otolaryngology (25%), Dermatology (31%), and Endocrinology (32%), the latter two of which are lower in the Southern Region, where specialty telemedicine use was lower.

Preventive care metrics reviewed for under-utilization in this time period are:

- Childhood Immunization Status, as reflected by CIS-10. Vaccination rates declined in 2022, relative to 2020 and 2021. The major driver for this was the active COVID-19 pandemic. Rates were especially low in the Northern Region, driven largely by the low vaccination in the White population, with different framing of vaccination exacerbated during the rollout of the COVID-19 vaccines in 2021.
  Interventions for childhood vaccination include: Media messages in some markets, provider education, and partnering with sites on QI projects, eReports tools and dashboards, and participation in DHCS affinity workgroup. This measure is part of the PCP QIP.
- Cervical Cancer Screening (reviewed in May): improved in 2022 compared to 2021, with lower performance in the northern counties compared to the southern counties. Rates were lowest in the self-identified Native American population, in the northern counties, and in the Korean and Guamanian population in the Southern counties.
  Interventions include PDSA cycles as part of DHCS mandated improvement plans, provider trainings and provider engagement efforts. A pilot of self collection of HPV tests for screening was approved to be done in 2023-24.
- Breast Cancer Screening: Breast cancer screening rates have improved in 2022, with three of four reporting regions above the 50th percentile.
  Interventions: In 2022 and 2023: promoting and expansion of mobile mammography availability, especially in remote and rural areas. This measure remains part of the PCP QIP.

Other evaluations for potential under-utilization included:

- ~~Rapid strep~~ T~~t~~esting for streptococcal infection before treating pharyngitis with antibiotics is an NCQA HEDIS® measure. Performance is low in all regions, probably exacerbated by the increased use of virtual visits, where such tests cannot be done. Educational content and data feedback to PCP leaders was done to help encourage appropriate testing processes.
- Blood lead testing was evaluated by county. Screening rates are below national levels in all areas, have increased each year through 2019, but considerable under-utilization in the North eastern counties is noted. Rates of screening dropped slightly in 2020 and 2021, due to preventive visit decreases associated with COVID-19, but began to rise again in 2022. Additional educational activities done by PHC and increased monitoring/compliance activities through the site review process. Additionally, this measure was added to the PCP QIP for 2022, and was made into a core measure set measure in 2024.
- Tobacco Screening and referral to treatment rates appear low, but this service is frequently not coded as part of the PCP visit. It was added as a unit of service measure in 2020, and the rate increased that year, but has since stabilized. DHCS was tracking this measure from two years in 2020 and 2021, but has removed it from their pediatric dashboard in late 2023.

- Rate of Fluoride Varnish Treatment rates decreased from a high in 2019, and throughout the pandemic, with a minimal recovery in 2022 over 2021, largely because one provider that was doing a lot of fluoride varnish applications before the pandemic has not really restarted. This is a Unit of Service QIP measure. Partnership has a dental hygienist who educates primary care practices on the use of fluoride varnish in the office.
- Vasectomies: While the number of ~~men~~ members who had vasectomies increased steadily from 2020 to 2022, the rate is very uneven, with high rates in Lassen and Humboldt counties and low rates in Shasta and Siskiyou Counties. Investigation showed low numbers of providers trained to offer vasectomies in these latter counties; the rate is dependent on the training and experience of the physicians practicing in the area.
- Opioid Overprescribing. Data from Magellan were analyzed, showing an increasing rate of prescription of opioid pain medication in 2022 over 2021: 16.6% increase in unique members with opioid utilization, 8.8% increase in unique members PMPM, and 14% increase in total MED prescribed, all reversing the gains achieved when Partnership had control over the pharmacy benefit for our members. The State DUR was notified of this, but no changes in prescription policies are known to have taken place within MediCal Rx.
- Mental health utilization: PHC's level of mental health utilization ranks among the highest of all managed care plans in California, but the level still is below the underlying need of the population. Mental health conditions are treated in many settings: the PCP office, by Carelon-credentialed mental health providers, and by county mental health plans. The percentage of unique members receiving mental health services fell slightly in the PCP setting, county mental health setting, and Carelon (mild to moderate mental health), but rose for prescription rates. Providers have largely adapted to the use of virtual visits for mental health. These decreased rates may be artificial, due to a higher denominator of non-utilizers due to the lack of redetermination.
- Vaccination in Pregnancy (Flu and TDAP): rates were rising in 2023 compared to 2022. Rates are lower in Modoc and Siskiyou counties. This is part of the perinatal QIP, and the results are shared with PCP medical directors, perinatal providers, and public health officers each year.

Analyses for potential over-utilization that were presented at the Over-/Under-utilization Workgroup include the following:

An annual review of hospital utilization was conducted in January and reviewed again in May with an additional data source for Hospital ADT Data. Major findings were a small decrease in Average Length of Stay (ALOS), but hospital admission rates remain steady.

Specific comparison of capitated hospitals, who are responsible for their own utilization management, and non-capitated hospitals (where PHC does UM), showed that hospitalization rates appeared to be lower at Queen of the Valley Hospital and Woodland, and medium at Adventist Hospitals, Marin and NorthBay.

Emergency Department Utilization: The overall trend is an increase in ED utilization from 2021 to 2022, although the 2022 levels were still below the pre-pandemic levels. Modoc continues to

have the highest rates of ED utilization, since no outpatient practices are open after hours and no providers take call. Marin and Yolo counties have the lowest rates, reflecting a robust after hours call system. ED utilization is highest in the Native American population and homeless populations. The #1 ED diagnosis in 2022 was still COVID-19.

Evaluations of potential areas of over-utilization

1. In January, the rate of bunionectomies for different practices was evaluated. No single provider was a major outlier.
2. ER visits with CT scans was reviewed in the October meeting. The trend has changed over the years; currently the highest rates are UC Davis Medical Center, Sutter Santa Rosa, St. Elizabeth's Hospital in Red Bluff and Mercy Redding (latter two serviced by the same ED staffing group). The lowest rates where in Ukiah Valley Adventist Hospital, Queen of the Valley Hospital, and several small rural hospitals. Overall rates fell from 2021 to 2022; these will continue to be monitored with feedback given to the ED groups where the rates are highest.

Areas of over-utilization with ongoing activities

- C-Section rates and other maternity measures by hospital were reviewed for 2021 data, and some hospitals were found to have relatively higher levels of NTSV (nulliparous, term, singleton, vertex) C-section rates. Interventions: This measure is part of the hospital QIP. Educational interventions of major OB providers by the perinatal provider education workgroup at PHC highlighted differences.

D. INFORMATION SOURCE USED TO DETERMINE BENEFIT COVERAGE AND MEDICAL NECESSITY

PHC uses the most currently available InterQual® Criteria sets as the primary review guidelines for UM medical necessity decisions. For calendar year 2023, UM used the 2022 InterQual decision criteria until the 2023 version became electronically available.

InterQual® criteria and other approved UM criteria outside of InterQual®, are reviewed, discussed, and evaluated at PHC's Q/UAC and PAC as described in policy MCUP3139 Criteria and Guidelines for Utilization Management. Criteria utilized include, but are not limited to, Medi-Cal (State of California) guidelines, Medicare criteria, State policy letters, national treatment guidelines, and clinical practice recommendations from UpToDate®. UM criteria are also reviewed at the monthly internal CMO/MD meeting attended by the CMO and Medical Directors, leadership from UM, Population Health, Care Coordination, Quality, Pharmacy, and Grievances & Appeals, as well as ad hoc specialists in the appropriate field of the policies being developed.

In addition, PHC's medication decision criteria and pharmacological drug classes are reviewed in collaboration with external and internal providers on an on-going and annual basis. Criteria are selected, reviewed, updated or modified using feedback from the PHC staff, the P&T Committee, the PAC, the Consumer Advisory Committee (CAC), external providers, State policy letters, or medical

literature among other sources.

Summary: UM and Pharmacy criteria are timely and comprehensively reviewed. No change to this aspect of the program was deemed necessary.

E. INVOLVEMENT OF SENIOR LEVEL PHYSICIANS IN THE UM PROCESS

PHC's CMO and Medical Directors actively participate in the monthly review, discussion, and approval of policies and procedures in PHC's IQI, P&T, and Q/UAC Committees. Policies approved in IQI, P&T, and Q/UAC are presented at PAC where attending network practitioners and PHC's CMO and Medical Directors discuss and approve the presented policies. The CMO and Medical Directors also actively participate in clinical rounds and perform UM review and decisions to fulfill their assigned responsibilities for their scope of work. PHC delegates the behavioral health UM process to NCQA Accredited organizations. However, PHC has a designated Behavioral Health Clinical Director who actively participates in PHC's UM Program. PHC's committees also include network behavioral health practitioners who actively participate and contribute to PHC's UM Program. Throughout the year, PHC's UM Program demonstrated practitioners were actively involved in key aspects of the UM program, and therefore no further action is needed.

F. ASSESSING EXPERIENCE WITH THE UM PROCESS

1. IMPROVING PRACTITIONER EXPERIENCE WITH THE UM PROCESS

PHC contracts with an external entity, Press Ganey (PG), to administer the Physician Satisfaction Survey annually. All contracted Primary Care Provider (PCP) sites and Specialists were surveyed across PHC's Northern and Southern Region network. A total of 250 physician/specialist surveys were completed from May 30 – June 5, 2023. The response rates for the two types of providers are as follows: PCPs 43%, Specialists 49%.

PHC establishes a minimum threshold of 90% satisfaction and tracks and trends variations greater than 5% from the preceding year.

Please refer to Appendix I for Physician Satisfaction Survey Data.

Summary of PCP Outcomes:

- All UM and Pharmacy questions among PCPs met their respective goal of 90% for strongly agree or agree. No further interventions needed.

Summary of Specialist Outcomes:

- Three UM questions among Specialists did not meet the 90% goal for strongly agree or agree:
  1. "I know how to determine whether or not a service requires that TAR (Authorization) be submitted to PHC." (89%)
  2. "My TARs are approved in a timely manner." (85%)
  3. "When a TAR for medical service is denied by the plan, the basis for denial is clearly specified." (84%)

Interventions:
The PHC UM Department has implemented the following interventions to address the Specialist Outcomes listed above that did not meet threshold:

1. PHC UM makes available comprehensive listings of TAR requirements. A gap in provider education was identified as a potential root cause and driver of this result. Over the past year, UM has engaged with the Provider Relations team in educating network providers about PHC's online resources available on our website, including UM policies and TAR requirements.
2. PHC UM experienced a high turnover of experienced staff, which resulted in an influx of newer, untrained staff during 2023. This resulted in the UM team experiencing periodic challenges in meeting timeliness requirements for UM decisions. UM Leadership has taken the following actions in addressing overall timeliness concerns:
    a. Hiring of permanent nursing staff in order to address work volume in excess of budgetary projections.
    b. Hiring of temporary staff to address staffing gaps created by leaves of absences.
    c. Adjustments to UM workflows to remove barriers created by nurses working only in specific review categories and provide cross-training across the review continuum. This will allow nursing staff to effectively respond to fluctuations in TAR volume and staffing levels on a daily basis.
3. PHC UM experienced a high turnover of experienced staff, which resulted in an influx of newer, untrained staff during 2023. The result presented UM with challenges in addressing quality control issues identified for newly trained staff. UM Leadership conducts daily, weekly, and quarterly monitoring of denial notifications sent to providers to ensure that all DHCS and NCQA-required elements are present in denial letters. In the event that elements are not included, UM Leadership works with staff on education and re-training on requirements.

Conclusion:
The results from the 2023 Physician Satisfaction Survey revealed opportunities to improve provider satisfaction with PHC's UM process. UM and Pharmacy departments will continue to monitor survey results annually and provide interventions as needed.

2. MEMBER EXPERIENCE WITH THE UM AND PHARMACY PROCESS

This portion of the program evaluation was provided by the Grievance and Appeals (G&A) department through the G&A PULSE Report. The report contains an analysis of member-reported Grievance concerns about any dissatisfactory experience related to Utilization Management (UM). If the number of grievances per 1,000 members in the current period (2023) increases by more than 10% from the previous period (2022), then the Threshold is triggered. An unmet NCQA Threshold identifies growing areas of member dissatisfaction and intervention(s) may be required.

Despite an increase in PHC's membership and the total number of cases received in 2023, there was a decrease in the number of grievances related to the UM process overall. In 2023, a total of 205 concerns were reported regarding the UM process, compared to 222 concerns in the previous year.

Because of this decrease, PHC did not exceed the threshold in any category in 2023.
The primary issue reported concerning the UM process was access-related issues. Notably, 65.4% of these access-related issues were associated with PHC's Referral Authorization Form (RAF) process, while the remaining 34.6% were linked to the Treatment Authorization Request (TAR) process.

Among the reported issues within the referral process, delays by providers was the most reported concern. Members alleged that their primary care providers were delaying submission of RAFs, consequently causing delays in obtaining appointments with specialists. Upon investigation of these 97 cases, G&A determined that the provider was at fault in 37 of the reported Grievances.

The most prominent driver behind member dissatisfaction with the TAR process was related to providers delaying submission of TARs to PHC. Upon closer examination of the TARs, it was found that 35.0% were for imaging services, while 22.5% were for Durable Medical Equipment (DME). Following investigation of these TAR-related concerns, G&A determined that the provider was responsible in 15 reported grievances.

Upon review, G&A leadership found no discernible trends in providers delaying RAF and TAR requests.

Additionally, after examining the 15 grievances related to RAFs and TARs delayed or refused by PHC, no opportunities for improvement through system changes or UM staff training were identified, as it was concluded, following investigation, that PHC did not cause delays in the UM process.

Please refer to Appendix II for further details of member satisfaction data for 2023.

II. Conclusion:

The UM Program Evaluation report assesses the program's effectiveness, capacity, and integrity in managing the utilization of healthcare resources delivered to our members and ensures our members receive the appropriate quality and quantity of care at the appropriate time and setting. In addition, the evaluation report identifies gaps and improvement opportunities for which interventions are developed.

In this evaluation, the results demonstrated strengths in the areas of consistency in applying criteria, comprehensive review of information sources, program structure and others. Opportunities were identified in improving TAR timeliness.

Based on the results from the 2023 UM program evaluation, PHC concludes there are no significant changes required for the UM program. PHC's UM program functions effectively and efficiently through a solid program structure, comprehensive set of policies, and robust support, guidance, and engagement from senior level physicians and advisory committee members. Activities addressing the improvement opportunities will continue to be monitored, measured, and reported in future

evaluations.

APPENDIX I: Improving Practitioner Experience with the UM process

Key:

- ≥5% Improvement relative to prior year
- ≥5% Decline relative to prior year
- n= total respondents

Trended PCP Regional and Plan-wide Performance on the Physician Satisfaction Survey

PCP (% Strongly Agree or Agree)	2022			2023			% Difference			
	North (n=66)	South (n=148)	2022 Total	North (n=23)	South (n=86)	2023 Total	North	South	2023 Goal	2023 Performance Goal Met
I am satisfied with my interactions with UM Staff.	100%	97%	98%	95%	99%	98%	-5%	2%	90%	Yes
I am satisfied with the PHC e-RAF system.	91%	96%	94%	86%	97%	94%	-5%	1%	90%	Yes
I am satisfied with my interactions with PHC Pharmacy Staff[1]	N/A	N/A	NA	100%	91%	93%	N/A	N/A	90%	Yes

[1]New survey question.

Trended Specialist Regional and Plan-wide Performance on the Provider Satisfaction Survey

Specialist (% Strongly Agree or Agree)	2022			2023			% Difference			
	North (n=46)	South (n=141)	2022 Total	North (n=43)	South (n=98)	2023 Total	North	South	2023 Goal	2023 Performance Goal Met
I know how to determine whether or not a service requires that TAR (Auth) be submitted to PHC.	98%	92%	93%	93%	88%	89%	-5%	-4%	90%	No
My TARs are approved in a timely manner.	90%	92%	92%	97%	80%	85%	7%	8%	90%	No
When a TAR for medical service is denied by the plan, the basis for denial is clearly specified.	88%	95%	93%	97%	79%	84%	9%	-16%	90%	No
When one of my TARs is returned/deferred for more information, I know what additional documentation I need to submit.	84%	90%	89%	97%	95%	96%	13%	5%	90%	Yes
I am satisfied with my interactions with UM	100%	99%	99%	97%	100%	99%	-3%	1%	90%	Yes

Specialist (% Strongly Agree or Agree)	2022			2023			% Difference			
	North (n=46)	South (n=141)	2022 Total	North (n=43)	South (n=98)	2023 Total	North	South	2023 Goal	2023 Performance Goal Met
Staff.										
I am satisfied with the PHC e-RAF system.	97%	91%	93%	77%	100%	92%	-20%	9%	90%	Yes
I am satisfied with the PHC e-TAR system.	98%	88%	90%	94%	99%	97%	-4%	11%	90%	Yes
I am satisfied with my interactions with PHC Pharmacy Staff[1]	N/A	N/A	NA	9%	91%	93%	N/A	N/A	90%	Yes

[1]New survey question.

APPENDIX II: Member Experience with the UM process

THE UM EXPERIENCE

REPORTING PERIOD

As required by NCQA, this section reports G&A findings about members who encountered problems with the authorization or referral process in 2023 compared to 2022. For more details, please reference the attached NCQA UM 1B: Member Experience-UM Threshold Report.

OVERVIEW

Despite an increase in Partnership's membership and the total number of cases received in 2023, there was a decrease in the number of grievances related to the UM process overall. In 2023, a total of 205 concerns were reported regarding the Utilization Management (UM) process, compared to 222 in the previous year. Because of this decrease, Partnership did not exceed the threshold in any category in 2023.

The primary issue reported concerning the UM process was access-related problems. Notably, 65.4% of these access-related issues were associated with Partnership's Referral Authorization Form (RAF) process, while the remaining 34.6% were linked to the Treatment Authorization Request (TAR) process.

DISSATISFACTION WITH RAF PROCESS

RAF Process	
# of Reported Concerns	
Delayed by Provider	96
Refused by Provider	19
Member dislikes overall	8
Other	9
Delayed by PHC	5
Refused by PHC	2
Request > 60 days	1
Total	140

Among the reported issues within the referral process, delays by providers was the most reported concern. Members alleged that their primary care providers were delaying submission of RAFs, consequently causing delays in obtaining appointments with specialists. Upon investigation of these 97 cases, G&A determined that the provider was at fault in 37 of the reported Grievances.

DISSATISFACTION WITH TAR PROCESS

TAR Process	
# of Reported Concerns	
Delayed by Provider	40
Delayed by PHC	8
Member dislikes overall	8
Refused by Provider	5
Other	3
Request > 60 days	1
Total	65

The most prominent driver behind member dissatisfaction with the TAR process was related to providers delaying submission of TARs to Partnership. Upon closer examination of the TARs, it was found that 35.0% were for imaging services, while 22.5% were for DME. Following investigation of these TAR-related concerns, G&A determined that the provider was responsible in 15 reported grievances.

Upon review, G&A leadership found no discernible trends in providers delaying RAF and TAR requests.

Additionally, after examining the 15 grievances related to RAFs and TARs delayed or refused by Partnership, no opportunities for improvement through system changes or UM staff training were identified, as it was concluded, following investigation, that Partnership did not cause delays in the UM process.

1Q24 Grievance and Appeals PULSE Report: Supplemental Data
NCQA UM 1B: Member Experience-UM Threshold Report
REPORTING PERIOD: 2022 and 2023
Year-to-Year Report

Grievances Only Reporting Period: Annual 2022 vs. 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Avg PHC Mship	Grievances	Grievances p/1,000	Avg PHC Mship	Grievances	Grievances p/1,000	Threshold	Threshold Met?
Access	638,303	144	0.23	678,546	139	0.20	0.25	Yes
Attitude/Service		55	0.09		46	0.07	0.09	Yes
Billing/Financial		0	0.00		0	0.00	0.00	Yes
Quality of Care		23	0.04		20	0.03	0.04	Yes
Quality of Provider Office		0	0.00		0	0.00	0.00	Yes
TOTAL		222	0.35		205	0.30	0.38	Yes

Purpose of report: It reflects a subset of data from the ME.7 Member Experience Report. Data reflects member-reported dissatisfaction related to experiences with the TAR and RAF process. If the number of cases per 1,000 members in the current period increases by more than 10% from the previous period, then the Threshold is triggered. An unmet NCQA Threshold(s) identifies growing areas of member dissatisfaction and an intervention(s) maybe required. This report is published bi-annually. The March report provides an annual depiction of the two years under evaluation. The September report provides a mid-year update. All data is reported with a 95% confidence level.

Published March 2024

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS & SYSTEMS (CAHPS®) PROGRAM

2022-2023

MEMBER EXPERIENCE GRAND ANALYSIS (NCQA ME 7 REPORT)

PERIOD
(JULY 1, 2022 – JUNE 30, 2023)

PRODUCTION DATE
SEPTEMBER 2023

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

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CAHPS® PROGRAM

I. OBJECTIVE

The purpose of this report is to meet the requirements of NCQA standards ME7: Element C and D with the objective to assess member experience through Grievance and Appeals (G&A) data along with the Consumer Assessment of Healthcare Providers & Systems (CAHPS®) scores. We've created and maintained a multi-disciplinary team to participate in all group activities throughout the duration of this process. The goal of our team is to identify opportunities for improvement, set priorities and decide on which opportunities to pursue based on our analysis findings.

DEPARTMENT OVERVIEW:

GRIEVANCE AND APPEALS

The Grievance & Appeals (G&A) Department is responsible for investigating, monitoring, and reporting member dissatisfaction regarding their experience with Partnership's Medi-Cal plan. They are advocators, mediators, and educators for our members, ensuring they receive high-quality healthcare services across the healthcare continuum. G&A works to transform member dissatisfaction into innovative system-wide changes. They recommend internal and external system-wide improvements and address members' experiences based on findings.

G&A is responsible for the execution of DHCS APL 21-011, also known as the "Final Rule", which mandates that members have a right to report any problem(s) while using their Partnership Medi-Cal plan and Partnership has an obligation to investigate objectively.

PROGRAM OVERVIEW:

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS & SYSTEMS (CAHPS®)

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

In 2021 Partnership achieved National Committee for Quality Assurance (NCQA) Accreditation. The organizational commitment to quality is rooted in our mission, "To help our members, and the communities we serve, be healthy." The method and accreditation requirement for how members rate our service is through an annual survey regulated by the Consumer Assessment of Healthcare Providers & Systems (CAHPS®)

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

In 2023, Partnership achieved a 3.5 NCQA Health Plan Rating (HPR), reaching a milestone achievement denoting the first HPR rating post-NCQA Health Plan Accreditation. The CAHPS® program score improvement focus is

included in the multi-year 5-Star Quality Strategy to include corresponding tactical and annual work plans that support the overarching goal of achieving an NCQA 5-Star Health Plan Rating (HPR).

VALUE STATEMENT: Provide a sustainable member-centric program that supports the health plan's mission and values. In our commitment, we will strive in the spirit of continuous improvement to focus on improving and maintaining member satisfaction and overall experience across all service lines including equitable access to high-quality healthcare

II. METHODOLOGY

DATA SOURCES

Grievance and Appeals - Partnership utilized NCQA's required data sources, which are G&A reporting and CAHPS® scores. Our G&A analysts provide reporting from January 1, 2022, through December 31, 2022. Also shown is the previous year, 2021 G&A data. It's important to note that multiple reporting categories can apply to any given grievance, appeal, or second-level grievance. Therefore, the stated metrics herein reflect the number of concerns expressed by our members during the reporting periods, rather than actual case counts. In addition, please note that internally, Partnership refers to a member's dispute of a denied grievance as a "Second Level Grievance". Throughout this document, we will reference appeals as "Appeals" and "Second Level Grievances".

CAHPS® Survey - The second data source used is our CAHPS® scores from the last two survey cycles, MY 2021 and 2022. In addition to the standard methodology of evaluating state-administered CAHPS® survey, Partnership contracts with an NCQA-certified vendor, PressGaney to administer the annual regulated survey and provide results of our CAHPS® survey on a yearly basis, which are the data points used throughout this evaluation.

DATA MAPPING

Grievance and Appeals - NCQA standards ME7: Element C & D requires that the organization aggregate G&A data into five specific categories (Quality of Care, Quality of Practitioner Office Site, Attitude and Service, Billing/Financial Issues, and Access). Since Partnerships categorization is structured to meet DHCS requirements, the team (consisting of key individuals from impacted departments, including Member Services, Health Services, G&A, Quality Improvement, and Communications) mapped Partnership reporting categories to that of the five NCQA required categories.

CAHPS® Survey - Partnership reports on the eight CAHPS® composites categories, including Rating of Health Plan, Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, Getting Needed Care, Getting Care Quickly, Care Coordination, and Customer Service.

ANALYSIS WORK GROUPS

As noted in ME7: Element C & D, the health plan is required to conduct a side-by-side, annual, quantitative, and qualitative analysis of our data sources and make recommendations for interventions to ultimately improve our healthcare delivery system and most importantly, overall member experience. This workgroup established the thresholds and benchmarks for performance measurement, which are covered in the next section.

As shown in **Table 1**, CAHPS® Program Charter Stakeholders and in **Table 2,** FY 2022-2023 QI Department CAHPS® Score Improvement (CSI) Goal cross-department workgroups. The tables illustrate organization-wide participants involved in a multi-disciplinary approach focused on improvement activities and strategic CSI planning during this reporting and evaluation period.

Table: 1

CHARTER STAKEHOLDERS			
DEPARTMENT	**NAMES**	**DEPARTMENT**	**NAMES**
Health Services: Office of CMO	Robert Moore Mark Netherda	Administration: Behavioral Health	Mark Bontrager Nicole Talley
Health Services: Quality Improvement	Nancy Steffen Isaac Brown Barb Selig Anthony Sackett	Administration: Operations	Sonja Bjork, CEO Wendi West, COO
Population Health Management	Rebecca Boyd Anderson	Administration: Member Services	Kevin Spencer
Quality Improvement: NCQA	Sue Lee	Member Services: Grievances and Appeals	Kory Watkins
Quality Improvement: HEDIS	Sue Quichocho	Transportation	Melissa McCartney
Quality Improvement QI Program (PCP)	Amy McCune	Pharmacy	Stan Leung

TABLE: 2

QI CAHPS® SCORE IMPROVEMENT (CSI) DEPARTMENT GOAL	
WORKGROUP	**DEPARTMENT | NAME**
CAHPS® Oversight Lead: Anthony Sackett	**Member Services**: Anna Hernandez, Kevin Spencer
	Population Health: Greg Allen-Friedman, Rebecca Boyd Anderson, Nicole Curreri, Shauntessa Aguon-Clark
	Quality Improvement: Amy McCune, Barb Selig, Francesca Bautista, Isaac Brown, Kristine Gual, Nancy Steffen
Data Analytics Lead: Stephanie Chandler	**Finance Health Analytics**: Dejene Bikila, Liat Vaisenberg, Margarita Garcia-Hernandez, Shivani Sivasankar, Revanth Kasireddy, Radha Chebolu, Jen Kung
	Member Experience: Kory Watkins
	Population Health: Greg Allen-Friedman
	Quality Improvement: Amy McCune, Anne Gulley, Anthony Sackett, Barb Selig, Francesca Bautista, James Devan, Justin Sears
Member Experience Lead: Anthony Sackett	**Communications**: Dustin Lyda, Patty Hayes
	Finance Health Analytics: Stephanie Chandler
	Member Services: Anna Hernandez, Kevin Spencer, Kory Watkins
	Population Health: Greg Allen-Friedman, Rebecca Boyd Anderson, Nicole Curreri, Shauntessa Aguon-Clark

	Quality Improvement: Barb Selig, Francesca Bautista, Isaac Brown, Nancy Steffen
Access Lead: Lynn Scuri	**HR (Workforce Development/T & D):** Cody Thompson, Naomi Gordon
	Community Relations/Policy: Kathryn Powers
	Health Services Medical Directors: Colleen Townsend, Jeff Ribordy, Marshall Kubota
	Member Experience: Kory Watkins
	PMO/OpEx: William Kinder
	Provider Relations: Mary Kerlin, Renee Trosky, Ledra Guillory, Garnet Booth, Stephanie Nakatani
	Quality Improvement: Anthony Sackett, Barb Selig, Kristine Gual

THRESHOLDS & BENCHMARKS

As part of the NCQA process and to better evaluate member experience, thresholds, and benchmarks have been set to measure our performance.

Grievances and Appeals

For each category, a ratio of the number of grievances per 1,000 members is used as a performance metric. Our numerator will be the total amount of Grievances or Appeals/Second Level Grievances for the reporting period, and our denominator will be the monthly average member base of each reporting period. If we see a 10% increase in any of the five categories, it is flagged for discussion based on the number of grievances per 1,000 members.

CAHPS® Survey – For the eight composite scores (aforementioned in the Data Mapping section), benchmarks have been set at or above the 25th percentile. If any of the composite scores fall below our threshold, those categories are flagged for review and discussion.

QUANTITATIVE ANALYSIS

CAHPS® PROGRAM

III. QUANTITATIVE ANALYSIS

GRIEVANCES AND APPEALS & SECOND LEVEL GRIEVANCES

The Grievance and Appeals data and quantitative analysis are grouped by 1) Grievances and 2) Appeals & Second Level Grievances (SLG), and include the total cases filed for current and prior reporting periods. Data is further stratified by NCQA service category, includes threshold calculations by reported cases, (category/avg. monthly member base), and denotes if the threshold is met or not.

RESULTS & THRESHOLDS – GRIEVANCES ONLY

The trending data in Table 3 includes reporting periods; January 1, 2022 – December 31, 2022, and the previous year, January 1, 2021 – December 31, 2021.

In 2022, there were a total of 2,555 grievances submitted by our members. The analysis attributes 91% of all cases to Attitude and Service (50%) and Access (41%).

In comparison to the 2021 reporting period, there were a total of 2,745 grievances submitted by our members. Similarly, analysis attributes 87% of all cases to Attitude and Service (53%) followed by Access (34%).

TABLE: 3

Grievances Only
Reporting Period: Annual 2021 vs. 2022

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

RESULTS & THRESHOLDS – APPEALS & SECOND LEVEL GRIEVANCES

The trending data in Table 4 includes reporting periods; January 1, 2022 – December 31, 2022, and the previous year, January 1, 2021 – December 31, 2021. In 2022, the health plan received 762 Appeals and Second Level Grievance cases, a 10% increase in case filings from 2021, related to; Access, Attitude/Service, and QOC.

In comparison to the 2021 reporting period, the health plan received a total of 642 Appeals and Second Level Grievances cases.

It is also important to note that the total number of Appeals & SLGs increased by 19%, while membership only increased by 4.4%, resulting in not meeting the minimum threshold for Access, Attitude/Service, Billing/Financial, and Quality of Care.

Considering membership growth, the total number of cases filed per 1,000 members increased from 1.05 to 1.16.

TABLE: 4

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

SUMMARY HIGHLIGHTS:

GRIEVANCES AND APPEALS & SECOND LEVEL GRIEVANCES

Grievances Summary: Partnership met four out of the five grievance thresholds for 2022, including Access, Attitude/Service, Billing/Financial, and Quality of Provider Office. The one threshold that was not met in 2022 is Quality of Care (QOC). Of note, the Access threshold was not met in 2021 but was met in 2022.

Appeals & Second Level Grievances Summary: One out of five thresholds were met in 2022, Quality of Provider Office. Although the threshold for QOC was not met in the current reporting period, it is important to call attention that QOC cases went from zero (0) cases in 2021, to one (1) case in 2022.

2022 HIGHLIGHTS:

- Access-related issues continue to impact our members as the provider network, in particular in our more rural service areas, struggles to attract and retain clinical staff.
- Despite a decrease in overall cases year over year, respectively, there was an increase of 29 (67.6%) QOC Grievances cases from 2021.

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

The most frequently reported QOC concerns were related to treatment plan disputes, which accounted for 58% of all cases. For example, members disagreed with the provider's treatment plan to have them attend a methadone clinic to be weaned off their pain medication. The member felt that because they only took three (3) Vicodin per day, this treatment plan was excessive.

- The QOC measure is comprised of several grievance types within the provider network, and provider-focused grievances represent a total of 84 within the 2022 reporting period.
- Examples of concerns filed against primary care providers (PCP) or provider office staff are:
    - Access, in-person or by phone, and the reported concerns reflect a common theme, lack-of-appointment availability.
    - Providers refusing to see members and long wait times. PCPs located in Partnerships southern region accounted for 53 cases, while PCPs located in Partnerships northern regions accounted for 20 cases.

  - In 2022, there were eight (8) cases filed against specialists. This is a reduction from 19 cases reported in 2021. All Grievances against specialists were categorized as appointment availability concerns. Members reported having a difficult time finding appointments with specialists that were soon enough to address their concerns.

- Membership increased by 4.4% in 2022, from 610,183 to 638,303.
- Total number of Grievance cases filed per 1,000 members decreased from 4.50 to 4.00.

IV. QUANTITATIVE ANALYSIS

CONSUMER ASSESSMENT OF PROVIDERS AND SYSTEMS (CAHPS®)

The member experience, health plan delivery, and survey analysis covers Measure Year (MY) 2022 and Reporting Year (RY) 2023. The analysis herein will interchangeably reference this period as a measure year or MY 2022-2023. Also included in the evaluation is the 2022 Grievances and Appeals Annual Report, and the continuous monitoring of complaints, grievances, and appeals data for calendar year 2022.

PROGRAMMATIC APPROACH TO ANALYSIS

The applied methodology includes qualitative and quantitative analysis of current and prior CAHPS® MY 2022-2023 survey responses, internal member-reported data, sector trends, and benchmarks.

MEDICAID HEALTHCARE HEALTH PLAN TRENDS

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

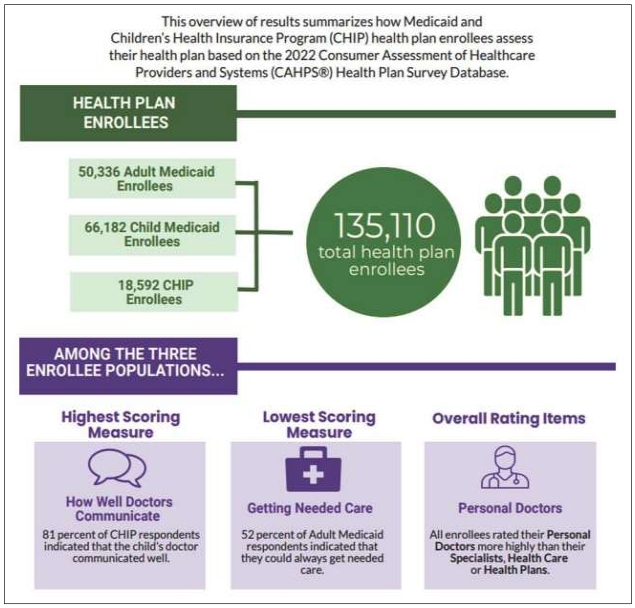
PressGaney completed a thorough CAHPS® 5.1 H portfolio data analysis of their administered MY 2022 Medicaid Adult and Child samples, survey responses include 164 Plans / 45,216 respondents. Their analysis compares the current Partnership HealthPlan respondent rate and measures performance against our year-over-year performance, HEDIS®, and PressGaney book-of-business (BoB) benchmarks. The SPH Analytics BoB is used to monitor health plan trends by comparing side-by-side aggregate scores over the past four years.

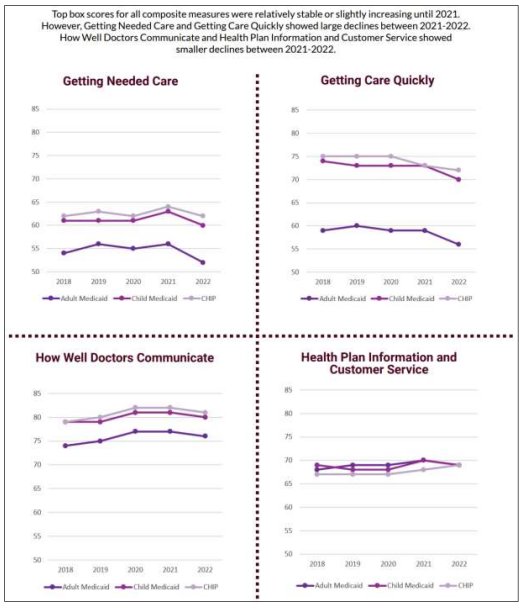
MY 2022-2023 TREND HIGHLIGHTS

- **COVID-19 Impact:** The pandemic caused significant disruption throughout most of 2020 and continues through today. The disruption is reflected in the variation we've seen in health system experience scores over the last few years.
- **Medicaid Adult Population:** Among the Medicaid Adult population, one measure declined by more than 1% compared to last year - Rating of Specialist, while one measure increased - Getting urgent care. Most scores rose at the beginning of the pandemic, but Rating of Health Plan and Coordination of Care are the only measures still rated at least 1% higher than they were in 2019. Flu Vaccine continues to be 4% lower than the 2019 scores.
- **Medicaid Child Population:** Among the Medicaid Child population, several measures declined by more than 1% compared to last year. The biggest decreases, which continue from 2021, were in Rating of Health Care, Getting specialist appointments, and Getting Needed Care. Getting Care Quickly is an area of

concern, continuing it's decline since 2019 seeing a drop of 4.5%. This is primarily due to the ability of getting routine care dropping 7.5% since 2020, at the beginning of the pandemic.

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





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

MEDICAID HEALTHCARE SECTOR CONCLUSIONS:

The survey data indicates a post-COVID lag in service delivery derived from CAHPS® survey responses. Noted, the AHRQ chart book declining composite measure are similar areas of focus to the Partnership MY 2022-2023 CAHPS® scores; Getting care quickly, and Getting needed care, both scored lower relative to pre-COVID scores. Similarly, the PressGaney BoB Medicaid Adult and Child population noted that several measures declined by more than 1% compared to MY 2021-2022. The biggest decreases were in the Getting Care Quickly, Rating of Health Care, Coordination of Care, and Getting specialist appointments.

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

MEMBER EXPERIENCE DATA

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

CAHPS®

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

CAHPS® Survey Methodology

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

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

CAHPS® MY 2022-2023 Survey Results

Initial MY 2022 / RY 2023 CAHPS® survey analysis, intervention pre-planning, and collaboration between the Quality Improvement (QI) and Member Services (MS) Departments included a thorough transition of survey administration and documentation of processes.

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

Respondent Rate Trending

Internal stakeholders analyzed the MY 2022-2023 CAHPS® survey results for Adult and Child populations. The strategy to oversample in both populations, Adult 100%, and Child 150% did not yield the desired respondent rates. Survey participation is a noticeable declining trend with the PressGaney BoB and AHRQ Medicare/Medicaid chart book rates.

Response Rate Comparison

A response rate is calculated for those members who were eligible and able to respond.

Year	Adult	Child
FY 2022-2023	14.3%	14.9%
FY 2021-2022	14.1%	14.5%

The complete sample size and respondent results by survey methodology are illustrated in Tables 5 & 6.

SAMPLE SIZE

ADULT

Year	Sample size	Total completes	English completes	Spanish completes	Mail completes	Phone completes	Internet completes
FY 2022-2023	2,700	380	297	83	199	137	44
FY 2021-2022	2,700	372	163	33	196	124	52

CHILD

Year	Sample size	Total completes	English completes	Spanish completes	Mail completes	Phone completes	Internet completes
FY 2022-2023	4,125	611	354	257	213	310	88
FY 2021-2022	4,125	587	173	160	333	204	50

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

- Adult: Oversample size of (2,700-34 ineligible) responses, 380 completed 14.3% (2,666/380) compared to prior MY 2021-2022, 14.1%.

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

- Child: Oversample size of (4,125-30 ineligible) responses, 611 completed 14.9% (4,095/611) compared to prior MY 2021-2022, 14.5%.

RESPONDENT RATE ANALYSIS

- ❖ The BoB respondent rates for both populations had a noticeable downward between reporting years 2021 and 2022.
- ❖ Relative to Partnership respondent rates, the health plan performed above the average Press Ganey BoB rates (169 Plans). For two of the three adult survey cycles, and for child all three. Conversely, rates have kept pace with reduced respondent rates comparing 2020 through 2022.

