Quality and Performance Improvement Program Evaluation 2023

CONTRA COSTA HEALTH

ACCREDITED NCQA HEALTH PLAN ACCREDITED ★★★★☆

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1 INTRODUCTION

The objective of the 2023 Annual Evaluation is to assess Contra Costa Health Plan's (CCHP) Quality Improvement Program. This evaluation aims to assess the quality and overall efficacy of the program by examining all initiatives implemented by various CCHP departments in 2023. It encompasses an assessment of areas of success, identified areas for improvement in services, and the potential necessity for restructuring or modifying the quality program for the subsequent year. The annual evaluation comprehensively examines committee and subcommittee structures, adequacy of resources, internal and external submission of minutes and reports, practitioner participation, leadership involvement, and quantitative and qualitative data to assess program outcomes.

The Quality Departments leads CCHP's annual evaluation, gathering input from a variety of stakeholders. This involves utilizing data and reports from committees, departments, content experts, data analysts, and work plans to thoroughly analyze and evaluate the effectiveness of the Quality at CCHP. The assessment of the overall effectiveness of quality initiatives involves a comprehensive analysis and monitoring of their objectives and actions. This includes reviewing qualitative and quantitative results, conducting causal analyses, identifying barriers, interventions, opportunities for improvement, and outlining the next steps.

1.1 MAJOR ACCOMPLISHMENTS

In 2023, CCHP Quality Department led a number of initiatives with notable successes:

- On March 1, 2023, CCHP was awarded the National Committee on Quality Assurance (NCQA) health plan accreditation for the Medi-Cal line of business. This demonstrates CCHP's commitment to delivering high-quality healthcare services, contributing to improved patient outcomes, and fostering a culture of continuous quality improvement.
- In NCQA's Annual Health Plan Rating, CCHP ranked with 4 stars (out of 5). These ratings evaluate health plans on the quality of care patients receive, how satisfied patients are with their care, and health plans' efforts to keep improving.
- CCHP exceeded the 90th percentile nationally for Breast Cancer Screening, Cervical Cancer Screening, Immunizations for Adolescents, Prenatal & Postpartum Care, Asthma Medication Ratio, Follow Up Care for Children Prescribed ADHD Medication, Ambulatory Care-ED Visits, and Prenatal Immunization Status.
- CCHP enrolled 6,488 in Enhanced Care Management, of which 1,081 were experiencing homelessness. CCHP is the highest amongst all health plans in the state in the provision of ECM according to overall membership size.
- CCHP provided Community Supports to 1,461 members, with 719 members receiving housing transition/navigation services and 600 receiving medically tailored meals.
- CCHP developed a Quality Dashboard to allow for near-real-time insight into quality metrics. This tool will ensure members are receiving needed preventive care by

providing continuous monitoring and used to support providers in continuous quality improvement efforts.

- CCHP successfully began conducting regularly scheduled meetings with contracted Federally Qualified Health Center (FQHC) quality staff to discuss location specific performance on quality measures and collaborate on provider specific initiatives.
- CCHP engaged in a wide array of performance improvement projects, including activities aimed to address well care visits, flu vaccination, colorectal cancer screening, and lead screening in children, and improve follow-up care after emergency department visits for mental health.

2 Program Purpose, Goals, and Scope

Contra Costa Health Plan (CCHP) is a federally qualified, licensed, county sponsored Health Maintenance Organization serving Contra Costa County. In 1973, CCHP become the first county sponsored HMO in the United States.

Contra Costa County is located in the East Bay of the San Francisco Bay Area. In 2022, according to the American Community Survey 1-year estimate from the United States Census Bureau, the county population was 1.156 million residents. Contra Costa Health Plan currently serves more than 267,000 Medi-Cal members, providing health insurance to nearly one-quarter of the county population. CCHP is one of two Medi-Cal Health Plans serving the region, the other being Anthem Blue Cross. In 2023, CCHP served 87% of Medi-Cal managed care members in Contra Costa. CCHP also administers a commercial product for County employees and In-Home Support Services (IHSS) caregivers. It serves more than 7,000 commercial members.

The CCHP provider network consists of Contra Costa Regional Medical Center, the Community Provider Network (Federally Qualified Community Health Centers, contracted provider groups, and private practices), and Kaiser Permanente. The Quality Program collaborates with internal departments, provider networks, and community-based organizations to facilitate safe, effective, cost efficient, equitable, and timely care to members.

The Quality Council, a multi-disciplinary physician group, guides the overall development, implementation, and evaluation of the Quality Program. The Joint Conference Committee was delegated by the Board of Supervisors to oversee the Quality Program for CCHP. The design of CCHP's Quality Program is to support CCHP's program purpose and goals to improve the quality, safety, and equity of care and services provided to members. CCHP is committed to continuous quality improvement for both the health plan and its care delivery system.

CCHP's quality program is designed to measure, monitor, evaluate, and improve the quality, safety, and equity of care and services provided to members. CCHP's overarching quality goals are to achieve better health outcomes, refine population health management, promote health equity, ensure patient safety, improve member experience, avoid unnecessary ED and hospital utilization, stabilize or reduce healthcare costs, and optimize

the provider experience. To achieve these goals, CCHP utilizes data analysis, solicits input from providers and members through committees, collaborates with community-based organizations, establishes aims, measures, interventions, and improvement teams for Performance Improvement Projects (PIPs), leverages technology for proactive identification, and continuously monitors and sustains performance. The Quality Program encompasses clinical care and services for all Medi-Cal and Commercial members, involving partnerships with various entities. The scope includes access to care, care coordination, population health strategy, utilization evaluation, patient safety standards compliance, health education, cultural linguistic services, addressing health disparities, managing clinical services usage, member appeals, and grievances, and adherence to accreditation standards. CCHP ensures accessibility to all members, regardless of demographics or health status, complying with applicable civil rights laws.