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

Table A: CAHPS® Composite and Rating Measure Targets

CAHPS® COMPOSITE MEASURES	TARGET
Getting Needed Care	All rating and composite measures are: ≥ 25th percentile
Getting Care Quickly	
Getting Care Coordination	
Customer Service	
CAHPS® RATING MEASURES	
Rating of Health Plan	

Rating of All Health Care	
Rating of Specialist Seen Most Often	
Rating of Personal Doctor	

Table B: CAHPS® survey results are measured against these eight CAHPS® composite categories.

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

The MY 2022 CAHPS® survey results and measure performance on Rating and Composite Measures for the Adult and Child Surveys and measures below the 25th percentile are referenced in Tables 5 and 6 below.

Table 5 - Adult CAHPS® Composite - Adult Response rate 14.3%

	ADULT CAHPS Composite	2021-2022 (14.1% Response Rate) Sample Size 2,700 Total Returns 372	2021 Percentile Rate	PHC Benchmark	PHC Benchmark Met?	2022-2023 (14.3% Response Rate) Sample Size 2,700 Total Returns 380	2022 Percentile Rate	PHC Benchmark	PHC Benchmark Met?
Rating Measure	Rating of Health Plan (% 8, 9, 10)	69.9%	<5th	PHC ≥ 25th	No	73.8%	18th	PHC ≥ 25th	No
	Rating of All Health Care (% 8, 9, 10)	70.0%	<5th	PHC ≥ 25th	No	74.9%	40th	PHC ≥ 25th	Yes
	Rating of Personal Doctor (% 8, 9, 10)	77.6%	6th	PHC ≥ 25th	No	81.5%	42nd	PHC ≥ 25th	Yes
	Rating of Specialist Seen Most Often (% 8, 9, 10)	82.3%	34th	PHC ≥ 25th	Yes	81.1%	26th	PHC ≥ 25th	Yes
Composite Measure	Getting Needed Care (% Always or Usually)	76.0%	7th	PHC ≥ 25th	No	76.4%	14th	PHC ≥ 25th	No
	Getting Care Quickly (% Always or Usually)	72.9%	5th	PHC ≥ 25th	No	69.5%	5th	PHC ≥ 25th	No
	Care Coordination (% Always or Usually)	81.3%	15th	PHC ≥ 25th	No	86.6%	73rd	PHC ≥ 25th	Yes
	Customer Service (% Always or Usually)	87.2%	25th	PHC ≥ 25th	Yes	88.6%	38th	PHC ≥ 25th	Yes

Table 5: Measure Performance Comparison

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

- A noticeable improvement in the Adult MY 2022 Rating Measures compared to MY 2021. Rating of Health Plan, only one (1) of four (4) measures did not meet or exceed the Partnership 25th percentile target. Noteworthy, is an observed improvement in Rating of Health Plan percentile rating. Although the Rating of Specialist Seen Most Often exceeded the 25th percentile target, there is a decrease in performance.
- Adult Composite Measures compared to MY 2021 not meeting or exceeding the Partnership 25th percentile target, are two (2) out of four (4) measures; Getting Needed Care, and Getting Care Quickly. An observed decrease in Getting Care Quickly is noted, which aligns with both industry and Press Ganey BoB composite score trends related to Access to Care.
- Adult oversampling strategy contributed to meeting the reportable threshold of 100 survey responses for each rating and composite measure.

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

Stakeholders determined that continued intervention focused on; Getting Needed Care, Getting Care Quickly, and Rating of the Health Plan composite measures and Rating of Health Plan would be in scope for the CAHPS® Score Improvement (CSI) Department Goal for FY 2023-2024.

Table 6: Child CAHPS® Composite - Child Response rate 14.9%

	CHILD CAHPS Composite	2021-2022 (14.5% Response Rate) Sample Size 4,125 Total Returns 587	2021 Percentile Rate	PHC Benchmark	PHC Benchmark Met?	2022-2023 (14.9% Response Rate) Sample Size 4,125 Total Returns 611	2022 Percentile Rate	PHC Benchmark	PHC Benchmark Met?
Rating Measure	Rating of Health Plan (% 8, 9, 10)	82.2%	11th	PHC ≥ 25th	No	84.7%	33rd	PHC ≥ 25th	Yes
	Rating of All Health Care (% 8, 9, 10)	83.7%	<5th	PHC ≥ 25th	No	80.4%	<5th	PHC ≥ 25th	No
	Rating of Personal Doctor (% 8, 9, 10)	89.0%	26th	PHC ≥ 25th	Yes	90.5%	51st	PHC ≥ 25th	Yes
	Rating of Specialist Seen Most Often (% 8, 9, 10)	81.6%	6th	PHC ≥ 25th	No	85.2%	34th	PHC ≥ 25th	Yes
Composite Measure	Getting Needed Care (% Always or Usually)	79.6%	10th	PHC ≥ 25th	No	76.7%	10th	PHC ≥ 25th	No
	Getting Care Quickly (% Always or Usually)	84.1%	25th	PHC ≥ 25th	Yes	76.3%	<5th	PHC ≥ 25th	No
	Care Coordination (% Always or Usually)	85.3%	34th	PHC ≥ 25th	Yes	81.1%	19th	PHC ≥ 25th	No
	Customer Service (% Always or Usually)	89.4%	60th	PHC ≥ 25th	Yes	89.9%	73rd	PHC ≥ 25th	Yes

Table 6: Measure Performance Comparison

The comparison table above illustrates Child CAHPS® survey composite scores by measure years; MY 2022 and MY 2021

- A noticeable improvement in the Child MY 2022 Rating Measures compared to MY 2021. Rating of All Health Care, only one (1) of four (4) measures did not meet or exceed the Partnership 25th percentile target.
- MY 2022 Child Composite Measures compared to MY 2021 that did not meet or exceed the Partnership 25th percentile benchmark is three (3) out of four (4) in; Getting Needed Care, Getting Care Quickly, and Care Coordination. An observed decrease in both measures align with both industry and Press Ganey BoB trends. As reference Access to Care continues to be a barrier and an area Partnership is focused on improving.
- Child oversampling strategy contributed to meeting the reportable threshold of 100 survey responses for each rating and composite measure.

The Child survey responses relative to Partnership covered members indicate we continue to have dissatisfaction with member access and correlating impact to member experience which influences health plan ratings. Stakeholders determined that continued intervention focused on; Getting Needed Care, Getting Care Quickly, and Rating of the Health Plan composite measures would be in scope for the CAHPS® Score Improvement (CSI) Department Goal for FY 2023-2024.

QUANTITATIVE ANALYSIS BY COUNTY

CAHPS® PROGRAM

CAHPS® COUNTY-LEVEL DATA ANALYSIS

The county-level data analysis is an effort to take a closer look at the survey respondent scores relative to each respective county and region. While the workgroup dedicated to evaluate this data was part of the FY 2022-2023 Department goal year, the CAHPS® program administration will continue to evaluate and report on MY 2022 / RY 2023 trends and analysis. Under review is how we report and display this data in the Member Experience Grand Analysis (ME 7) report next year.

The data received from the CAHPS® vendor, Press Ganey (formerly known as SPH), for MY 2019 did not include county-level data, only regional-level data. This limits the ability to trend and analyze at the county level across the three years. Furthermore, the RY 2021 and RY 2022 county-level data has or no respondent numbers, which creates issues with statistical significance.

RY 2021 and RY 2022 data from the vendor has established a baseline indicator and continuing to monitor at the county level combined with other existing sources of data may lend itself to identifying future intervention activities.

There are low rates for "Getting Needed Care" for both adult and child members.

- Humboldt and Siskiyou counties related to adults are tracking lower across measures that correlate to "Getting Needed Care."
- Yolo County shows a significantly low rate at 40% for getting appointments with specialists when needed, in the child survey. Even though the volume is low (N=15), it may be worth investigating what specialist members want to see and the challenge of seeing these specialists. Yolo County is lower than other counties in the adult survey for "Getting Care Quickly."

Key questions and discussion points addressed by both the Data Analytics and Member Experience Sub-workgroups:

1. Would the 3rd next available survey or coordinated care data be helpful – to see how long it takes members to get appointments with specialists?

   During the Access sub-workgroup meeting, it was determined that the 3rd next available survey or coordinated care data would not be an appropriate indicator to measure the CAHPS® member experience.

2. What are the types of specialists they are trying to see?

   This question can be answered using the Specialty Office Visits Dashboard which offers another data source when considering what is happening with PHC members seeking care with specialists. There have been recent updates to the dashboard to increase the filtering of information by providers, county, and CCS/Non-CCS.

3. Is there a way to check the geographic coverage of the specialists that members want to see, pediatric specialists for kids?

   The Specialty Office Visits dashboards provide the ability to see members utilizing a specialty by provider and county.

4. There are low rates for customer service and coordination of care for certain regions

   - Coordination of care rating for the northeast region (driven by Shasta County) is lower than the other regions in the child survey

- Lake County is reporting the lowest scores on customer service in the child survey. The volume of Lake County respondents likely does not affect region-level results.
- Humboldt and Siskiyou are also trending lower in the customer service measure. This may be related to not Getting Needed Care.

Summary of County and Regional Results in the Adult and Child Survey

The data in the county and regional result summary highlight measures and geographies that are performing lower in the child and adult surveys. The measures covered in the summary generally have lower overall scores and greater variations among the geographic regions compared to other measures on the survey. Refer to the CAHPS® survey data for complete results across all measures.

County Results

The County summary findings are separated for the Child and Adult surveys and cover survey results from RY 2021 and RY 2022. The survey results do not cover all counties. The summary will therefore be limited to the counties available in the survey results.

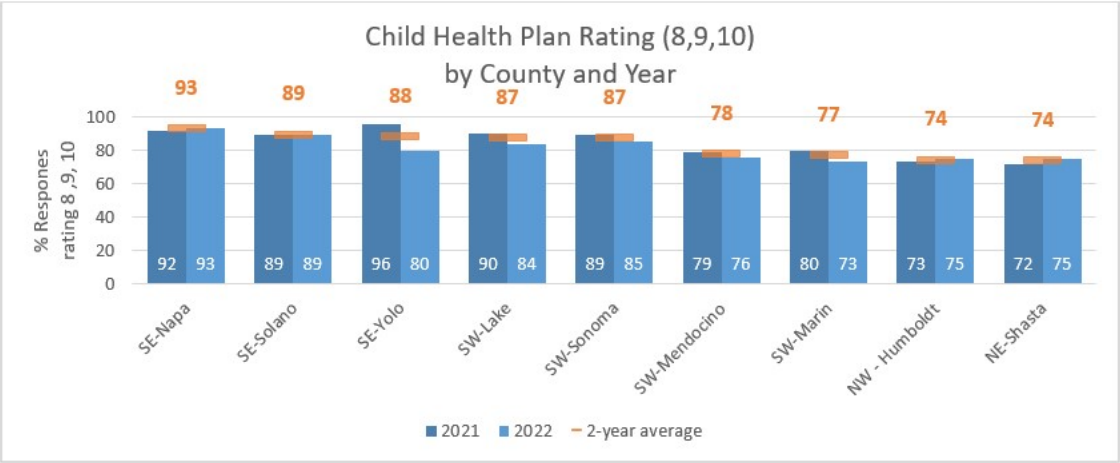
Child Survey

County-level child survey results for RY 2021 and RY 2022 are not available for Lassen (NE), Modoc (NE), Siskiyou (NE), Trinity (NE), and Del Norte (NW) due to low sample size.

Health Plan Rating

Shasta and Humboldt have the lowest two-year average for the Health Plan Rating (8,9,10) in the RY 2021 and RY 2022 surveys. Marin, however, has the lowest rating for RY 2022 at 73%. Napa has the highest average rating in both years with over 90% of responses rating the health plan with an 8, 9, or 10.

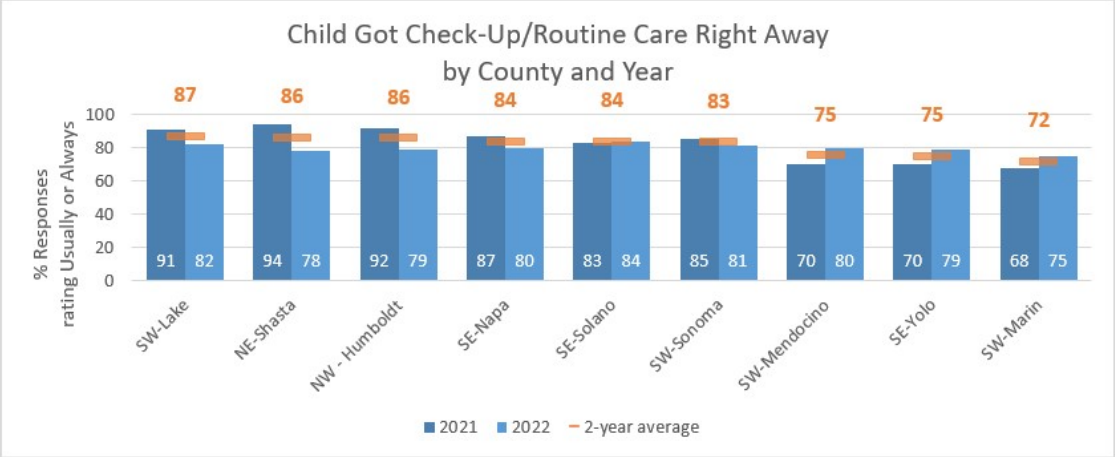
Yolo County saw the largest decline of -16 percentage points year over year from 96% to 80%. All counties in the Southwest region – Lake, Marin, Mendocino, and Sonoma – saw a moderate decline averaging -5 percentage points year over year.



Getting Care Quickly – Check-up/Routine Care

The share of respondents getting check-up/routine care right away responding "Usually or Always" is comparatively lower for Yolo (75%), Marin (72%), and Mendocino (75%) based on the two-year average of RY 2021 and RY 2022 results. The lowest value on the RY 2022 survey is 75% in Marin County.

The counties showing declines in percentage points year over year from largest to smallest are Shasta (-16), Humboldt (-13), Lake (-9), Napa (-7), and Sonoma (-4). The percentages for Marin, Yolo, and Mendocino all improved by +7 or more percentage points. Although Marin improved by +7 percentage points from RY 2021 to RY 2022, the county still has the lowest rating for this measure in RY 2022 and is below the RY 2022 average by 5 percentage points.

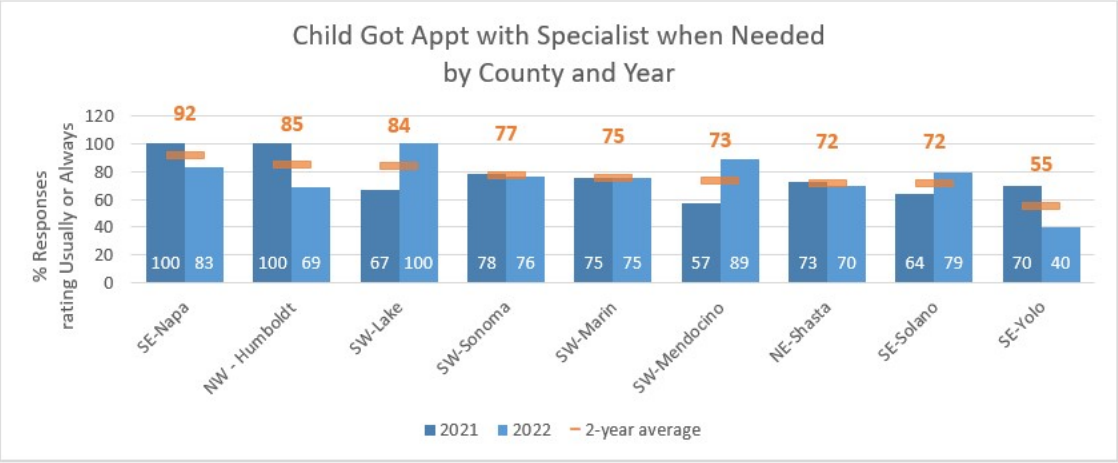


Getting Needed Care – Specialist Appointments

For the composite measure of Getting Needed Care, the survey results on getting appointments with specialists when needed are generally lower than the results for ease of getting care, tests, or treatment needed.

Yolo County has the lowest percentage of respondents reporting that they were able to get appointments "Usually or Always" with specialists when needed. The percentage is only 40% in RY 2022, almost -30 or more percentage points lower than other counties reported in the same year.

Humboldt and Yolo saw a decline year over year by around -30 percentage points. Napa declined -17 percentage points. Counties with improvement year over year were Solano, Lake, and Mendocino at +15, +33, and +32 points respectively.



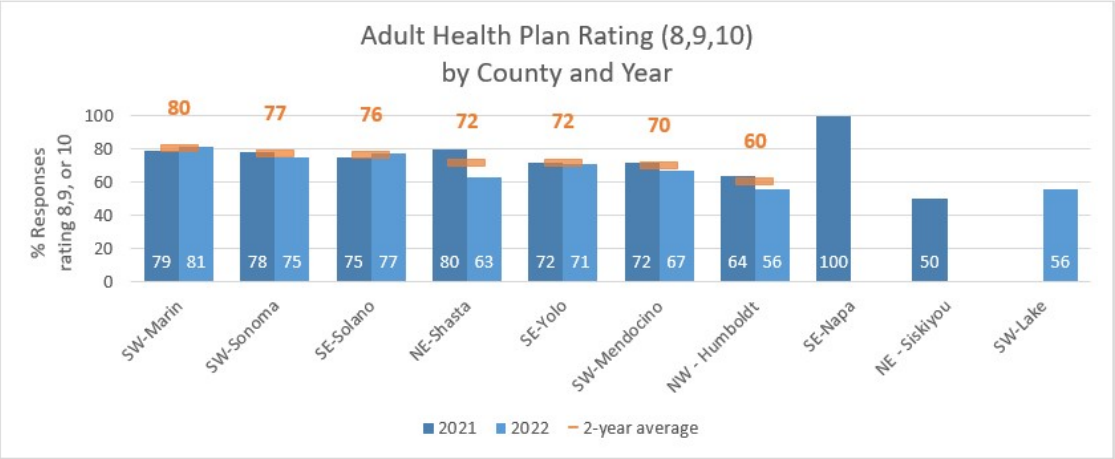
Adult Survey

County-level adult survey results are not available for Lassen (NE), Modoc (NE), Trinity (NE), and Del Norte (NW) in either RY 2021 or RY 2022.

Health Plan Rating

The regions with the lowest percentage of respondents rating the health plan with an 8, 9, or 10 are Lake, Siskiyou, and Humboldt; the percentages are less than 60% for the three counties in RY 2022.

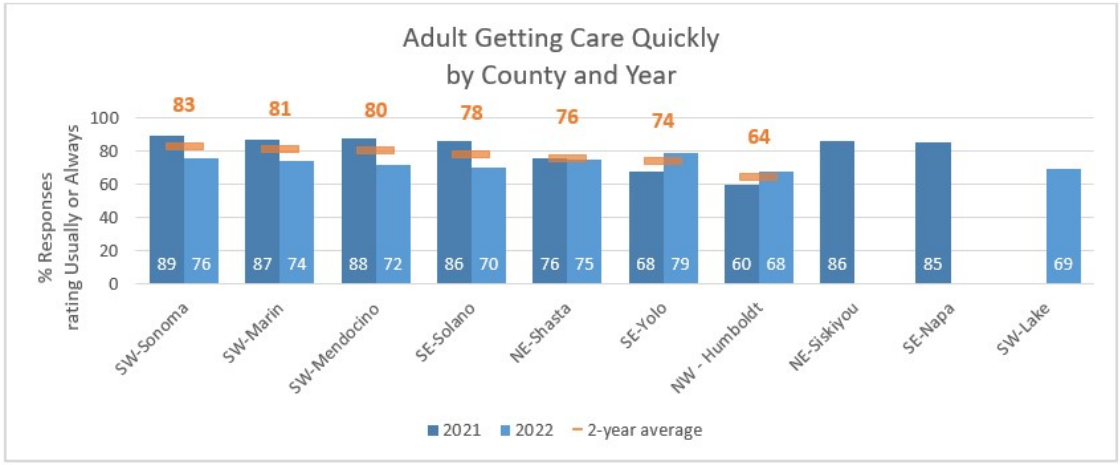
The counties that show the largest decline in rating are Shasta, Humboldt, and Mendocino; the percentage point decline in 8, 9, or 10 ratings are respectively -17, -8, and -5. All counties, with data for RY 2021 and RY 2022, except for Solano and Marin showed a decline in ratings. Solano and Marin both saw a slight improvement of +2 percentage points in the rating percentage.



Getting Care Quickly

Counties with 70% or less of respondents indicating they get care quickly "Usually or Always" in the RY 2022 survey are Humboldt, Solano, and Lake.

Solano and Mendocino counties have both trended down by -16 percentage points from RY 2021 to RY 2022 on this measure. Marin and Sonoma both trended down by -13 percentage points. Humboldt and Yolo have improved by +8 and +11 percentage points respectively.



Getting Care Quickly is composed of results for the two questions:

- Got care as soon as needed when care was needed right away
- Got check-up/routine care appointment as soon as needed

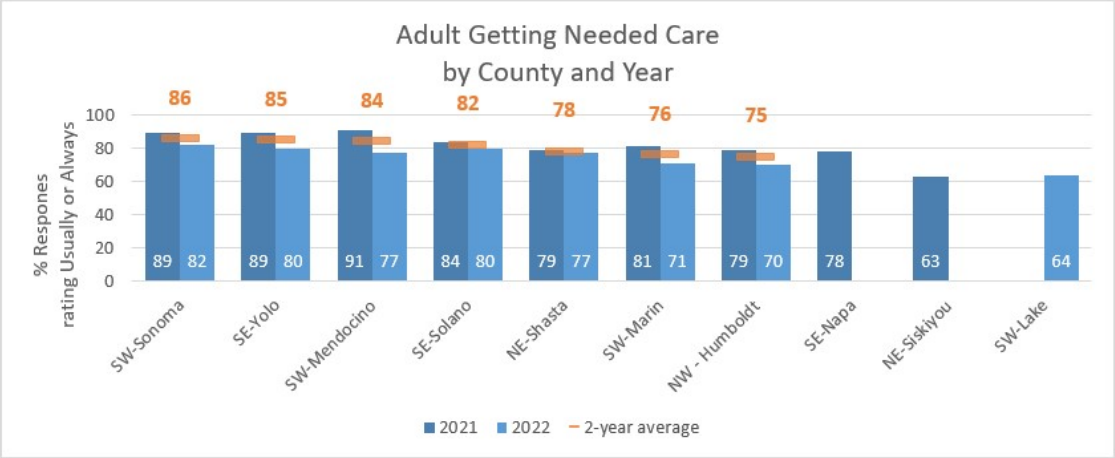
The counties below show a spread of at least 15 absolute percentage points between the survey results for the two questions relating to Getting Care Quickly in at least one survey year.

- Shasta, Yolo, and Siskiyou counties show lower percentages for getting care as soon as needed compared to getting check-ups/routine care appointments as soon as needed.
- Solano shows lower percentages for getting care as soon as needed in RY 2022 as well, however, the question that received the lower percentage flipped in RY 2022. In RY 2021, the question with the lower percentage was getting check-ups/routine care appointments as soon as needed.

Getting Needed Care

Lake and Siskiyou counties report the lowest percentages of "Usually and Always" responses for Getting Needed Care at 64% and 63% respectively. Humboldt and Marin also have low percentages hovering around 70% in RY 2022. These two counties have seen a decline of about -10 percentage points year over year.

All counties show a downward trend in percentages from RY 2021 to RY 2022. The average drop in percentage points from RY 2021 to RY 2022 is -8. Mendocino shows the largest drop of -14 percentage points from RY 2021 to RY 2022.



Getting Needed Care is a composite measure based on the results of two separate survey questions:

- Ease of getting necessary care, tests, or treatments needed
- Getting appointments with specialists as soon as needed

Some counties show a high percentage for one question and a low percentage for another. The spread of percentages is masked under the composite rating.

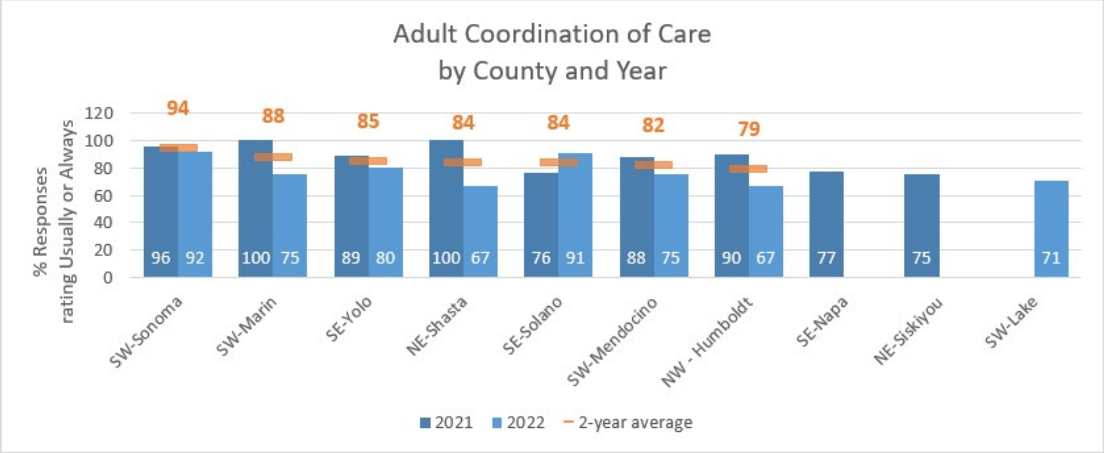
The counties listed below show a spread of at least 15 absolute percentage points between the survey results for the two questions relating to Getting Needed Care in at least one survey year.

- Shasta, Siskiyou, and Napa show lower percentages for getting appointments with specialists as soon as needed compared to the ease of getting necessary care, tests, or treatment needed.
- Humboldt and Mendocino show lower percentages for ease of getting necessary care, tests, or treatment needed compared to getting appointments with specialists as soon as needed.

Coordination of Care

The counties with the lowest percentage of respondents indicating there is a coordination of care among patients' care providers "Usually or Always" on the RY 2022 survey are Shasta and Humboldt at 67%.

The average drop in the Coordination of Care measure across counties with data available in both RY 2021 and RY 2022 is 13 percentage points. The measure dropped the most percentage points for Shasta (-33), Marin (-25), and Humboldt (-23). All counties showed a downward decline except for Solano, which had an improvement of +15 percentage points.

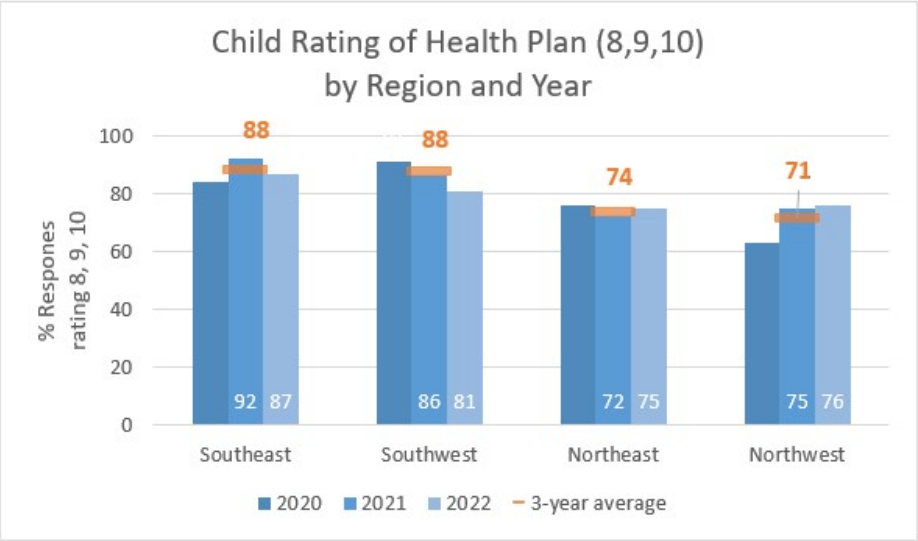


Regional Results

The Regional summary findings are separated for the Child and Adult surveys and cover the RY 2020, RY 2021, and RY 2022 surveys.

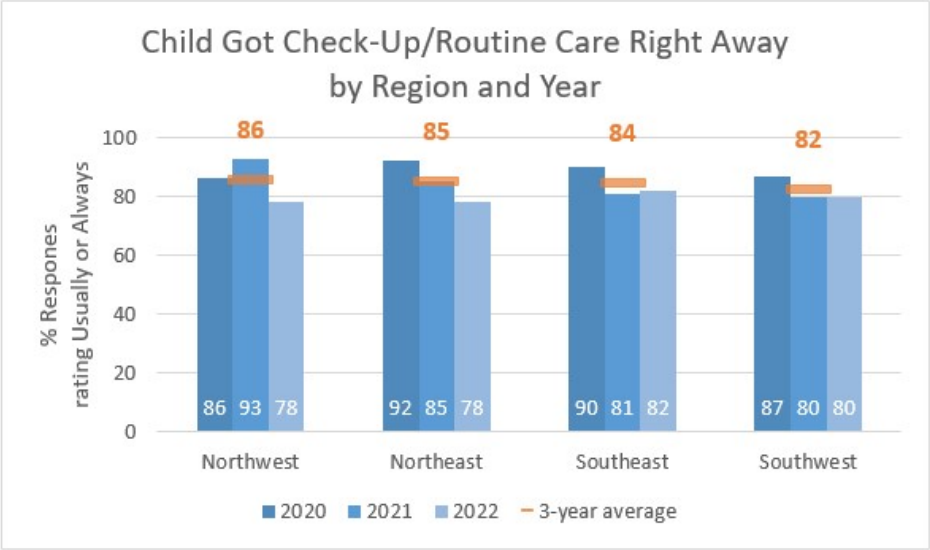
Child Survey

The Health Plan Rating on the Child survey shows that the Northern regions have lower ratings compared to the Southern regions. The average percentage of responses rating the health plan 8,9,10 is below 75% for the Northern regions and above 85% for the Southern regions. However, the Southern regions show a decline of -5 percentage points from RY 2021 to RY 2022 whereas the Northern regions show a slight increase of +1 and +3 percentage points respectively for the Northwest and Northeast regions.



Getting Care Quickly – Check-Up/Routine Care

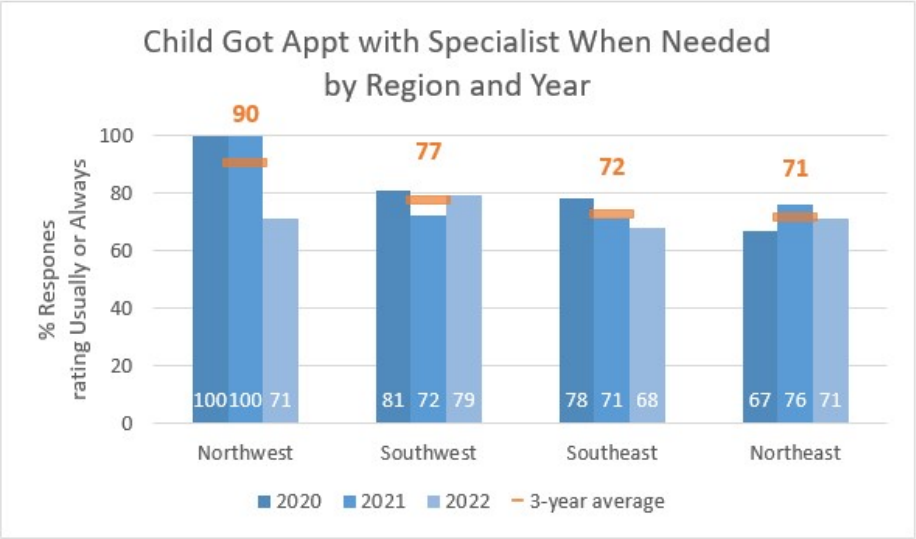
The three-year average for getting check-ups up/routine care quickly is comparable across the regions with the Northern regions having a slightly higher three-year average compared to the Southern regions. However, in the RY 2022 survey, the Northern regions have a lower yearly percentage compared to the Southern regions because the Northern regions have a larger downward yearly differential. There is a general downward trend for this measure across the regions. The Northeast region showed the largest decline of -7 percentage points year over year for a total decline of -14 percentage points from RY 2020 to RY 2022.



Getting Needed Care – Specialist Appointments

The percentage of respondents getting appointments with specialists when needed "Usually or Always" is less than 80% across all regions in the RY 2022 survey. The measure is the lowest in

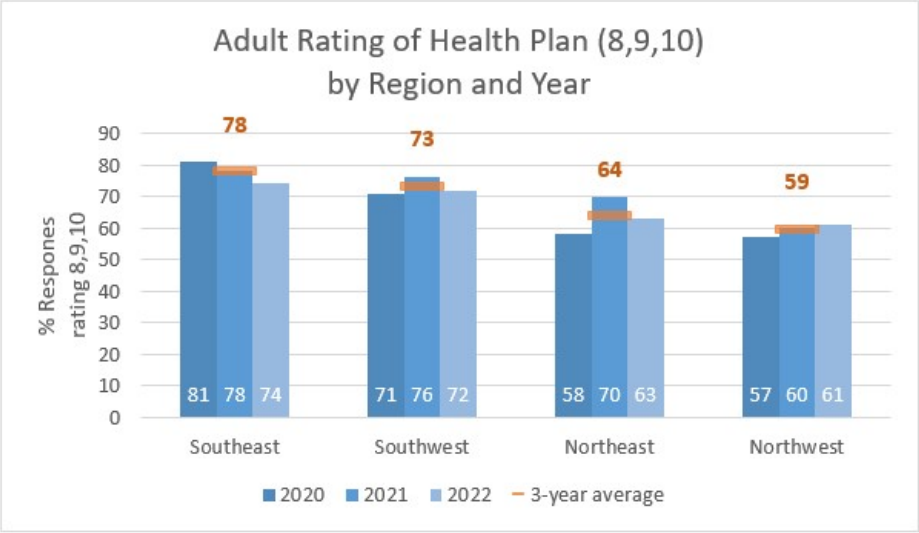
RY 2022 in the Southeast region at 68% and highest for the Southwest region at 79%. The Northwest region saw the largest decline of -29 percentage points from 100% in 2020 and RY 2021 to 71% in RY 2022.



Adult Survey

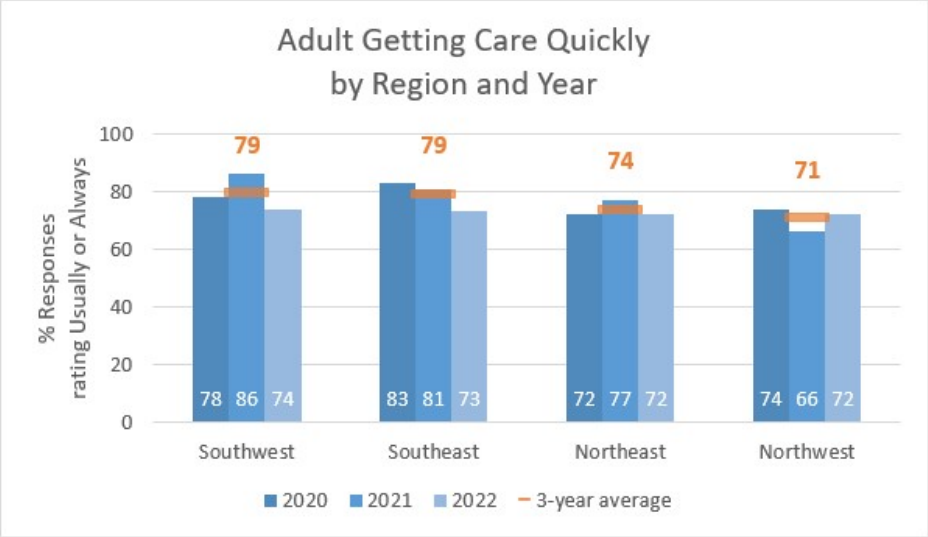
Health Plan Rating

The Health Plan Rating (8, 9,10) for adults is lowest for the Northwest region and highest for the Southwest region. The Northern regions have lower overall ratings as compared to the Southern regions. The Northern regions are below 65% and the Southern regions are above 70% in RY 2022. The Health Plan Rating percentages on the Adult survey are lower across the board when compared to ratings for the same year and region on the Child survey.

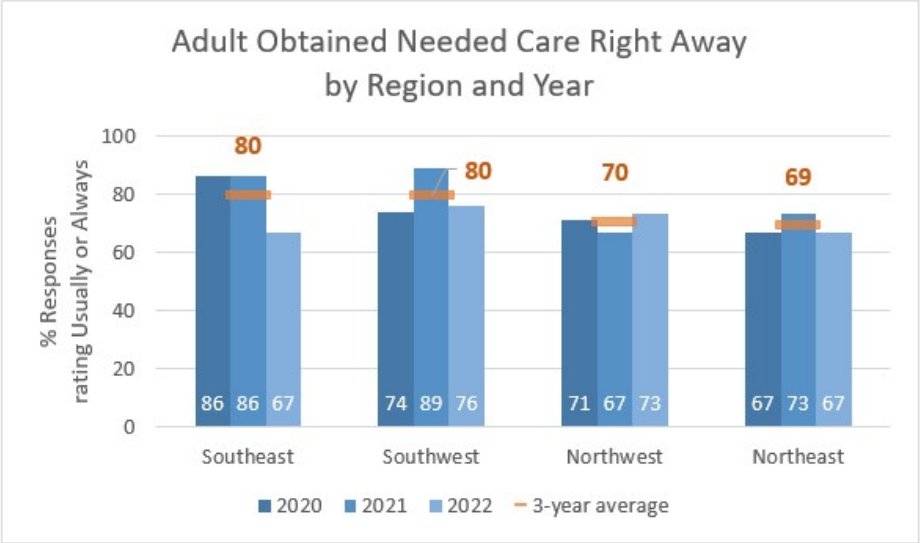


Getting Care Quickly

The Northeast and Northwest regions report lower three-year averages for Getting Care Quickly. In the year RY 2022, the difference in rating across the four regions is within two percentage points. All regions show a downward trend between RY 2021 and RY 2022 of more than -5 percentage points except for the Northwest region, which improved +6 percentage points from 66% to 72%.



When comparing the two survey components of Getting Care Quickly, the Obtained Needed Care Right Away demonstrates lower ratings (71%) in RY 2022 as compared to Obtained Check-up/Routine Care Right Away (74%). The Northeast and Southeast regions have the lowest rating at 67% for RY 2022. The trend from RY 2021 to RY 2022 mirrors that of the overall measure with all regions showing a downward trend except for the Northwest region.



Coordination of Care

According to the three-year averages for each of these regions, the percentages for the Northeast and Northwest regions fall around 70% for "Usually or Always" responses. In RY 2022, the percentages are

62% for the Northeast region and 75% for the Northwest region. Both the Southeast and Southwest regions are above 80% in RY 2022. The Coordination of Care rating for the Northeast and Northwest regions have respectively dropped -32 and -16 percentage points from RY 2021 to RY 2022.

Question 1: Are there recent programs/interventions that target these measures that we can refer to for learnings on what has and has not worked in the past?

Partnership has begun to keep an inventory and tracking the interventions and programs that may impact member experience will be important for a holistic view of potential impacts on the CAHPS® survey results.

Question 2: Are there other member satisfaction surveys where there is more direct feedback from members to understand member pain points? Maybe the call center or other member-facing teams?

The sub-workgroup members discussed other data sources to consider in the future:

- G & A
- Call Center data
- Member portal access-if possible
- Consumer Groups (CG), CG-CAHPS®
- Supplement CAHPS® questions
- Interim CAHPS® Survey

QUALITATIVE ANALYSIS

CAHPS® PROGRAM

V. QUALITATIVE ANALYSIS

GRIEVANCES AND APPEALS & SECOND LEVEL GRIEVANCES

The COVID-19 pandemic continued to have a significant impact on the accessibility of medical services in 2022. The healthcare system in California and throughout the country grappled with workforce shortages for both clinical and non-clinical staff. Thus resulting in greater difficulty in obtaining timely appointments. There was a substantial increase in Grievances related to the Quality of Provider Offices in 2022. Members reported 84 concerns against their primary care provider (PCP) or provider's office staff regarding access to appointments in person or by phone, compared to 39 in 2021. The majority of the concerns members reported were in relation to appointment availability, for example, having to wait up to 30 days for an appointment and even longer for specialty appointments and procedures. Partnership continues to work on addressing this challenge by working to support our network and seeking to contract with new providers, predominantly in rural areas.

Provider Service accounted for 86% of the concerns expressed by members. Treatment Plan Disputes, Poor Provider Communication, and Poor Provider Attitude were the top three concerns related to Provider Service. Specific examples members shared were providers being non-responsive to inquiries, and providers and or their staff being abrupt. These concerns are undoubtedly a direct correlation to staffing shortages due to COVID.

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

Access, Attitude/Service, and QOC Appeals & Second Level Grievances (SLG) increased by more than 10%, due to the overall increase of cases. For example, QOC cases went from zero (0) cases in 2021, to one (1) case in 2022. It is also important to note that the total number of Appeals & SLGs increased by 19%, but membership only increased by 4.6%, thus causing the categories to exceed the threshold. Considering membership growth, the total number of cases filed per 1,000 members increased from 1.05 to 1.19. G&A continues to track and trend Quality of Provider Office concerns in addition to Attitude and Service concerns to ensure feedback is provided to the applicable provider.

CAHPS® SURVEY RESULTS

Survey analysis of current and prior measure years indicate a continued decline in health plan delivery and member satisfaction in Adult and Child populations related to Access, Health Plan Ratings, and Member Experience.

Insufficient county-level data for all years limits the ability to provide a complete analysis for survey reporting years. The comprehensive analysis does include trending for two years of county and regional results and evaluated specific measure domains that had large differences between geographies or measures with relatively lower scores compared to other measures.

The findings of this review indicate that of the measures examined in this report:

- The measure with the largest decline regionally was Coordination of Care on the adult survey with a decline of 32 percentage points in the Northeast region and the Northwest with a decline of 16 percentage points. In general, all counties showed a decline in this measure except for Solano.
- For the child survey, the largest regional decline was for Getting Care Quickly – Specialist Appointments,

with the Northwest region showing a decline of 29 percentage points. Humboldt, Yolo, and Napa saw the largest decline for this measure however, Solano, Lake, and Mendocino saw an improvement.

- The Health Plan Rating percentages on the Adult survey are lower across the board when compared to ratings for the same year and region on the Child survey.

When looking at the data by county, the following counties had lower 2-year averages more frequently:

- Humboldt for adult surveys
- Yolo for child surveys except for Health Plan Rating

While there were limitations in some of the data at the county level, two-year trending made our analysis possible and offers a view of potential areas for PHC to focus on for interventions in the future.

MEMBER EXPERIENCE

In 2022, the impact of COVID-19 on the healthcare industry continued to be significant, both in terms of patient experience and the overall healthcare landscape, and is evident that COVID-19 has had both a national and regional impact.

It is no surprise to the CAHPS® Oversight Workgroup that Access continues to be a recurring theme when comparing data sources Grievance and Appeals and Second Level Grievances and CAHPS® survey results. It is important to note the correlation to the CAHPS® survey and the majority of member-reported concerns during this period relate to appointment availability for primary and specialty care, and access-related issues continue to impact our rural service areas. In regard to the Grievance and Appeals, we will continue to monitor the provider's communication and attitude.

It is understood that the gateway to an improved member experience is getting access to care, and improving the perception in this regard will have an impact on the composite scores in both member experience and health plan ratings.

We must also acknowledge that prior to the pandemic onset, Access in Adult and Child populations has and continues to be low performing CAHPS® composite measures in "Getting Needed Care" and "Getting Care Quickly."

Important to note, the 2022 NET 3 Grand Analysis Report (Appendix D) for this reporting period provides insightful differences. For example, Network Adequacy Analysis in Practitioner/Provider Ratios indicate that our primary care provider network to include high-volume and high-impact specialists are meeting the health plan standards, with no interventions required. This means our member to provider ratios are aligned with DHCS network adequacy standards.

Another area is the Third Next Available Appointment (3NA), the 3NA survey results show that as a plan we met our 2021 performance goal of 90% across all Primary Care Provider appointments. Of note, there continues to be network adequacy opportunities when looking at regional level, in particular our rural northern counties.

To put this in perspective, the combined MY 2022/RY 2023 surveyed population (Adult 2,700/Child, 4,125) represented 1% of our population in December of 2022. Of that population, only 0.15% responded and their opinion and perception represent Partnership membership totaling approximately 675,000.

As we continue improvement activities we plan to further explore and evaluate the health plan delivery and network adequacy analysis to broaden operational competencies, and develop methods to navigate through member perception or actual health plan delivery deficiencies, and where to focus improvement activities.

IMPROVEMENT & ACTIONS TAKEN

CAHPS® PROGRAM

VI. IMPROVEMENT ACTIVITIES & ACTIONS TAKEN

In FY 2022-2023, CAHPS® stakeholders continued the established FY 2021-2022 process to evaluate data sources, including CAHPS® MY 2022 survey results and the 2022 Annual Grievance and Appeals and Second Level Grievances data. This included the analysis of said sources, improvement recommendations and NCQA Steering Committee approval to proceed with intervention activities focused on improving Access to Care and Member Experience.

The goal-setting approach this reporting period was slightly different to account for organizational change from a team goal to a department goal structure. It is also important to note that in December of 2022 the oversight of the CAHPS® survey administration transitioned from the Member Services to the Quality Improvement Department, which underscored our commitment to implement interventions aimed at driving improvement and operational changes focused on developing the CAHPS® program framework.

The FY 22-23 QI CAHPS Score Improvement (CSI) Department goal aimed to address overall member experience with an emphasis on improving equitable access to care as evaluated using MY 2021 / RY 2022 CAHPS® survey results and G&A data. The approach will include implementation of short and long term interventions[1] that target workforce development, expand primary care access and favorable member experience, and increased HealthPlan branding and promotion.

QI Department CAHPS® Score Improvement (CSI) Goal

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

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

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

Workgroup	Accomplishments	Action / Focus
CAHPS® Program Oversight Workgroup		
Goal 1: By June 30, 2023, the CAHPS® Score Improvement goal aims to address overall member experience with an emphasis on improving equitable access to care.	• CAHPS® survey administration transition, from the Member Services to the Quality Improvement department. • Created CAHPS® survey administration and created desktop procedures to be used in the development and oversight of the new program.	**Internal** Process Improvement **Intended Outcome:**

The CAHPS® Program Oversight workgroup is responsible for overseeing the administration of the CAHPS® program and may provide guidance to sub-workgroups that drive and supports the completion of goals/milestones, relative to the CAHPS® program. Using data-driven decisions, the overarching CAHPS® goal aims to define, develop, and drive strategies focused on improving a favorable perception of the HealthPlan rating, access, and overall member experience.	• Established a CAHPS® program charter. • Developed program and primary drivers within the CAHPS® programmatic framework. Tenets of the program will offer proactive, reactive, monitoring, and long-term strategies aimed to improve a favorable perception of the HealthPlan. Targeted focus: Access, Member Experience, and HealthPlan Rating. The outcome aims to maintain consistent activities and interventions that offer no disruption of improvement drivers as we transition through each fiscal year's CAHPS® survey results and process. • Key stakeholders joined the first ACAP CAHPS® collaborative which aims to; focus on current and prior years adult and child population data analysis, consultative support on proposed improvements; and collaboration with local and national Medicaid plans.	Develop a cyclical programmatic framework that is based on QI, PDSA /CQI data driven methodologies.
WORKGROUP	**ACCOMPLISHMENTS**	**ACTION / FOCUS**
DATA ANALYTICS WORKGROUP		
Goal 2: By June 30, 2023, the CAHPS® Score Improvement goal aims to address overall member experience with an emphasis on improving equitable access to care. The Data Analytics sub-workgroup will drive the data discovery, reporting, and analytics to inform and support goal period intervention activities.	• Created a report repository of existing tableau dashboards, routine reports, and on-demand Business Object reports. • Identified two dashboard reports to monitor claims/member data specific to; Specialty Office Visit Report, and PCP Office Visits Report • Member Experience workgroup activities led to additions to the Specialty Office Visit dashboard • Trended and analyzed existing CAHPS® survey results by county. • Formalized and documented methods to correlate CAHPS® survey results to interventions • Analyzed MY 2022-2023 CAHPS® survey results, G & A Pulse report, and other identified data to support the development of the Member Experience Grand Analysis report.	**Internal** Process Improvement **Intended Outcome:** The program framework includes understanding and inventorying all member data sources that can be used as key preventive indicators. Such sources include network adequacy and utilization.
MEMBER EXPERIENCE WORKGROUP		
Goal 3: By June 30, 2023, the CAHPS® Score Improvement goal aims to address overall member experience with an emphasis on improving equitable access to care. Using MY 2021/RY 2022 CAHPS® survey results the Member Experience sub-workgroup will implement short and long-term interventions[1], which improve the perception of the HealthPlan and member experience through provider engagement, incentives, marketing, and promotion of the HealthPlan with the intent of improving the overall member experience.	**Improvement Activity:** Real time member satisfaction data **Action:** • Modified existing Population-Health in-person survey and call campaigns by adding two questions related to member experience. This new member engagement data paved the way for a new pilot where collected data is reviewed monthly. Identifying satisfaction or dissatisfaction indicators, used for operational or provider network changes. **Barrier:** Partnership is aware that we have a population of members who don't know who their Managed Care Plan is, they correlate their coverage with Medical. We can't market, so we need to be strategic in our approach. Who we are, etc. **Action:** • Leveraged social media to establish PHC brand awareness, and improve communication and awareness about the member experience survey and whom to contact if they have questions or concerns about their coverage.	**External** Member Experience **Intended Outcome:** Member engagement information sharing and collection of more real time member data, (active listening).

	Barrier: Member covered benefit literacy. We identified lack of benefit awareness themes from collecting real-time survey data at Pop-Health community (see above). **Action:** We are partnering with our Communications department to offer on demand information for members to access with the mobile device. • Incorporated the use of QR codes on printed materials distributed at community events and member mailers. This provides access to on-demand information without barriers.	
ACCESS WORKGROUP		
Goal 4: By June 30, 2023, the CAHPS® Score Improvement goal aims to address overall member experience with an emphasis on improving equitable access to care. Using MY 2021/RY 2022 CAHPS® survey results the Access Improvement sub-workgroup will implement long-term interventions[1], which improve the perception of the HealthPlan and member experience through workforce development, primary care access, and pediatric specialty care access.	**Barrier:** Provider Education / How well doctors communicate. Using current Grievances and Appeals data to identify member dissatisfaction themes. We identified trends linking a handful of provider TAR submission that may be procedural in nature and being submitted without proper medical justification. The lack of appeals supports the notions. **Action:** • Analyzed pediatric outpatient TAR denials to identify opportunities for reducing the number of denied TARs, employing strategies to improve submission of appropriate TARs and reduce the number of TARs overturned upon appeal. • Reviewed access-related grievances for pediatric members to better understand dissatisfaction with access to services. **Barriers:** 1) Member Abrasion Avoidance. Linking provider education to cause and effect of unnecessary requests or lack of coverage leads to misinformed members, and subsequent confusion of denials. 2) Denial letters too technical. **Action:** • Simplify member communications focused on the Child population to reduce member abrasion with reduced technical verbiage related to the top three TAR Denials; Orthotics, Dental Anesthesia, and Genetic testing.	**External** Member Experience "Getting Needed Care Improvement Strategies." **Intended Outcome:** Evaluate and simplify member communications, assuring that members are clearly told why something is not approved. When appropriate, offer suggestions for next steps or alternatives. **Recommendations:** Explore provided education avenues with Provider Relations or QI lead efforts Revaluate TAR denials against baseline to determine effectiveness and evaluate next steps.

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

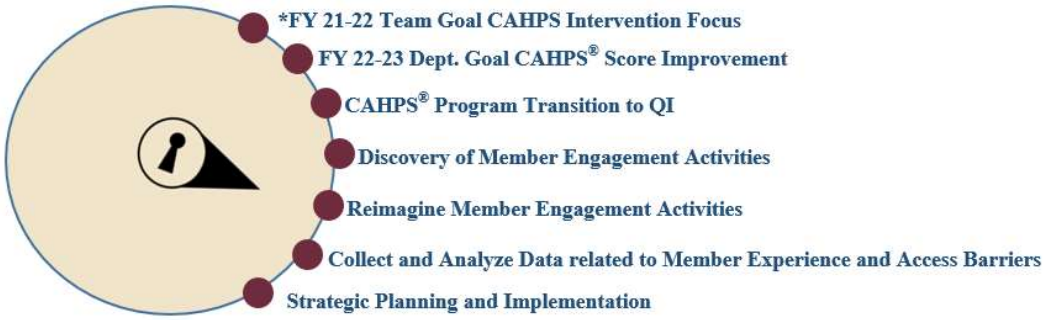
RECOMMENDATIONS & LESSONS LEARNED

CAHPS® PROGRAM

MEMBER EXPERIENCE | MOVE THE DIAL

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

As the CAHPS® Program Administration transitions into FY 2023-2024 we highlight FY 2022-2023 accomplishments of nine (9) organization-wide departments, and four (4) sub-workgroups, totaling 42 individual participants. In addition, a high-level update on continued improvement activities with Access to Care and Health Plan Ratings including in prior years ME 7 report, lessons learned and improvement recommendations for next fiscal year.



LESSONS LEARNED

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

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

As we conclude reporting period FY 2022-2023 we bring forward updates to from prior FY 2021-2022 activities focused on improving Access to Care and Rating of Health Plan outlined in the 2022 ME 7 - Member Experience Grand Analysis Report (Appendix C).

Access

- Workforce Development continues to focus on provider recruitment including the development of a regional medical resident retention program.
    - The provider recruitment program, nearing its tenth year of existence, will be enhanced to include a larger bonus, and a longer payment schedule.
    - A new component to the program will focus specifically on recruiting medical residents in our region while still in residency to retain them to the Partnership network after graduation

- Workforce Development is also working to supplement partner sites' recruitment infrastructure. After meeting certain criteria, a site may participate in a new initiative to use a Partnership-contracted recruitment firm whose cost has been offset with Partnership funds to assist with aligning physicians to available job opportunities
- The completion of a provider network vacancy report, that first took place in 2022, will be repeated in 2023 to learn of provider vacancies, current recruitment needs, and learn of trending
    - Plans to continue the survey on a more regular basis (i.e. quarterly) are ongoing
- OpEx/PMO Telehealth Program continues to improve utilization and provider engagement of program services in Video Telehealth, eConsult, Pediatric Telehealth, and Direct Telehealth Specialty Services. Notable year-over-year utilization growth in by service modality is illustrated in the table below.

Services	Completed Visits	
	2021	2020
Adult Telemedicine	5,159	4,275
Direct Telehealth Specialty Services	332	10
Pediatric Telemedicine	471	198
eConsult	2,344	2,046

Rating of Health Plan

Competing organization priorities and resource allocation slowed the production and circulation of video-related content intended to help inform and educate our members. To date, we have completed the following videos;

- ❖ Who is Partnership HealthPlan
- ❖ My Partnership ID Card
- ❖ Family Planning
- ❖ How to file a Grievance or Appeal

The list below represents a blend of potential FY 2023-2024 interventions and lessons learned that the CAHPS® Stakeholders support the NCQA categories: Attitude and Service, Access, and Rating of Health Plan, provided in Table C below.

- ❑ FY 2021-2022 Intervention activities to improve access and rating of health plan are activities we believe are providing a benefit to or members, but these may be too difficult to correlate to CAHPS® regulated survey results and may be a long-term commitment that could include focus groups geared to validate helpfulness of these videos while also inquiring on other topics that may been helpful to know.
- ❑ Listen more through all established member engagement channels and determine whether these are adequate. Member focus groups are a potential intervention under evaluation.
- ❑ Operational awareness of member-supporting activities and internal/external communication. An operational improvement to remove work silos between departments is under review and consideration.
- ❑ Continue to support PHC branding and broader member and community awareness of the importance of CAHPS® survey participation.
- ❑ PHC Transportation, support, collaborate, and evaluate member experience with the Transportation Services Department and take timely action with what we learn.
- ❑ Workforce Development, Partner with Workforce Dev Associate Dir and regional staff to:
    - Support local activities to bolster residency programs by engaging residents to help improve retention
    - Provide resources to help update and analyze PCP vacancy data and support other Workforce Development tactics linked to improving Access

- ❑ Telehealth, where applicable support PMO regional-based telehealth to improve member and provider utilization and the influence of improving access and member experience.
- ❑ Develop key preventative indicators (KPI) to resolve service line issues quickly. An operational improvement pilot is under review and consideration.
    - Develop satisfaction thresholds and targets.
    - G & A complaints to identify member service delivery dissatisfaction themes.
    - Population Health Management community member engagement survey and call campaign data
    - Transportation member satisfaction data collection, analysis, and if applicable proposed interventions
    - Develop a process to quickly identify service delivery issues through real-time data with the intent to proactively investigate, validate, and implement solutions to improve member satisfaction.
    - Remove operational barriers, TAR denials, and provider training opportunities.

VII. OPPORTUNITIES FOR IMPROVEMENT

Table C

Prioritization Ranking	NCQA Category
1	Access
2	Rating of Health Plan
3	Attitude and Service

Healthcare Effectiveness Data and Information Set (HEDIS)

Measurement Year 2023 / Reporting Year 2024

Managed Care Accountability Set (MCAS)
Summary of Performance
July 2024

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1.0 Notable Changes to the MY2023 Annual Summary of Performance Report

MY2023 continued to host two required separate audits:

- DHCS / MCAS required reporting: Health Service Advisory Group Auditor (this report's focus)
- NCQA HEDIS Health Plan Accreditation / HPA: Advent Advisory Auditor

In MY2023, Partnership observed an increase in overall membership by approximately 5.80%, which resulted in an increase in the eligible population across a subset of measures. A contributing factor to this growth occurred as the state did not begin to reinstate Medi-Cal eligibility re-determinations until April 1, 2023 and the effect on eligibility did not begin until mid-year in 2023. The overall impact of resumed re-determinations is expected to bring greater stabilization to membership over the next 1-2 years. Additionally, Partnership observed a slight increase in membership in the age range of 50 years and older which is likely a result of the expanded scope of Medi-Cal which began on May 1, 2022, in which immigration status was no longer a determining factor for eligibility for full scope of Medi-Cal for those age 50 years and older.

Partnership observed an increase in pharmacy and mental health claims impacting multiple measures. Integration of new data sources is ongoing and contributed to an overall improvement in a subset of clinical measures.

Additionally, in MY2023 Partnership focused on collecting new Electronic Clinical Data Systems (ECDS) data to primarily support the depression screening measures, which are presently designated as reporting only measures by DHCS. This required the primary source verification process mandated and audited by NCQA and its certified auditors. The ECDS data collection method is still new to many providers; many of whom are still learning to ensure their EHR system and source data align, as is required for primary source verification. Consequently, Partnership was only able to integrate ECDS data from eight (8) providers. We are continuing efforts to collect and integrate this data utilizing an NCQA data aggregator, which we are currently piloting.

NCQA released a number of changes to HEDIS® measurement specifications that applied to MY2023 including the following:

- **Deceased Members, General Guideline 16:** Exclude members who die any time during the measurement year. *Deceased members were previously considered an optional exclusion.*
- **Race and Ethnicity Stratification, General Guideline 31:** Listed additional measures which have instructions to categorize members by their RES. Added instructions on reporting "Unknown" race and ethnicity category values.
- **Exclusions**: Moved all optional exclusions to required exclusions.
- **Palliative Care Direct Reference:** In measures where palliative care is specified as a required exclusion, added a direct reference code for palliative *care: ICD-10-CM code Z51.5*
- **Frailty Cross-Cutting Exclusion:** In measures with the frailty cross-cutting exclusion (i.e. exclude members 66 years and older with frailty and advanced illness), updated the number of occurrences of frailty required. Increased from one (1) to two (2) required occurrences of frailty.

Additionally, NCQA released changes to an existing clinical measure used in DHCS MCAS for MY2023:

- Breast Cancer Screening (BCS-E) using ECDS methodology replaced Breast Cancer Screening (BCS), which was an administrative measure.

Partnership successfully launched our HEDIS® MY2023/RY2024 data collection and reporting audits incorporating all changes as noted above.

DHCS MCAS Accountable Measures

In MY2023/RY2024 HEDIS® Annual Final Reporting, DHCS is holding managed care plans (MCPs) accountable and imposing financial sanctions on 18 selected Hybrid and Administrative measures performing below the minimum performance level (MPL - 50th national Medicaid percentile) by reporting region, up from 15 accountable MCAS measures in MY2022.

Results of an additional 24 MCAS measures were reported, but were not part of the accountability measure set in MY2023 ("reporting only measures"). The full list of MY2023 MCAS measures can be found on the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Accountability-Set-Reporting-Year-2024.pdf

The same 15 MCAS measures from MY2022 continued into MY2023. The three new accountable measures added include reinstatement of the Asthma Medication Ratio (AMR) measure, which was paused in MY2022, but was previously an accountable measure. Two controversial non-HEDIS measures were also added, based on the 2022 CMS Core Measure Set: Developmental Screening in the First Three Years of Life (DEV), an administrative measure specified by CMS and Topical Fluoride for Children (TFL-CH), an administrative measure specified by the Dental Quality Alliance (DQA). Per recently released APL 24-004, DHCS designates MPLs for CMS Core Set measures in the current MY using previous Federal Fiscal Year (FFY) benchmarks as its basis.

Much of the measure performance analysis that follows is based on the performance of the 16 accountable MCAS measures per NCQA Quality Compass 2023 Benchmarks, developed on MY2022 performance.

2.0 MCAS Summary of Performance by Region

Regional Distribution of Measures by Percentile Ranking

	NORTHEAST	NORTHWEST	SOUTHEAST	SOUTHWEST
90th (HPL)			2	2
75th		2	4	2
50th (MPL)	4	3	4	8
25th	3	5	4	2
<25th	9	6	2	2

2.1 MCAS Measures at or Above the High Performance Level (HPL) – 90th Percentile

Measures	SOUTHEAST	SOUTHWEST
Immunizations for Adolescents (IMA) - Combo 2	●	
Prenatal and Postpartum Care (PPC) - Postpartum care	●	●
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care		●

2.2 MCAS Measures below the Minimum Performance Level (MPL) - 50th Percentile

In MY2023/RY2024 HEDIS Annual Final Reporting, DHCS is holding managed care plans (MCPs) accountable and imposing sanctions on selected Hybrid and Administrative measures performing below the minimum performance level (MPL- Medicaid 50th national percentile) by reporting region.

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

Measures	NORTHEAST	NORTHWEST	SOUTHEAST	SOUTHWEST
Asthma Medication Ratio (AMR) - Asthma Medication Ratio*	●	●		
***Breast Cancer Screening (BCS-E)*	●	●		
Cervical Cancer Screening (CCS)	●			
Childhood Immunization Status (CIS) - Combo 10	●	●		
Chlamydia Screening in Women (CHL) - Total*	●	●		
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	●	●	●	●
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total*		●	●	●
Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)	●			
Immunizations for Adolescents (IMA) - Combo 2	●	●		
Lead Screening in Children (LSC)	●		●	●
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care		●		
Well Care Visits (WCV) - Total*	●	●	●	
Well Child 30 (W30) - Well child visits for age15-30 months*	●	●	●	
Well Child 30 (W30) - Well child visits in the first 15 months*	●	●	●	●

Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).* ***Note:* *This report excludes measures reported to DHCS not held to DHCS MPL. ***BCS-E in historical measurement years was named BCS. HBD - HbA1c Poor Control is an inverted measure; a lower rate reflects a better performance. AMR is a reinstated measure held to MPL for MY2023.*

3.0 MCAS Performance Relative to Quality Compass® Medicaid Benchmarks

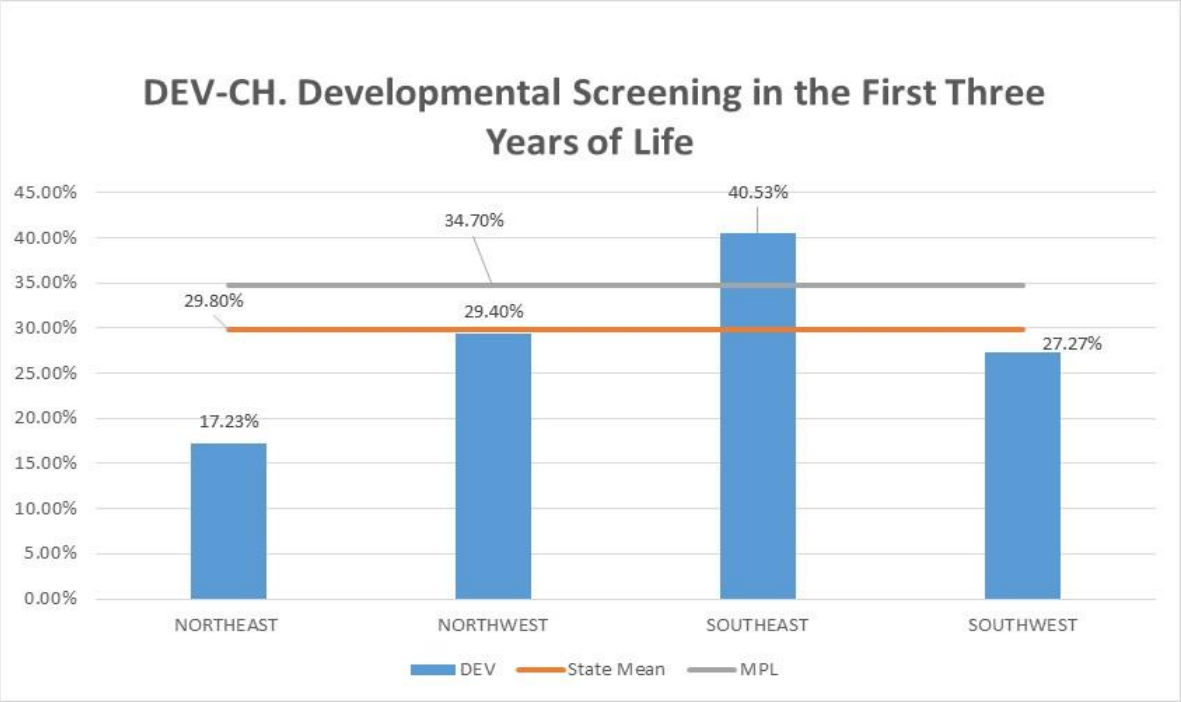
Note: *This table provides the final rankings on rates in which Partnership performed at or above the 50th MPL and the 90th percentile rankings provided by DHCS.*

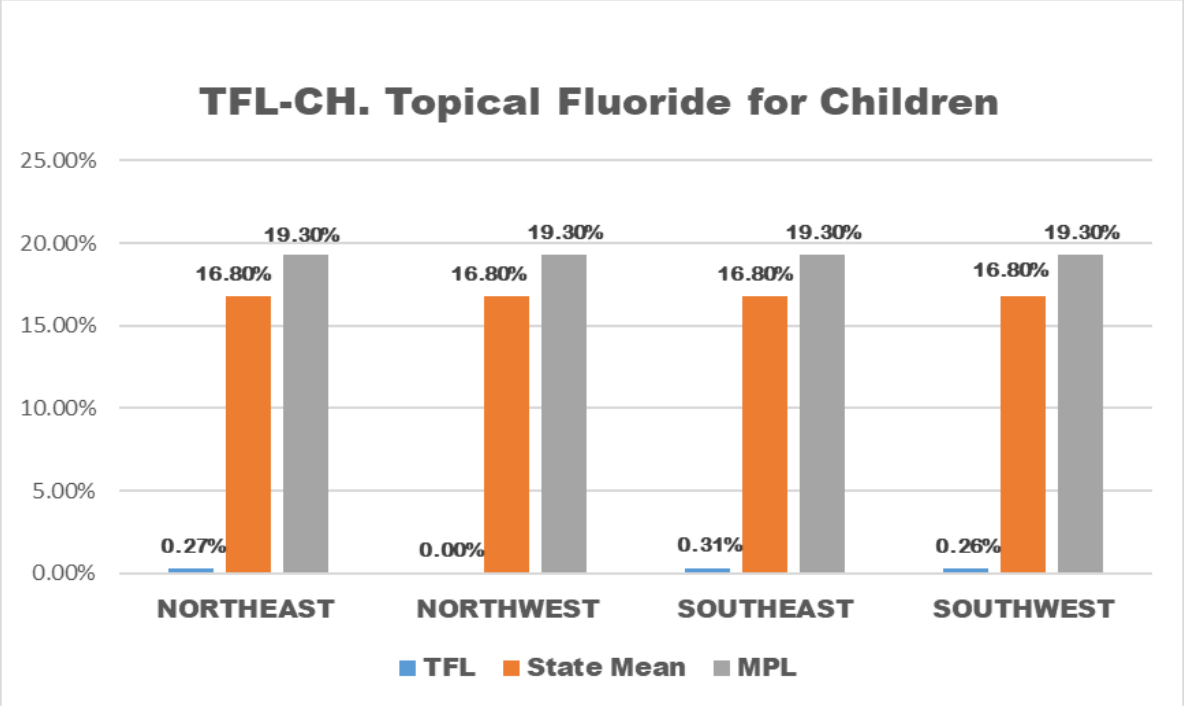
- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MPL** (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

	Regional Performance				National Medicaid Benchmarks			
Measures	**NORTHEAST**	**NORTHWEST**	**SOUTHEAST**	**SOUTHWEST**	**25TH**	**50TH**	**75TH**	**90TH**
Asthma Medication Ratio (AMR) - Asthma Medication Ratio*	49.92%	58.54%	69.61%	66.50%	58.94%	65.61%	70.82%	75.92%
***Breast Cancer Screening (BCS-E)*	50.00%	45.64%	59.95%	57.06%	47.09%	52.60%	57.48%	62.67%
Cervical Cancer Screening (CCS)	45.97%	58.72%	59.84%	61.75%	50.85%	57.11%	61.80%	66.48%
Childhood Immunization Status (CIS) - Combo 10	8.03%	18.98%	44.53%	37.47%	24.57%	30.90%	37.64%	45.26%
Chlamydia Screening in Women (CHL) - Total*	49.23%	51.78%	59.02%	57.40%	49.65%	56.04%	62.90%	67.39%
Controlling High Blood Pressure (CBP)	61.34%	63.14%	64.29%	64.75%	55.47%	61.31%	67.27%	72.22%
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	30.34%	31.60%	27.35%	34.81%	47.01%	54.87%	64.29%	73.26%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total*	38.85%	32.46%	29.85%	30.00%	27.75%	36.34%	42.67%	53.44%
Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)	38.81%	33.15%	31.32%	33.06%	44.77%	37.96%	33.45%	29.44%
Immunizations for Adolescents (IMA) - Combo 2	20.19%	31.87%	51.82%	47.93%	29.44%	34.31%	40.88%	48.80%
Lead Screening in Children (LSC)	51.09%	64.96%	61.07%	59.37%	49.61%	62.79%	70.07%	79.26%
Prenatal and Postpartum Care (PPC) - Postpartum care	81.36%	82.19%	87.50%	93.71%	73.97%	78.10%	82.00%	84.59%
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care	85.30%	79.00%	88.75%	93.71%	79.63%	84.23%	88.33%	91.07%
Well Care Visits (WCV) - Total*	41.64%	48.03%	47.79%	49.45%	42.99%	48.07%	55.08%	61.15%
Well Child 30 (W30) - Well child visits for age15-30 months*	56.09%	65.44%	65.20%	67.47%	62.07%	66.76%	71.35%	77.78%
Well Child 30 (W30) - Well child visits in the first 15 months*	39.25%	45.26%	36.83%	46.28%	52.84%	58.38%	63.34%	68.09%

Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).* ***Note:* *This report excludes measures reported to DHCS not held to DHCS MPL. ***BCS-E in historical measurement years was named BCS. HBD - HbA1c Poor Control is an inverted measure; a lower rate reflects a better performance. AMR is a reinstated measure held to MPL for MY2023.*

In MY2023/RY2024 the Developmental Screening in the First Three Years of Life (DEV) and the Topical Fluoride for Children (TFL-CH) measures are newly held accountable to the DHCS minimum performance level (MPL). Performance of both of these measures are presented below using the CMS FFY 2022 State Medians as the designated MPL benchmarks.





3.1 MCAS Percentile Ranking Change from Prior Year

Where measures remained in the MCAS in MY2023, the next table shows that Partnership observed a number of measures within our four reporting regions that declined or improved in percentile ranking relative to prior year. The NCQA Quality Compass 2023 Benchmarks, which were developed based on MY2022 performance, result in the percentile rankings below.

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

Regional Performance

Measures	NORTHEAST		NORTHWEST		SOUTHEAST		SOUTHWEST	
	MY2022	2023	MY2022	2023	MY2022	2023	MY2022	2023
Asthma Medication Ratio (AMR) - Asthma Medication Ratio*		<25th		<25th		50th		50th
***Breast Cancer Screening (BCS-E)*	25th	25th	<25th	<25th	75th	75th	50th	50th
Cervical Cancer Screening (CCS)	25th	<25th	25th	50th	75th	50th	90th	50th
Childhood Immunization Status (CIS) - Combo 10	<25th	<25th	<25th	<25th	75th	75th	50th	50th
Chlamydia Screening in Women (CHL) - Total*	25th	<25th	25th	25th	50th	50th	50th	50th
Controlling High Blood Pressure (CBP)	50th	50th	50th	50th	50th	50th	75th	50th
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total*	90th	50th	75th	25th	90th	25th	75th	25th
Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)	75th	25th	75th	75th	50th	75th	75th	75th
Immunizations for Adolescents (IMA) - Combo 2	<25th	<25th	<25th	25th	90th	90th	90th	75th
Lead Screening in Children (LSC)	<25th	25th	<25th	50th	<25th	25th	<25th	25th
Prenatal and Postpartum Care (PPC) - Postpartum care	50th	50th	90th	75th	90th	90th	90th	90th
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care	75th	50th	50th	<25th	25th	75th	90th	90th
Well Care Visits (WCV) - Total*	<25th	<25th	25th	25th	25th	25th	25th	50th
Well Child 30 (W30) - Well child visits for age15-30 months*	<25th	<25th	25th	25th	25th	25th	25th	50th
Well Child 30 (W30) - Well child visits in the first 15 months*	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th

Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).* ***Note:* *This report excludes measures reported to DHCS not held to DHCS MPL. ***BCS-E in historical measurement years was named BCS. HBD - HbA1c Poor Control is an inverted measure; a lower rate reflects a better performance. AMR is a reinstated measure held to MPL for MY2023.*

4.0 MCAS Summary of Performance by County

4.1 MCAS Distribution of Percentile Rankings by County

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

Distribution of Percentile Rankings by County

Sub Region	County	<25th	25th	50th (MPL)	75th	90th (HPL)
NORTHEAST	SHASTA	8	6	1	1	
	SISKIYOU	9	4	1		2
	LASSEN	12	2		2	
	TRINITY	9	1	5	1	
	MODOC	10	2	1		3
NORTHWEST	HUMBOLDT	4	5	5	1	1
	DEL NORTE	12	3		1	
SOUTHEAST	SOLANO	4	3	4	3	2
	YOLO	3	2	4	4	3
	NAPA	2	2	2	2	8
SOUTHWEST	SONOMA	3	3	2	4	4
	MENDOCINO	3	7	2	2	2
	MARIN	2	1	2	7	4
	LAKE	6	6	3		1

Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).* ***Note:* *This report excludes measures reported to DHCS not held to DHCS MPL. ***BCS-E in historical measurement years was named BCS. HBD - HbA1c Poor Control is an inverted measure; a lower rate reflects a better performance. AMR is a reinstated measure held to MPL for MY2023.*

4.2 MCAS Northeast Region: Modoc, Trinity, Siskiyou, Shasta, and Lassen Counties

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

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

** - Denominator at the county level is less than 20, interpret rate with caution.

	Northeast Region					National Medicaid Benchmarks			
Measures	MODOC	TRINITY	SISKIYOU	SHASTA	LASSEN	25TH	50TH	75TH	90TH
Asthma Medication Ratio (AMR) - Asthma Medication Ratio*	46.88%	48.00%	49.05%	49.94%	54.64%	58.94%	65.61%	70.82%	75.92%
***Breast Cancer Screening (BCS-E)*	45.65%	43.46%	51.66%	50.90%	45.98%	47.09%	52.60%	57.48%	62.67%
**Cervical Cancer Screening (CCS)	33.33%	44.00%	53.41%	44.02%	48.00%	50.85%	57.11%	61.80%	66.48%
**Childhood Immunization Status (CIS) - Combo 10	0.00%	7.41%	17.24%	7.69%	0.00%	24.57%	30.90%	37.64%	45.26%
Chlamydia Screening in Women (CHL) - Total*	30.39%	35.96%	46.15%	53.06%	37.37%	49.65%	56.04%	62.90%	67.39%
**Controlling High Blood Pressure (CBP)	46.15%	66.67%	73.33%	60.08%	58.70%	55.47%	61.31%	67.27%	72.22%
**Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	15.00%	26.32%	27.16%	33.66%	12.50%	47.01%	54.87%	64.29%	73.26%
**Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total*	35.29%	36.84%	28.57%	43.66%	16.00%	27.75%	36.34%	42.67%	53.44%
**Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)	25.00%	33.33%	40.35%	40.31%	32.14%	44.77%	37.96%	33.45%	29.44%
**Immunizations for Adolescents (IMA) - Combo 2	20.00%	13.04%	14.04%	23.32%	9.09%	29.44%	34.31%	40.88%	48.80%
Lead Screening in Children (LSC)	66.67%	62.96%	43.08%	51.37%	46.51%	49.61%	62.79%	70.07%	79.26%
**Prenatal and Postpartum Care (PPC) - Postpartum care	100.00%	78.57%	81.63%	80.93%	82.35%	73.97%	78.10%	82.00%	84.59%
**Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care	100.00%	85.71%	97.96%	81.96%	82.35%	79.63%	84.23%	88.33%	91.07%
Well Care Visits (WCV) - Total*	41.32%	47.73%	40.81%	41.93%	37.84%	42.99%	48.07%	55.08%	61.15%
Well Child 30 (W30) - Well child visits for age15-30 months*	62.26%	53.75%	57.85%	57.25%	43.08%	62.07%	66.76%	71.35%	77.78%
**Well Child 30 (W30) - Well child visits in the first 15 months*	31.58%	37.74%	32.05%	41.60%	26.23%	52.84%	58.38%	63.34%	68.09%

Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).* ***Note:* *This report excludes measures reported to DHCS not held to DHCS MPL. ***BCS-E in historical measurement years was named BCS. HBD - HbA1c Poor Control is an inverted measure; a lower rate reflects a better performance. AMR is a reinstated measure held to MPL for MY2023.*

4.3 MCAS Northwest Region: Del Norte and Humboldt Counties

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

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

** - Denominator at the county level is less than 20, interpret rate with caution.

	Northwest Region		National Medicaid Benchmarks			
Measures	DEL NORTE	HUMBOLDT	25TH	50TH	75TH	90TH
Asthma Medication Ratio (AMR) - Asthma Medication Ratio*	46.79%	60.64%	58.94%	65.61%	70.82%	75.92%
***Breast Cancer Screening (BCS-E)*	38.88%	47.35%	47.09%	52.60%	57.48%	62.67%
Cervical Cancer Screening (CCS)	48.89%	59.94%	50.85%	57.11%	61.80%	66.48%
Childhood Immunization Status (CIS) - Combo 10	3.53%	23.01%	24.57%	30.90%	37.64%	45.26%
Chlamydia Screening in Women (CHL) - Total*	44.16%	53.17%	49.65%	56.04%	62.90%	67.39%
Controlling High Blood Pressure (CBP)	51.65%	66.67%	55.47%	61.31%	67.27%	72.22%
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	21.78%	34.87%	47.01%	54.87%	64.29%	73.26%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total*	21.09%	34.87%	27.75%	36.34%	42.67%	53.44%
Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)	33.33%	33.11%	44.77%	37.96%	33.45%	29.44%
Immunizations for Adolescents (IMA) - Combo 2	18.42%	34.93%	29.44%	34.31%	40.88%	48.80%
Lead Screening in Children (LSC)	50.00%	68.58%	49.61%	62.79%	70.07%	79.26%
Prenatal and Postpartum Care (PPC) - Postpartum care	66.67%	86.55%	73.97%	78.10%	82.00%	84.59%
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care	81.25%	78.36%	79.63%	84.23%	88.33%	91.07%
Well Care Visits (WCV) - Total*	45.91%	48.51%	42.99%	48.07%	55.08%	61.15%
Well Child 30 (W30) - Well child visits for age15-30 months*	59.63%	66.62%	62.07%	66.76%	71.35%	77.78%
Well Child 30 (W30) - Well child visits in the first 15 months*	40.31%	46.58%	52.84%	58.38%	63.34%	68.09%

Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).* ***Note:* *This report excludes measures reported to DHCS not held to DHCS MPL. ***BCS-E in historical measurement years was named BCS. HBD - HbA1c Poor Control is an inverted measure; a lower rate reflects a better performance. AMR is a reinstated measure held to MPL for MY2023.*

4.4 MCAS Southeast Region: Solano, Yolo, and Napa Counties

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

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

** - Denominator at the county level is less than 20, interpret rate with caution.

	Southeast Region			National Medicaid Benchmarks			
Measures	NAPA	SOLANO	YOLO	25TH	50TH	75TH	90TH
Asthma Medication Ratio (AMR) - Asthma Medication Ratio*	78.34%	68.85%	65.93%	58.94%	65.61%	70.82%	75.92%
***Breast Cancer Screening (BCS-E)*	67.20%	58.12%	59.99%	47.09%	52.60%	57.48%	62.67%
Cervical Cancer Screening (CCS)	77.08%	56.17%	60.22%	50.85%	57.11%	61.80%	66.48%
Childhood Immunization Status (CIS) - Combo 10	58.18%	43.31%	40.20%	24.57%	30.90%	37.64%	45.26%
Chlamydia Screening in Women (CHL) - Total*	55.05%	62.67%	53.32%	49.65%	56.04%	62.90%	67.39%
Controlling High Blood Pressure (CBP)	64.18%	67.56%	57.00%	55.47%	61.31%	67.27%	72.22%
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	42.16%	26.27%	25.19%	47.01%	54.87%	64.29%	73.26%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total*	29.66%	31.58%	27.02%	27.75%	36.34%	42.67%	53.44%
Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)	29.03%	34.78%	23.86%	44.77%	37.96%	33.45%	29.44%
Immunizations for Adolescents (IMA) - Combo 2	68.42%	49.34%	45.28%	29.44%	34.31%	40.88%	48.80%
Lead Screening in Children (LSC)	66.67%	56.57%	69.00%	49.61%	62.79%	70.07%	79.26%
Prenatal and Postpartum Care (PPC) - Postpartum care	94.59%	85.21%	88.52%	73.97%	78.10%	82.00%	84.59%
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care	91.89%	85.92%	93.44%	79.63%	84.23%	88.33%	91.07%
Well Care Visits (WCV) - Total*	56.08%	42.80%	53.44%	42.99%	48.07%	55.08%	61.15%
Well Child 30 (W30) - Well child visits for age15-30 months*	71.53%	59.35%	75.38%	62.07%	66.76%	71.35%	77.78%
Well Child 30 (W30) - Well child visits in the first 15 months*	32.35%	35.70%	43.47%	52.84%	58.38%	63.34%	68.09%

Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).* ***Note:* *This report excludes measures reported to DHCS not held to DHCS MPL. ***BCS-E in historical measurement years was named BCS. HBD - HbA1c Poor Control is an inverted measure; a lower rate reflects a better performance. AMR is a reinstated measure held to MPL for MY2023.*

4.5 MCAS Southwest Region: Lake, Marin, Mendocino, and Sonoma Counties

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

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

** - Denominator at the county level is less than 20, interpret rate with caution.

	Southwest Region				National Medicaid Benchmarks			
Measures	LAKE	MARIN	MENDOCINO	SONOMA	25TH	50TH	75TH	90TH
Asthma Medication Ratio (AMR) - Asthma Medication Ratio*	51.71%	65.65%	60.71%	71.78%	58.94%	65.61%	70.82%	75.92%
***Breast Cancer Screening (BCS-E)*	47.56%	58.02%	50.43%	61.94%	47.09%	52.60%	57.48%	62.67%
Cervical Cancer Screening (CCS)	48.08%	73.68%	47.62%	66.49%	50.85%	57.11%	61.80%	66.48%
Childhood Immunization Status (CIS) - Combo 10	25.86%	43.37%	24.18%	45.25%	24.57%	30.90%	37.64%	45.26%
Chlamydia Screening in Women (CHL) - Total*	51.56%	72.34%	52.96%	54.05%	49.65%	56.04%	62.90%	67.39%
Controlling High Blood Pressure (CBP)	61.82%	68.00%	68.85%	62.86%	55.47%	61.31%	67.27%	72.22%
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	23.04%	43.55%	17.07%	42.82%	47.01%	54.87%	64.29%	73.26%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total*	28.39%	33.81%	30.41%	28.27%	27.75%	36.34%	42.67%	53.44%
Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)	34.62%	31.94%	37.74%	31.69%	44.77%	37.96%	33.45%	29.44%
Immunizations for Adolescents (IMA) - Combo 2	39.39%	41.94%	32.43%	57.89%	29.44%	34.31%	40.88%	48.80%
Lead Screening in Children (LSC)	44.59%	83.78%	77.14%	49.22%	49.61%	62.79%	70.07%	79.26%
**Prenatal and Postpartum Care (PPC) - Postpartum care	77.78%	100.00%	100.00%	93.33%	73.97%	78.10%	82.00%	84.59%
**Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care	94.44%	86.67%	95.24%	95.56%	79.63%	84.23%	88.33%	91.07%
Well Care Visits (WCV) - Total*	43.84%	55.51%	44.68%	50.51%	42.99%	48.07%	55.08%	61.15%
Well Child 30 (W30) - Well child visits for age15-30 months*	60.47%	76.28%	70.65%	65.11%	62.07%	66.76%	71.35%	77.78%
Well Child 30 (W30) - Well child visits in the first 15 months*	43.59%	48.69%	53.94%	42.70%	52.84%	58.38%	63.34%	68.09%

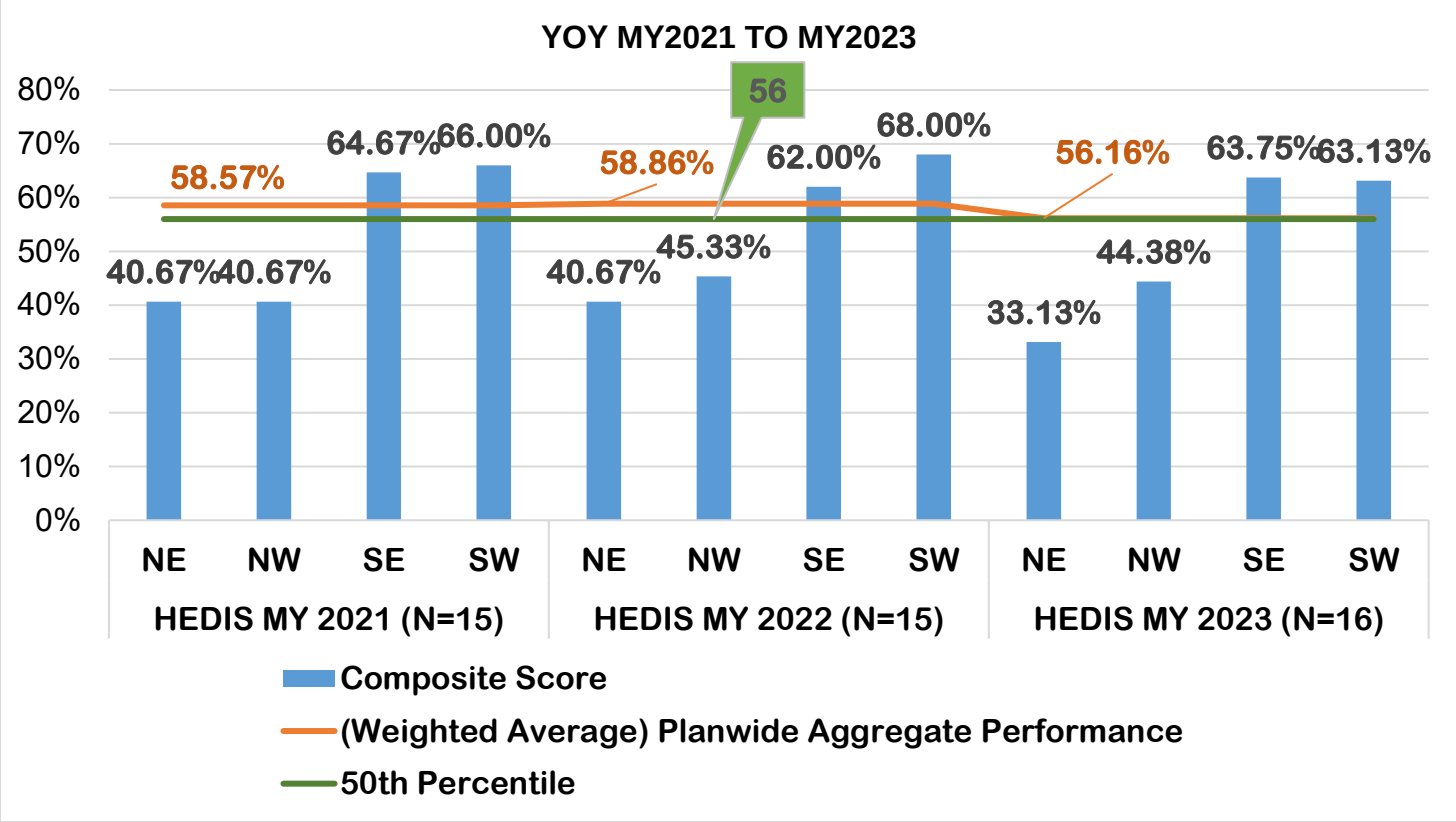
Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).* ***Note:* *This report excludes measures reported to DHCS not held to DHCS MPL. ***BCS-E in historical measurement years was named BCS. HBD - HbA1c Poor Control is an inverted measure; a lower rate reflects a better performance. AMR is a reinstated measure held to MPL for MY2023.*

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

DHCS uses a scoring methodology to determine an aggregated Quality Factor Score (QFS), which ranks health plan performance relative to California Medicaid reporting health plans. Partnership adopts DHCS' scoring methodology to determine Partnership's regional and plan-wide composite scores year over year. Each measure in each reporting region is given a score from one to ten (1-10) based on performance relative to national benchmarks. A regional composite score is then calculated by dividing total earned points by total possible points. The plan-wide composite score represents a weighted aggregate score based on the eligible populations by region, given membership is significantly greater in the southern region reporting units versus the northern region reporting units.

The Quality Compass 2023 Benchmarks, which were developed based on national MY2022 performance, are the most currently available benchmarks. These benchmarks were used by Partnership to determine percentile rankings and the following composite scoring year over year analysis. Annually each fall, DHCS releases a dashboard indicating the plan's regional Quality Factor Scores and associated rankings to other health plans. The results of this ranking will be published upon the release of this information and will be utilized by DHCS to assess mandated improvement activities and any sanctions.

MY2023 HEDIS® Composite Performance Year over Year Comparison: DHCS Managed Care Accountability Set (MCAS)



➢**Reported Measures held to MPL MY 2021:** BCS, CBP, CCS, CDC-H9, CHL, CIS-10, IMA-2, PPC-Pre, PPC-Post, W30-0-15, W30-15-30, WCC-BMI, WCC-PA, WCC-Nut, WCV

➢**Reported Measures held to MPL MY 2022:** BCS, CBP, CCS, CHL, CIS-10, HBD-H9, IMA-2,FUM-30, FUA-30, LSC, PPC-Pre, PPC-Post, W30-0-15, W30-15-30, WCV

➢**Reported Measures held to MPL MY 2023:** AMR, BCS-E, CBP, CCS, CHL, CIS-10, HBD-H9, IMA-2,FUM-30, FUA-30, LSC, PPC-Pre, PPC-Post, W30-0-15, W30-15-30, WCV

Note: MY2023/RY2024: Total Points Earned: 290 Points out of 640 Total Points (16 measures included)

- In MY2023 there were 18 measures held accountable to the MPL. The chart above shows 16 measures, excluding the DEV and TFL-CH measures. Both of these new measures are held accountable to the State's designated minimum performance level (MPL), which utilizes the CMS FFY 2022 State Median as the MPL benchmark. To date, DHCS has only established the MPLs for these new measures and therefore these measures are not included in composite scoring and year over year comparisons,
- The NCQA Quality Compass 2023 Benchmarks reflected increases for several measures, contributing to declines in final percentile rankings versus MY2022.

6.0 Year-over-year Performance Trends and Initial Assessment of Results

6.1 Year-over-year Performance Trends

The MY2023 HEDIS® Composite Performance Year over Year Comparison is based on NCQA Quality Compass 2023 (MY2022) Benchmarks. To date, DHCS has only established state-wide MPLs for the newly accountable CMS Core set measures, Developmental Screening in the First Three Years of Life (DEV) and Topical Fluoride for Children (TFL-CH), therefore these measures are not included in composite scoring and performance trend analysis.

Overall, the MY2023 HEDIS® Composite Performance Year over Year Comparison indicates a 2.70% decline in aggregate plan-wide performance from MY2022 to MY2023. The composite score trend across Partnership's four designated reporting regions versus prior year indicates a 0.95% decline in the NW, a 7.54% decline in the NE, a 1.75% increase in the SE, and a 4.87% decline in the SW.

The declines in composite scoring reflect no change in the total number of accountable measures performing below the MPL. Across all reporting regions, the total number of below MPL measures increased from 31 out of 60 measures (52%) in MY2022 to 33 out of 64 measures (52%) in MY2023. Within the 33 measures reporting below MPL, 26 are continuing measures remaining below MPL versus prior year, five (5) are continuing measures dropping below MPL versus prior year, and two (2) are previous measures returning as accountable measures in MY2023. In contrast, Partnership reported rates at or exceeding the MPL in 31 out of 64 measures (48%) in MY2023, of which the majority (29) are continuing measures from prior year.

6.2 Trends in Continuing Measures from MY2022:

- The 26 measures remaining with below MPL rates are predominantly representing reporting in the NE and NW. These measures include Breast Cancer Screening (BCS), Chlamydia Screening (CHL), Childhood Immunizations (CIS), and Immunizations for Adolescents (IMA). All reporting regions continued reporting below MPL rates for Well Child Visits in the First 15 Months (W30+6). The NE, NW, and SE continued below MPL reporting for Well Child Visits for ages 15-30 Months (W30+2) and Child and Adolescent Well Care Visits (WCV). With the exception of immunization measures, all of these rates reflect less than a 5% change versus prior year.
- Of the continuing measures, five (5) measures met or exceeded the MPL in MY2023 after reporting below MPL rates in MY2022. Specifically, the NW region achieved above MPL rates in Cervical Cancer Screening (CCS) and Lead Screening for Children (LSC). While only one region exceeded the MPL in LSC, it is important to note that the other three regions achieved improvement gains ranging from 10-21%. Ongoing improvement activities attributed to these results are continuing to spread in 2024; see Section 9 for details. The SW region is the first Partnership reporting region to exceed the MPL in Well Child Visits for ages 15-30 Months (W30+2) and Child and Adolescent Well Care Visits (WCV). Notably, the SE region also achieved above MPL results in the Timeliness of Prenatal Care (PPC-Pre) measure.
- Of the 24 measures with continued strong performance versus prior year, Partnership demonstrates above MPL performance across all its reporting regions in Controlling High BP (CBP) and Postpartum Care (PPC-Post). Additionally, the SE and SW continue to exceed the MPL in Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), Childhood

Immunizations (CIS), and Immunizations for Adolescents (IMA), while both suffering declines yet still achieving the MPL for Chlamydia Screening (CHL). The NW, SE, and SW all continue to exceed the MPL for Hemoglobin A1c Control (HBD). The NE and SW continue to meet or exceed the MPL for Timeliness of Prenatal Care (PPC-Pre) versus prior year.

- Of the five (5) continuing measures dropping below MPL, Partnership reported significant declines in the Follow-up After Emergency Department (ED) Visit for Substance Use (FUA) measure in the NW, SE, and SW after all four reporting regions reported above MPL performance in MY2022. FUA performance is now comparable to continued below MPL performance across all four regions in the other behavioral health accountable measure, Follow-up After ED Visit for Mental Health (FUM). While the accountable measures dedicated to diabetes care have varied in recent years, Partnership has maintained above MPL rates in all regions for hemoglobin A1c control measures dating back to MY2018. In MY2023, the NE region reported below MPL with just over a 5% decline in its rate while the percentiles for the current hemoglobin A1c control measure (HBD) improved. Partnership has reported varying rates across its reporting regions in the Timeliness of Prenatal Care (PPC-Pre) in MY2021 and MY2022, with 1-2 reporting regions reporting below MPL, although the regions have varied. In MY2023, the NW region is the only region reporting below MPL after meeting the MPL in MY2022. This rate reflects a 6.7% decline in the reported rate versus MY2022, with percentiles remaining stable.

6.3 Trends in New Accountable Measures in MY2023:

- The Asthma Medication Ratio (AMR) measure split with below MPL rates reported in the NE and NW regions, while meeting or exceeding the MPL in the SW and SE, respectively.
- The Developmental Screening in the First Three Years of Life (DEV) measure rates reported below DHCS' newly designated MPL in the NE, NW, and SW, while exceeding the MPL in the SE.
- The Topical Fluoride for Children (TFL-CH) reported below DHCS' newly designated MPL in all regions.

6.4 Initial Assessment of Annual MCAS MY2023 Results

Overall, the measures reaching or achieving above MPL performance were not enough to offset composite scoring of measures continuing below the MPL, returning measures reporting below the MPL, and continuing measures dropping below the MPL versus prior year. Another contributor to the declining aggregate scoring trend is 67% of measures (43 of the total 64 measures) scored demonstrated less than a 5% change in rate versus prior year. This minimal change rate occurred with an overall increasing trend in national benchmarks across the accountable measure set.

After analyzing the MY2023 annual results and year over year performance comparisons, the stagnant below MPL and declining trends can be categorized across three primary drivers.

1.) Performance – Members qualifying under a measure did not receive the required care per measure specifications and designated timeframes

2.) **Data Incompleteness** – Data used to generate reported rates has gaps, decreasing confidence that reported rates accurately reflect performance.

3.) Measure Limitations – Measure specifications determine how data is collected through the reporting of rate performance. Measure specifications can detract from a measure's intended purpose. In these cases, specifications can limit accurate representation of performance as well as detection of recent improvements that are in alignment with the measure's purpose and clinical practice.

In this initial assessment, measures with reported rates contributing to declining performance trends are accounted for under the driver considered primary. In many cases, other drivers contribute to the reported rate and are cited accordingly.

1.) Performance

The following measures are cited as having reported rates indicative of members not receiving the required care as defined by each accountable measure's purpose and design. Refer to Section 9 for a summary of improvement initiatives completed over 2023-2024, which are presently being adapted by cross-functional measure domain workgroups based on these annual reported rates to affect performance in 2024-2025.

- Childhood Immunizations (CIS): Partnership continues to struggle in its NW and NE regions, with 5-10% declines, respectively, in reported rates versus prior year. These rates are comparable to less than the 10th percentile nationally. In comparison, the national percentiles reflect a 4% on average decline between MY2021 and MY2022. The PCP QIP plan-wide performance rate in MY2023 was 27.98%, which is below the MPL and comparable to the range of rates reported across the MCAS regions. In review of HEDIS sampled medical records, the second required influenza immunization and fourth Pneumovax immunization were observed as the most common missing immunizations. In cases where the immunizations were administered, the dates of service were often outside the measurement compliance timeframe. Additionally, high rates of parental refusal continue to be a major factor in measure performance, which even when documented in the record is not a permitted exclusion under the HEDIS measure. Similarly, the PCP QIP team noted multiple exclusion requests by providers in MY2023 due to parental refusals. Additionally, as cited below, Data Incompleteness was another contributing driver to low reported rates.
- Immunizations for Adolescents: Like CIS, Partnership continues to struggle in its NW and NE regions with continued low rates. While the NW region reported a 7% gain, this was not enough to exceed the 25th percentile and the NE remains below the 10th percentile. The PCP QIP plan-wide performance rate in MY2023 was 38.89%, which is just above the MPL, but comparable to the range of rates reported across the MCAS regions. The predominant causes of low rates are missing or late secondary doses of the HPV immunization series and high rates of parental refusal. Additionally, as cited below, Data Incompleteness was another contributing driver to low reported rates.
- Well Child Visits for ages 15-30 Months (W30+2): Partnership continues to struggle in the majority of its regions, with only the SW region reaching the MPL. While improvement gains were observed across all regions, less than a 5% change in rates were reported versus MY2022. Performance is largely impacted by access constraints in the Partnership PCP network.
- Child and Adolescent Well Care Visits (WCV): This measure requires an annual well care visit for children and adolescents between the ages of 3-21. Similar to the well child visit measures, improvement gains were observed across all regions but constituted less than a 5% change in rates versus prior year. Given this measure's demand, performance is largely impacted by the

same access constraints cited for the well child visit measures. When providers face capacity challenges, they are prioritizing babies and toddlers for visits versus older adolescents. Additionally, as members age through adolescence their engagement in seeking annual well care visits lessens as the perceived needs is not as great amongst this generally healthy and active population.

- Timeliness of Prenatal Care (PPC-Pre): The NE and NW experienced, on average, a 6% decline in reported rates versus prior year. While the NE just met the MPL, the NW region is reporting below MPL after meeting the MPL in MY2022. In contrast, the SE experienced a significant improvement over prior year, reporting just over a 5.5% gain. Initiatives central to the improving access in the SE, as summarized in Section 9, are being studied for spread opportunities to improve access in the NE and NW.
- Breast Cancer Screening (BCS): Notable improvement gains were achieved in the NE and NW, which positively influenced composite scoring, but did not result in achievement of the MPL. These gains are largely attributed to initiatives cited in Section 9, focused on creating greater access through mobile mammography events. This measure continues in the PCP QIP to bring continued PCP focus in utilizing available access to mammography services on an ongoing basis. PCP QIP MY2023 plan-wide results demonstrate comparable performance to the rates reported across MCAS regions. Of note, performance in this measure is expected to drop next year and in the following few years, as the U.S. Preventive Services Task Force (USPSTF) lowered the recommended age for initiating breast cancer screening from age 50 years to 40 years in April 2024. While the NCQA HEDIS measure has not yet been updated to reflect this recommendation, Partnership anticipates this will result in larger demand for already limited availability of mammography services. As this is occurring nationally, an adjustment in the benchmarks for this measure may follow, but some negative impact on performance is anticipated. The initiatives cited in Section 9 are of even more importance given this development.

2.) Data Incompleteness

In MY2023, Partnership was unable to obtain HEDIS auditor approval to integrate regional HIE, Sacramento Valley Medical Share (SVMS), as a supplemental data source for lab and immunization data. This was a qualified data source in MY2022 and in prior years. This influenced declining rates reported under measures with large dependencies on lab data, as outlined below. Partnership is working with SVMS to improve validation processes for increased confidence when seeking auditor approval next year.

- Cervical Cancer Screening (CCS): The SW, SE, and NE reported rates representing a 5.5-8.0% decline over prior year. No shifts were observed in MPL status, but composite scores were adversely impacted as the benchmarks are narrow. Secondly, this measure has performance struggles due primarily to access constraints resulting from low staffing across the PCP network. As noted in Section 9, Partnership is attempting to address access via piloting self-swab test kit distribution to members through PCPs.
- Chlamydia Screening in Women (CHL): All reporting regions experienced slight declines in rates versus prior year. The NE and NW rate changes were enough to impact positioning relative to increasing national benchmarks, thereby adversely influencing composite scoring. In initial analysis of members qualifying in the NE and NW, most were the result of pregnancy testing or filling of contraceptives ordered by non-PCP providers. As such, the absence of SVMS data may

have limited capturing screenings completed outside of the PCP network where administrative data capture is less robust. These data observations have also been shared with large PCP organizations in the NE and NW to inform improvement activities through primary care workflows.

- Hemoglobin A1c Control (HBD): All reporting regions have consistently reported above MPL performance in diabetes hemoglobin A1c controls measures dating back to MY2018. A 5.0% decline in the NE rate resulted in below MPL, at the 37.5th percentile, after reporting at the 75th percentile in MY2022. In comparison, the SW rate experienced a 2% decline, no change in the NW rate, and an almost a 5% improvement in the SE versus prior year. For reference, the 50th percentile (MPL) to the 90th percentile only represents an 8.5% span. While the absence of SVMS alone does not explain the declines in the NE and SW, because of varied coding practices across the network, it is believed to be a contributing driver. Another driver influencing reported HBD rates is cited under Measure Limitations (see below).
- While the California Immunization Registry (CAIR) and claims data serve as primary data sources for immunization measures, SVMS also represents a supplemental data source for assuring data completeness in these measures.

In MY2023, Partnership utilized data provided by DHCS to fully represent performance under the following measures:

- Topical Fluoride for Children (TFL-CH): Each region reported rates of less than 1% for this new accountable measure. The largest driver is incomplete dental claims data provided by DHCS; major gaps have been identified relative to qualifying members under this measure. This measure can be fulfilled through services provided in either the primary care or dental setting. While Partnership is leveraging its PCP QIP to incentivize completing this service during well child visits, most medical providers opt-out due to capacity and access constraints. A secondary driver to the low rates is related to the measure specifications. In surveying Federally Qualified Health Centers with embedded dental clinics, Partnership learned the Prospective Payment System (PPS) does not offer any additional reimbursement when billing for this service, thereby limiting accurate representation of performance (i.e., providers failing to bill despite completing the service).
- Follow-up After Emergency Department (ED) Visit for Mental Illness or Substance Use (FUM/FUA): These measures are accountable because members are eligible for both medical and mental health benefits under Medi-Cal. Unlike other state Medicaid systems (which drive national benchmarks), Medi-Cal divides mental health benefits from medical benefits, and then further divides these benefits between managed care plans and “County Mental Health Plans (MHPs)”. Benefits for those requiring “Specialty Mental Health Services (SMHS): aka Serious and Persistent Mental Health Services” are the responsibility of the County MHPs, while the benefits for those requiring Non-Specialty Mental Health Services (NSMHS) are the responsibility of Partnership. This complicated dual delivery system limits Partnership’s ability to capture, through internal means, all follow-up visits, as it relies on reporting from the state, which currently provides this data on behalf of counties in SMHS cases (where the county is responsible for follow-up visits). In prior years, when these measures were reporting only, inconsistencies in the mental health data received by the state were cited. Over the course of MY2023, Partnership and several other health plans observed significant drops in monthly data provided by DHCS. To help address this, Partnership is actively pursuing data agreements with over 20 of its counties to improve capturing follow-up visits from county mental health and SUD providers through SVMS.

Interventions with large PCP organizations are also underway, focused on timely referral processing and/or timely follow-up to ED discharge reporting. Incomplete data is the largest driver, but Measure Limitations and Performance drivers are also contributing to the low reported rates. The current measure specifications limit counting timely follow-up visits if they do not have a diagnosis matching the ED visit. Partnership also acknowledges there is significant performance improvement potential under both measures, which can be more fully addressed once data is more complete and anticipated specification updates occur.

- Well Child Visits in the First 15 months of Life (W30+6): The Medi-Cal eligibility process was designed to ease the process by which newborns apply and gain Medi-Cal, not for capturing newborn well baby visits. Partnership has identified significant gaps in newborn data because early visits occur under a temporary ID before newborns are granted Medi-Cal and enrolled with Partnership. These visits are subsequently difficult to link to the permanent ID when the member becomes eligible under this HEDIS measure in the MY they turn 15 months old. DHCS recently launched a Newborn Gateway program, which has been offered as a solution to improve linking of records, however the process by which this will happen is unclear and will be monitored closely by Partnership. Partnership is launching new initiatives this summer to expedite newborn member enrollment and PCP selection, which also supports performance by helping moms establish newborn care with a PCP earlier. The HEDIS team is also evaluating creation of a supplemental data source to better match the higher performance rates captured in the PCP QIP.

3.) Measure Limitations

- Developmental Screening (DEV): This measure was formerly a reporting only measure. In MY2023, the SE, NW, and NE reported improved rates ranging from 3-8% versus prior year, but only the SE was able to exceed DHCS' designated MPL. Starting in 2019, Partnership's Site Review team incorporated chart audits for this measure into their workflow. The results from these and other chart audits suggest that more screenings are occurring than what this measure's performance reflects. Accurate measurement of this developmental screening is significantly limited by prescriptive coding requirements. Along with the chart audits, the Site Review team includes counseling of providers performing these screenings to update their coding practices. This resulted in very limited success, due to struggles to gain provider adoption of coding these screenings properly to capture compliance. A review of efforts to improve performance on this measure is indicated.
- Hemoglobin A1c Control (HBD): In addition to the Data Incompleteness driver, the reported rates in MY2023 are also influenced by measure specification inclusion of GLP-1 antagonist medications for weight loss (not diabetes). When these medications are filled by members, it qualifies them for the measure denominator even when a diagnosis for diabetes is not present. In reviewing sampled medical records, the HEDIS team observed an increase in members taking these medications without evidence of a diabetes diagnosis. When these medications are used for weight loss in non-diabetic patients, providers are less likely to order and assure HbA1c testing, for which a threshold must be met for the member to be compliant with the measure. This observation was further substantiated by the PCP QIP team, who received unprecedented exclusion requests from providers for this reason in MY2023. Partnership's PCP QIP and the

NCQA HEDIS measure specifications have been updated for MY2024, each now requiring a documented diagnosis of diabetes for members to qualify.

- Asthma Medication Ration (AMR): While only the NW and NE reported below MPL performance, all reporting regions experienced declines, averaging over 6.5%. In contrast, the year-over-year benchmarks remained stable. Partnership removed AMR from its PCP QIP at the conclusion of MY2023, given continued year-over-year performance gains in recent years. In preparation for this year's annual MCAS project, Partnership proposed and gained auditor approval of an AMR custom code mapping to better reflect medications actively used in clinical practice. This is to mitigate the impact of lagging updates to the medications cited for use in the measure specifications. Given the unexpected declines, the Partnership Pharmacy team evaluated the MY2023 HEDIS eligible population and their use of medications over the course of 2023 contributing to member-level ratio calculations. In total, eight controller medications were being used that were not included in the approved custom code mapping. With additional claims analysis, an impact on AMR rates was not found. Next steps include a closer evaluation of performance improvement opportunities by Partnership's cross-functional Chronic Disease and Medication Management improvement workgroup. Given the risk of lagging updates to the medications permitted in this measure, the HEDIS team will review updates to its AMR custom code mapping more frequently based on medication use across this population.

6.5 Comparing MY2023 MCAS Results to MY2023 PCP QIP Results

Overall, the PCP QIP in MY2023 improved about 4% year over year from MY2022. Members eligible under the QIP must be assigned to contracted PCPs in good standing for at least 9 months of the year and qualify under criteria unique to each clinical measure. In contrast, members qualifying under HEDIS clinical measures are required 11 of 12 months enrollment with the health plan. As a result, the member populations are similar but not equal across comparable clinical measures. The clinical measures included in the PCP QIP are designed to reflect HEDIS measure priorities. In some cases, Partnership allows medical record data to supplement measure rates in the PCP QIP, whereas this is not permitted in all HEDIS measures.

The accountable MCAS measure performance trends for MY2023 were compared to corresponding MY2023 PCP QIP results. The only significant differences observed were in the well child and well care visit measures. WCV reported rates under MCAS ranged between 41.64-49.45% for qualifying members 3-21 years of age. For reasons noted previously, the PCP QIP WCV measure only includes members 3-17 years of age. This, combined with permitting supplemental medical records not allowed under MCAS WCV, influenced the higher achievement of 53.37% in PCP QIP plan-wide performance. In the well child visit measure specific to members 0-15 months of age (W30+6), the MCAS reported rates ranged between 36.83%-46.28% whereas the PCP QIP measure, reflecting the same age range, achieved 63.95% plan-wide performance. This difference is largely attributed to QIP permitting supplemental medical record data. As noted previously under the Data Incompleteness driver, Partnership is evaluating creation of a supplemental data source for HEDIS to better match higher performance rates captured in the PCP QIP. If this is determined to be feasible and gains approval from the HEDIS auditor, this would help offset incomplete newborn data in HEDIS with the goal of achieving rates in MCAS more reflective of the PCP QIP.

6.6 Next Steps in Finalizing Assessment of Results

- In the SE and SW, where a delegated arrangement once existed between Kaiser and Partnership, the impact on accountable measures reported by Partnership is still being analyzed.
- DHCS will finalize Quality Factor Scoring of all managed care plans, based on composite scoring per reporting region, late this fall and assess mandated performance improvement activities and sanctions thereafter.
- Final assessment of results will be used to adapt quality measure score improvement strategies and tactics in 2024-2025.

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

The table below provides a summary of Primary Care Provider Quality Improvement Program measures included in the Measures Managed Care Accountability Sets (MCAS) for Medi-Cal Managed Care Plans Measurement Year 2023 | Reporting Year 2024.

HEDIS Measures	MY2022 PCP QIP Measures	*MY2023 PCP QIP Measures*	Alternate Measure in PCP QIP Measures
Adult Body Mass Index (BMI) Assessment (ABA)			
Antidepressant Medication Management: Acute Phase Treatment (AMM-Acute)*			
Antidepressant Medication Management: Continuation PhaseTreatment (AMM-Cont.)*			
Asthma Medication Ration (AMR)*	X	X	
Breast Cancer Screening (BCS)*	X	X	
Cervical Cancer Screening (CCS)	X	X	
Childhood Immunization Status (CIS) – Combo 10	X	X	
Chlamydia Screening in Women (CHL)*			
Comprehensive Diabetes Care (CDC-H9) – HbA1c PoorControl (>9.0%)*	X	X	For the PCP QIP, we use the inverse of this measure: Good Control, HbA1c Good Control
Comprehensive Diabetes Care (CDC-HT) – HbA1c Testing			
Controlling High Blood Pressure (CBP)	X	X	
Immunizations for Adolescents (IMA) – Combo 2	X	X	
Prenatal and Postpartum Care (PPC) – Postpartum Care			Measure is in the perinatal QIP
Prenatal and Postpartum Care (PPC) – Timeliness of PrenatalCare			Measure is in the perinatal QIP
Weight Assessment and Counseling for Children/Adolescents(WCC) – BMI Assessment			
Well-Child Visits in the First 15 Months of Life: Six or MoreWell-Child Visits (W15)	X	X	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years ofLife (W34)			
Eye Exam for Patients with Diabetes (EED)		X	
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)		X	
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)		X	
Child and Adolescent Well-Care Visits (WCV)	X	X	
Colorectal Cancer Screening (COL)	X	X	

PCP QIP Measurement Set: http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx

8.0 Measurement Year 2023 Managed Care Accountability Site (MCAS) Measurement Set Descriptions-Accountable Measures

HEDIS Measure	Measure Indicator	Measure Definition
*Asthma Medication Ratio (AMR)	• Total	• The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
*Breast Cancer Screening (BCS-E)	• Non-Medicare Total	• The percentage of women 52–74 years of age who had a mammogram to screen for breast cancer as of December 31 of the measurement year.
Cervical Cancer Screening (CCS)	• Total	• The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: o Women 21–64 years of age who had cervical cytology performed within the last 3 years o Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years
*Child and Adolescent Well-Care Visits (WCV)	• Total	• The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. • Total. The sum of the age stratifications (ages 3–21) as of December 31 of the measurement year.
Childhood Immunization Status (CIS)	• Combination 10	• The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.
*Chlamydia Screening in Women (CHL)	• Total	• The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. o Total. The sum of the age stratifications.

HEDIS Measure	Measure Indicator	Measure Definition
Controlling High Blood Pressure (CBP)	• Total	• The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
*Developmental Screening in the First Three Years of Life (DEV_CH)	• Total All Ages	• Percentage of children screened for risk of developmental, behavioral, and social delays screening tool in the 12 months preceding or on their first, second, or third birthday. • This measure is a CMS FFY 2022 Child Core Set Measure, held to the DHCS designated MPL.
*Follow-Up After ED Visit for Mental Illness – 30 days (FUM)	• Total	• The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
*Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)	• Total	• The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
Immunizations for Adolescents (IMA)	• Combination 2	• The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. • Combination 2. Adolescents who have had all three indicators (meningococcal, Tdap and HPV).
Hemoglobin A1c Control for Patients With Diabetes (HBD)	• HbA1c poor control (>9.0%)	• The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the Measure Indicators performed. ○ HbA1c poor control (>9.0%). The most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Lead Screening in Children (LSC)	• Total	• The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. • At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday.
Prenatal and Postpartum Care (PPC)	• Timeliness of Prenatal Care • Postpartum Care	• The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. o Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. o Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
*Topical Fluoride for Children (TFL-CH)	• Total ages 1 through 20	• Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year. • This measure is a CMS FFY 2022 Child Core Set Measure, held to the DHCS designated MPL.
*Well-Child Visits in the First 30 Months of Life (W30)	• Well-Child Visits in the First 15 Months • Well-Child Visits for Age 15 Months–30 Months.	• The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: • Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. • Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

**-Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures*

9.0 Quality Improvement Initiatives - HEDIS Score Improvement

Partnership's Quality Improvement organization-wide goals for 2023-2024 focused on five measure domains similar to those defined under the DHCS Managed Care Accountability Set (MCAS) measures:

1. **Medication Management**
2. **Chronic Diseases**
3. **Behavioral Health**
4. **Pediatrics**
5. **Women's Health and Perinatal**

The Quality Measure Score Improvement (QMSI) effort continues to better coordinate service and performance across the organization and to raise Partnership's overall performance in quality measures, as defined under DHCS MCAS and NCQA Health Plan Accreditation (HPA). This effort involved team formation under QMSI to encompass all current and potentially future accountable measures by measure family within each workgroup team: Pediatric, Chronic Diseases, Medication Management, Behavioral Health, Women's Health and Perinatal Care. Each workgroup monitored and reviewed all measure performance where data was available, assessed current improvement efforts, identified gaps and initiated new performance improvement activities.

QMSI workgroups consisted of cross-functional teams led by Quality and included representation from across the organization, such as: Care Coordination, Claims, Health Education, Office of the CMO, Pharmacy, Population Health, Provider Relations, Quality and/or regional leadership. The following summaries include what each measure-family QMSI Workgroup Team achieved in 2023-2024.

9.1 Medication Management Measure Activities

ADD measure project (ADD=ADHD medication monitoring) Initial Visit: The goal of this project was to improve timely ADHD follow-up visit rates for children newly prescribed and dispensed an ADHD medication by sending a fax of 1st fill with 30-day appointment reminder. A total of 332 faxes were sent on behalf of members from March 8, 2023 through December 29, 2023. A total of 145 of those members received appropriate follow-up care with their prescriber within 30 days of starting their new ADHD medication, which translates to a rate of 43.67% for the intervention group. This is an improvement from the baseline rate of 40.09% (rate from MY2022). The results suggest that continual communications with prescribers through these faxes may be beneficial in ensuring appropriate and timely follow-up care for these children.

POD (Pharmacotherapy for Opioid Use Disorder) Project: The Pharmacy team identified members on buprenorphine for opiate use disorder. The focus of this project was on pharmacy outreach via fax,

using daily reports to identify those who are three (3) days overdue. Summary of results: It would appear that pharmacy fax intervention performed better than no intervention (36.4% vs 24%) and provider fax intervention did not perform better than control (22.7% vs 24%).

AMR (Asthma Medication Ratio) Pilot Analysis: This intervention looked at members who appear on the Collective Medical (now Point Click Care) 72-hour asthma ED event report, with an ED discharge within seven (7) days, who are 18 and older. The goal was to improve AMR HEDIS® measure performance and lower repeat ED visit/hospitalization among members reached and educated, compared to those who were not reached. Results: Compared to the control group (members not reached), members who received a phone call had a higher chance of increasing their AMR after their phone call. Members also showed an increase in PCP visits and a decrease in ED visits for asthma in the follow up period.