In 2023, there were no substantial changes made to the overarching purpose, goals, and scope of the quality program. The existing framework effectively addresses the outlined goals, demonstrating the program's stability and effectiveness. Looking ahead to 2024, under a new California Department of Health Care Services (DHCS) contract and the goal of working toward National Committee on Quality Assurance (NCQA) Health Equity accreditation, CCHP will refine the purpose and goals to place a greater focus on equity. As such, the quality program will be renamed the Quality Improvement and Health Equity Transformation Program to accurately reflect this transformative change.

3 Program Structure and Governance

3.1 Overview

The Quality Council is the principal committee for directing and overseeing quality and patient safety operations and activities for CCHP. It plays a crucial role in directing clinical and service-related performance improvement projects, access to care studies, member grievances, potential quality issues, utilization management, and other programs requiring quality oversight. The Quality Council's recommendations to the Joint Conference Committee contribute to the approval process for the Quality Program by the Contra Costa County Board of Supervisors.

3.2 Governing Body – Joint Conference Committee

The Joint Conference Committee (JCC) is one of the mechanisms by which the Contra Costa County Board of Supervisors exercises oversight of CCHP, including quality operations and activities. With two Board of Supervisors members assigned to the JCC, it operates transparently under the Brown Act, ensuring accessibility to the public. The JCC meets quarterly and responsibilities include: promoting communication between the Board of Supervisors, the CCHP Quality Council, and CCHP administration; assessing and monitoring the overall performance of CCHP and its contracted providers including, but not limited to, the quality of care and service provided to members; and reviewing, evaluating, and

making recommendations regarding modifications to the Annual Quality Program Description, Annual Quality Program Evaluation, and Quality Work Plan; and reviewing, evaluating, and acting on reports from the Quality Council, CCHP's Quality Director and Chief Medical Officer on a quarterly basis.

Throughout 2023, the JCC actively engaged in a series of activities aimed at overseeing and improving the quality of CCHP's operations. At each meeting, a comprehensive quality report was presented, facilitating a continuous assessment of the health plan's performance. The JCC approved essential program documents, including the Annual Quality Program Description, Quality Evaluation, and Quality Work Plan. The committee further engaged in a detailed review and discussion of access and availability, evaluating the efficacy of CCHP's strategies in ensuring timely access to care. Another focal point was the assessment of population health management, evaluating the overall effectiveness of CCHP's strategies in addressing broader health trends and enhancing the well-being of the population. The JCC reviewed CCHP's Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results, involving a thorough examination of CCHP's performance against key quality measures in accordance with national standards.

3.3 QUALITY COUNCIL

The Quality Council of CCHP plays a pivotal role in overseeing and ensuring the quality of clinical care, patient access, service excellence, and patient safety. Key responsibilities include reviewing and acting on subcommittee reports, approving program documents, and providing recommendations to governing bodies. The Council, chaired by the Chief Medical Officer and co-chaired by the Quality Director, comprises a multi-specialty group of clinicians meeting nine times per year. Voting members, including the Chief Medical Officer and contracted clinicians, represent specialties crucial to the Medi-Cal population.

Subcommittees reporting to the Quality Council, such as the Pharmacy and Therapeutics (P&T) Advisory Committee, Peer Review and Credentialing Committee (PRCC), and Utilization Management (UM) Committee, play integral roles in pharmaceutical management, credentialing operations, and oversight of outpatient and inpatient utilization management activities. These committee report regularly to the Quality Council for oversight.

Throughout 2023, the Quality Council's effectiveness and member participation were evaluated based on feedback from Quality Council members and a thorough review of agendas and minutes from past meetings. The assessment revealed consistent attendance from providers, and a vacant position resulting from retirement was promptly filled by a network provider. In 2022, an opportunity for increased engagement was identified, and in 2023 adjustments were implemented in the meeting structure. The focus was on developing thematic meeting agendas and limiting CCHP staff participation to presenting as subject matter experts. This restructuring aimed to address the complexity of topics and the use of industry jargon, ensuring more accessible and engaging discussions for external providers. The revised approach, informed by Quality Council member feedback and a

critical review of past meetings, facilitated increased engagement, and garnered valuable insights from external participants. Moreover, enhancements were introduced to report presentations, integrating discussion points to actively seek provider input and advisement.

To enhance formalization, the PQI (Potentially Quality Issue) was established as a formal Quality Council subcommittee. Although this may not have substantially changed existing practices, the formalization reinforces consistent reporting and updates within the Quality Council framework. This subcommittee meets regularly and reports potential quality issue findings during (at minimum) two Quality Council meetings a year, contributing to the overall quality oversight process.

Looking forward to 2024, a new governing body, the Equity Council will be created to oversee equity focused initiatives and bring in a wider stakeholder group including: community-based organization, homeless services, public health, and other community health advocacy groups. The Equity Council will be co-chaired by the Chief Health Equity Officer and the CCHP Medical Director.

3.4 The Community Advisory Committee

Contra Costa Health Plan (CCHP) has a Community Advisory Committee (CAC) to ensure that its members have meaningful impact into CCHP's policies and decision making and are engaged as partners in the delivery of Medi-Cal Covered Services. The CAC focuses on cultural and linguistic services, health education, and health equity, fostering community participation and advocacy. With a commitment to addressing health disparities, CAC members actively contribute to discussions on preventive care practices. CCHP's integration strategy enhances services with cultural and linguistic appropriateness.

In 2023, CCHP successfully launched this newly formed Community Advisory Committee. This involved recruiting new members and community-based organizations, fostering engagement through regular meetings, and organizing focus groups with CAC members to gather valuable input for health plan enhancements. As CCHP moves into 2024, an additional area of opportunity lies in enhancing executive-level engagement to facilitate collaboration with community-based organizations and other stakeholders. This will be led by the newly appointed Chief Health Equity Officer.

3.5 Quality Department Structure

Quality staff at CCHP play a vital role in implementing and monitoring quality projects and improvement activities, supporting CCHP leadership in strategic priorities, and collaborating with CCHP providers on ensuring quality of care for members. Led by the Chief Medical Officer, the staff encompass roles such as directors, managers, analysts, nurses, health educators, and administrative support.

In response to the evolving healthcare landscape, the Quality Department underwent restructuring in 2023, ensuring nursing staff received direct clinical supervision from a

Family Nurse Practitioner. A new department was created, the Clinical Quality Auditing Department which oversee functions such as facility site reviews, potential quality issues, HEDIS chart abstraction, and other ad hoc clinical auditing functions. As part of this restructuring, nursing staff underwent cross-training in all these functions, enhancing their versatility. This department reports directly to the Chief Medical Officer.

The Quality Department remains committed to ongoing initiatives, including quality measurement, access and availability monitoring, member and provider experience, Performance Improvement Projects (PIPs), population health management, provider engagement, and NCQA health plan accreditation oversight.

Anticipating the increasing focus on equity in 2024, a dedicated Equity Department was established at the end of 2023 led by the newly hired Chief Health Equity Officer. This new department, bolstered by additional staffing, will focus on cultural and linguistic services, NCQA equity accreditation, collaboration with community-based organizations, and Diversity, Equity, and Inclusion (DEI) initiatives.

4 Quality Improvement and Population Health Programs

4.1 Quality Program Planning

CCHP incorporates documentation cycles that applies a systematic process of assessment, identifying opportunities, implementing actions, and evaluating initiatives. This documentation cycle includes: Quality Program Description, Quality Work Plan, and Quality Program Evaluation. These documents, along with the Quality Council charter, are reviewed annually by the Quality Council.

In 2023, significant revisions were made to these documents to foster a more interconnected and coordinated approach to quality activities. The process involved extensive collaboration with various departments to capture a comprehensive view of quality across CCHP, transcending perspectives within the quality department. Furthermore, the refined quality framework was shared with provider groups to encourage collaborative engagement in quality initiatives. Periodic reviews of the quality plan throughout the year ensured activities remained on course, meeting established deliverables. The evaluation was used as a framework with which to craft the subsequent year quality plan and overall program description.

4.2 NCQA Accreditation

The quality department plays a central role in interpreting standards, identifying gaps, collaborating with other department functions to address deficiencies, ensuring the submission of appropriate and timely documentation, and maintaining oversight of the NCQA health plan accreditation status.

In March 2023, CCHP achieved its fourth consecutive three-year NCQA Health Plan Accreditation for Medi-Cal, earning an overall score of 93.7%, a notable increase from 88.6% in 2019. This success included surpassing 80% in all sections, meeting all "must pass" areas. Surveyors acknowledged CCHP's strengths, such as dedicated and knowledgeable staff, enduring community presence, an integrated delivery system enhancing member care, and excellent practitioner documentation, and behavioral health member-facing letters regarding utilization management and appeals. Surveyors identified several areas of opportunity for CCHP including improving contract language as it pertains to cooperation with quality activities, improving denial notices, improving functionality of the website and telephone service for members, including additional information in credentialing policies, and improving analysis documents across quality, member experience, network adequacy.

Looking ahead to 2026, there are increasing accreditation requirements. In addition to the Medi-Cal NCQA Health Plan Accreditation, CCHP will need to expand Health Plan Accreditation to its Commercial line of business, undergo Long-Term Support Services certification, and achieve Health Equity accreditation. CCHP will enhance regular training sessions for staff on NCQA standards. CCHP aims to build a culture of survey readiness through more frequent document collection on an annual cycle, ensuring strict adherence to accreditation standards and fostering an environment of continuous improvement.

4.3 Measurement, Analytics, Reporting, and Data Sharing

CCHP, in collaboration with Contra Costa Health's centralized IT department, boasts a robust technology infrastructure and data analytics capabilities to facilitate quality management and improvement activities. As an integrated health system, the centralized data infrastructure collects, analyzes, and integrates health plan data with clinical delivery system data and social services data to bolster quality initiatives. This integrated data warehouse enables the comprehensive collection of all quality performance data across the health plan and delivery system.

4.3.1 Healthcare Effectiveness Data and Information Set (HEDIS)

The Quality Department collaborates with the CCH Business Intelligence team to annually collect HEDIS data. Medi-Cal Managed Care plans are mandated by both the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA) to report annually on two distinct sets of measures. DHCS requires Medi-Cal Managed Care plans to report annually on a set of quality measures, known as the Medi-Cal Managed Care Accountability Set (MCAS), while NCQA requires health plans report on a set of health plan accreditation measures. In sum, this encompasses over 70 measures spanning clinical effectiveness, clinical resource utilization, access and availability, and member experience with care. CCHP, utilizing a certified HEDIS benefits engine for reporting and undergoing compliance audits, ensures the certification of all measures by June 15 each year. In June 2023, CCHP reported 2022 measurement year data.

The MCAS measures are comprised of various health-related outcomes, HEDIS measure and Center for Medicaid and Medicare (CMS) Core Measures. DHCS establishes the target or Minimum Performance Level (MPL) on qualifying measures based on the NCQA national Medicaid 50th percentile benchmark. CCHP's performance on Measurement Year (MY) 2022 MCAS measures and their trends over time are illustrated in Table 1.