9.2 Chronic Disease Measure Activities

Colorectal Cancer Screening: Cologuard. To focus on colorectal cancer screening, the workgroup continued the collaboration with Exact Sciences, maker of Cologuard (FIT DNA test), through a pilot test which began in June 2023. Partnership engaged interested sites, which resulted in the completion of four (4) successful bulk order cycles in 2023. This program expands colorectal cancer screening access by offering a bulk order option to sites for eligible members not seen annually by their primary care provider. Currently, 27 distinct parent organizations in all three (3) regions are participating in various planning and deployment stages. Initial pilot results show increased testing but overall evaluation of impact on Colorectal Cancer Screening rates remains pending.

Best Practices for at-home Blood Pressure Monitoring and Member Engagement: The Partnership Medical Equipment Distribution Services (PMEDS) program distributes medical devices to eligible members based on diagnosis of related conditions. The work group has collaborated with a PCP who has experienced success in this measure by utilizing the PMEDS program. Their work flows and interdisciplinary care approach has been documented. The work group will consider piloting a similar interdisciplinary approach with interested PCP Quality Incentive Program (QIP) organizations to increase measure success annually. This may increase measure success by implementing workflow best practices alongside the PMEDS program.

9.3 Behavioral Health Measure Activities

Activities for FUA and FUM Measures:

- Review performance rates for measures in communication with Health Analytics Team to ensure regular dissemination of rates throughout year.
- Track Behavioral Health data, specifically focusing on the data sharing component that is included in the Memorandums of Understanding (MOUs) that will be executed with County Behavioral Health departments.
- Completed DHCS mandated fishbone diagrams for Northern and Southern regions assessing root causes for lower rates of follow-up visit for mental illness within 30 days of discharge from ED.
- Evaluated and documented discharge process at Partnership's EDs related to discharge with a diagnosis

of mental illness
- Evaluated provider utilization of ER Notification and Alerts features for behavioral health in Partnership's Provider Online Services.
- Tracking of DHCS Nonclinical Performance Improvement (PIP) related to Follow-Up After Emergency Department Visit for Mental Illness (FUM).
- Partnership is participating in DHCS' Behavioral Health Collaborative

9.4 Pediatric Medicine Measure Activities

School-Focused Immunization Clinics: Conducted 5 school-focused immunization clinics in Shasta County as part of a building pilot program resulting in 260 students vaccinated. The pilot program partners included a team of enthusiastic school nurses and a locally owned pharmacy partner. Key learnings from this year's program included the need for education, where possible, about the importance of the cancer-preventing HPV vaccine.

Launch of the State-Mandated Performance Improvement Project (PIP) Focused on Early Well-Care in Black/African American Members in Solano County: During this fiscal year, Partnership staff completed a Root Cause Analysis where the largest identified themes impacting 0-15-month well-baby visits for Black/African-American children in Solano County are: Member education, trust and cultural barriers, access, provider-specific issues. This PIP's initial intervention will likely address delays in Medi-Cal enrollment, which have a significant impact on all families, including African American families, continuity of care with their chosen PCP and on Partnership's ability to capture all well-child visits in babies' first 15 months of life.

Improve the Completion of Lead Screening: The following strategies were developed and launched: Strategy one (1): Increased practice access to lead Point of Care Devices (POC), which resulted in 38 POC device grants being awarded. Strategy two (2): Provided lead prevention education to clinical practices that see children, including best practices identified through outreach to high and low performing practices. Strategy three (3): Ensure education for clinical practices includes both information on and the importance of billing for lead testing so that testing numbers may be captured. Strategy four (4): Increased member and provider awareness of the importance of lead prevention and lead testing through educational articles and webinars.

QI Measures and Claims Investigation Pilot. This was a micro pilot working with QI Analyst and QI Manager to research coding and billing practices for underperforming sites specific to well-child visit (WCV) and W15 measures. The results of research did not identify specific coding errors, but did identify several non-numerator compliant members that had visits during the measurement year with a potential to be converted to a well-child visit. These missed opportunities were shared with the pilot sites along with best practices for addressing opportunities for incorporating preventative care during all patient visits.

Increase HPV and Flu Vaccine Uptake through New Provider Incentives for Early Administration: In order to address continuing low rates of childhood and adolescent immunizations, the Pediatric

workgroup proposed 2 new measures for the 2024 calendar year to incentivize family and pediatric practices for early administration of two (2) multidose vaccines: HPV and Influenza. These incentives are currently part of Partnership's PCP Quality Incentive Program (PCP QIP) for 2024.

Promote Pediatric Group Well-Care Visits through Expanded Provider Incentive: Group Well-Care Visits is one (1) proven strategy to increase completion of these important pediatric preventative care services early in a child's life. The Pediatric workgroup proposed implementing a new measure in Partnership PCP QIP program to incentivize providers to conduct group well-visit cohorts in the 2024 calendar year, focusing on the 0-15-month old population. This incentive was approved and is currently part of the 2024 PCP QIP unit-of-service measure set, as an expansion of the existing "Peer-Lead Group Visits" measure.

Completed Participation in the Centers for Medicare and Medicaid Services (CMS) Affinity Group to Improve Baby Well-Care Visit Completion: Partnership completed participation in this 2-year collaborative focused on improving early well-baby visits in December 2023. In the intervention, Partnership focused on outreach to new mothers to ensure they have their first well-baby appointments scheduled at or shortly after discharge and found that 86% of members that were reached by Population Health attended their appointments that had been scheduled at discharge.

Launch Participation in DHCS/Institute for Healthcare Improvement (IHI) Collaborative to Improve Pediatric Well-Care Visits: In March of 2024, Partnership engaged in the launch of a one (1)-year, mandated collaborative led by DCHS, intended to improve access, coordination and equity across the communities we serve by initiating a focused effort to improve the completion of pediatric well-care visits, with a specific lens towards equity. The front-line project work is conducted in partnership with a primary care organization who have agreed to participate in this program as a pilot partner. Their role is to work with their managed care plan to develop and execute the project phases:

- Equity and Transparent, Stratified, and Actionable Data (April-May, 2024)
- Understand Provider and Patient/Caregiver Experiences (June-July, 2024)
- Reliable and Equitable Scheduling Processes (August-October, 2024)
- Asset Mapping and Community Partnerships (November-December, 2024)
- Partnering for Effective Education and Communication (January-March, 2024)

9.5 Women's Health and Perinatal Care Measure Activities

Improve Breast Cancer Screening by Engaging Mobile Mammography: The major effort to improve BCS performance this year was focused on scheduling mobile mammography event days in our most rural, access challenged areas. Partnership continued to contract with Alinea Medical Imaging, the sole provider of mobile mammography services in Northern California. In FY 23-24, there were 67 Mobile Mammography event days with 27 provider organizations at 42 geographical sites. These events resulted in 923 completed mammograms for Partnership members. There was an overall no-show rate of 26%.

Cervical Cancer Screening Self-Swab Pilot: A Cervical Cancer self-swab pilot launched in January 2024 with five (5) strategically selected primary care clinics in all four (4) sub-regions and of all different sizes. The scale of the pilot was to use 200 kits across the five (5) sites. The pilot was planned to wrap up at the end of May 2024 but is being extended by 12 weeks to allow more time to use all of the 200 kits. The most common barriers to using the test kits reported by the clinics is the process to register the self-swab kit for testing. This process is outside of their normal workflow, thus cumbersome to manage. The equally most common barrier is that patients are still reluctant to be screened, even when they can collect the sample themselves.

Perinatal Care Improvement Efforts: Efforts to improve perinatal care included through CME/CEU educational presentations, provider newsletter articles, targeted perinatal outreach to Native American/Alaskan Native populations, participation in a Solano County collaborative group that focused on improving access to obstetrical care by developing better systems of care across organizations and improving methods of patient-related and professional communication. The outcomes of the Solano collaboration resulted in one of the Federally Qualified Health Centers (FQHCs) were able to add additional prenatal providers, one FQHC added new prenatal services which reduced average wait time for new patient appoint from six (6) weeks to one (1) week at most of the practices. With improved access for routine care throughout Solano County, the community hospital system is able to focus on high-risk care, which alleviates other access concerns.

Chlamydia Screening Improvement Efforts: Activities to improve this measure in the past year included a new educational session for providers and initial querying of providers about contributing factors to low performance. The educational session included content on screening and treatment best practices and screening disparities by race/ethnicity. Practices indicated that there are complicating factors for chlamydia screening, especially among adolescents. The providers also reported challenges in implementing universal screening for chlamydia that relate to practice work flows and limited provider capacity for soliciting the appropriate history regarding sexual activity. Pilot tests are being planned for the next fiscal year.

Healthcare Effectiveness Data and Information Set (HEDIS)

Measurement Year 2023 / Reporting Year 2024

NCQA HealthPlan Accreditation (HPA) Summary of Performance

PHC – HPA Star Rating

July 2024

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1.0 Notable Changes to the MY2023 Annual Summary of Performance Report:

MY2023 continued to host two required separate audits:

- DHCS / MCAS required reporting: Health Services Advisory Group Auditor
- NCQA HEDIS Health Plan Accreditation / HPA: Advent Advisory Group Auditor

In MY2023, Partnership observed an increase in overall membership by approximately 5.80%, which resulted in an increase in the eligible population across a subset of measures. A contributing factor to this growth occurred as the state did not begin to reinstate Medi-Cal eligibility re-determinations until April 1, 2023 and the effect of eligibility did not begin until mid-year in 2023. The overall impact of resumed re-determinations and adverse benefit determinations is expected to bring greater stabilization to membership over the next 1-2 years. Additionally, Partnership observed a slight increase in membership in the age range of 50 years and older which is likely a result of the expanded scope of Medi-Cal which began on May 1, 2022 in which immigration status was not a determining factor for eligibility for full scope of Medi-Cal for those aged 50 years and older.

Partnership observed an increase in pharmacy and mental health claims impacting multiple measures. Integration of new data sources is ongoing and contributed to an overall improvement in a subset of clinical measures.

Additionally, in MY2023 Partnership focused on collecting new ECDS data to primarily support the depression screening measures. This required the primary source verification process mandated and audited by NCQA and its certified auditors. The ECDS data collection method is still new to many providers; many of whom are still learning to ensure their EHR system and source data align, as is required for primary source verification. Consequently, Partnership was only able to integrate ECDS data from eight (8) providers. We are continuing efforts to collect and integrate this data utilizing an NCQA data aggregator, which we are currently piloting.

NCQA released a number of changes to HEDIS® measurement specifications that applied to MY2023 including the following:

- Deceased Members, General Guideline 16: Exclude members who die any time during the measurement year. Deceased members were previously considered an optional exclusion.
- Race and Ethnicity Stratification, General Guideline 31: Listed additional measures which have instructions to categorize members by the RES. Added instructions on reporting "Unknown" race and ethnicity category values.
- Exclusions: Moved all optional exclusions to required exclusions.
- Palliative Care Direct Reference: In measures where palliative care is specified as a required exclusion, added a direct reference code for palliative care: ICD-10-CM code Z51.5

- Frailty Cross-Cutting Exclusion: In measures with the frailty cross-cutting exclusion (i.e. exclude members 66 years and older with frailty and advanced illness), updated the number of occurrences of frailty required. Increased from one (1) to two (2) required occurrences of frailty.

Clinical Measure Changes for MY2023 HPA Required Reporting:

- Changed Measures:
  - Breast Cancer Screening (BCS) hybrid measure to the Breast Cancer Screening (BCS-E) ECDS measure
  - Flu Vaccinations for Adults Ages 18–64 (FVA) and the Flu Vaccinations for Adults Ages 65 and Older (FVO) both based on CAHPS results changed to the Influenza immunizations for adults (AIS-E), an ECDS measure.
- Retired Clinical Measures:
  - Annual Dental Visit (ADV).
  - Pneumococcal Vaccination Status for Older Adults (PNU)
  - Use of Opioids at High Dosage (HDO)
  - Use of Opioids from Multiple Providers (UOP)
  - Risk of Continued Opioid Use—31-day rate (COU)
- Removed Clinical Measures:
  - Appropriate Treatment for Upper Respiratory Infection (URI) – removed from the Medicaid LOB
  - Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit (MSC)

Retired the following CAHPS Measures beginning with HPR 2023:

- Rating of Specialist Seen Most Often (Medicaid)
- Coordination of Care (Medicaid)

***Note**: These CAHPS measures were removed due to low response rates and inability to score them in prior HPR years.*

Partnership successfully launched our HEDIS® MY2023/RY2024 data collection and reporting audits incorporating all changes as noted above.

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

As an NCQA Accredited plan, PHC was required to report HEDIS and CAHPS annually, starting June 2022, for measurement year 2021 (MY2021). The overall Health Plan Rating (HPR) is the weighted average of a plan's HEDIS and CAHPS measure ratings, plus bonus points for plans with current Accreditation status. In MY2023 Partnership chose to be formally scored utilizing the Adult CAHPS results.

2.0 HPA Summary of Performance Plan-wide Relative to National All Lines of Business Benchmarks – CAHPS Results

2.1 HPA Plan-wide Performance Child CAHPS Results – Patient Experience:

This table shows the results of the MY2023 baseline performance on the Patient Experience NCQA Accreditation measures relative to the National All Lines of Business 10th, 33.33rd, 66.67th and 90th benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

4-5 points 3 points 1-2 points

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Patient Experience						
Getting Care						
MY 2022	***Getting Needed Care (Usually + Always)	76.68%	76.18%	83.02%	86.66%	89.48%
MY 2023		77.06%	74.98%	79.83%	83.11%	86.50%
MY 2022	Getting Care Quickly (Usually + Always)	76.32%	79.85%	85.31%	89.34%	91.90%
MY 2023		78.92%	73.36%	77.73%	83.78%	86.94%
Satisfaction with Plan Physicians						
MY 2022	Rating of Personal Doctor (9+10)	74.37%	71.82%	75.46%	78.81%	82.18%
MY 2023		75.51%	61.79%	65.38%	70.59%	74.03%
Satisfaction with Health Plan Services						
MY 2022	Rating of All Health Care (9+10)	64.25%	65.35%	68.39%	73.19%	77.06%
MY 2023		68.13%	48.00%	53.48%	58.27%	62.50%
MY 2022	***Rating of Health Plan (9+10)	68.03%	65.22%	69.57%	74.36%	78.64%
MY 2023		58.89%	52.72%	59.30%	64.02%	68.70%

2.2 HPA Plan-wide Performance Adult CAHPS Results – Patient Experience:

This table shows the results of the MY2023 baseline performance on the Patient Experience NCQA Accreditation measures relative to the National All Lines of Business 10th, 33.33rd, 66.67th and 90th benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

4-5 points 3 points 1-2 points

NCQA Accreditation Measures - Planwide Performance w/Adult CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Patient Experience						
Getting Care						
MY 2022	***Getting Needed Care (Usually + Always)	76.37%	75.64%	80.37%	84.60%	87.47%
MY 2023		73.98%	73.36%	77.73%	83.78%	86.94%
MY 2022	Getting Care Quickly (Usually + Always)	69.45%	70.19%	77.90%	83.82%	86.85%
MY 2023		68.09%	74.98%	79.83%	83.11%	86.50%
Satisfaction with Plan Physicians						
MY 2022	Rating of Personal Doctor (9+10)	66.92%	61.79%	65.34%	71.14%	75.00%
MY 2023		70.00%	61.79%	65.38%	70.59%	74.03%
Satisfaction with Health Plan Services						
MY 2022	Rating of All Health Care (9+10)	55.69%	49.34%	54.22%	58.77%	63.02%
MY 2023		54.49%	48.00%	53.48%	58.27%	62.50%
MY 2022	***Rating of Health Plan (9+10)	56.83%	53.85%	59.78%	64.94%	70.09%
MY 2023		46.62%	52.72%	59.30%	64.02%	68.70%

2.2 HPA HEDIS Plan-wide Performance – Prevention and Equity:

This table shows the MY2023 baseline performance on the **Prevention and Equity** NCQA Accreditation measures relative to the National All Lines of Business 10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

NCQA Accreditation Measures - Planwide Performance w/Adult CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Prevention and Equity						
Children and Adolescent Well-Care						
MY 2022	*****CIS - Childhood Immunization Status (Combination 10)**	34.55%	23.71%	31.14%	39.42%	49.76%
MY 2023		29.68%	20.68%	26.76%	35.04%	45.26%
MY 2022	*****IMA - Immunizations for Adolescents (Combination 2)**	43.80%	25.79%	31.87%	39.16%	48.42%
MY 2023		43.07%	24.82%	30.66%	38.93%	48.80%
MY 2022	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	86.25%	60.83%	74.94%	82.73%	88.31%
MY 2023		85.99%	62.77%	74.70%	83.21%	89.72%
Women's reproductive health						
MY 2022	*****PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care**	86.92%	73.49%	82.73%	87.83%	91.89%
MY 2023		90.34%	73.48%	81.75%	86.86%	91.07%
MY 2022	*****PPC - Prenatal and Postpartum Care—Postpartum Care**	89.23%	64.57%	74.94%	80.00%	84.18%
MY 2023		86.96%	67.31%	75.18%	80.78%	84.59%
MY 2022	PRS-E - Prenatal Immunization Status - Combination Rate	35.59%	8.65%	15.16%	27.32%	39.12%
MY 2023		35.40%	7.94%	15.17%	25.81%	37.75%
Cancer screening						
MY 2022	**BCS - Breast Cancer Screening**	53.45%	40.72%	47.76%	53.96%	61.27%
MY 2023	**BCS-E - Breast Cancer Screening**	55.52%	42.98%	48.33%	54.94%	62.67%
MY 2022	**CCS - Cervical Cancer Screening**	59.75%	42.71%	54.27%	60.83%	66.88%
MY 2023		58.04%	43.50%	53.37%	59.85%	66.48%
Equity						
MY 2022	Race/Ethnicity Diversity of Membership (Reporting Only)	100.00%	66.33%	100.00%	100.00%	100.00%
MY 2023		100.00%	0.03%	56.73%	100.00%	100.00%
Other preventive services						
MY 2022	**CHL - Chlamydia Screening in Women—Total**	57.21%	41.89%	51.41%	60.24%	67.84%
MY 2023		56.00%	42.61%	51.39%	61.07%	67.39%
MY 2023	AIS-E- Influenza immunizations for adults	17.61%	6.50%	10.82%	16.32%	21.05%
MY 2023	AIS-E-Td/Tdap immunizations for adults	36.43%	18.67%	29.84%	41.54%	56.53%
MY 2023	AIS-E-Zoster immunizations for adults	14.63%	1.72%	4.42%	10.27%	14.54%
MY 2023	AIS-E-Adult Immunization Status—Pneumococcal	49.15%	N/A	N/A	N/A	N/A

Note:	Removed the Appropriate Treatment for Upper Respiratory Infection (URI) measure for the Medicaid product line. Removed the following measures: **HDO,UOP,COU,FVA,FVO,PNU,ADV, MSC** Retired the following measures from HPR (beginning with HPR 2023): – Rating of Specialist Seen Most Often (Medicaid) – Coordination of Care (Medicaid) **Note:** *These CAHPS measures were removed due to low response rates and inability to score them in prior HPR years.* Replaced the following measures/indicator:BSC to BSC-E Added the following measures: AIS-E-Influenza (Total) AIS-E-Td/Tdap (Total) AIS-E-Zoster(Total) AIS-E-Pneumococcal (Total)
**	Inverted measures, a lower rate results in better performance
***	DHCS Withhold Measures
BOLD	Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

2.3 HPA HEDIS Plan-wide Performance– Treatment:

This table shows the MY2023 baseline performance on the **Treatment** NCQA Accreditation measures relative to the National All Lines of Business 10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used f whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

Treatment						
Respiratory						
MY 2022	**AMR - Asthma Medication Ratio- Total**	71.21%	54.60%	61.38%	68.21%	74.21%
MY 2023		64.01%	55.09%	61.81%	69.41%	75.92%
MY 2022	CWP - Appropriate Testing for Pharyngitis—Total	62.42%	48.98%	65.56%	74.02%	79.40%
MY 2023		71.45%	57.41%	68.76%	77.56%	82.40%
MY 2022	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	75.05%	43.17%	50.98%	58.74%	70.79%
MY 2023		74.30%	50.05%	57.16%	66.19%	77.11%
MY 2022	PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	75.93%	55.58%	67.45%	74.76%	82.81%
MY 2023		73.71%	56.05%	68.39%	75.79%	82.43%
MY 2022	PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	87.23%	67.19%	82.32%	87.83%	91.22%
MY 2023		88.15%	72.88%	82.35%	86.96%	90.53%
Diabetes						
MY 2022	EED - Eye Exams for Patients with Diabetes	53.53%	38.20%	47.93%	54.74%	63.75%
MY 2023		52.59%	36.74%	46.96%	56.20%	63.33%
MY 2022	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	68.61%	48.91%	57.66%	65.21%	72.75%
MY 2023		67.50%	52.07%	59.85%	68.61%	74.56%
MY 2022	**HBD -Hemoglobin A1c Control for Patients with Diabetes-- HbA1c Control (<8%)**	56.93%	36.01%	46.96%	52.80%	58.39%
MY 2023		54.81%	38.93%	49.39%	55.72%	60.34%
MY 2022	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	64.07%	53.18%	64.17%	68.32%	72.92%
MY 2023		63.12%	54.15%	62.58%	67.07%	72.15%
MY 2022	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	76.61%	54.57%	63.51%	70.00%	77.40%
MY 2023		94.76%	52.67%	62.50%	70.37%	77.97%
MY 2022	KED - Kidney Health Evaluation for Patients with Diabetes	46.16%	21.05%	28.15%	37.70%	46.76%
MY 2023		42.13%	22.73%	29.42%	38.80%	47.55%
Heart Disease						
MY 2022	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	81.09%	65.09%	78.97%	82.29%	85.91%
MY 2023		81.90%	70.02%	78.80%	81.64%	85.04%
MY 2022	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	81.00%	59.20%	66.84%	73.75%	81.25%
MY 2023		95.45%	56.67%	66.48%	73.63%	80.95%
MY 2022	***CBP - Controlling High Blood Pressure	58.93%	46.96%	56.20%	63.50%	69.19%
MY 2023		70.57%	50.36%	57.66%	65.45%	72.22%

Note:	Removed the Appropriate Treatment for Upper Respiratory Infection (URI) measure for the Medicaid product line. Removed the following measures: **HDO,UOP,COU,FVA,FVO,PNU,ADV, MSC** Retired the following measures from HPR (beginning with HPR 2023): – Rating of Specialist Seen Most Often (Medicaid) – Coordination of Care (Medicaid) **Note:** *These CAHPS measures were removed due to low response rates and inability to score them in prior HPR years.* Replaced the following measures/indicator:BSC to BSC-E Added the following measures: AIS-E-Influenza (Total) AIS-E-Td/Tdap (Total) AIS-E-Zoster(Total) AIS-E-Pneumococcal (Total)
**	Inverted measures, a lower rate results in better performance
***	DHCS Withhold Measures
BOLD	Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

2.4 HPA HEDIS Plan-wide Performance – Behavioral Health:

This table shows the MY2023 baseline performance on the **Behavioral Health** NCQA Accreditation measures relative to the National All Lines of Business 10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Behavioral Health--Care Coordination						
MY 2022	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	21.66%	22.94%	33.54%	42.75%	54.55%
MY 2023		29.05%	21.77%	31.23%	41.03%	52.90%
MY 2022	**FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total**	13.43%	20.54%	31.97%	45.35%	60.58%
MY 2023		18.92%	23.74%	33.61%	46.35%	61.68%
MY 2022	**FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total**	24.18%	3.47%	8.93%	16.16%	21.97%
MY 2023		22.68%	13.83%	20.00%	27.73%	38.15%
MY 2022	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	32.80%	13.33%	23.24%	37.86%	49.39%
MY 2023		32.29%	15.16%	23.12%	37.31%	49.55%
Behavioral Health--Medication Adherence						
MY 2022	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	51.83%	32.78%	40.68%	46.09%	56.24%
MY 2023		81.49%	31.59%	40.01%	46.74%	58.06%
MY 2022	POD - Pharmacotherapy for Opioid Use Disorder—Total	24.25%	13.00%	23.48%	33.15%	41.67%
MY 2023		43.53%	14.94%	23.38%	31.93%	40.34%
MY 2022	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	74.44%	42.20%	57.14%	64.52%	72.94%
MY 2023		73.46%	41.24%	57.79%	64.90%	72.61%
Behavioral Health-- Access, Monitoring and Safety						
MY 2022	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	36.01%	24.51%	29.67%	39.29%	51.69%
MY 2023		32.80%	26.36%	31.97%	40.50%	53.58%
MY 2022	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	42.53%	34.95%	46.72%	55.40%	62.96%
MY 2023		31.45%	40.38%	50.98%	57.90%	63.92%
MY 2022	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.57%	72.71%	77.48%	81.21%	86.28%
MY 2023		81.90%	72.83%	77.40%	80.86%	85.52%
MY 2022	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	22.69%	33.33%	57.05%	65.63%	75.59%
MY 2023		25.95%	36.65%	55.19%	63.89%	73.87%
MY 2022	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	8.53%	5.90%	11.25%	16.57%	22.12%
MY 2023		8.50%	36.57%	41.92%	46.91%	55.24%

Note:	Removed the Appropriate Treatment for Upper Respiratory Infection (URI) measure for the Medicaid product line. Removed the following measures: **HDO,UOP,COU,FVA,FVO,PNU,ADV, MSC** Retired the following measures from HPR (beginning with HPR 2023): – Rating of Specialist Seen Most Often (Medicaid) – Coordination of Care (Medicaid) **Note:** *These CAHPS measures were removed due to low response rates and inability to score them in prior HPR years.* Replaced the following measures/indicator:BSC to BSC-E Added the following measures: AIS-E-Influenza (Total) AIS-E-Td/Tdap (Total) AIS-E-Zoster(Total) AIS-E-Pneumococcal (Total)
**	Inverted measures, a lower rate results in better performance
***	DHCS Withhold Measures
BOLD	Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

2.5 HPA HEDIS Plan-wide Performance – Risk Adjusted / Other:

This table shows the MY2023 baseline performance on the **Risk Adjusted** / Other NCQA Accreditation measures relative to the National All Lines of Business 10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

NCQA Accreditation Measures - Planwide Performance w/Adult CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Risk-Adjusted Utilization						
MY 2022	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.8269	1.1995	1.0428	0.9444	0.8511
MY 2023		0.8951	1.1874	1.0305	0.9272	0.8314
Other Treatment Measure						
MY 2022	**LBP - Use of Imaging Studies for Low Back Pain	80.91%	67.97%	72.20%	76.82%	81.24%
MY 2023		76.71%	67.72%	71.32%	75.44%	79.96%

Note:	Removed the Appropriate Treatment for Upper Respiratory Infection (URI) measure for the Medicaid product line. Removed the following measures: **HDO,UOP,COU,FVA,FVO,PNU,ADV, MSC** Retired the following measures from HPR (beginning with HPR 2023): – Rating of Specialist Seen Most Often (Medicaid) – Coordination of Care (Medicaid) **Note:** *These CAHPS measures were removed due to low response rates and inability to score them in prior HPR years.* Replaced the following measures/indicator:BSC to BSC-E Added the following measures: AIS-E-Influenza (Total) AIS-E-Td/Tdap (Total) AIS-E-Zoster(Total) AIS-E-Pneumococcal (Total)
**	Inverted measures, a lower rate results in better performance
***	DHCS Withhold Measures
BOLD	Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.0 HPA HEDIS Rate Performance by County: Change from Prior Year

3.1 HPA HEDIS Rate Performance by County: Prevention and Equity Measures

Note: CAHPS is not captured by County

4-5 points ○ 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance														National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Lassen	Marin	Mendocino	Modoc	Napa	Shasta	Siskiyou	Solano	Sonoma	Trinity	Yolo	10th	33.33rd	66.67th	90th
Prevention and Equity																			
Children and Adolescent Well-Care																			
MY 2023	***CIS - Childhood Immunization	10.00%	19.44%	18.75%	10.00%	28.13%	21.88%	0.00%	45.00%	13.95%	20.00%	33.33%	44.74%	0.00%	41.38%	20.68%	26.76%	35.04%	45.26%
MY 2022	Status (Combination 10)	50.00%	19.05%	38.10%	28.57%	52.78%	34.29%	20.00%	25.00%	13.73%	30.77%	43.55%	36.99%	0.00%	54.05%	23.71%	31.14%	39.42%	49.76%
MY 2023	***IMA - Immunizations for	50.00%	40.48%	28.57%	0.00%	64.29%	33.33%	50.00%	70.37%	21.82%	18.18%	39.13%	65.43%	33.33%	37.93%	24.82%	30.66%	38.93%	48.80%
MY 2022	Adolescents (Combination 2)	44.44%	32.00%	27.27%	0.00%	42.31%	35.14%	0.00%	82.76%	25.64%	6.67%	49.35%	59.49%	100.00%	37.78%	25.79%	31.87%	39.16%	48.42%
MY 2023	WCC - Weight Assessment and	100.00%	88.89%	92.86%	66.67%	89.47%	91.67%	100.00%	100.00%	86.67%	66.67%	97.22%	77.50%	66.67%	69.23%	62.77%	74.70%	83.21%	89.72%
MY 2022	Counseling for Nutrition and	100.00%	80.00%	88.24%	100.00%	80.00%	80.95%	100.00%	100.00%	94.12%	100.00%	78.38%	90.48%	0.00%	75.00%	60.83%	74.94%	82.73%	88.31%
Women's Reproductive Health																			
MY 2023	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	100.00%	80.00%	100.00%	100.00%	88.89%	92.31%	75.00%	90.91%	93.75%	66.67%	90.70%	91.67%	0.00%	89.47%	73.48%	81.75%	86.86%	91.07%
MY 2022		100.00%	86.96%	73.33%	66.67%	95.65%	89.47%	100.00%	87.50%	88.46%	60.00%	83.93%	92.45%	100.00%	82.61%	73.49%	82.73%	87.83%	91.89%
MY 2023	***PPC - Prenatal and Postpartum Care—Postpartum Care	100.00%	80.00%	85.71%	100.00%	100.00%	92.31%	25.00%	81.82%	84.38%	33.33%	93.02%	88.89%	0.00%	94.74%	67.31%	75.18%	80.78%	84.59%
MY 2022		100.00%	86.96%	73.33%	100.00%	100.00%	100.00%	0.00%	100.00%	88.46%	60.00%	91.07%	90.57%	0.00%	86.96%	64.57%	74.94%	80.00%	84.18%
MY 2023	PRS-E - Prenatal Immunization	19.67%	19.46%	32.27%	11.70%	57.21%	38.89%	15.63%	35.87%	14.29%	20.00%	41.85%	45.31%	8.51%	38.39%	7.94%	15.17%	25.81%	37.75%
MY 2022	Status - Combination Rate	17.22%	21.00%	31.05%	16.13%	54.37%	36.79%	19.35%	39.93%	19.14%	11.89%	40.14%	43.64%	11.36%	42.42%	8.65%	15.16%	27.32%	39.12%
Cancer Screening																			
MY 2023	BCS-E- Breast Cancer Screening	38.88%	47.35%	47.56%	45.98%	58.02%	50.43%	45.65%	67.20%	50.90%	51.66%	58.12%	61.94%	43.46%	59.99%	42.98%	48.33%	54.94%	62.67%
MY 2022		39.68%	41.88%	48.15%	39.36%	54.86%	48.68%	45.00%	64.75%	46.91%	49.32%	56.72%	62.48%	28.87%	57.75%	40.72%	47.76%	53.96%	61.27%
MY 2023	CCS - Cervical Cancer Screening	30.00%	48.78%	65.52%	33.33%	75.00%	66.67%	0.00%	77.27%	39.47%	66.67%	66.07%	58.62%	66.67%	48.78%	43.50%	53.37%	59.85%	66.48%
MY 2022		63.64%	56.86%	43.48%	0.00%	65.52%	56.52%	0.00%	75.00%	52.17%	57.14%	69.44%	64.00%	33.33%	53.85%	42.71%	54.27%	60.83%	66.88%
Equity																			
MY 2023	RDM-Race/Ethnicity Diversity of	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	63.20%	95.91%	100.00%	100.00%
MY 2022	Membership	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	66.33%	100.00%	100.00%	100.00%

3.2 HPA HEDIS Rate Performance by County: Treatment Measures

Note: CAHPS is not captured by Count

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance														National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Lassen	Marin	Mendocino	Modoc	Napa	Shasta	Siskiyou	Solano	Sonoma	Trinity	Yolo	10th	33.33rd	66.67th	90th
Treatment																			
Respiratory																			
MY 2023	**AMR - Asthma Medication Ratio-Total**	46.79%	60.64%	51.71%	54.64%	65.65%	60.71%	46.88%	78.34%	49.94%	49.05%	68.85%	71.78%	48.00%	65.93%	55.09%	61.81%	69.41%	75.92%
MY 2022		60.67%	61.42%	62.92%	65.12%	76.32%	65.58%	54.24%	84.33%	84.33%	59.50%	77.48%	79.09%	57.14%	74.02%	54.60%	61.38%	68.21%	74.21%
MY 2023	CWP - Appropriate Testing for Pharyngitis—Total	68.86%	72.81%	60.75%	83.33%	77.41%	69.21%	74.39%	65.48%	60.26%	52.12%	62.85%	75.36%	47.44%	89.19%	57.41%	68.76%	77.56%	82.40%
MY 2022		71.31%	73.18%	46.95%	69.05%	56.19%	70.23%	44.74%	40.00%	66.47%	44.96%	51.89%	68.07%	44.64%	75.41%	48.98%	65.56%	74.02%	79.40%
MY 2023	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	73.28%	71.76%	58.58%	71.01%	87.50%	68.16%	46.67%	76.10%	69.48%	67.18%	81.13%	79.66%	72.41%	78.71%	50.05%	57.16%	66.19%	77.11%
MY 2022		73.33%	74.07%	64.24%	61.54%	87.30%	79.13%	70.59%	80.65%	75.06%	64.96%	78.14%	73.77%	70.00%	84.28%	43.17%	50.98%	58.74%	70.79%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	75.76%	79.26%	75.20%	90.48%	72.22%	74.47%	75.00%	69.70%	66.06%	61.11%	74.00%	75.00%	77.78%	75.00%	56.05%	68.39%	75.79%	82.43%
MY 2022		83.33%	81.01%	74.68%	81.25%	70.00%	66.67%	72.73%	60.00%	81.25%	80.00%	77.57%	71.76%	83.33%	78.43%	55.58%	67.45%	74.76%	82.81%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	87.88%	88.89%	83.20%	95.24%	86.11%	87.94%	75.00%	100.00%	87.27%	86.11%	89.50%	91.88%	88.89%	84.52%	72.88%	82.35%	86.96%	90.53%
MY 2022		88.89%	82.28%	91.14%	93.75%	70.00%	93.06%	90.91%	90.00%	91.07%	96.67%	81.31%	87.79%	100.00%	82.35%	67.19%	82.32%	87.83%	91.22%
Diabetes																			
MY 2023	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	75.00%	59.09%	68.00%	66.67%	66.67%	75.00%	80.00%	66.67%	73.81%	70.00%	71.23%	59.76%	66.67%	67.86%	52.07%	59.85%	68.61%	74.56%
MY 2022		60.00%	64.52%	58.62%	63.64%	79.17%	70.00%	0.00%	66.67%	71.43%	75.00%	67.82%	73.91%	0.00%	69.05%	48.91%	57.66%	65.21%	72.75%
MY 2023	EED - Eye Exams for Patients with Diabetes	22.22%	44.12%	56.52%	100.00%	50.00%	44.00%	100.00%	69.57%	68.42%	85.71%	58.76%	41.77%	50.00%	43.24%	36.74%	46.96%	56.20%	63.33%
MY 2022		14.29%	45.00%	62.50%	100.00%	63.16%	48.00%	0.00%	50.00%	50.00%	56.25%	54.17%	62.50%	50.00%	48.98%	38.20%	47.93%	54.74%	63.75%
MY 2023	HBD -Hemoglobin A1c Control for Patients with Diabetes-- HbA1c Control (<8%)	77.78%	55.88%	52.17%	0.00%	73.08%	44.00%	100.00%	52.17%	65.79%	42.86%	56.70%	49.37%	25.00%	48.65%	38.93%	49.39%	55.72%	60.34%
MY 2022		57.14%	57.50%	56.25%	100.00%	52.63%	56.00%	0.00%	50.00%	57.14%	68.75%	58.33%	55.00%	100.00%	55.10%	36.01%	46.96%	52.80%	58.39%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	54.32%	54.86%	58.43%	55.29%	65.65%	53.94%	64.13%	69.71%	54.82%	56.68%	69.35%	65.80%	47.73%	68.62%	54.15%	62.58%	67.07%	72.15%
MY 2022		58.80%	54.37%	58.49%	58.90%	62.47%	54.67%	59.78%	70.64%	56.23%	58.44%	70.18%	68.42%	43.24%	68.79%	53.18%	64.17%	68.32%	72.92%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	95.45%	96.36%	92.39%	93.62%	95.35%	92.45%	98.31%	94.88%	93.45%	93.50%	96.63%	93.54%	97.62%	94.49%	52.67%	62.50%	70.37%	77.97%
MY 2022		78.44%	78.45%	71.88%	68.75%	77.41%	71.46%	76.36%	80.14%	76.88%	75.56%	79.20%	74.51%	75.00%	76.65%	54.57%	63.51%	70.00%	77.40%
MY 2023	KED - Kidney Health Evaluation for Patients with Diabetes	25.32%	31.69%	19.91%	18.15%	43.55%	19.26%	25.00%	59.81%	38.24%	26.56%	55.47%	44.30%	24.83%	47.04%	22.73%	29.42%	38.80%	47.55%
MY 2022		30.26%	29.61%	32.33%	17.48%	56.26%	21.83%	37.42%	63.47%	46.92%	33.99%	56.27%	51.02%	22.81%	45.09%	21.05%	28.15%	37.70%	46.76%
Heart Disease																			
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	77.78%	83.72%	80.12%	72.73%	87.74%	83.33%	50.00%	85.26%	75.22%	87.50%	82.35%	83.18%	78.57%	84.31%	70.02%	78.80%	81.64%	85.04%
MY 2022		74.07%	75.83%	80.42%	65.22%	85.71%	86.32%	83.33%	87.06%	77.55%	72.00%	80.56%	82.21%	88.89%	85.81%	65.09%	78.97%	82.29%	85.91%
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	91.43%	95.37%	92.70%	100.00%	100.00%	96.25%	100.00%	97.53%	96.47%	91.43%	96.94%	93.38%	100.00%	93.80%	56.67%	66.48%	73.63%	80.95%
MY 2022		80.00%	79.12%	79.13%	80.00%	88.89%	80.49%	80.00%	86.49%	80.26%	88.89%	81.23%	79.59%	87.50%	76.38%	59.20%	66.84%	73.75%	81.25%
MY 2023	***CBP - Controlling High Blood Pressure	37.50%	78.13%	72.22%	100.00%	62.07%	74.07%	75.00%	86.67%	80.65%	80.00%	65.71%	71.64%	100.00%	63.64%	50.36%	57.66%	65.45%	72.22%
MY 2022		36.36%	56.52%	43.48%	62.50%	62.96%	61.54%	25.00%	60.00%	58.14%	88.89%	62.79%	64.38%	75.00%	40.74%	46.96%	56.20%	63.50%	69.19%