Table 1. Summary Performance in MCAS Measures Overall MY 2019-2022

Measures	MY 2019	MY 2020	MY 2021	MY 2022	Trend	National Percentile
Adults' Access to Preventive/Ambulatory Health Services	-	-	-	69.75		<25th ☆
Ambulatory Care - Emergency Dept Visits/1000 MM	52.90	36.45	40.27	46.92		90th ★
Antidepressant Medication Management - Effective Acute Phase Treatment	62.59	63.07	65.97	66.25		75th ★
Antidepressant Medication Management - Effective Continuation Phase Treatment	41.17	41.01	44.16	45.23		50th ☆
Asthma Medication Ratio	60.48	63.93	64.48	75.23		90th ★
Breast Cancer Screening	68.86	58.33	58.66	63.95		90th ★
Cervical Cancer Screening	68.37	68.06	68.33	68.33		90th ★
Child and Adolescent Well-Care Visits	-	42.09	55.05	53.09		75th ★
Childhood Immunization Status - Combination 10	51.09	51.34	47.93	44.04		75th ★
Chlamydia Screening in Women	68.36	62.81	62.22	66.65		75th ★
Colorectal Cancer Screening	-	-	-	39.69		-
Contraceptive Care – All Women - Ages 15-20	19.78	18.34	17.59	19.01		-
Contraceptive Care – All Women - Ages 21-44	27.85	25.52	25.38	25.43		-
Contraceptive Care – Postpartum - Ages 15-20: 60 Days	57.89	57.78	47.32	46.43		50th ☆
Contraceptive Care – Postpartum - Ages 21-44: 60 Days	46.44	46.19	45.03	46.73		50th ☆
Controlling Blood Pressure	73.73	64.96	62.37	67.27		75th ★
Depression Remission or Response- Follow-up	-	-	-	29.14		-
Depression Remission or Response- Remission	-	-	-	8.26		-
Depression Remission or Response- Response	-	-	-	11.48		-
Depression Screening and Follow-Up for Adolescents and Adults - Screening	-	-	-	29.73		-
Depression Screening and Follow-Up for Adolescents and Adults - Follow-up	-	-	-	81.66		-
Developmental Screening in the First Three Years of Life	24.38	21.68	37.45	52.57		50th ☆
Diabetes - HbA1c Poor Control (>9.0%)*	37.71	38.93	34.55	33.99		75th ★
Diabetes Screening for People Who Are Using Antipsychotic Medications	87.78	79.41	84.32	85.31		75th ★
Follow-up after ED for AOD - 7 Day	2.94	8.94	4.46	16.53		50th ☆
Follow-up after ED for AOD - 30 Day	6.42	8.94	10.00	26.61		75th ★
Follow-up after ED for Mental Illness - 7 Day	10.39	11.74	15.21	27.02		<25th ☆
Follow-up after ED for Mental Illness - 30 Day	20.25	21.81	23.15	45.97		25th ☆
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	53.03	51.63	44.92	50.60		90th ★
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	47.23	62.50	48.65	62.50		75th ★
Immunizations for Adolescents (IMA) - Combo2	50.85	43.80	44.28	53.36		90th ★
Lead Screening in Children	-	-	44.23	51.51		<25th ☆
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing	61.11	42.22	54.00	46.08		75th ★
Pharmacotherapy for Opioid Use Disorder	-	-	37.04	27.32		25th ☆
Plan All-Cause Readmissions*	100.39	82.84	87.67	86.93		75th ★
Prenatal Care	93.43	93.40	94.34	93.88		90th ★
Prenatal Immunization Status	-	-	46.11	46.05		90th ★
Prenatal Depression Screening and Follow Up- SCR	-	-	-	76.95		-
Prenatal Depression Screening and Follow Up- FU	-	-	-	66.67		-
Postpartum Care	88.08	90.97	91.19	90.48		90th ★
Postpartum Depression Screening and Follow Up- SCR	-	-	-	53.07		-
Postpartum Depression Screening and Follow Up- FU	-	-	-	79.63		-
Topical Fluoride for Children	-	-	-	12.73		50th ☆
Well-Child Visits in the First 30 Months of Life (31d-15m)	70.32	56.69	54.35	65.88		75th ★
Well-Child Visits in the First 30 Months of Life (15m-30m)	-	69.85	64.58	73.05		75th ★

CCHP improved performance in a number of key MCAS measures in MY 2022. CCHP accomplished this through data improvements, performance improvement initiatives, and increased collaboration with contracted providers. CCHP performed at the 90th percentile

for Follow Up Care for Children Prescribed ADHD Medication (Initiation Phase), Ambulatory Care-ED Visits/1000 MM, Asthma Medication Ratio, Breast Cancer Screening, Cervical Cancer Screening, Immunizations for Adolescents, Prenatal & Postpartum Care, and Prenatal Immunization Status. This nearly doubles the number of MCAS measures at the High-Performance Level (HPL) from five in MY 2021 to nine in MY 2022. Additionally, CCHP achieved the 75th percentile for 13 measures and the 50th percentile for 6 additional measures. CCHP was under the 50th percentile for 5 measures, 2 of which were target measures (Follow-up for ED for Mental Health and Lead Screening in Children).

CCHP saw marked improvement in well child visit rates for children less than 30 months, which was under the 50th percentile benchmark in MY 2021. In MY 2022, Well-Child Visits in the First 30 Months of Life (31 days – 15 months) increased from 54.35% to 65.88% and this moved CCHP from the 33rd percentile nationally to 75th. For Well-Child Visits in the First 30 Months of Life (15 – 30 months), rates improved from 64.58% in 2021 to 73.05% in 2022 and CCHP moved from 10th percentile nationally to 75th percentile.

For Lead Screening in Children and Follow-Up after ED for Mental Illness – 30 Days (FUM-30), which were below the MPL, rates in MY 2022 increased substantially compared to MY 2021. To ensure that CCHP exceeds the MPL for FUM-30, CCHP has instigated a Performance Improvement Project (PIP) for the 2023-2026 improvement cycle. This project will focus on connecting CCHP members who present to the ED with a SUD or mental health concern to care management. CCHP will also continue to implement improvement activities to address Lead Screening in Children. These efforts include targeted provider education and gap in care lists and are more detailed in 4.4.1.3.

4.3.2 Member Experience – CAHPS

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is a standardized tool used to assess patients' experiences with healthcare services and providers. CCHP administers the survey yearly and the data from the Adult Medi-Cal population in MY 2022 are presented in Table 2.