3.3 HPA HEDIS Rate Performance by County: Behavioral Health Measures

Note: CAHPS is not captured by County

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance														National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Lassen	Marin	Mendocino	Modoc	Napa	Shasta	Siskiyou	Solano	Sonoma	Trinity	Yolo	10th	33.33rd	66.67th	90th
Behavioral Health - Care Coordination																			
MY 2023	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	0.00%	0.00%	0.00%	0.00%	11.11%	0.00%	0.00%	16.67%	0.00%	0.00%	58.10%	15.79%	0.00%	0.00%	21.77%	31.23%	41.03%	52.90%
MY 2022		0.00%	0.00%	0.00%	0.00%	17.65%	0.00%	0.00%	14.29%	0.00%	0.00%	43.22%	9.30%	0.00%	5.26%	22.94%	33.54%	42.75%	54.55%
MY 2023	**FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total**	10.89%	22.04%	10.78%	10.00%	28.49%	5.69%	0.00%	20.59%	17.44%	13.58%	19.43%	26.91%	21.05%	15.58%	23.74%	33.61%	46.35%	61.68%
MY 2022		7.81%	7.77%	11.11%	25.00%	22.15%	6.67%	0.00%	14.58%	19.25%	4.69%	13.32%	17.53%	9.09%	10.13%	20.54%	31.97%	45.35%	60.58%
MY 2023	**FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total**	14.97%	26.22%	19.35%	6.67%	22.95%	22.27%	35.29%	17.37%	34.58%	18.37%	24.81%	17.08%	21.05%	17.45%	13.83%	20.00%	27.73%	38.15%
MY 2022		5.50%	27.05%	17.41%	13.51%	17.19%	27.46%	32.14%	23.60%	39.62%	18.07%	26.62%	18.48%	35.48%	18.56%	3.47%	8.93%	16.16%	21.97%
MY 2023	FUI - Follow-Up After High-Intensity Care for Substance Use	20.00%	35.39%	8.00%	26.09%	17.81%	53.69%	40.00%	17.39%	31.27%	40.00%	36.08%	13.57%	0.00%	11.76%	15.16%	23.12%	37.31%	49.55%
MY 2022		18.18%	43.67%	6.67%	37.50%	20.75%	54.10%	66.67%	4.00%	33.47%	43.24%	30.60%	10.34%	100.00%	11.76%	13.33%	23.24%	37.86%	49.39%
Behavioral Health - Medication Adherence																			
MY 2023	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	76.92%	73.83%	67.38%	75.00%	85.71%	71.65%	73.68%	78.02%	72.43%	84.38%	73.23%	73.57%	50.00%	67.11%	41.24%	57.79%	64.90%	72.61%
MY 2022		66.67%	72.31%	76.47%	62.50%	80.00%	78.41%	87.50%	75.81%	74.51%	62.50%	73.84%	76.00%	100.00%	70.00%	42.20%	57.14%	64.52%	72.94%
MY 2023	AMM - Antidepressant Medication Management—Effective	86.96%	82.99%	73.58%	81.05%	82.33%	79.39%	72.41%	86.92%	81.78%	86.41%	84.74%	80.13%	86.36%	79.92%	31.59%	40.01%	46.74%	58.06%
MY 2022		57.50%	55.19%	43.46%	54.67%	55.15%	41.43%	45.71%	53.26%	51.18%	49.44%	54.97%	50.17%	39.53%	55.82%	32.78%	40.68%	46.09%	56.24%
MY 2023	POD - Pharmacotherapy for Opioid Use Disorder—Total	61.90%	40.96%	48.40%	52.94%	47.22%	47.30%	66.67%	38.46%	33.63%	37.63%	42.53%	46.89%	46.15%	39.68%	14.94%	23.38%	31.93%	40.34%
MY 2022		31.11%	22.99%	24.34%	12.90%	25.71%	32.01%	50.00%	29.79%	12.92%	31.13%	28.08%	31.30%	14.29%	22.64%	13.00%	23.48%	33.15%	41.67%
Behavioral Health - Access, Monitoring and Safety																			
MY 2023	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	54.05%	21.32%	29.52%	30.43%	40.00%	37.04%	11.11%	47.73%	29.11%	34.78%	33.57%	41.84%	37.50%	21.18%	26.36%	31.97%	40.50%	53.58%
MY 2022		28.00%	26.40%	20.48%	33.33%	38.46%	32.84%	0.00%	61.76%	40.27%	33.33%	41.91%	42.92%	16.67%	31.65%	24.51%	29.67%	39.29%	51.69%
MY 2023	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	55.00%	36.00%	25.00%	15.38%	27.03%	43.33%	25.00%	37.50%	32.43%	37.50%	16.22%	33.74%	37.50%	38.78%	40.38%	50.98%	57.90%	63.92%
MY 2022		29.41%	53.13%	70.59%	0.00%	43.75%	30.00%	0.00%	50.00%	39.19%	44.44%	39.58%	44.23%	100.00%	41.46%	34.95%	46.72%	55.40%	62.96%
MY 2023	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	88.76%	81.56%	78.73%	67.92%	79.34%	86.96%	96.15%	82.55%	78.12%	87.62%	85.45%	81.45%	76.47%	83.85%	72.83%	77.40%	80.86%	85.52%
MY 2022		83.33%	79.35%	76.14%	72.09%	78.17%	78.61%	86.67%	77.10%	82.20%	82.96%	83.92%	80.90%	83.33%	80.13%	72.71%	77.48%	81.21%	86.28%
MY 2023	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	40.00%	30.36%	16.67%	20.83%	22.73%	11.11%	14.29%	28.00%	31.97%	18.18%	20.37%	32.47%	20.00%	17.39%	36.65%	55.19%	63.89%	73.87%
MY 2022		7.14%	23.53%	14.52%	0.00%	45.45%	9.09%	0.00%	29.41%	30.17%	14.29%	24.49%	27.66%	100.00%	29.63%	33.33%	57.05%	65.63%	75.59%
MY 2023	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	6.85%	10.11%	8.55%	6.51%	6.69%	10.44%	2.59%	6.32%	9.95%	11.13%	9.24%	7.17%	5.00%	4.34%	7.05%	11.11%	16.94%	24.37%
MY 2022		4.21%	11.25%	5.78%	10.50%	4.49%	11.36%	3.77%	5.72%	11.44%	9.69%	8.59%	7.85%	5.36%	5.48%	5.90%	11.25%	16.57%	22.12%

3.4 HPA HEDIS Rate Performance by County: Risk Adjusted / Other Measures

Note: CAHPS is not captured by County

4-5 points ○ 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance														National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Lassen	Marin	Mendocino	Modoc	Napa	Shasta	Siskiyou	Solano	Sonoma	Trinity	Yolo	10th	33.33rd	66.67th	90th
Risk-Adjusted Utilization																			
MY 2023	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.7160	0.8959	0.9614	0.7435	0.9021	0.7823	1.2776	1.0566	0.8396	0.9745	0.8160	0.9640	0.8752	0.9892	1.1874	1.0305	0.9272	0.8314
MY 2022		0.3591	0.6492	0.6400	1.2278	1.0576	0.8044	0.5046	0.8172	0.7886	0.8646	0.8922	0.8556	0.9066	0.9902	1.1995	1.0428	0.9444	0.8511
Other Treatment Measures																			
MY 2023	**LBP - Use of Imaging Studies for Low Back Pain	66.82%	82.27%	72.25%	68.93%	75.28%	79.77%	73.91%	75.78%	76.68%	61.90%	77.01%	78.80%	75.76%	76.37%	67.72%	71.32%	75.44%	79.96%
MY 2022		78.05%	79.74%	83.77%	73.24%	78.61%	83.55%	67.86%	81.74%	79.28%	63.55%	82.15%	85.07%	77.75%	83.77%	67.97%	72.20%	76.82%	81.24%

4.0 MY2023 HEDIS HealthPlan Accreditation (HPA) – Measurement Set Descriptions

HEDIS Measure	Measure Indicator	Measure Definition
Antidepressant Medication Management (AMM)	• Continuation Phase Treatment • Acute Phase Treatment	• The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. ○ Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). ○ Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	• Total	• The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event. ***Note**: This measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that did not result in an antibiotic dispensing event).*
Adult Immunization Status (AIS-E)	• Influenza immunizations for adults • Td/Tdap immunizations for adults • Zoster immunizations for adults • Pneumococcal immunizations for adults	• The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.

HEDIS Measure	Measure Indicator	Measure Definition
Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ADD)	• Initiation Phase • Continuation and Maintenance (C&M) Phase	• The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. ○ Initiation Phase. The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. ○ Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.
Asthma Medication Ratio (AMR)	• 5–64 years • Total	• The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (APP)	• Total	• The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
Breast Cancer Screening (BCS-E)	• Total	• The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

HEDIS Measure	Measure Indicator	Measure Definition
Cervical Cancer Screening (CCS)	• Total	• The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: ○ Women 21–64 years of age who had cervical cytology performed within the last 3 years ○ Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years ○ Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years
Childhood Immunization Status (CIS)	• Combination 10	• The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. ○ Combination 10. Children who have had all ten indicators (DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV and Influenza).
Chlamydia Screening in Women (CHL)	• Total	• The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
Controlling High Blood Pressure (CBP)	• Total	• The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Appropriate Testing for Pharyngitis(CWP)	• Total	• The percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	• Diabetes Screening	• The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
Follow-Up After Hospitalization for Mental Illness (FUH)	• 7 Days	• The percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported: ○ The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge. ○ The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	• 7 days • Total	• The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. ○ The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

HEDIS Measure	Measure Indicator	Measure Definition
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA)	• 7 days • Total	• The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. ○ The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	• 7 days • Total	• The percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. ○ The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.
Blood Pressure Control (<140/90) for Patients With Diabetes (BPD)	• Total	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.
Hemoglobin A1c Control for Patients With Diabetes — (HBD)	• HbA1c Control (<8%)	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: ○ HbA1c Control (<8%) ○ HbA1c poor control (>9.0%). ***Note:*** *Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators.*

HEDIS Measure	Measure Indicator	Measure Definition
Eye Exam for Patients With Diabetes (EED)	• Eye Exam for Patients With Diabetes	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.
Kidney Health Evaluation for Patients with Diabetes (KED)	• Kidney Health Evaluation for Patients With Diabetes—Total	• The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.
Initiation and Engagement of Substance Use Disorder Treatment—(IET)	• Engagement of SUD Treatment • Total	• The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: ○ Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visits or medication treatment within 14 days. ○ Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
Use of Imaging Studies for Low Back Pain (LBP)	• Imaging for Low Back Pain	• The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. ○ The measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

HEDIS Measure	Measure Indicator	Measure Definition
Immunizations for Adolescents (IMA)	• Combination 2	• The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. o Combination 2. Adolescents who have had all three indicators (meningococcal, Tdap and HPV).
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	• Total	• The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported, the percentage of children and adolescents on antipsychotics who received blood glucose testing, cholesterol testing, and both blood glucose and cholesterol testing. o Total. The sum of the age stratifications (1-17) as of December 31 of the measurement year.
Prenatal and Postpartum Care (PPC)	• Timeliness of Prenatal Care • Postpartum Care	• The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. o Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. o Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
Prenatal Immunization Status (PRS-E)	• Combination Rate	• The percentage of deliveries in the Measurement Period in which women had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.

HEDIS Measure	Measure Indicator	Measure Definition
Pharmacotherapy Management of COPD Exacerbation(PCE)	• Systemic Corticosteroid • Bronchodilator	• The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported: 1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event. 2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event. ○ ***Note:*** *The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.*
Pharmacotherapy for Opioid Use Disorder(POD)	• Total	• The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD. ○ A 12-month period that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.
Plan All-Cause Readmissions— (PCR)	• Observed-to-Expected Ratio • 18-64 years • Total	• For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. ***Note****: For commercial and Medicaid, report only members 18–64 years of age.*
Race/Ethnicity Diversity of Membership-(RDM)	• Race/Ethnicity Direct	• An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	• Non-Medicare 80% Coverage	• The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

HEDIS Measure	Measure Indicator	Measure Definition
Statin Therapy for Patients With Cardiovascular Disease (SPC)	• Total. • Statin Therapy • Statin Adherence 80%	• The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: ○ Received Statin Therapy. Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. ○ Statin Adherence 80%. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.
Statin Therapy Statin Therapy for Patients With Diabetes (SPD)	• Received Statin Therapy • Statin Adherence 80%	• The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: ○ Received Statin Therapy. Members who were dispensed at least one statin medication of any intensity during the measurement year. ○ Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	• BMI Percentile Documentation	• The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. ○ BMI Percentile Documentation. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

5.0 HEDIS HealthPlan Accreditation (HPA) – Healthplan Rating Methodology

Health plans are rated in three categories: private/commercial plans in which people enroll through employers or on their own; plans that serve Medicare beneficiaries in the Medicare Advantage program (not supplemental plans); and plans that serve Medicaid beneficiaries.

NCQA ratings are based on three types of quality measures: 1) measures of clinical quality from NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) and Health Outcomes Survey (HOS); 2) measures of patient experience using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®); and 3) results from NCQA's review of a health plan's health quality processes (NCQA Accreditation). NCQA rates health plans that choose to report measures publicly.

The overall rating is the weighted average of a plan's HEDIS, HOS and CAHPS measure ratings, plus Accreditation bonus points (if the plan is Accredited by NCQA), rounded to the nearest half point displayed as stars.

The overall rating is based on performance on dozens of measures of care and is calculated on a 0–5 scale in half points (5 is highest). Performance includes three subcategories:

1. **Patient Experience:** Patient-reported experience of care, including experience with doctors, services and customer service (measures in the Patient Experience category).

2. **Rates for Clinical Measures:** The proportion of eligible members who received preventive services (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures).

3. **NCQA Health Plan Accreditation:** For a plan with an Accredited or Provisional status, 0.5 bonus points are added to the overall rating before rounding to the nearest half point and displayed as stars.

6.0 HEDIS/CAHPS Measures Required for HP Accreditation—Medicaid

Measure Name		Display Name	Weight
PATIENT EXPERIENCE			
Getting Care			
Getting Needed Care (Usually + Always)		Getting care easily	1.5
Getting Care Quickly (Usually + Always)		Getting care quickly	1.5
Satisfaction With Plan Physicians			
Rating of Personal Doctor (9 + 10)		Rating of primary care doctor	1.5
Satisfaction With Plan and Plan Services			
Rating of Health Plan (9 + 10)		Rating of health plan	1.5
Rating of All Health Care (9 + 10)		Rating of care	1.5
PREVENTION AND EQUITY			
Children and Adolescent Well-Care			
CIS	Childhood Immunization Status—Combination 10	Childhood immunizations	3
IMA	Immunizations for Adolescents—Combination 2	Adolescent immunizations	3
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	BMI percentile assessment	1

Women's Reproductive Health			
PPC	Prenatal and Postpartum Care—Timeliness of Prenatal Care	Prenatal checkups	1
	Prenatal and Postpartum Care—Postpartum Care	Postpartum care	1
PRS-E	Prenatal Immunization Status—Combination Rate	Prenatal immunizations	1
Cancer Screening			
BCS-E	Breast Cancer Screening ***(NEW REPORTING METHOD)***	Breast cancer screening	1
CCS	Cervical Cancer Screening	Cervical cancer screening	1
Equity			
RDM	Race/Ethnicity Diversity of Membership	Race and ethnicity of members	1
Other Preventive Services			
CHL	Chlamydia Screening in Women—Total	Chlamydia screening	1
AIS-E	Adult Immunization Status—Influenza—Total ***(NEW MEASURE)***	Influenza immunizations for adults	1
	Adult Immunization Status—Td/Tdap—Total ***(NEW MEASURE)***	Td/Tdap immunizations for adults	1
	Adult Immunization Status—Zoster—Total ***(NEW MEASURE)***	Zoster immunizations for adults	1
	Adult Immunization Status—Pneumococcal—66+ ***(NEW MEASURE)***	Pneumococcal immunizations for adults	1

TREATMENT			
Respiratory			
AMR	Asthma Medication Ratio—Total	Asthma control	1
CWP	Appropriate Testing for Pharyngitis—Total	Appropriate testing and care for a sore throat	1
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	Appropriate antibiotic use for acute bronchitis/bronchiolitis	1
PCE	Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	Steroid after hospitalization for acute COPD	1
	Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	Bronchodilator after hospitalization for acute COPD	1
Diabetes			
BPD	Blood Pressure Control for Patients With Diabetes	Patients with diabetes—blood pressure control (140/90)	3
EED	Eye Exam for Patients With Diabetes	Patients with diabetes—eye exams	1
HBD	Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8%)	Patients with diabetes—glucose control	3

	Measure Name	Display Name	Weight
SPD	Statin Therapy for Patients With Diabetes—Received Statin Therapy	Patients with diabetes—received statin therapy	1
	Statin Therapy for Patients With Diabetes—Statin Adherence 80%	Patients with diabetes—statin adherence 80%	1
KED	Kidney Health Evaluation for Patients With Diabetes—Total	Patients with diabetes—kidney health evaluation	1
Heart Disease			
SPC	Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	Patients with cardiovascular disease—received statin therapy	1
	Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	Patients with cardiovascular disease—statin adherence 80%	1
CBP	Controlling High Blood Pressure	Controlling high blood pressure	3
Behavioral Health—Care Coordination			
FUH	Follow-Up After Hospitalization for Mental Illness—7 days—Total	Follow-up after hospitalization for mental illness	1
FUM	Follow-Up After Emergency Department Visit for Mental Illness—7 days—Total	Follow-up after ED for mental illness	1
FUA	Follow-Up After Emergency Department Visit for Substance Use—7 days—Total	Follow-up after ED for substance use disorder	1
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	Follow-up after high-intensity care for substance use disorder	1

Behavioral Health—Medication Adherence			
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Adherence to antipsychotic medications for individuals with schizophrenia	1
AMM	Antidepressant Medication Management—Effective Continuation Phase Treatment	Patients with a new episode of depression—medication adherence for 6 months	1
POD	Pharmacotherapy for Opioid Use Disorder—Total	Patients with opioid use disorder—medication adherence for 6 months	1
Behavioral Health—Access, Monitoring and Safety			
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	Cholesterol and blood sugar testing for youth on antipsychotic medications	1
ADD	Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	Continued follow-up after ADHD diagnosis	1
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Diabetes screening for individuals with schizophrenia or bipolar disorder	1
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	First-line psychosocial care for youth on antipsychotic medications	1
IET	Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total	Substance use disorder treatment engagement	1

Measure Name		Display Name	Weight
Risk-Adjusted Utilization			
PCR	Plan All-Cause Readmissions—Observed-to-Expected Ratio—18-64 years	Plan all-cause readmissions	1
Other Treatment Measures			
LBP	Use of Imaging Studies for Low Back Pain—Total	Appropriate use of imaging studies for low back pain	1

7.0 HEDIS/CAHPS MY2023 / RY2024 HPA Overall Star Rating Results: with Child CAHPS Survey Results (Projected)

MY2023 / RY2024 below is Partnership's projected Star Rating to be formally scored under the Health Plan Accreditation (HPA) Star Rating. This rating is calculated based on the MY2023 Adult CAHPS® (regulated) survey results and plan-wide HEDIS rates per the NCQA Health Plan scoring methodology. Final scores will be confirmed by NCQA in Fall of 2024.

7.1 MY2023 HEDIS HealthPlan Accreditation (HPA) – HealthPlan Rating Score Child CAHPS - Change from Prior Year

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

MY2023 Projected Star Rating w/Child CAHPS survey results:

Final Overall Rating +.5 Bonus	3.752101

HEDIS HealthPlan Accreditation Star Rating Scoring MY2023 With Child CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2022	TOTAL ACCRD Score MY2023	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	59.5	153	155	193.5	3.252101	4.0
Child CAHPS Rating	7.5	12	9	13.5		
Patient Experience	7.5	12	9	13.5	1.800	2
Prevention and Equity	18	39	52	66	3.667	3.5
Treatment	34	102	94	114	3.353	3.5

MY2022 Star Rating w/Child CAHPS Formal **Final** survey results:

Final Overall Rating +.5 Bonus	3.69167

HEDIS HealthPlan Accreditation Star Rating Scoring MY2022 With Child CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2021	TOTAL ACCRD Score MY2022	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	60	135	156	191.5	3.191667	3.5
Child CAHPS Rating	7.5	18	10	15		
Patient Experience	10.5	14	14	21	2.000	2
Prevention and Equity	14.5	34	39	50.5	3.483	3.5
Treatment	38	83	103	125	3.289	3.5

7.2 MY2023 HEDIS HealthPlan Accreditation (HPA) – HealthPlan Rating Score Adults CAHPS - Change from Prior Year

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

MY2023 Projected Star Rating w/Adult CAHPS survey results:

Final Overall Rating +.5 Bonus	3.70661157

HEDIS HealthPlan Accreditation Star Rating Scoring MY2023 With Adult CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2022	TOTAL ACCRD Score MY2023	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	60.5	158	63	194	3.20661157	3.5
Adult CAHPS Rating	7.5	17	8	12		
Patient Experience	7.5	17	8	12	1.600	1.5
Prevention and Equity	19	39	54	68	3.579	3.5
Treatment	34	102	1	114	3.353	3.5

MY2022 Projected Star Rating w/Adult CAHPS survey results:

Final Overall Rating +.5 Bonus	3.607692308

HEDIS HealthPlan Accreditation Star Rating Scoring MY2022 With Adult CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2021	TOTAL ACCRD Score MY2022	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	65	132	158	202	3.107692308	3.5
Adult CAHPS Rating	10.5	15	17	25.5		
Patient Experience	10.5	11	17	25.5	2.429	2.5
Prevention and Equity	16.5	34	39	52.5	3.182	3
Treatment	38	83	102	124	3.263	3.5

8.0 MY2023 PHC HPA Overall Star Rating: Comparison to MY2022 – with Child CAHPS

8.1 MY2023 PHC Star Rating (Child CAHPS): Patient Experience & Prevention and Equity Scores

HEDIS HealthPlan Accreditation Star Rating Scoring MY2023 With Child CAHPS Survey Results	MY 2023 Final Rate	TOTAL Weight	TOTAL ACCRD Score MY2022	TOTAL ACCRD Score MY2023	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)		59.5	153	155	193.5	3.25210084	4.0 ★★★★☆
Child CAHPS Rating		7.5	12	9	13.5		
Patient Experience		7.5	12	9	13.5	1.800	2 ★★☆☆☆
Getting Care							
***Getting Needed Care (Usually+ Always)	77.06%	1.5	2	2	3		
***Getting Care Quickly (Usually + Always)	78.92%	1.5	1	1	1.5		
Satisfaction with Plan Physicians							
Rating of Personal Doctor (9+10)	75.51%	1.5	2	3	4.5		
Satisfaction with Health Plan Services							
Rating of Health Plan (9+10)	68.13%	1.5	2	2	3		
Rating of All Health Plan (9+10)	58.89%	1.5	2	1	1.5		
NCQA Accreditation Measures Rating		52	141	146	180	3.461538462	
Prevention and Equity		18	39	52	66	3.667	3.5 ★★★★☆
Children and Adolescent Well-Care							
***CIS - Childhood Immunization Status (Combination 10)**	29.68%	3	2	3	9		
***IMA - Immunizations for Adolescents (Combination 2)**	43.07%	3	4	4	12		
WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	85.99%	1	4	4	4		
Women's reproductive health							
***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care**	90.34%	1	5	4	4		
***PPC - Prenatal and Postpartum Care—Postpartum Care**	86.96%	1	5	5	5		
PRS-E - Prenatal Immunization Status - Combination Rate	35.40%	1	4	4	4		
Cancer screening							
BCS - E Breast Cancer Screening	55.52%	1	3	4	4		
CCS - Cervical Cancer Screening	58.04%	1	3	3	3		
Equity							
Race/Ethnicity Diversity of Membership - Race/Ethnicity Direct Total	100.00%	1	5	5	5		
Other preventive services							
CHL - Chlamydia Screening in Women—Total	56.00%	1	3	3	3		
AIS-E-Adult Immunization Status—Influenza	17.61%	1	N/A	4	4		
AIS-E-Adult Immunization Status—Td/Tdap	36.43%	1	N/A	3	3		
AIS-E-Adult Immunization Status—Zoster	14.63%	1	N/A	5	5		
AIS-E-Adult Immunization Status—Pneumococcal	49.15%	1	N/A	1	1		

Overall Rating Source	
Field	**Calculation**
Measure points	193.5
Overall Rating Not Rounded	3.25210084
Final Overall Rating +.5 Bonus	3.752
Final Score Rounded	4.0

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

*Inverted Rate
**Inverted Measures
***Withhold Measures
New Measures
BOLD: Also MCAS Measures held to MPL

8.2 MY2022 PHC Star Rating (Child CAHPS): Treatment / Behavioral Health Scores

HEDIS HealthPlan Accreditation Star Rating Scoring MY2023 With Child CAHPS Survey Results	MY 2023 Final Rate	TOTAL Weight	TOTAL ACCRD Score MY2022	TOTAL ACCRD Score MY2023	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)		59.5	153	155	193.5	3.25210084	4.0 ☆☆☆☆☆
Child CAHPS Rating		7.5	12	9	13.5		
Treatment		34	102	94	114	3.353	3.5 ☆☆☆½☆
Respiratory							
AMR - Asthma Medication Ratio- Total	64.01%	1	4	3	3		
CWP - Appropriate Testing for Pharyngitis—Total	71.45%	1	2	3	3		
*AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	74.30%	1	5	4	4		
PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	73.71%	1	4	3	3		
PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	88.15%	1	3	4	4		
Diabetes							
EED - Eye Exams for Patients with Diabetes	52.59%	1	3	3	3		
BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	67.50%	3	4	3	9		
HBD -Hemoglobin A1c Control for Patients with Diabetes-- HbA1c Control (<8%	54.81%	3	4	3	9		
SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	63.12%	1	2	3	3		
SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	94.76%	1	4	5	5		
KED - Kidney Health Evaluation for Patients with Diabetes	42.13%	1	4	4	4		
SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	81.90%	1	3	4	4		
SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	95.45%	1	4	5	5		
***CBP - Controlling High Blood Pressure**	70.57%	3	3	4	12		
Behavioral Health--Care Coordination							
FUH - Follow-Up After Hospitalization for Mental Illness-7 days	29.05%	1	1	2	2		
FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	18.92%	1	1	1	1		
FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	22.68%	1	5	3	3		
FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	32.29%	1	3	3	3		
Behavioral Health--Medication Adherence							
AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	81.49%	1	4	5	5		
POD - Pharmacotherapy for Opioid Use Disorder—Total	43.53%	1	3	5	5		
SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	73.46%	1	5	5	5		
Behavioral Health-- Access, Monitoring and Safety							
APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	32.80%	1	3	3	3		
ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	31.45%	1	2	1	1		
SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.90%	1	3	4	4		
APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	25.95%	1	1	1	1		
IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	8.50%	1	2	2	2		
Risk-Adjusted Utilization							
PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.8951	1	5	4	4		
Other Treatment Measure							
*LBP - Use of Imaging Studies for Low Back Pain	76.71%	1	4	4	4		

Overall Rating Source	
Field	**Calculation**
Measure points	193.5
Overall Rating Not Rounded	3.25210084
Final Overall Rating +.5 Bonus	3.752
Final Score Rounded	4.0

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

*Inverted Rate
**Inverted Measures
***Withhold Measures
New Measures
BOLD: Also MCAS Measures held to MPL

9.0 MY2023 PHC HPA Overall Star Rating: Comparison to MY2022 – with Adult CAHPS

9.1 MY2023 PHC Star Rating (Adults): Patient Experience & Prevention and Equity Scores

HEDIS HealthPlan Accreditation Star Rating Scoring MY2023 With Adult CAHPS Survey Results	MY 2023 Final Rate	TOTAL Weight	TOTAL ACCRD Score MY2022	TOTAL ACCRD Score MY2023	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)		59.5	158	61	192	3.226890756	3.5
Adult CAHPS Rating		7.5	17	8	12		
Patient Experience		7.5	17	8	12	1.600	1.5
Getting Care							
***Getting Needed Care (Usually+ Always)	73.98%	1.5	2	1	1.5		
***Getting Care Quickly (Usually + Always)	68.09%	1.5	1	1	1.5		
Satisfaction with Plan Physicians							
Rating of Personal Doctor (9+10)	70.00%	1.5	3	3	4.5		
Satisfaction with Health Plan Services							
Rating of Health Plan (9+10)	54.49%	1.5	2	2	3		
Rating of All Health Plan (9+10)	46.32%	1.5	3	1	1.5		
NCQA Accreditation Measures Rating		52	143	53	180	3.461538462	
Prevention and Equity		18	39	52	66	3.667	3.5
Children and Adolescent Well-Care							
***CIS - Childhood Immunization Status (Combination 10)	29.68%	3	3	3	9		
***IMA - Immunizations for Adolescents (Combination 2)	43.07%	3	4	4	12		
WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	85.99%	1	4	4	4		
Women's reproductive health							
***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.34%	1	4	4	4		
***PPC - Prenatal and Postpartum Care—Postpartum Care	86.96%	1	5	5	5		
PRS-E - Prenatal Immunization Status - Combination Rate	35.40%	1	4	4	4		
Cancer screening							
BCS - E Breast Cancer Screening	55.52%	1	3	4	4		
CCS - Cervical Cancer Screening	58.04%	1	3	3	3		
Equity							
Race/Ethnicity Diversity of Membership - Race/Ethnicity Direct Total	100.00%	1	5	5	5		
Other preventive services							
CHL - Chlamydia Screening in Women—Total	56.00%	1	3	3	3		
AIS-E-Adult Immunization Status—Influenza	17.61%	1	N/A	4	4		
AIS-E-Adult Immunization Status—Td/Tdap	36.43%	1	N/A	3	3		
AIS-E-Adult Immunization Status—Zoster	14.63%	1	N/A	5	5		
AIS-E-Adult Immunization Status—Pneumococcal	49.15%	1	N/A	1	1		

Overall Rating Source	
Field	**Calculation**
Measure points	194
Overall Rating Not Rounded	3.20661157
Final Overall Rating +.5 Bonus	3.707
Final Score Rounded	3.5

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

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0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
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2.250–2.749 → 2.5	

*Inverted Rate
**Inverted Measures
***Withhold Measures
New Measures
BOLD: Also MCAS Measures held to MPL

9.2 MY2023 PHC Star Rating (Adults): Treatment / Behavioral Health Scores

HEDIS HealthPlan Accreditation Star Rating Scoring MY2023 With Adult CAHPS Survey Results	MY 2023 Final Rate	TOTAL Weight	TOTAL ACCRD Score MY2022	TOTAL ACCRD Score MY2023	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
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IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	8.50%	1	2	2	2		
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Other Treatment Measure							
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0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

*Inverted Rate
**Inverted Measures
***Withhold Measures
New Measures
BOLD: Also MCAS Measures held to MPL

2023-24 Quality Improvement Work Plan

Deliverable
Complete
On Track
Delayed
Terminated

Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
	1. QI Program Infrastructure										
1.a.	QI Program Documents	Continued	**Goal #1:** By July 30 2024, complete draft QI Program Description, QI Work Plan and QI Evaluation revisions in preparation for August Quality Committee meetings.	**Deliverable #1:** Finalize 2024 - 2025 QI Program Description.	10/1/2023	7/30/2024	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
1.a.				**Deliverable #2:** Finalize 2023 - 2024 QI Work Plan.	10/1/2023	7/30/2024	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.a.				**Deliverable #3:** Finalize 2023 - 2024 QI Evaluation.	10/01/203	7/30/2024	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.a.				**Deliverable #4:** 2024 - 2025 QI Work Plan – Complete Draft.	5/1/2024	7/30/2024	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.b.	Physician Advisory Committee (PAC) Oversight of QI Program	Continued	**Goal #1:** By September 30, 2023, ensure PAC oversight of Partnership's QI Program through semi-annual monitoring of the QI Work Plan.	**Deliverable #1:** By September 30, 2023 QI Trilogy Documents to be reviewed for approval by PAC in September 2023, post-review of other Quality committees to include but not limited to; • FY 2023-24 - Work Plan • FY 2023-24 - Program Descriptions • FY 2022-23 - QI Program Evaluation	9/13/2023	9/30/2023	Title: Chief Medical Officer Name: Robert Moore	Title: Executive Assistant Name: Sarah Browning	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**

2023-24 Quality Improvement Work Plan

Deliverable: Complete | On Track | Delayed | Terminated

Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
	2. Measurement, Analytics and Reporting										
2.a.	HEDIS Reporting	Continued	**Goal #1:** By June 30, 2024, report HEDIS® MY2023 final rate performance as required annually for NCQA Health Plan Accreditation (HPA) and the DHCS Managed Care Accountability Set (MCAS).	**Deliverable #1:** Analyze, validate, and disseminate HEDIS® MY2023 results for the required NCQA HPA and the DHCS MCAS Measure Sets. • Annual Project Work Plan updated by 07/30/2023 to accommodate HPA and MCAS unique activities/deliverables.	6/30/2023	9/30/2023	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.a.				**Deliverable #2:** By May 31, 2024, conclude the HEDIS® Annual Medical Record projects for MCAS and HPA required reporting in support of the HEDIS® MY2023 Annual Project. • Medical Record Work plan updated by 07/30/2023 to accommodate HPA and MCAS unique activities/deliverables. • Build and conduct Medical Record Projects for DHCS MCAS & NCQA HPA • Collect data from approximately 17,000 medical records • Pass the annual HEDIS Medical Record Review Validation (MRRV) Audit • Perform timely record retrieval and abstraction	10/1/2023	5/31/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.a.				**Deliverable #3:** By April 1, 2024 build production environments for the Annual project and prepare and integrate administrative data, inclusive of new ECDS data sources and contingent on the HRP production implementation, for HEDIS MY2024 Monthly reporting.	1/31/2024	4/1/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.	Member Experience Data	Continue	**Goal #1:** By June 30, 2024, gather, analyze and highlight areas of opportunity for the plan using the CAHPS survey and Grievances & Appeals (G&A) data as it relates to NCQA requirements.	**Deliverable #1:** Present measure year (MY) 2022 CAHPS and Member Experience result to internal and external committees and board members.	7/1/2023	12/30/2023	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.b.				**Deliverable #2:** By June 30, 2024, continue the fiscal/quarterly year process to collect and analyze G&A data. Ensure stakeholders at a minimum meet quarterly or as needed to review data compared to prior and current year CAHPS® survey results.	7/1/2023	6/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #3:** By June 30, 2024, collect and analyze CAHPS-regulated measure year 2023 survey results, 2023 G&A annual filings, mock-drill down, and other data sources.	7/1/2023	6/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.		New	**Goal #2:** By August 31, 2024, implement new interventions or reimagine established member engagement and communication activities, with an intent to incorporate CAHPS HealthPlan scoring improvement opportunities as key components.	**Deliverable #1:** By September 1, 2023, implement at least five (2) improvement activities (3) interventions, which may include adoption of other department goals but must have a direct or indirect influence on CSI focus area.	7/1/2023	9/1/2023	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.b.				**Deliverable #2:** By June 30, 2024, successfully complete all required FY 23/24 all deliverables as stated in the CAHPS program charter.	7/1/2023	6/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #3:** By August 31, 2024, evaluate improvement opportunities and interventions and incorporate outcomes within QI Evaluation and Grand Analysis Reporting.	7/1/2023	8/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.c.	Member Services Access	Continued	**Goal #1:** By June 30, 2024, ensure compliance of internal and delegated access standards as it related to inbound call handling.	**Deliverable #1:** Monitor, Analyze and Recommend CAP(s) when appropriate which includes: • Review internal call center performance stats monthly (performance benchmarks tracked quarterly) on several service level agreements (SLAs) • Plan to continue to track quarterly delegate call center performance (submitted quarterly by each respective delegate) against established performance thresholds (based on SLAs above) during Delegate Oversight quarterly meetings	7/1/2023	6/30/2024	Title: Senior Director of Member Services & Grievances Name: Edna Villasenor	Title: Senior Manager of Member Services Name: Cypress Mendiola	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**

2023-24 Quality Improvement Work Plan

Deliverable
Complete
On Track
Delayed
Terminated

Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
									July 1 - Dec 31	**Jan 1 - June 30**	
2.d.	Primary Care Provider QIP Payment Processing Report	New	**Goal #1:** By June 30, 2024, PCP QIP payment process documents and payment timelines will be updated with all of the necessary steps and deliverable dates to increase efficiency, improve accuracy and strengthen the validation process for payment and scoring.	**Deliverable #1:** Evaluate current payment process documents to identify areas of improvement or gaps.	7/1/2023	9/15/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.d.				**Deliverable #2:** Collaborate with team contributors to gain a better understanding of their responsibilities within the payment process, gather feedback and share process improvement ideas. This will include discussion and strategy for the new equity adjustment in development and to be implemented for MY2023 payment.	7/1/2023	9/15/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
2.d.				**Deliverable #3:** Update desktop procedure documents and payment timelines with the necessary changes to provide a more structured and systematic process and protocol for PCP QIP payment including updates for the new equity adjustment payment methodology. Share timelines with PCP QIP Payment stakeholders.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
2.d.				**Deliverable #4:** Beginning January 1, 2024 (start of Grace Period), implement updated desktop policy and procedure and document outcomes of payment for MY 2023 with improved processes to report to the Executive Team in June 2024.	1/1/2024	6/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
2.e.	Web Based Member Information Assessment	Continued	**Goal #1:** By June 30, 2024, complete annual evaluation of the quality and accuracy of information provided to members via e-mail and telephone as stated in MEM 6 Element C: Quality and Accuracy of Information.	**Deliverable #1:** Complete annual evaluation of the quality and accuracy of information provided to members via e-mail and telephone as stated in ME 6 C: Quality and Accuracy of Information.	7/1/2023	6/30/2024	Title: Senior Director of Member Services & Grievances Name: Edna Villasenor Title: Senior Manager of Member Services Name: Cyress Mendiola	Title: Supervisor of Quality & Training Name: Kristen Clark	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	**Yes**

2023-24 Quality Improvement Work Plan

Deliverable
Complete
On Track
Delayed
Terminated

Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
									July 1 - Dec 31	Jan 1 - June 30	
2.f.	PCP QIP eReports System	Continued *(Monitoring of previous issue)*	**Goal #1:** By June 30, 2024, 2024 eReports with HRP (Health Rules Payor) data will be released, March 1, 2024. Adapt HRP implementation plan no later than June 2024.	**Deliverable #1:** Meet for annual eReports scoping and development with Web Team and QIA to review completed progress documented in eReports HRP Business Requirement Documents (BRD) and plan for changes and/or enhancement for MY2024.	7/1/2023	10/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☒ Delayed ☐ Terminated	No
2.f.				**Deliverable #2:** Complete 2024 eReports User Acceptance Testing (UAT) for on-time release to provider network goal of March 1, 2024. This UAT builds on the HRP UAT for 2023 eReports already completed.	7/1/2023	3/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☒ Delayed ☐ Terminated	
2.f.				**Deliverable #3:** Conduct eReports audit(s) to evaluate accuracy of provider uploaded medical record data. Audit outcomes will be used to inform targeted 1:1 and plan-wide provider education on using the eReports platform. Recommendations and Best Practices observed from the 2023 eReports upload audit will be shared during the 2023 eReports Wrap-Up and 2024 eReports Kick-Off webinars.	7/1/2023	1/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
2.g.	Partnership Quality	Continued	**Goal #1:** By June 30, 2024, apply annual development updates of the HEDIS Monthly Exploratory Dashboard in accordance with identified stakeholder needs.	**Deliverable #1:** Complete an annual HEDIS Monthly data user needs assessment.	7/1/2023	3/30/2024	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☒ Delayed ☐ Terminated	No
2.g.				**Deliverable #2:** Complete updated HEDIS Monthly Exploratory business requirements documentation.	7/1/2023	3/30/2024	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☒ Delayed ☐ Terminated	
2.g.				**Deliverable #3:** Timely publication of the HEDIS Monthly Exploratory dashboard.	4/1/2024	6/30/2024	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☒ Delayed ☐ Terminated	
2.g.		Continued	**Goal #2:** By June 30, 2024, apply annual development updates of the PCP QIP Provider and Internal View Dashboards in accordance with identified stakeholder needs.	**Deliverable #1:** Work with stakeholders to submit updated annual dashboard business requirements document (BRD) to developers for review and approval.	7/1/2023	4/30/2024	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
2.g.				**Deliverable #2:** Gain agreements between developers and business owners for identified new business requirements.	1/1/2024	5/30/2024	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #3:** Completion of user acceptance testing (UAT) of dashboards.	4/1/2024	6/30/2024	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #4:** Timely publication of the dashboards in PQD for internal and external use.	4/1/2024	6/30/2024	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #1:** Secure stakeholder approval for publication of the provider facing Disparity Analysis dashboard.	7/1/2023	8/30/2023	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	

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Deliverable
Complete
On Track
Delayed
Terminated

Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
2.g.	Partnership Quality Dashboard (PQD)	New	**Goal #3:** By June 30, 2024, implement a network-facing disparity analysis dashboard.	**Deliverable #2:** Communicate dashboard availability with Partnership's primary care network.	9/1/2023	12/31/2023	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.g.				**Deliverable #3:** Identify updated dashboard requirements based on user feedback.	1/1/2024	3/30/2024	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #4:** Publish updated dashboard with newly identified user requirements.	4/1/2024	6/30/2024	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.g.		New	**Goal #4:** By June 30, 2024, publish updated PCP QIP Maximizing Visibility of Quality Data (MVQD) - Stars dashboard.	**Deliverable #1:** Email notification to PCP QIP network stakeholders of updated measurement year 2022 PCP MVQD - Stars dashboard.	7/1/2023	8/31/2023	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.g.				**Deliverable #2:** Identify updated requirements for measurement year 2023 dashboard based on stakeholder feedback.	9/1/2023	12/31/2023	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #3:** Apply updated requirements for measurement year 2023 MVQD Stars dashboard.	1/1/2024	6/30/2024	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #4:** Evaluate scope for inclusion of MVQD Stars performance in Partnership web applications.	1/1/2024	6/30/2024	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #5:** Identify optimal platform(s) for public reporting of data.	1/1/2024	6/30/2024	Title: Chief Medical Officer Name: Robert Moore Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Director of Quality Mgmt Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

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Deliverable: Complete / On Track / Delayed / Terminated

Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status: July 1 - Dec 31	Deliverable Evaluation Status: Jan 1 - June 30	Goal Met (Yes No)
2.h.	Data Governance	New	**Goal #1:** By June 30, 2024, Develop and test HRP clinical and non-clinical data for the PQD QIP-PCP project and be ready for Production go-live. Integrate the HEDIS HRP data to EDW environment and test PQD-HEDIS module.	**Deliverable #1:** Develop PQD QIP-PCP module using HRP data.	7/1/2023	8/31/2023	Title: Director of Data Governance Name: Dave Hosford	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	No
2.h.				**Deliverable #2:** Test the PQD QIP-PCP module with the HRP data.	9/1/2023	9/30/2023	Title: Director of Data Governance Name: Dave Hosford	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.h.				**Deliverable #3:** Integrate HEDIS HRP data in to EDW environment and make necessary programming changes to populate PQD-HEDIS tables.	7/15/2023	8/31/2023	Title: Director of Data Governance Name: Dave Hosford	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	
2.h.				**Deliverable #4:** Test the PQD-HEDIS module with the HRP data.	9/1/2023	9/30/2023	Title: Director of Data Governance Name: Dave Hosford	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	
2.h.		New	**Goal #2:** By June 30, 2024, Integrate ECDS data (depression screening, alcohol screening and behavioral health) from external entities to QI programs. This data will help driving quality improvement efforts for HEDIS, and other QIP programs.	**Deliverable #1:** Establish a connection to receive depression screening and/or alcohol screening data from external providers and validate the data for completeness & accuracy.	7/1/2023	11/30/2023	Title: Director of Data Governance Name: Dave Hosford	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	Yes
2.h.				**Deliverable #2:** Integrate the depression screening and/or alcohol screening data to HEDIS, and other QIP programs.	12/1/2023	1/31/2024	Title: Director of Data Governance Name: Dave Hosford	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.h.				**Deliverable #3:** Establish a connection to receive behavioral health data from several counties through SVMS.	7/1/2023	11/15/2023	Title: Director of Data Governance Name: Dave Hosford	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.h.				**Deliverable #4:** Integrate the behavioral health data to HEDIS Monthly/Annual project.	11/16/2023	12/31/2023	Title: Director of Data Governance Name: Dave Hosford	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.h.		New	**Goal #3:** By June 30, 2024, integrate lab and measurements data from Sutter Health into QI processes to use it as a supplemental data for HEDIS and other QIP programs	**Deliverable #1:** Establish a connection to receive lab and measurements data from Sutter Health.	7/1/2023	10/31/2023	Title: Director of Data Governance Name: Dave Hosford	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	No
2.h.				**Deliverable #2:** Integrate the lab and measurements data to HEDIS, and other QIP programs.	11/1/2023	6/30/2024	Title: Director of Data Governance Name: Dave Hosford	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	
	3. Value Based Payment Programs - QIP										
3.a.				**Deliverable #1:** If a warm hand-off is made to the QIP team as the result of the work completed by initial PI Needs Assessment, the QIP team will meet with individual modified QIP providers and perform a PCP QIP specific needs assessment to determine QIP tools skill-set level amongst modified QIP staff. Assessment will inform the QIP team how to move forward and what level of engagement/training is needed. May include monthly or quarterly check-ins meetings.	7/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

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Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
									July 1 - Dec 31	Jan 1 - June 30	
3.a.	Primary Care Provider Quality Improvement Program (PCP QIP)	New	**Goal #1:** By June 30, 2024, the PCP QIP Program will be leveraged to support low performing providers in the Modified QIP measure set supporting both their efforts to use data to improve reporting and performance improvement activities.	**Deliverable #2:** Create DRIP email campaign specific to Modified QIP providers and distribute on a monthly basis. DRIP content to include content covered in Modified QIP trainings and general, QIP programmatic education.	7/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ Delayed ☒ Terminated	Yes
3.a.				**Deliverable #3:** Develop policy and procedure for yearly Practice Type review for eReports and Partnership Quality Dashboard (PQD) development work. To include criteria for approval by the Quality Improvement Analyst Team (QIA) and Provider Relations (PR) Leadership and the creation of a program task timeline, if needed.	7/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
3.a.				**Deliverable #1:** By August 31, 2023, identify Stage 2 Modified QIP providers based on mid-year 2023 performance and includes Parent Orgs with greater than 500 members assigned and less than 33% of clinical points for MY2022.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	

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Delayed
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Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
									July 1 - Dec 31	Jan 1 - June 30	
3.a.	Program (PCP QIP)	New	**Goal #2:** Develop strategy with the PI and QIA teams for Modified QIP Stage 2 providers beginning January 1, 2024.	**Deliverable #2:** Develop communication strategy with PI for providers identified as Stage 2 Modified QIP providers for 2024.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
3.a.				**Deliverable #3:** Meet with providers identified as Stage 2 Modified QIP providers before 12/31/2023 as needed, or as a warm-handoff from second round of Needs Assessments performed by PI team.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
3.a.		New	**Goal #3:** By June 30, 2024, the PCP QIP Program will be leveraged to support new Eastern Region PCPs starting January 1, 2024 both in their efforts to use data to improve reporting and performance improvement activities.	**Deliverable #1:** Develop and schedule on-boarding content that includes a recurring webinar series. This series will include Kick-off webinar content tailored to new providers then move into using PCP QIP specific Tools/Analysis to help with visualizing their data - eReports, PQD, Disparity Dashboard, Preventative Care Dashboard.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
3.a.				**Deliverable #2:** Conduct Deliverable #1 webinar series targeting expansion county providers to support regular on-boarding and answer questions for continued education about the PCP QIP.	1/1/2024	6/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
3.b.	Hospital Quality Improvement Program (H-QIP)	New	**Goal #1:** By June 30, 2024, develop Measurement set to support Hospital Performance Improvement.	**Deliverable #1:** Complete development of measures for 2024-25 H-QIP.	7/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
3.b.		New	**Goal #2:** By December 31, 2023, develop measurement set to support HQIP expansion county hospitals.	**Deliverable #1:** Complete development of 6-month measure set for expansion county hospitals for December 31, 2023.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
3.b.				**Deliverable #2:** Develop Hospital Quality Symposium for 2024-2025 H-QIP measurement year.	10/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
3.b.				**Deliverable #3:** Identify which hospitals will be participating in the expansion measurement set by requesting information for small/large hospitals from Nancy McAdoo in Contracting.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
3.b.		New	**Goal #3:** By January 31, 2024, complete evaluation of the 2022-2023 HQIP.	**Deliverable #1:** Evaluate 2022-2023 hospital program performance by measure in comparison to prior measurement year.	7/1/2023	1/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
3.b.		New	**Goal #4:** By January 1, 2024, engage expansion county hospitals who attended 23/24 HQS prior to January 1, 2024.	**Deliverable #1:** Coordinate meetings with key stakeholders and providers in expansion county regions through on-boarding sessions with internal Partnership departments.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
3.b.				**Deliverable #2:** Coordinate meetings with Small and Large hospitals in expansion counties for H-QIP onboarding.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	

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Delayed
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Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
3.c.	Palliative Care Quality Improvement Program (PC QIP)	New	**Goal #1:** By December 31, 2023, develop a measurement set for the calendar year (CY) 2024 PC QIP, that supports quality improvement.	**Deliverable #1:** Complete measure development for CY 2024 PC QIP.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.c.		New	**Goal #2:** By December 31, 2023, complete CY 2022 PC QIP evaluation.	**Deliverable #1:** Complete evaluation of the program's CY 2022 measurement year to monitor performance.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	**No**
3.c.		New	**Goal #3:** By June 30, 2024, develop a QIP payment protocol document for payment process improvement.	**Deliverable #1:** Develop an incentive payment protocol document including the Quality Improvement Analysts (QIA) and Palliative Care Quality Collaborative (PCQC) processes.	7/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.d.	Perinatal QIP (PQIP)	Continued	**Goal #1:** Continue to develop Perinatal QIP Measurement set to support HEDIS Score Improvement through May 30, 2024, and leverage support from Partnership's Population Health team and the Growing Together Program to improve scores for the Timely Prenatal Care measure.	**Deliverable #1:** Develop Perinatal QIP Measurement set to support HEDIS Score Improvement through May 30, 2024 and leverage support from Partnership's Population Health team and the Growing Together Program to improve scores for the Timely Prenatal Care measure.	7/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.d.		New	**Goal #2:** Continue to support provider on-boarding and ECDS implementation to satisfy programmatic gateway measure (ECDS).	**Deliverable #1:** For existing PQIP providers: Continue ECDS education and on-boarding for gateway measure compliance.	7/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.d.				**Deliverable #2:** For new PQIP providers: Support implementation of ECDS by providing education and 1:1 meetings with provider staff.	7/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.d.		Continued	**Goal #3:** PQIP FY 22-23 Program Evaluation.	**Deliverable #1:** Complete PQIP FY 22-23 Program Evaluation.	7/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.e.	Enhanced Care Management Quality Improvement Program (ECM QIP)	Continued	**Goal #1:** By December 31, 2023, develop a measurement set for the calendar year (CY) 2024 ECM QIP that supports quality improvement and aligns with DHCS' CalAIM initiatives.	**Deliverable #1:** Complete measure development for CY 2024 ECM QIP.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager Name: Deanna Watson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.e.		New	**Goal #2:** By December 31, 2023, complete CY 2022 ECM QIP evaluation.	**Deliverable #1:** Complete evaluation of the program's CY 2022 measurement year to monitor performance.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.e.		New	**Goal #3:** By June 30, 2024, improve provider engagement Advisory Group and offering one-on-one assistance through meetings and trainings.	**Deliverable #1:** Outreach to new ECM providers and offer one-on-one meetings to include an overview of the ECM QIP, review the detailed specifications and answer questions.	7/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.e.				**Deliverable #2:** Outreach to low-performing ECM providers immediately after payment processing and offer one-on-one meetings to review the areas needing improvement, re-review relevant areas in the specifications, and share best practices for success.	7/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**

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Deliverable: Complete / On Track / Delayed / Terminated

Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
3.e.				**Deliverable #3:** Facilitate Advisory Group meeting for providers to review proposed CY 2024 measurement set and offer their feedback and suggestions for improvement.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager Name: Deanna Watson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
	4. Improvement Projects, Clinical Quality										
4.a.	Quality Measure Score Improvement (QMSI)	Continued	**Goal #1:** By June 30, 2024, the Quality Measure Score Improvement group will complete all defined deliverables for each measure-specific workgroup. The goal the Quality Measure Score Improvement group is to improve is Partnership's Quality performance over measurement years 2023 and 2024 under the DHCS Managed Care Accountability Measure Set as well as additional HEDIS® measures required of accredited NCQA Medicaid health plans. There are five (5) measure-specific workgroups: 1. Pediatrics 2. Behavioral Health 3. Chronic Diseases 4. Medication Management 5. Women's Health	**Deliverable #1:** Define five (5) specific deliverables for each measure-specific workgroup by December 1, 2023.	7/1/2023	12/1/2023	Title: Director of Quality Management Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan Title: Senior Project Manager Name: Amanda Kim	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
4.a.				**Deliverable #2:** Successfully complete all required deliverables for each measure-specific workgroup by June 30, 2024.	12/2/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan Title: Senior Project Manager Name: Amanda Kim	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
4.b.	Follow-up Care for Initial ADHD Medication	New	**Goal #1:** By June 30, 2024, send provider fax notification for all identified members (ages 6 through 12) newly started on ADHD medication as a reminder to schedule follow-up visits for ADHD within 30 days of IPSD (Index Prescription Start Date) to improve performance for HEDIS® ADD Initiation Phase. Also complete one PDSA cycle of member outreach calls to increase the Initiation Phase follow up appointments.	**Deliverable #1:** Send provider fax notifications to all members (ages 6 to 12 years old) identified as newly prescribed and dispensed an ADHD medication necessitating an initial follow-up care visit. Conduct analysis to determine if changes should be implemented, continue intervention if no changes are determined to be needed, or terminate intervention due to poor outcome.	7/1/2023	6/30/2024	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Andrea Ocampo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
4.b.				**Deliverable #2:** (1) Create desktop procedure integrating both provider fax notification and member outreach that outlines the following: •Process for identifying members newly started on ADHD medication •Timeline for provider fax notification(s) and member outreach call(s) •Processes for sending provider faxes and conducting member outreach calls •Utilizing spreadsheet to track and monitor members newly started on ADHD medication •Process for data analysis (2) Create member outreach script for member outreach call.	7/1/2023	12/31/2023	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Andrea Ocampo	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
4.b.				**Deliverable #3:** Complete PDSA Cycle 1: To test if member outreach with pharmacist asking member to schedule a follow up appointment will result in increase in Initiation Phase follow up appointment rate. •Complete 20 outreach calls for members newly started on ADHD medication, asking them to schedule follow-up visit within 30 days of initial prescription start date. •Conduct analysis for 20 completed member calls to determine if changes should be implemented for cycle 2, scale up intervention to 50 members if no changes are determined to be needed, or terminate intervention due to poor outcome.	7/1/2023	6/30/2024	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Andrea Ocampo	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☒ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
4.c.				**Deliverable #1:** By June 30, 2024, conduct at least two immunization poster campaigns with schools, offering education to students on the importance of adolescent immunizations and asking students to create vaccine-informing posters which will be voted upon by student peers.	7/1/2023	6/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan Title: Manager of Performance Improvement (SR) Name: Kristine Gual Title: Manager of Population Health Name: Hannah O'Leary	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

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Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
									July 1 - Dec 31	Jan 1 - June 30	
4.c.	Local School Collaboration to Drive Adolescent Immunizations	New	**Goal 1:** By June 30, 2024, partner with local schools across the Partnership network to offer immunization clinics and education for students in partnership with local pharmacies and clinics.	**Deliverable #2:** By June 30, 2024, conduct at least two immunization clinics for students attending local schools. When possible, coordinate to occur with poster campaign trainings offered in Deliverable 1.	7/1/2023	6/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan Title: Manager of Performance Improvement (SR) Name: Kristine Gual Title: Manager of Population Health Name: Hannah O'Leary	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	No
4.c.				**Deliverable #3:** By June 30, 2024, conduct an evaluation of immunization events offered prior to back-to-school events. Results of the poster campaign events will be completed after the end of the 23/24 year given proximity to the end of the goal year.	7/1/2023	6/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan Title: Manager of Performance Improvement (SR) Name: Kristine Gual Title: Manager of Population Health Name: Hannah O'Leary	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☒ Delayed ☐ Terminated	
4.d.				**Deliverable #1:** By September 30, 2023, meet with analyst to update report refresh to accommodate monthly data.	7/1/2023	9/30/2023	Title: Manager of Performance Improvement (NR) Name: James Devan	Title: QI Analyst Name: Justin Sears Title: Project Manager I Name: Lindsey Bushey	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	

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Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
									July 1 - Dec 31	Jan 1 - June 30	
4.d.	Reduced Missed Opportunities	New	**Goal 1:** By June 30, 2024, Partnership's QI team will work with analysts to determine appropriate location for the report and potential pilot tool to be made available to providers, and ensure report logic is updated to reflect monthly data.	**Deliverable #2:** By November 30, 2023, meet with provider stakeholders to solicit input on updated dashboard use and determine scope of requirements for making the dashboard provider-facing.	7/1/2023	11/30/2023	Title: Manager of Performance Improvement (NR) Name: James Devan	Title: QI Analyst Name: Justin Sears Title: Project Manager I Name: Lindsey Bushey	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
4.d.				**Deliverable #3:** By January 1, 2024, submit provider-facing dashboard business requirements for development team review.	12/1/2023	1/31/2024	Title: Manager of Performance Improvement (NR) Name: James Devan	Title: QI Analyst Name: Justin Sears Title: Project Manager I Name: Lindsey Bushey	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
4.e.	Healthy Kids Growing Together Program	New	**Goal #1:** By June 30, 2024, expand the Healthy Kids Growing Together Program to include any 3 - 6 year old who has never had a well-child visit and offer an incentive to complete a well-child visit within 180 days.	**Deliverable #1:** Campaign lists showing members identified for the Healthy Kids Growing Together Program (GTP).	7/1/2023	9/30/2023	Title: Associate Director of Population Health Name: Monika Brunkal	Title: Manager of Population Health Name: Nicole Curreri Title: Supervisor of Population Health Name: Cynthia Galicia-Huizar	☒ Complete ☐ On Track ☐ Delayed	☒ Complete ☐ Delayed ☐ Terminated	Yes
4.e.				**Deliverable #2:** Program Impact Analysis report showing results of this intervention.	5/1/2024	6/30/2024	Title: Associate Director of Population Health Name: Monika Brunkal	Title: Manager of Population Health Name: Nicole Curreri Title: Supervisor of Population Health Name: Cynthia Galicia-Huizar	☐ Complete ☒ On Track ☐ Delayed	☒ Complete ☐ Delayed ☐ Terminated	
4.f.	Mobile Mammography Program	New	**Goal #1:** By December 31, 2023, the Mobile Mammography Project team will sponsor 40 mobile mammography event days throughout the provider network, resulting in 1040-1200 completed mammograms.	**Deliverable #1:** • Complete at least eight (8) event days in the NW Region. • Complete at least eight (8) event days in NE Region • Complete eight (8) event days in SE Region. • Complete eight (8) event days in SW Region. 40 days total with minimum of eight (8) per sub region	7/1/2023	12/31/2023	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
4.f.				**Deliverable #2:** Conduct an evaluation of the Mobile Mammography Program including gathering qualitative and quantitative information for the evaluation to ensure benchmarks were achieved and identify considerations and/or potential process improvement opportunities.	1/2/2024	3/29/2024	Title: Manager of Quality Improvement Name: Barbara Seligl	Title: Program Manager II Name: Arelí Carrillo	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
4.g.	Healthy Toddlers Growing Together	New	**Goal #1:** By June 30, 2024, launch and pilot at least 90 days of Healthy Toddlers Growing Together that identifies children ages 12 - 36 months who have never had a well child visit and offer incentives through their 3rd birthday to attend all recommended visits from date of enrollment.	**Deliverable #1:** Program Charter, Script, and Monthly Report showing eligible members for program.	7/1/2023	3/1/2024	Title: Associate Director of Population Health Name: Monika Brunkal	Title: Manager of Population Health Name: Nicole Curreri Title: Manager of Population Health Name: Hannah O'Leary	☐ Complete ☐ On Track ☐ Delayed ☒ Terminated	☐ Complete ☐ Delayed ☒ Terminated	No
4.g.				**Deliverable #2:** Summary showing • # of children identified for program each month • # of children ENGAGED • # of children ENGAGED who completed at least 1 WCV in the reporting period (at least 90 days)	1/1/2024	6/30/2024	Title: Associate Director of Population Health Name: Monika Brunkal	Title: Manager of Population Health Name: Nicole Curreri Title: Manager of Population Health Name: Hannah O'Leary	☐ Complete ☐ On Track ☐ Delayed ☒ Terminated	☐ Complete ☐ Delayed ☒ Terminated	
	5. Service and Patient Experience										
5.a.	Collect Member Experience Data	Continued	**Goal #1:** By June 30, 2024, launch the annual CAHPS survey for Measure Year (MY) 2023 Reporting Year (RY) 2024 and collect data results.	**Deliverable #1:** Provide sample frame to Press Ganey, launch survey, and collect results as part of the NCQA member experience process.	7/1/2023	6/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Program Manager II Name: Anthony Sackett	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
	6. Care for Members with Complex Needs										
6.a.				**Deliverable #1:** July 2023 Quarterly Internal Audit (audit period: 04/01/2023-06/30/2023)	7/1/2023	7/14/2023	Title: Director of CC Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	

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Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
6.a.	Complex Case Management	Continued	**Goal #1:** Ensure Partnership remains compliant with meeting NCQA (PHM5, A-E) standards for our NCQA Renewal Survey in October 2023 and thereafter as evidenced in the results of our upcoming NCQA renewal audit and continuous quarterly internal compliance audits of Complex Case Management to meet overall compliance of files by June 30, 2024.	**Deliverable #2:** File Universe due to NCQA Program Management Team (Partnership and Delegates' files)	10/4/2023	10/10/2023	Title: Director of CC Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
6.a.				**Deliverable #3:** Prepare annotated files and submit to NCQA Program Management Team.	11/27/2023	12/6/2023	Title: Director of CC Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #4:** Virtual File Review/Audit	12/11/2023	12/12/2023	Title: Director of CC Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #5:** February 2024 Quarterly Internal Audit (audit period: 11/01/23 – 01/31/24)	11/1/2023	2/15/2024	Title: Director of CC Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #6:** May 2024 Quarterly Internal Audit (audit period: 02/01/2024-04/30/2024)	2/1/2024	5/15/2024	Title: Director of CC Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
	7. Quality Assurance and Patient Safety										

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Delayed
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Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
7.a.	Potential Quality Issues (PQI) (safety)	Continued	**Goal #1:** By June 30, 2024, Member Safety Investigations team will provide Provider In-Service sessions and a provide an article for the Provider Relations Newsletter regarding Potential Quality Issues (PQI) focusing on acute care hospital's Provider Preventable Condition (PPC) reporting, investigation, and resolution.	**Deliverable #1:** Provide education to at least 2 acute care hospital staff to promote high quality medical care by identifying areas of non-compliance related to PPC reporting and reduce risks of adverse events to our members in the community settings and facilities.	7/1/2023	6/30/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Quality Assurance and Patient Safety Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.a.				**Deliverable #2:** Review and update the PPC article for the Provider Relations newsletter.	7/1/2023	6/30/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Quality Assurance and Patient Safety Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #3:** Enhance and refine internal PPC claims report.	7/1/2023	6/30/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Quality Assurance and Patient Safety Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.b.	Initial Health Appointment Focused Audits	New	**Goal #1:** The Inspections team will perform 18 Initial Health Appointment (IHA) focused audits on selected Partnership sites*, outside of and in addition to the scheduled Facility Site Review process. Focused audits will consist of 10 members eligible for an IHA. Partnership will issue a Corrective Action Plan (CAP) to those provider sites that are not meeting APL 22-030 standards. CAP will require staff education on the IHA process * In order to maximize reviews, only sites with an adequate number of new members to provide at least 10 eligible members will be audited.	**Deliverable #1:** The Inspections team will perform 18 Initial Health Appointment (IHA) focused audits on randomly selected PCP providers, outside of the Facility Site Review process. Focused audits will consist of up to 10 members that qualified for an IHA.	7/1/2023	6/30/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**

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Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
									July 1 - Dec 31	Jan 1 - June 30	
7.c.	Blood Lead Screening and Initial Health Appointment Presentations (safety)	New	**Goal #1:** The Inspections team will attend and present Blood Lead Screening (BLS) and Initial Health Appointment (IHA) slides at a minimum of 10 Clinical Operations Meetings. These customized meetings with providers and practice staff allow for direct interaction with Partnership staff from multiple departments. They provide a forum for Partnership to present updates on specific topics, review identified gaps in care and to field questions directly from providers about various topics of concern.	**Deliverable #1:** The Inspections team will attend and present Blood Lead Screening (BLS) and Initial Health Appointment (IHA) slides at a minimum of 10 Clinical Operations Meetings by 06/30/24.	7/1/2023	6/30/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
7.d.	Latent TB Infection Treatment (safety)	Continued	**Goal #1:** By June 30th 2024, a clinical pharmacist will conduct concurrent review of LTBI medication treatments and provide timely notification of all identified potential LTBI (latent tuberculosis infection) treatment regimen gaps, which result from late refill, non-adherence, inappropriate prescribing, and/or inappropriate dispensing. The regimens to be monitored will include 12-doses of isoniazid/rifapentine (3HP), 90-doses of isoniazid/rifampin (3HR), and 120-doses of rifampin (4R).	**Deliverable #1:** 1. Create and validate a Business Object / Magellan TB medication claims report that will be utilized to: ● Identify Partnership members who are newly started or currently on LTBI regimens (3HP, 3HR, or 4R). ● Monitor and track pharmacy claims data to confirm adherence to prescribed regimen. 2. Create desktop procedure for the monitoring of each LTBI regimen (3HP, 3HR, 4R) that specifically outlines: ● When and how often TB medication claims report will be processed (1st and 15th of each month). ● How medication claims data will be stratified to identify members who are prescribed the 3HP, 3HR, and 4R regimens. ● Utilizing a LTBI spreadsheet to monitor and track members who are prescribed the 3HP, 3HR, and 4R regimens. ● Utilizing LTBI letter templates to notify prescribers of: ○ Possible non-adherence to prescribed LTBI treatment regimen. ○ Inappropriate prescribing / dispensing of 100-dose rifampin. ● When identified, Pharmacist or pharmacy technician will notify dispensing pharmacy and/or prescriber of inappropriate dispensing. ● When identified, Pharmacist will notify prescriber (via fax) of their member's potential LTBI treatment gap from late refill and/or non-adherence to prescribed LTBI regimen.	7/1/2023	12/31/2023	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
7.d.				**Deliverable #2:** 1. Pharmacist will identify potential treatment gaps and provide notification to prescribers within two timeframes: day 16 and day 20. ● Pharmacist will identify and notify providers (via fax) whose members are ≥14 days late in refilling their prescribed LTBI medication. ● ≥ 80% of identified potential non-adherence cases will receive provider notification (via fax) no later than day 16 of their member not having their LTBI medication based on the last refill date. ● ≤ 20% of the identified potential non-adherence cases will receive provider notification (via fax) no later than day 20 of their member not having their LTBI medication based on the last refill date. 2. Pharmacist will verify gap and confirm member's prescribed LTBI regimen was not completed in the accepted timeframe. ● Pharmacist will provide notification to prescribers (via fax) of their member's potential non-adherence to their prescribed LTBI regimen.	7/1/2023	6/30/2024	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
7.d.				**Deliverable #3:** Pharmacist will monitor for inappropriate prescribing / dispensing of 100-dose rifampin (4R regimen). ● Pharmacist will identify and provide information for correct prescribing of 4R regimen. ● Pharmacist will notify prescriber (via fax) that 100-dose rifampin is insufficient and is not considered completion of 4R regimen.	7/1/2023	6/30/2024	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
7.d.				**Deliverable #4:** Pharmacist will provider semi-annual LTBI summary updates to Partnership's Medical Directors for tracked LTBI regimens (identified late fills, identified possible non-adherence to regimen, actions taken, and results of provider outreach).	7/1/2023	6/30/2024	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
	8. Quality Improvement Training and Coaching										

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Deliverable
Complete
On Track
Delayed
Terminated

Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
8.a.	QI Technical Assistance in Partnership with Northern	Continued	**Goal #1:** By June 30 2024, collaborate with Northern Region consortia to bring QI awareness and education to Northern Region providers: • Develop and post storyboards and infographics to demonstrate successful QI improvement projects over time • Host recurring forums for QI engagement	**Deliverable #1:** Develop at least two project storyboards outlining regional QI projects and post on consortia websites.	7/1/2023	6/30/2024	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.a.				**Deliverable #2:** Present Partnership updates and timely provider education at least 4 times via monthly QI and CMO Peer Network Calls and in-person Rural Round Table events.	7/1/2023	6/30/2024	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	Yes

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Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
8.a.	Partnership with Northern Region Consortia	Continued	• Host recurring forums for QI engagement • Develop measure best practices to share with Northern Region consortia members • Complete annual comprehensive organizational profiles for each member to inform and support Partnership and provider partnering in improvement activities	**Deliverable #3:** Develop materials that highlight best practices for focus HEDIS/QIP measures and proactively share with Northern Region consortia members via consortia hosted webinars, its eNews, or its Peer Network.	7/1/2023	6/30/2024	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	Yes
8.a.				**Deliverable #4:** Complete comprehensive organizational profiles (i.e. inclusive of QI, PCMH, Workforce, and Finance updates) for each FQHC member to support Partnership's assessment of current performance and identification of key areas for partnering in improvement.	7/1/2023	6/30/2024	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.b.	Performance Improvement Training Offerings	Continued	**Goal #1:** By June 30, 2024, offer multiple forms of Quality Improvement education to the Partnership provider network.	**Deliverable #1:** Offer at least four (4) virtual training sessions on priority MCAS measures across the provider network between January - June 2024.	1/1/2024	6/30/2024	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	Yes
8.b.				**Deliverable #2:** Offer at least two (2) virtual or in-person ABCs of Quality Improvement training series across the Partnership provider network.	7/1/2023	6/30/2024	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.b.				**Deliverable #3:** Develop a strategy to measure the impact of 2024 trainings focused on MCAS measures to evaluate improvement and implement at least one component of that strategy.	7/1/2023	6/30/2024	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.b.				**Deliverable #4:** Develop a marketing strategy for ABCs of QI and 2024 trainings focused on MCAS measures for the Eastern Region and implement two components of that strategy.	7/1/2023	6/30/2024	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.b.				**Deliverable #5:** Complete Sessions 2 and 3 of Health Equity Training series. Analyze and disseminate Health Equity Training evaluation results and recommend program transition or spread options to leadership.	7/1/2023	6/30/2024	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.c.	Joint Leadership Initiative	Continued	**Goal #1:** Continue Joint Leadership Initiative (JLI) meetings structure plan-wide as Partnership's strategic program for engaging executive teams of high-volume provider organizations around quality improvement. Revisit Partnership attendees to ensure proper alignment given organizational title and role changes, and streamline meeting preparation and debrief processes for efficiency to ensure scalability.	**Deliverable #1:** By September 30, 2023, review prior year JLI evaluation to assess program effectiveness, and identify updated Partnership attendees following organizational leadership role changes to ensure the right leaders are in attendance.	7/1/2023	9/30/2023	Title: Director of Quality Management Name: Isaac Brown	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	Yes
8.c.				**Deliverable #2:** By June 30, 2024, conduct all JLI meetings in accordance with new tier structure. The number of JLI meetings by parent organization can range from zero to four meetings during the calendar year, based on MY2022 QIP performance.	7/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.c.				**Deliverable #3:** By June 30, 2024, trial a more streamlined method of prep and/or debrief meetings for JLI providers to reduce total time invested. The current process requires a prep and debrief meeting for all JLI provider meetings.	1/1/2024	6/30/2024	Title: Director of Quality Management Name: Isaac Brown	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.c.				**Deliverable #4:** By June 30, 2024, evaluate potential JLI practices in new East region expansion after membership data is made available in January 2024. If candidates are identified, conduct a first meeting by June 30, 2024.	1/1/2024	6/30/2024	Title: Director of Quality Management Name: Isaac Brown	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

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Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
8.c.				**Deliverable #5:** By June 30, 2024, conduct a qualitative and quantitative evaluation of JLI providers for MY 2023 to determine effectiveness of JLI series.	1/1/2024	6/30/2024	Title: Director of Quality Management Name: Isaac Brown	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.d.	Practice Facilitation and Provider Coaching	Continued (Monitoring of previous issue)	**Goal #1:** By June 30, 2024, the Performance Improvement teams will align aspects of the Practice Facilitation and Enhanced Provider Engagement initiatives into a comprehensive coaching methodology that supports a tiered approach to provider coaching engagement.	**Deliverable #1:** Develop workflows, visualizations and other deliverables that support a comprehensive coaching methodology for internal and external stakeholders.	6/30/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown	Name: Kristine Gual Title: Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
8.d.				**Deliverable #2:** Review comprehensive coaching methodology with current Practice Facilitation providers and integrate feedback.	10/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown	Name: Kristine Gual Title: Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.d.				**Deliverable #3:** Train PI teams and other internal stakeholders in comprehensive coaching strategy and workflows.	12/1/2023	3/31/2024	Title: Director of Quality Management Name: Isaac Brown	Name: Kristine Gual Title: Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.e.	Enhanced Provider Engagement and Modified QIP Assignment	New	**Goal #1:** By December 31, 2023, the Performance Improvement teams will complete Needs Assessments with 80 percent of provider organizations identified as low performing providers on the 2022 PCP QIP in the Enhanced Provider Engagement program Phases 1 and 2.	**Deliverable #1:** The Performance Improvement teams will complete a Needs Assessment with at least 80 percent of the provider organizations assigned to Enhanced Provider Engagement Phases 1 and 2, based on 2022 PCP QIP performance.	3/1/2023	9/30/2023	Title: Director of Quality Management Name: Isaac Brown	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
8.e.				**Deliverable #2:** By October 31, 2023, the Performance Improvement teams and consultants will summarize strengths, opportunities and recommendations for all provider organizations with a completed Needs Assessment.	5/1/2023	10/31/2023	Title: Director of Quality Management Name: Isaac Brown	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.e.				**Deliverable #3:** By March 31, 2024, provider organizations with a completed Needs Assessment will select and implement at least 1 intervention aligned with a Needs Assessment recommendation provided by Partnership.	6/1/2023	3/31/2024	Title: Director of Quality Management Name: Isaac Brown	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.e.				**Deliverable #4:** By June 30, 2024, Partnership will evaluate selected interventions to assess implementation and determine effectiveness.	1/1/2024	6/30/2024	Title: Director of Quality Management Name: Isaac Brown	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.e.		New	**Goal #2:** By June 30, 2024, the Enhanced Provider Engagement and Modified QIP program's impact will be evaluated and lessons learned will be integrated into strategic planning for continuing to improve performance with low-performing provider organizations.	**Deliverable #1:** Complete an evaluation of Enhanced Provider Engagement and the Modified PCP QIP in 2023.	11/1/2023	3/31/2024	Title: Director of Quality Management Name: Isaac Brown	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
8.e.				**Deliverable #2:** Integrate lessons learned into 2024 strategic planning for improving performance for low-performing providers on the 2023 PCP QIP, either via the Enhanced Provider Engagement and the Modified PCP QIP initiatives or alternative programming.	12/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown	Name: James Devan Title: Manager of Performance Improvement (NR) Name: Kristine Gual Title: Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

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Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
									July 1 - Dec 31	Jan 1 - June 30	
8.f.	Expansion of Regional Quality Meetings	Continued	**Goal 1:** By June 30 2024, Partnership's Northern Region will pilot a regional meeting in the NE to address regional quality improvement topics with local stakeholders, and continue quarterly meetings in the NW in continuation of last year's goals.	**Deliverable #1:** By June 30, 2024, hold four quarterly meetings in the NW, ensuring local providers and stakeholders are aware of series and are participating.	7/1/2023	6/30/2024	Title: Director of Quality Management Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
8.f.				**Deliverable #2:** By December 31, 2023, determine audience and invite stakeholders to participate in a NE region QI meeting. Specific interest will be ensuring a connection to the Quality Measure Score Improvement workgroup deliverables, and will provide regional forums to problem-solve issues relevant to quality improvement.	7/1/2023	12/31/2023	Title: Director of Quality Management Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
8.f.				**Deliverable #3:** By June 30, 2024, solicit feedback from NE regional meeting attendees, and if successful operationalize to make the quarterly meetings permanent.	1/1/2024	6/30/2024	Title: Director of Quality Management Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
8.g.	Implementation of Plan Wide HEDIS Week in 2023	Continued	**Goal #1:** By June 30, 2024, the HEDIS team will develop and conduct a HEDIS Week to include plan wide activities focused on HEDIS education. HEDIS Week is planned to occur in mid-October 2023.	**Deliverable #1:** By August 31 2023, develop a work plan and materials to conduct a virtual HEDIS week. Material will be solicited from the HEDIS, Performance Improvement, Quality Incentive, and NCQA accreditation teams.	7/1/2023	8/31/2023	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Quality Measurement Name: Sue Quichocho	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
8.g.				**Deliverable #2:** By November 30 2023, conduct the virtual HEDIS week utilizing LMS created modules, online presentations and email communications.	7/1/2023	11/30/2023	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Quality Measurement Name: Sue Quichocho	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
8.g.				**Deliverable #3:** By December 30 2023: • Develop a survey and distribute to staff to solicit feedback on HEDIS week. • Review survey feedback to determine any changes or adjustments required for future events.	11/30/2023	12/31/2023	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Quality Measurement Name: Sue Quichocho	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
8.g.				**Deliverable #4:** By June 30 2024, develop a sustainability plan to ensure HEDIS week remains an annual event.	1/1/2024	6/30/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Quality Measurement Name: Sue Quichocho	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
	9. Cultural and Linguistics Services (See Partnership's 2020 Population Health and Health Education Work Plan)										
	10. Delegation Oversight										

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Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
									July 1 - Dec 31	Jan 1 - June 30	
10.a	QI Delegation Oversight	Continued	**Goal #1:** By June 30, 2024, Member Safety Investigations team will demonstrate strong delegation oversight process in support of delegation standards and Partnership policies and procedures.	**Deliverable #1:** Quarterly and annual review of delegation committee reports and delegated activities based on submitted documents. Present findings at the Delegation Oversight Committee (DORS) meetings with recommendations.	7/1/2023	6/30/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Quality Assurance and Patient Safety Name: Robert Bides	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
10.a				**Deliverable #2:** Review and discuss PQI delegation to Carelon Behavioral Health.	7/1/2023	6/30/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Quality Assurance and Patient Safety Name: Robert Bides	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
10.b.	Delegation Oversight	Continued (Monitoring of previous issue)	**Goal #1**: By June 30, 2024, will plan to update delegation agreements and conduct pre-dels for both DHCS and NCQA (in one audit) during the 23/24 QI work plan year.	**Deliverable #1:** Create pre-delegation evaluation tools for new DHCS requirements.	6/1/2023	8/1/2023	Title: Director of Regulatory Affairs/ Program Development Name: Danielle Ogren	Title: Manager of Governance and Compliance Name: Kenzie Hanusiak Title: Program Manager II Name: Gary Robinson	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	Yes
10.b.				**Deliverable #2:** Update all delegation agreements with new DHCS requirements for delegates that are delegated the new requirements.	8/1/2023	6/30/2024	Title: Director of Regulatory Affairs/ Program Development Name: Danielle Ogren	Title: Manager of Governance and Compliance Name: Kenzie Hanusiak Title: Program Manager II Name: Gary Robinson	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
10.b.				**Deliverable #3:** Conduct pre-delegation evaluations on all delegate that are delegated any new DHCS requirement.	8/1/2023	1/31/2024	Title: Director of Regulatory Affairs/ Program Development Name: Danielle Ogren	Title: Manager of Governance and Compliance Name: Kenzie Hanusiak Title: Program Manager II Name: Gary Robinson	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
	11. NCQA Program Management										
11.a.				**Deliverable #1:** By September 27, 2023, evaluate changes and assess impact to assigned standards by reviewing the 2024 HEA Standards Summary of Changes. • If further clarification is required, send specific questions to the NCQA Program Management Team, who will support and facilitate follow-up discussion. • Contributors identified from FY 22-23 should share their questions with Business Owners for further evaluation and discussion.	9/8/2023	9/27/2023	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	
11.a.				**Deliverable #2:** By November 17, 2023, submit the completed 2024 HEA Work Plan and the 2024-2025 HEA Report Schedule. The information provided should align with the look-back period of Partnership's HEA Initial Survey. • Work Plan • Review and confirm or update the Work Plan information based on 2024 HEA Standards and Guidelines; collect attestations from newly identify key stakeholders and contributors if applicable. • Report Schedule • Complete the HEA Report Schedule by indicating the contributors involved, timeline of the data sources, when data sources will become available, and the targeted approval date of the reports. The NCQA Program Management Team will share the 2024 HEA Work Plan and 2024-2025 HEA Report Schedule by September 29, 2023.	9/29/2023	11/17/2023	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ Delayed ☐ Terminated	

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11.a.	Compliance with NCQA HEA and Preparation for Initial Survey	New	**Goal #1:** Departments will prepare readiness of all assigned NCQA Health Equity Accreditation (HEA) Standards and Guidelines for Initial Survey, targeted for June 2025, as measured by the following five deliverables:	**Deliverable #3:** By March 29, 2024, review and confirm information in the HEA Evidence Submission Library. • HEA Evidence Submission Library • The HEA Evidence Submission Library includes a list of documents that will be submitted as evidence for each assigned requirement. Review and confirm the listed documents are correct, and the date reflected for each document is accurate and aligns with NCQA's definition of the look-back period. • Evidence for the Initial Survey is to be produced and dated based on the date listed in the Evidence Submission Library. The NCQA Program Management Team will share the HEA Evidence Submission Library by February 9, 2024.	2/9/2024	3/29/2024	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**

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Terminated

Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
11.a.				**Deliverable #4:** By June 28, 2024, achieve 80% compliance with assigned HEA requirements as demonstrated by the following activities. • By February 29, 2024, submit a draft of all documented processes for Diane's review. All subsequent revisions and recommendations must be addressed and re-submitted for review within 10 business days from receiving the feedback. Exceptions will only be considered if cross-departmental efforts are required, and meetings need to be scheduled to include multiple key stakeholders. • Submit all draft reports as indicated in the HEA Report Schedule for Diane's review. Coordination with the contributors is required to ensure timely completion. Please account for edits to the reports in order to meet the completion date as indicated in the HEA Report Schedule. All edits must be incorporated and approved by Diane. • Review all activities listed under the Action Items Tracker at least monthly. Any activities associated with any requirement where the status is at risk or delayed must be communicated to the NCQA Program Management Team promptly. • Inform and provide clarification to the NCQA Program Management Team as soon as possible if there is a plan to revise approved evidence that impact any NCQA requirements. • By June 14, 2024, submit a detailed work plan and timeline on how to address the 20% or less non-compliant Initial Survey requirements; collect attestations from contributors who are involved to complete the identified tasks. Percentage of compliance is defined as the total number of compliant HEA requirements, divided by the total number of HEA requirements assigned to the Business Owner.	7/1/2023	6/28/2024	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
11.a.				**Deliverable #5:** By June 28, 2024, submit all HEA Mock Survey annotated evidence. Evidence must be submitted following the submission guidelines. The HEA Mock Survey is targeted for August or September 2024. The NCQA Program Management Team will host an evidence collection training and provide the submission guidelines in April 2024.	4/1/2024	6/28/2024	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
11.b.	Compliance with NCQA HPA and Sustain Performance	New	**Goal #1:** Departments will sustain key NCQA reporting requirements and maintain up-to-date knowledge of HPA 2024 Standards and Guidelines, as measured by the following three deliverables:	**Deliverable #1:** By October 31, 2023, complete the HPA Report Schedule by indicating the contributors involved, timeline of the data sources, when data sources will become available, and the targeted approval date of the reports.	7/1/2023	10/31/2023	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**

11.b.				**Deliverable #2:** By February 29, 2024, submit a completed 2024 HPA Workbook that consists of the Summary of Changes, the HPA Work Plan and the HPA Evidence Submission Library. The information provided should align with the look-back period of HPA Renewal Survey.
				• Summary of Changes
				  • Review the 2024 HPA Summary of Changes, assess impact to assigned standards and confirm if further clarifications are required
				• Work plan
				  • Review and confirm or update the HPA Work Plan information based on 2024 HPA Standards and Guidelines; collect attestations from newly identify key stakeholders and contributors if applicable.
				• Evidence Submission Library
				  • Review and confirm or update the HPA Evidence Submission Library based on 2024 HPA Standards and Guidelines and documents submitted for 2023 HPA Renewal Survey.
				