Table 2 CAHPS Results MY 2021-2022

Measure	MY 2021	MY 2022	Percent Change	Percentile
Overall Ratings				
Rating of all health care	75.8%	78.2%	3.2%	66th ▲
Rating of personal doctor	84.7%	80.8%	-4.6%	33rd ▼
Rating of specialist talked to most often	76.0%	79.2%	4.2%	10th ▲
Rating of health plan	78.4%	79.6%	1.5%	33rd ▬
Composite Scores				
Getting needed care	76.6%	79.1%	3.3%	25th ▲
Getting care quickly	74.4%	79.4%	6.7%	33rd ▲
How well dotors communicate	93.5%	92.8%	-0.7%	33rd ▼
Customer service	82.3%	85.2%	3.5%	50th ▲
Effectiveness of Care				
Advising Smokers to Quit	75.9%	80.4%	5.9%	95th ▲
Discussing Cessation Medications	53.7%	63.0%	17.3%	95th ▲
Discussing Cessation Strategies	50.0%	70.5%	41.0%	95th ▲

In MY 2022, CCHP improved in national percentile rankings in two of the four overall ratings and three of four composite scores, and more importantly, saw increases from the prior year. While CCHP only achieved 10th percentile rankings for the rating of specialists and getting needed care, both of these measures saw increases in both the percentage of positive responses and overall national percentile ranking.

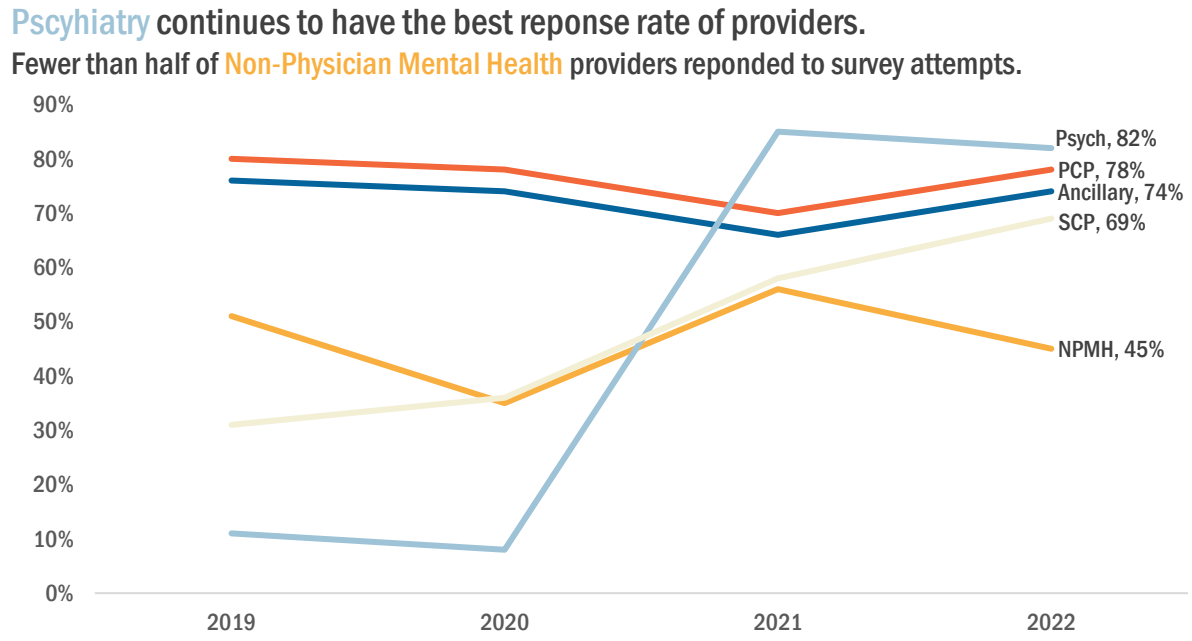
CCHP achieved the highest percentile rankings in the Effectiveness of Care domain, where 95th percentile was reached for Advising Smokers to Quit, Discussing Cessation Medications, and Discussing Cessation Strategies.

CCHP will work to improve member experience by garnering further input from members through the Community Advisory Committee (CAC). The CAC can provide valuable input on how to improve members' experiences by offering diverse perspective, insights, and recommendations that are informed by community needs and experiences. The CAC may offer some insights into the underlying factors contributing to areas with low scores and potential strategies for improvement, as well as identifying priority areas that warrant focused attention.

4.3.3 Network Adequacy

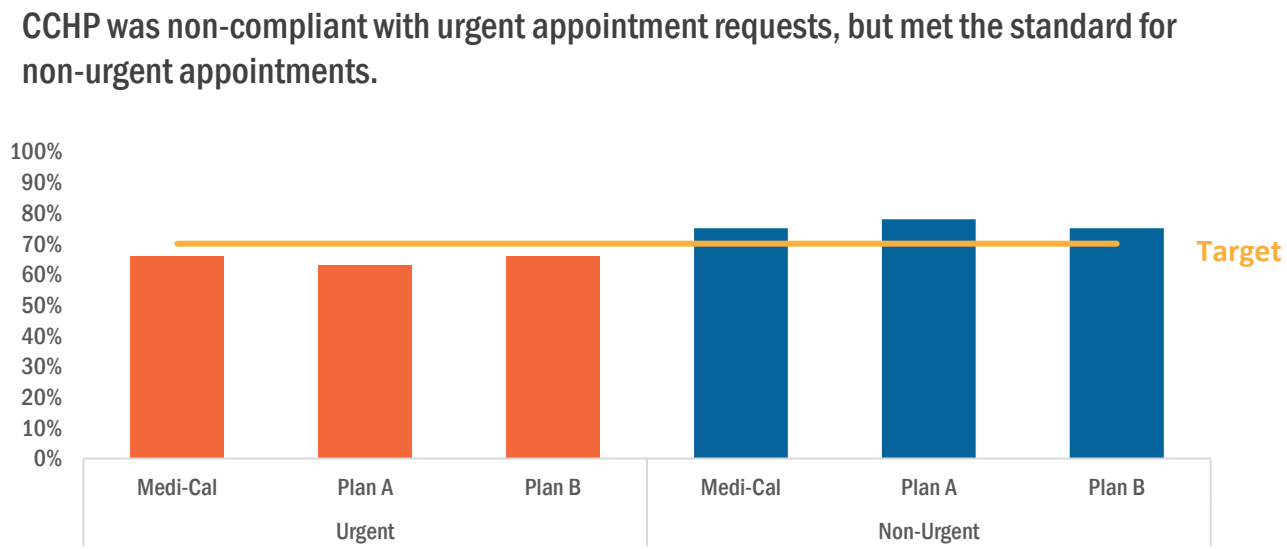
In 2022, CCHP made improvements to the annual Provider Appointment Availability Survey (PAAS) to improve response rates, which are illustrated in Figure 1. These improvement efforts led to continued improvement in response rates in 2022, except for non-physician mental health providers. While NPMH saw a decline in response rates in 2022 compared to 2021, preliminary results from the MY 2023 survey indicate improvement. Response rates are essential to a complete understanding of network adequacy.

Figure 1. MY 2022 PAAS Response Rate Trend



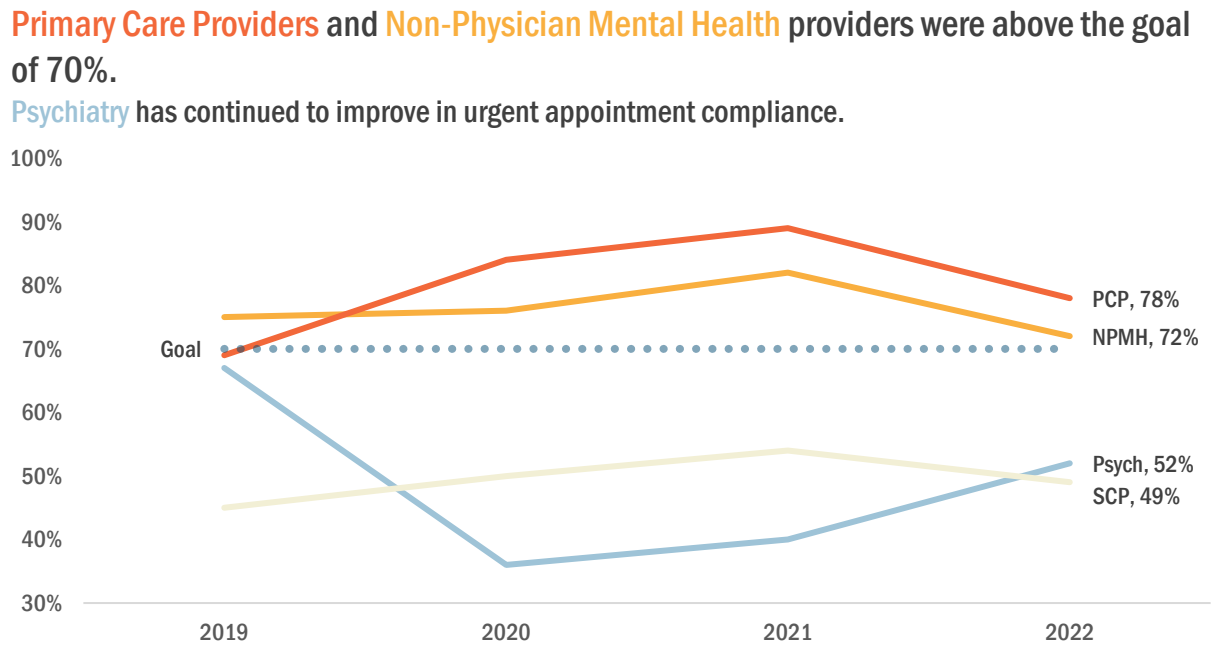
California Department of Managed Health Care (DMHC) monitors access and availability to urgent and non-urgent appointment, requiring at minimum 70% of providers meet these appointment availability standards.

Figure 2



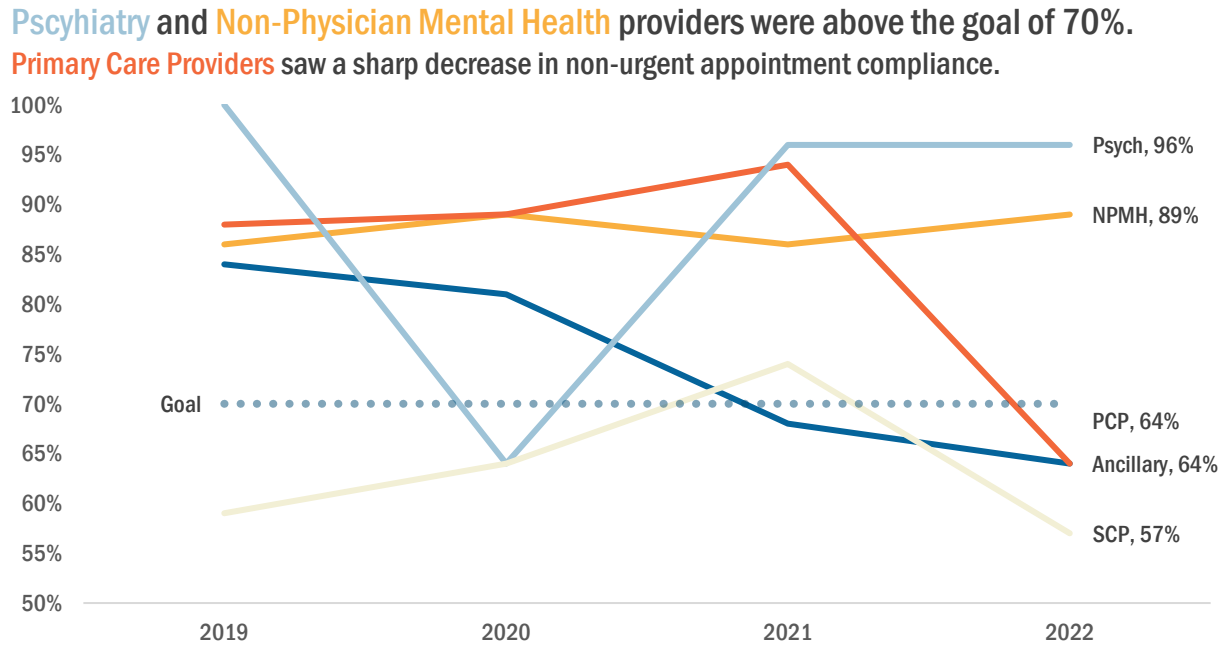
To further investigate non-compliance to the standard, CCHP reviewed compliance rates over time for urgent appointments by provider type. The results are illustrated in Figure 2. Overall, in 2022, CCHP's urgent appointment compliance was below the 70% threshold for the Medi-Cal network (66%), the Plan A network (63%) and the Plan B network (66%). While psychiatry continues to remain below the 70% threshold, there has been steady improvement in the compliance rate over time. Preliminary 2023 data show that the compliance rate across all plans for psychiatry is 70%, meeting the goal, and specialist compliance has increased to 69%.