				The NCQA Program Management Team will share the 2024 HPA Workbook by January 31, 2024.
					1/31/2024	2/29/2024	Title: Chief Medical Officer
							Name: Robert Moore, MD
							
							Title: Senior Director of Quality and Performance Improvement
							Name: Nancy Steffen
								Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services
								
								Primary Contact:
								Title: Manager of Quality Performance and Accreditation
								Name: Sue Lee
									July 1 - Dec 31
									
									☐ Complete
									☒ On Track
									☐ Delayed
									☐ Terminated
										Jan 1 - June 30
										
										☒ Complete
										☐ Delayed
										☐ Terminated	

2023-24 Quality Improvement Work Plan

Deliverable
Complete
On Track
Delayed
Terminated

Item #	Project/Program	Type of Goal	Goal	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status		Goal Met (Yes No)
11.b.				**Deliverable #3:** From July 1, 2023 – June 30, 2024, achieve HPA compliance and maintain readiness as demonstrated by the following activities: • File Review: Maintain strict oversight of Partnership and non-Accredited delegates' files • Continue the quarterly file review audit of Partnership files and share results with the NCQA Program Management Team, who will provide regular updates to the NCQA Steering Committee. Business Owners will implement a corrective action plan for files that do not score yes on each factor. • Continue ongoing monitoring of files from non-Accredited delegates. Business Owners will provide regular updates, including the annual audit results and risks identified, with the NCQA Program Management Team. These updates will be shared with the NCQA Steering Committee. • To ensure compliance throughout the 36-month look-back period, the Provider Relations Department will participate at a mock file review with Diane Williams by March 2024. • Analysis Reports: Complete the reports based on the approval date indicated in the HPA Report Schedule. All reports must be submitted to Diane Williams for review, and all edits must be incorporated prior to its approval.	7/1/2023	6/30/2024	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
	12. Contracting										
	13. Population Health Management: See Partnership's 2020 Population Health Work Plan										
	14. Grand Analysis										
14.a.	Grand Analysis - Member Experience (ME7) Report	Continued	**Goal #1:** By August 31, 2024, complete the annual Member Experience Grand Analysis (ME7) report. (Note, the ME 7 report is dependent on CAHPS data results, which are managed by an external vendor (Press Ganey) and not available until after the goal period ends).	**Deliverable #1:** Completion of Member Experience Grand Analysis Report (ME7) by 8/31/2024.	6/1/2023	8/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Project Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
14.a.	Grand Analysis - Pharmacy and Utilization Management (UM1B) Report	Continued	**Goal #1:** By June 30, 2024, complete annual Pharmacy & Utilization Management Grand Analysis (UM1B) reports per Health Plan Accreditation standards.	**Deliverable #1:** 2023 UM1B report.	7/1/2023	6/30/2024	Title: Chief Health Services Officer Name: Katherine Barresi	Title: Clinical Pharmacist Name: Andrea Ocampo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
14.a.	Grand Analysis - Continuity and Coordination of Medical Care (QI3) Report	Continued	**Goal #1:** By August 30, 2024, Quality Improvement will complete the annual Continuity and Coordination of Medical Care Grand Analysis (QI3) report.	**Deliverable #1:** Complete Continuity and Coordination of Medical Care Annual Grand Analysis Report (QI3) by 8/30/2024.	7/1/2023	8/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Improvement Advisor Name: Emily Wellander Title: Medical Director for Quality Name: Mark Netherda	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
14.a.	Grand Analysis - Continuity and Coordination of Behavioral Health (QI4) Report	Continued	**Goal #1:** By January 31, 2024, Behavioral Health will complete the annual Continuity and Coordination of Behavioral Health Grand Analysis (QI4).	**Deliverable #1:** Complete- QI4 Grand Analysis	7/1/2023	1/31/2024	Title: Chief Executive Officer Name: Sonja Bjork	Title: Behavioral Health Administrator Name: Mark Bontrager	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
14.a.				**Deliverable #2:** The QI4 report will be presented at IQI, QUAC meetings for review by committee.	1/1/2024	6/30/2024	Title: Chief Executive Officer Name: Sonja Bjork	Title: Behavioral Health Administrator Name: Mark Bontrager	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
14.a.	Grand Analysis - Access and Availability (NET3) Report	Continued	**Goal #1:** By September 30, 2023, the 2023 Access and Availability Grand Analysis NET 3 Report will be completed.	**Deliverable #1:** Network Adequacy will complete their Access and Availability Annual Grand Analysis (NET 3) Report by 09/30/2023.	6/1/2023	9/30/2023	Title: Senior Director of Provider Relations Name: Mary Kerlin	Title: Associate Director of Provider Relations Name: Priscila Ayala	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ACCREDITED NCQA HEALTH PLAN ACCREDITED

Grievance & Appeals Annual Report – CY 2023

Kory Watkins, MBA-HM
Director, Grievance & Appeals

June 2024

Agenda

- Overview
- The Numbers
- The Members
- The Reasons

Purpose Overview

The Grievance & Appeals (G&A) department is responsible for resolving member complaints, grievances, and appeals. Our primary goal is to **ensure that our members' rights are protected, and that they have a fair process to address any concerns or disputes** they may have regarding their healthcare services.

The G&A department is an integral piece of the health plan because we:

- Help members understand their benefits
- Improve how PHC delivers benefits
- Improve provider's service to members
- Solve conflicts between parties
- Identify new training opportunities

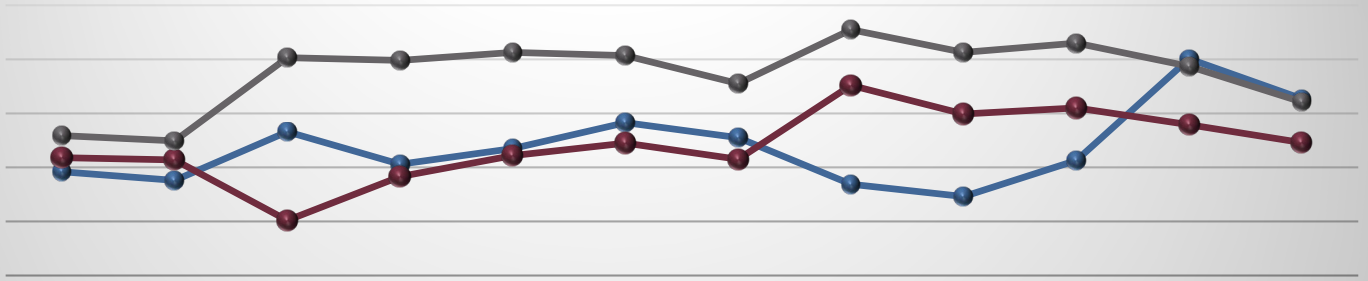
Process Overview

G&A processes 5 different case-types

- Appeal
- Grievance
- 2nd Grievance
- Exempt
- State Hearing

Annual Statistics By Year

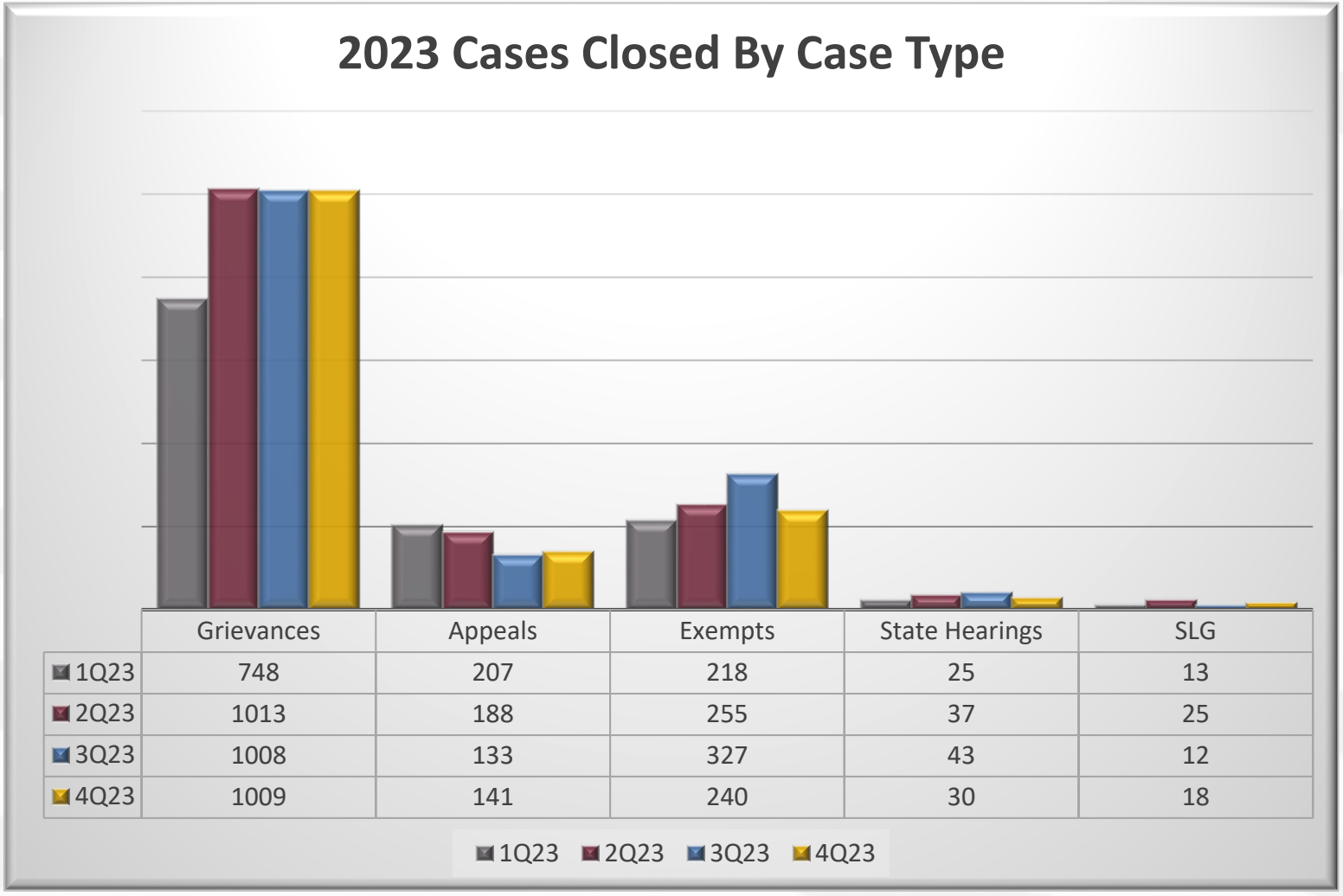
Cases Closed Per Month 2021 vs 2022 vs 2023



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2021	292	276	366	306	335	383	355	269	246	313	501	427
2022	318	314	202	283	322	345	315	452	399	410	379	346
2023	359	349	503	498	513	507	455	555	513	530	487	421

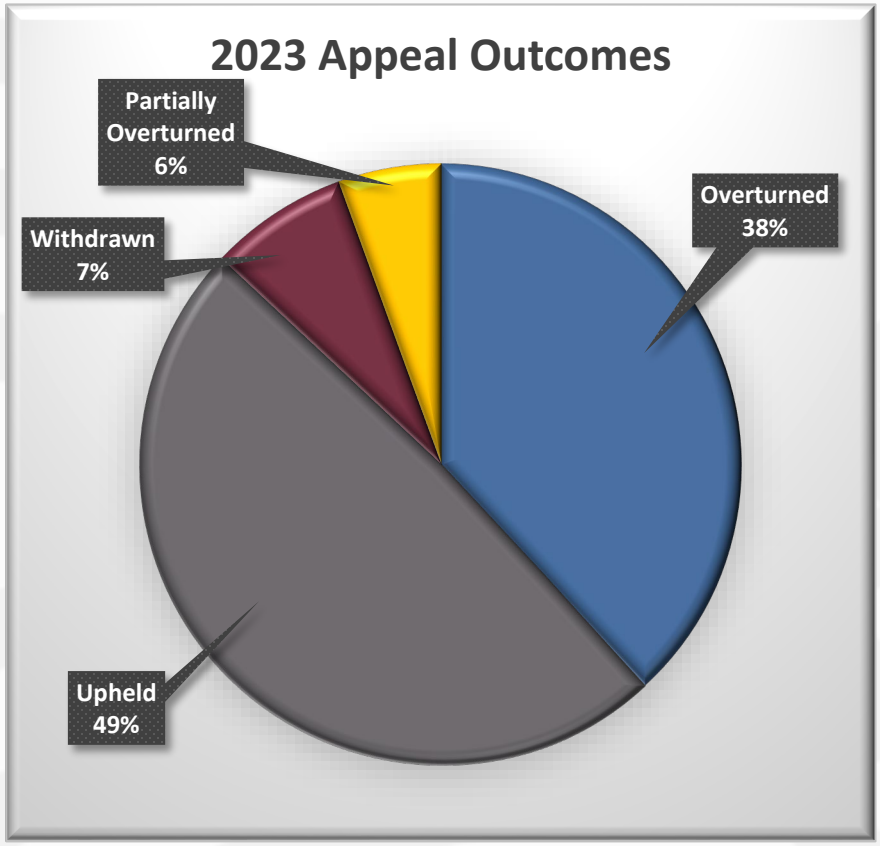
Total Annual Case Count
2023 – 5,690
2022 – 4,085
2021 – 4,069

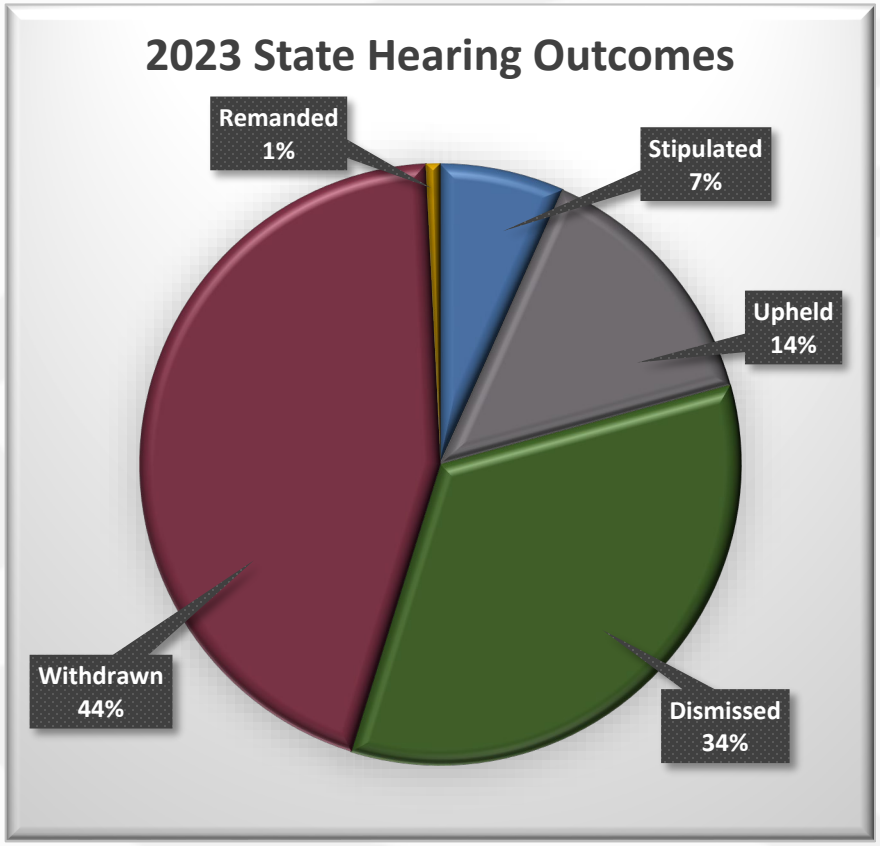
Annual Statistics By Quarter



	Grievances	Appeals	Exempts	State Hearings	SLG
1Q23	748	207	218	25	13
2Q23	1013	188	255	37	25
3Q23	1008	133	327	43	12
4Q23	1009	141	240	30	18

Case Outcomes





Timeliness

Performance Goals

Case Closure

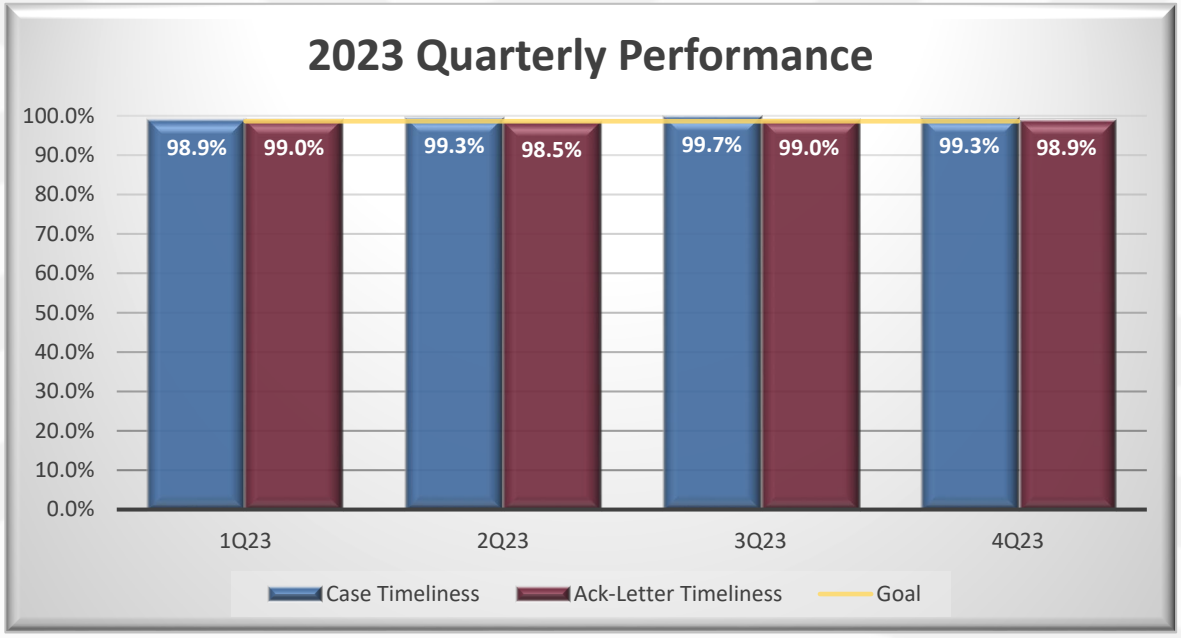
- Expedited cases – Investigate 98.6% of cases within 72 hours
- Standard Cases – Investigate 98.6% of cases within 30 days

Acknowledgment Letters

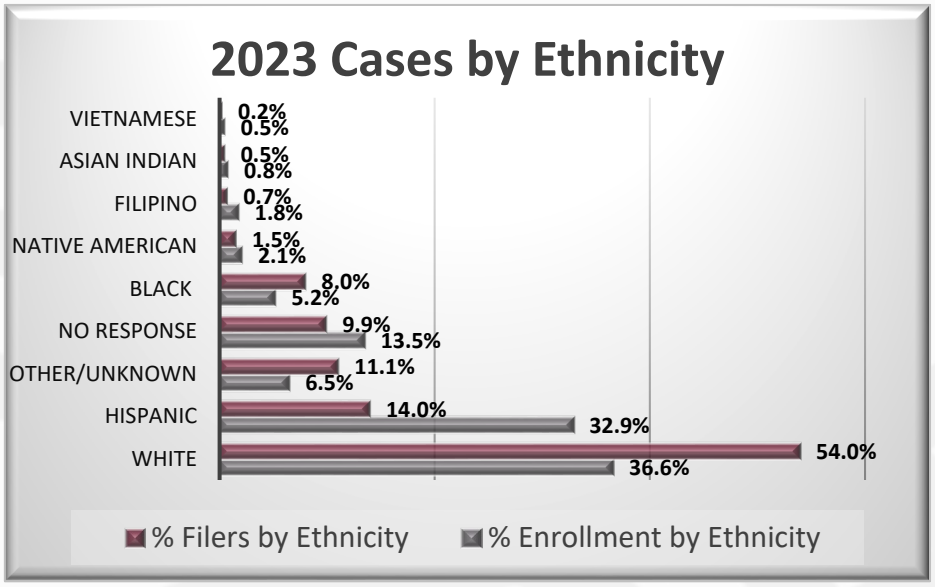
- Mail Acknowledgment Letters on or before the 5th calendar day after case received

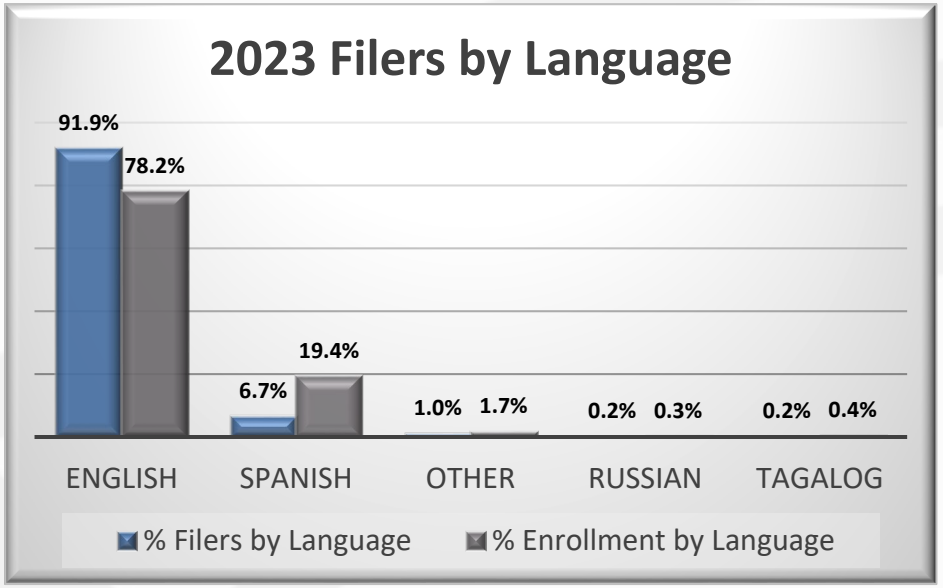
2023 Annual Performance

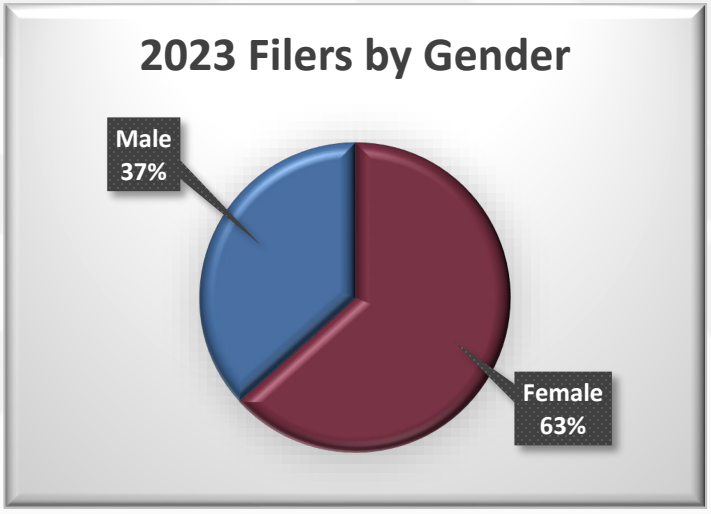
	Case Closure	Ack-Letters Mailed
# Cases Impacted by DHCS TAT	4,515	4,515
# Late	31	52
Goal	98.6%	98.6%
Actual Performance	99.3%	98.8%

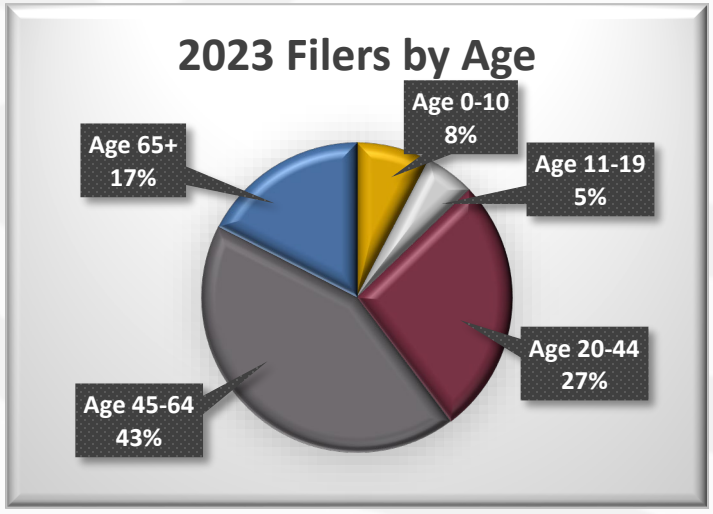


Member Demographics









Member Demographics Cont.

2023 Filers by County		
County	% Filers by County	% Eligibility by County
Solano	22.8%	20.5%
Sonoma	13.6%	19.4%
Shasta	12.4%	10.6%
Humboldt	12.0%	9.0%
Yolo	7.9%	9.1%
Marin	7.2%	7.5%
Mendocino	4.7%	6.1%
Lake	4.5%	5.2%
Napa	3.7%	5.1%
Lassen	3.1%	1.3%
Siskiyou	2.9%	2.9%
Del Norte	2.9%	1.9%
Trinity	1.4%	0.8%
Modoc	0.8%	0.6%

2023 Filers by Top 10 Cities		
City	# Cases	% Cases
Redding	421	7.4%
Vallejo	356	6.3%
Santa Rosa	346	6.1%
Fairfield	344	6.0%
Vacaville	246	4.3%
Eureka	242	4.3%
Crescent City	166	2.9%
Napa	151	2.7%
W. Sacramento	138	2.4%
Davis	119	2.1%

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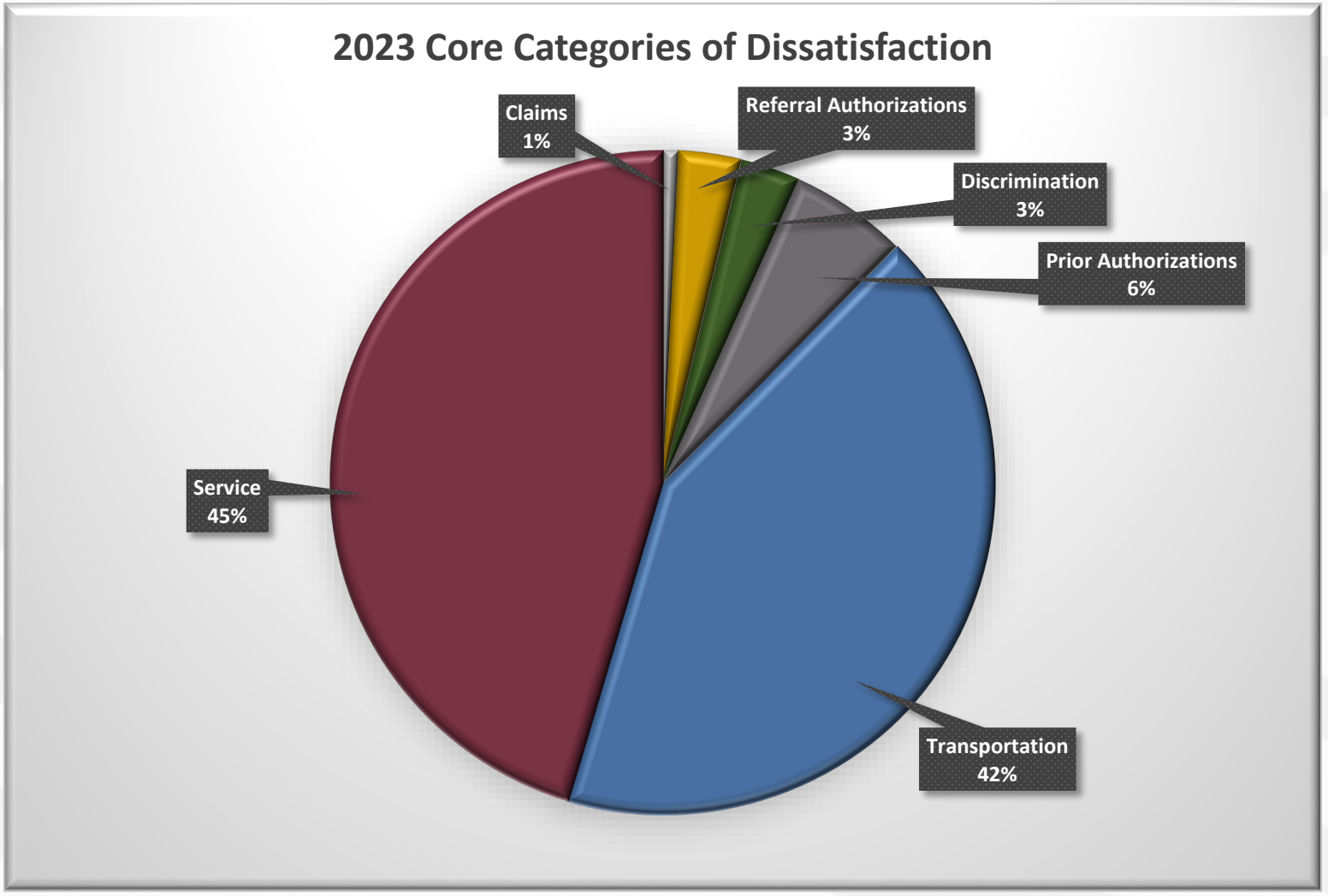
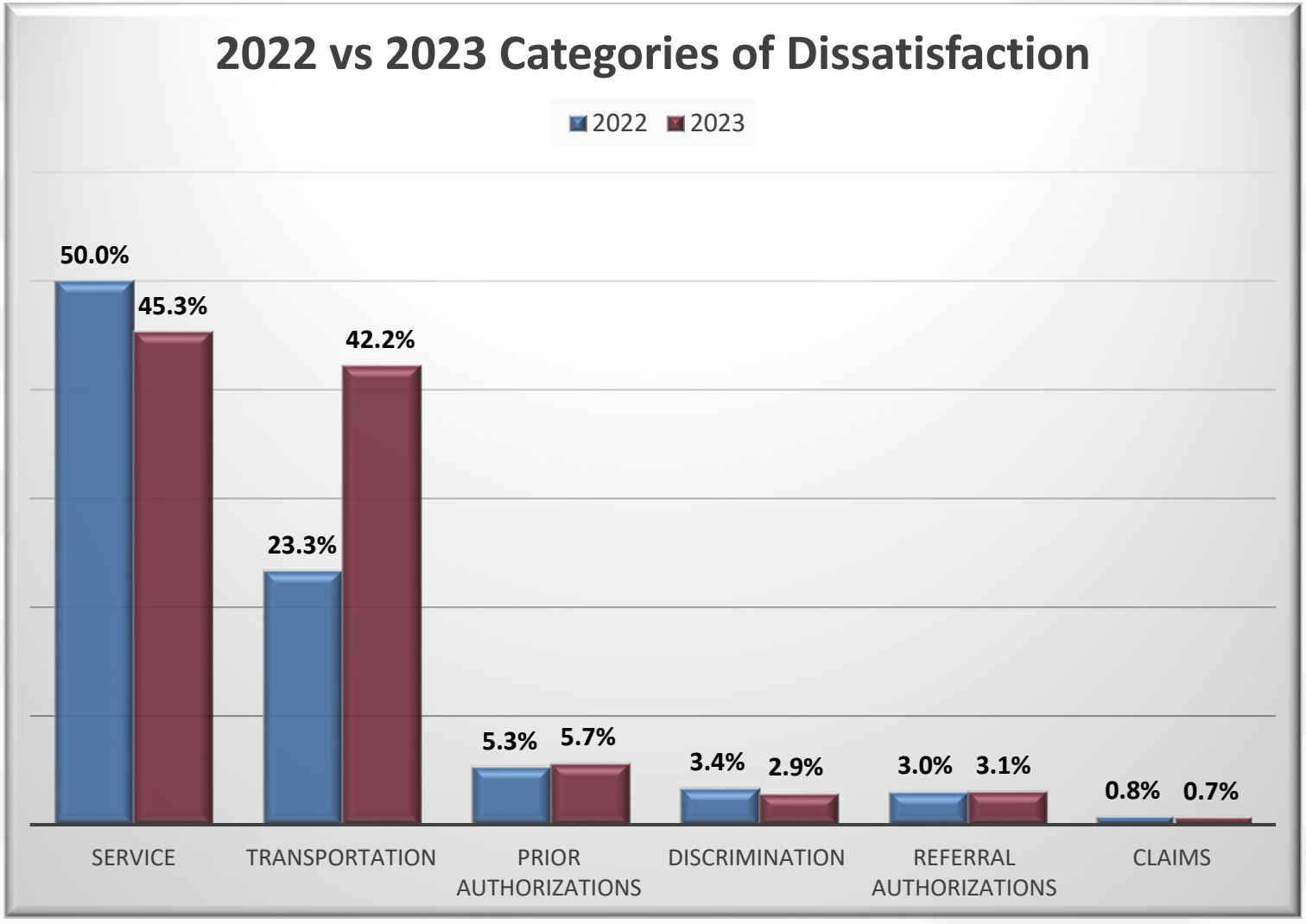
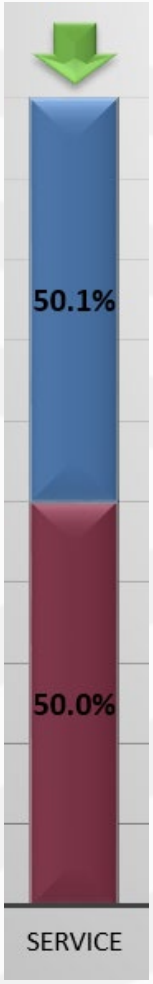
Categories of Dissatisfaction



The Reasons



Service Related Grievances



Breakdown of Service Issues

Provider Services account for 82.4% (3,427 concerns). The top four reported concerns related to Provider Services are:

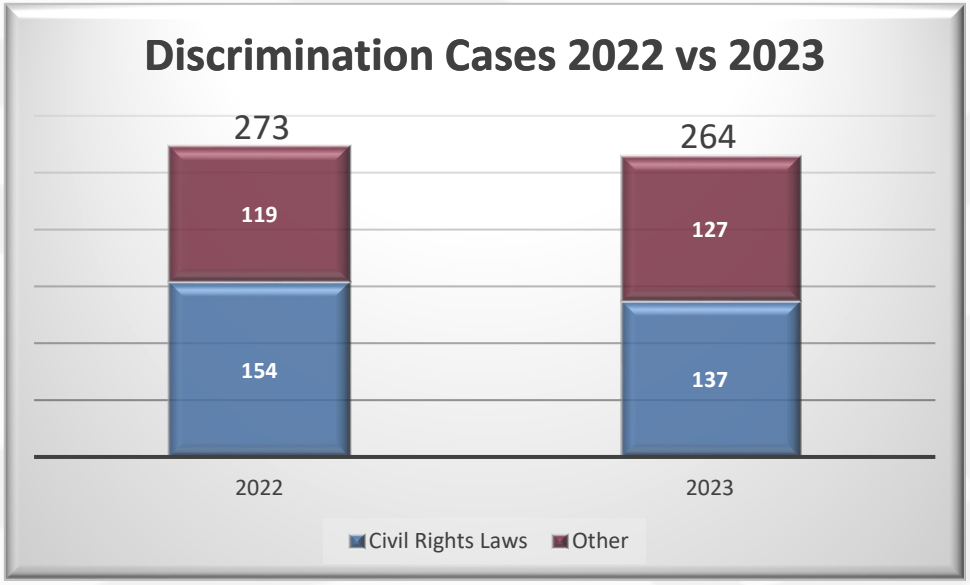
- Treatment Plan Disputes (24.7%)
- Access/Scheduling Appointments (24.6%)
- Poor Provider Communication (16.5%)
- Poor Provider Attitude (14.8%)

Other Service Issues include:

- PHC Service Complaints (12.2%)
- PCP Enrollment (4.1%)
- PHC Staff Complaints (4.4%)

Discrimination

Discrimination cases can fall into more than one category



Discrimination Categories	# Reported Concerns
Race or Ethnicity	50
Disability	44
Limited English Skills	13
Age	11
Auxiliary Aids and Services	8
Language	3
Language Assistance Services	2
Gender	2
Nationality	2
Sexual Orientation	1
Religion	1

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Questions?