Figure 3. PASS Urgent Appointment Compliance Over Time



While CCHP met the compliance standard of 70% for all lines of business for non-urgent appointments, in the spirit of continuous quality improvement, CCHP further investigates compliance by provider type to find opportunities for improvement. In MY 2022, for non-urgent appointments, psychiatry providers continued to have the best compliance rate at 96% (Figure 43). While NPMH providers had a low response rate, those who did respond to the survey showed 89% compliance with appointment standards. In MY 2022, Specialists (SCP) and Primary Care Providers (PCP) both saw declines in compliance that put them under goal for the first time. Additionally, ancillary providers (mammography and physical therapy) were under the goal for compliance for a second year. There is a possibility that these providers are impacted by the COVID-19 pandemic and the cumulative impact of delayed health care screenings and procedures. This is further evidenced by the fact that while CCHP's BCS rate is in the 90th percentile and has increased from 58.66% in 2021 to 63.95% in 2022, it is still below the 68.86% rate in MY 2019. Preliminary MY 2023 responses demonstrate PCP compliance with DMHC standards and improvement in specialty (SCP) compliance, though availability is still below goal. Importantly, the overall compliance for non-urgent appointments in all networks is over 70%, so no corrective actions are necessary at this time.

Figure 4 PAAS Non-Urgent Appointment Compliance Over Time



To address access and availability challenges, CCHP undertook initiatives in provider education and network expansion in 2023. Individualized information on access and availability survey results was provided to providers, along with educational efforts on access standards through newsletters, network training, and direct outreach. Additionally, in 2023, CCHP's provider relations actively expanded the network, particularly in psychiatry, aiming to enhance access to urgent care appointments.

4.3.4 Other Quality Measurement Activities

In 2023, CCHP successfully completed a number of other quality reporting activities including DHCS encounter data validation, a provider satisfaction survey, and comprehensive reporting on CalAIM requirements, including Enhanced Care Management and Community Supports monitoring reports, Incentive Payment Program reports, Housing and Homelessness Incentive Program reports, and CalAIM Population Health Key Performance Indicators (KPIs).

Amidst the introduction of numerous CalAIM metrics, CCHP is actively exploring effective ways to utilize them for continuous assessment and program improvement. The focus on CalAIM monitoring, initially process-oriented, needs to evolve towards assessing the impact and evaluation of programs in a more meaningful manner, understanding the health and quality of life impacts of these programs. CCHP is exploring a partnership with UC Berkeley School of Public Health to pursue a meaningful evaluation of these programs.

CCHP enhanced the collection of Race, Ethnicity, Age, and Language (REAL) data throughout the year. Recognizing an opportunity for improvement, the organization streamlined the initial member screening process with REAL data collection. There are ongoing efforts to explore workflows for incorporating Medi-Cal data race and ethnicity data from the 834 Medi-Cal file.

A noteworthy achievement in 2023 was the improvement of the quality infrastructure for real-time measurement of quality indicators. CCHP developed an internal dashboard capable of measuring and reporting rolling 12-month HEDIS measurements for MCAS measures. The dashboard provides the flexibility to stratify data by race, ethnicity, sex, provider group, and other demographic indicators. Additionally, CCHP worked with larger Epic providers in the network to implement Epic Population Health Queries. On a monthly basis, CCHP draws down clinical data from providers' electronic health records through CareEverywhere. This enhancement will allow CCHP to minimize claims lag and draw in more clinical data into HEDIS and regular quality measurement activities. Preliminary results show a substantial improvement in measures such as controlling high blood pressure, which demonstrates a 16% increase in administrative measurement. This real-time monitoring tool serves as a valuable resource for sharing live rates and gap-in-care lists with providers.

4.4 Performance Improvement Projects

The Quality Program at CCHP is dedicated to enhancing care and services for members through continuous evaluation and improvement, utilizing the Model for Improvement and Plan-Do-Study-Act (PDSA) cycles. Goals focus on improving health outcomes, member experience, health equity, and cost efficiency. Project prioritization considers regulatory requirements from DHCS, DMHC, and NCQA, along with insights from HEDIS and other quality metrics, findings from the Population Needs Assessment, potential quality issues (PQIs), member grievances, member and provider experience surveys, and access studies.

CCHP identifies additional performance improvements through annual reviews of quality metric data. This analysis assesses areas needing improvement, leading to the development of projects added to the work plan. Monthly reviews allow for timely adjustments to the work plan, addressing areas of declining performance or those falling below desired quality targets. Quality staff conduct root cause analyses and formulate plans for implementing performance improvement projects.

4.4.1 DHCS Performance Improvement Projects

CMS and DHCS requires CCHP to conduct a minimum of two Performance Improvement Projects annually as part of External Quality Review (EQR). CCHP has at least two active DHCS statewide performance improvement projects and, if needed, smaller mandated pilot projects for measures below the state's minimum performance level.

In 2023, CCHP completed the analysis of the 2022 PIPs and received high confidence ratings by DHCS. For the PIP focusing on improving A1c control in residents in East and West County with obesity, CCHP exceeded the stated goal of having fewer than 20% of members with an A1c>9.0%, with the final measure at 19.8%. For the PIP focused on improving Well Visit attendance for Black children aged 3 to 6, CCHP again exceeded the stated goal of 58.0% of members completing a well child visit, with a final measure of 63.4%.

Figure 5

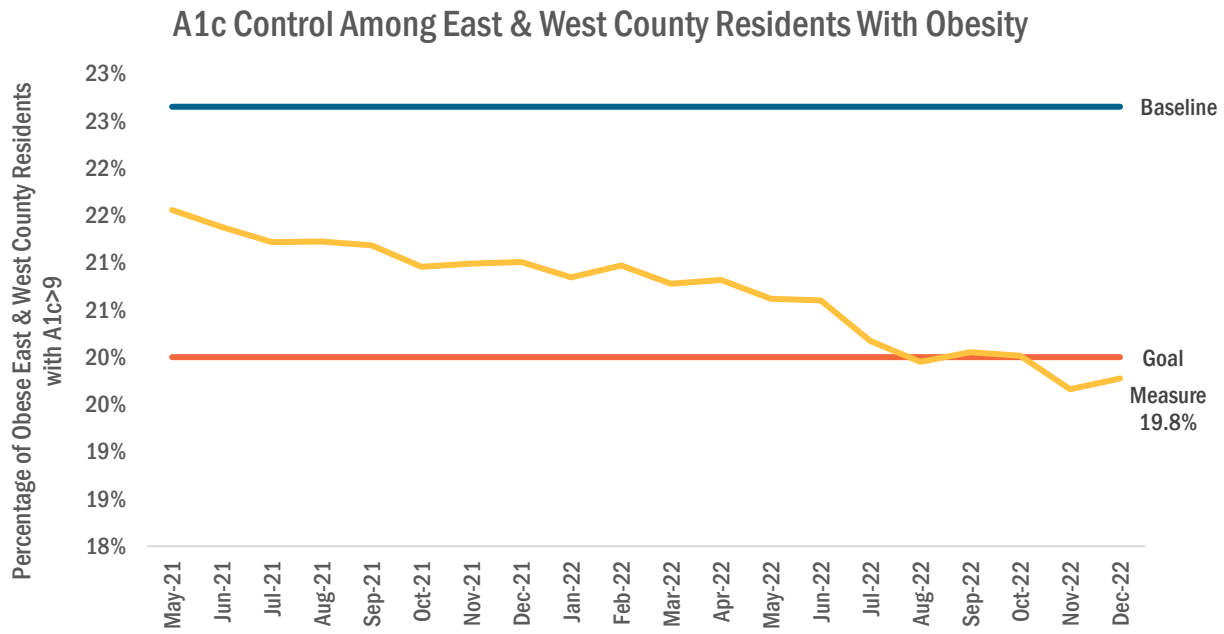
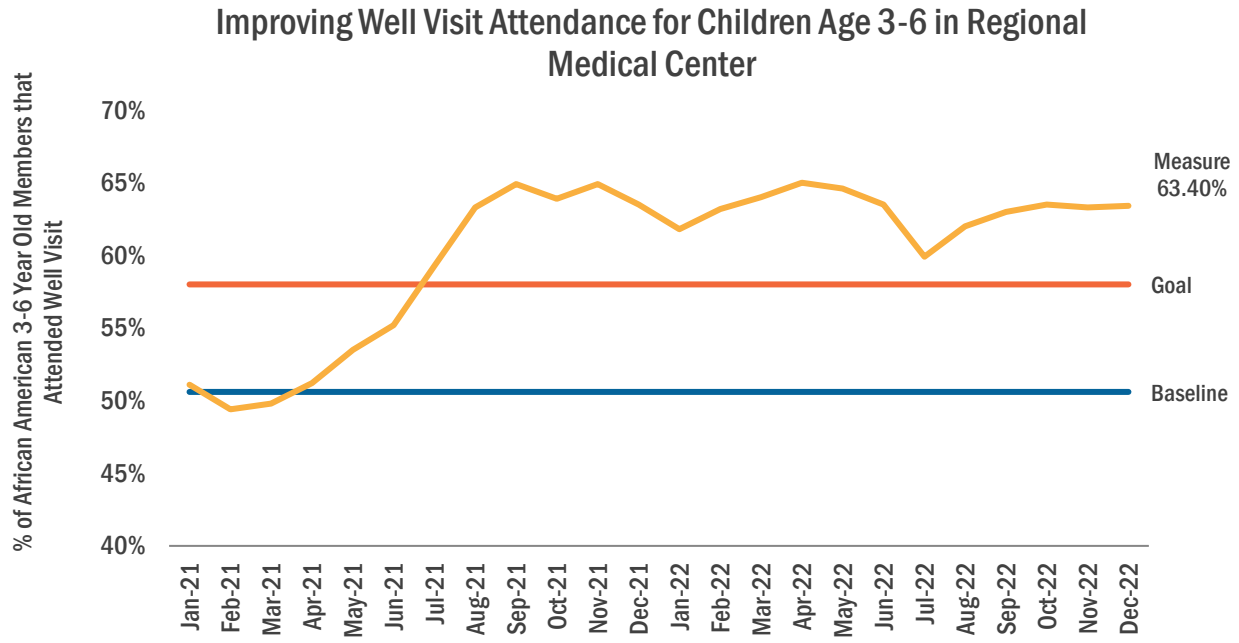


Figure 6



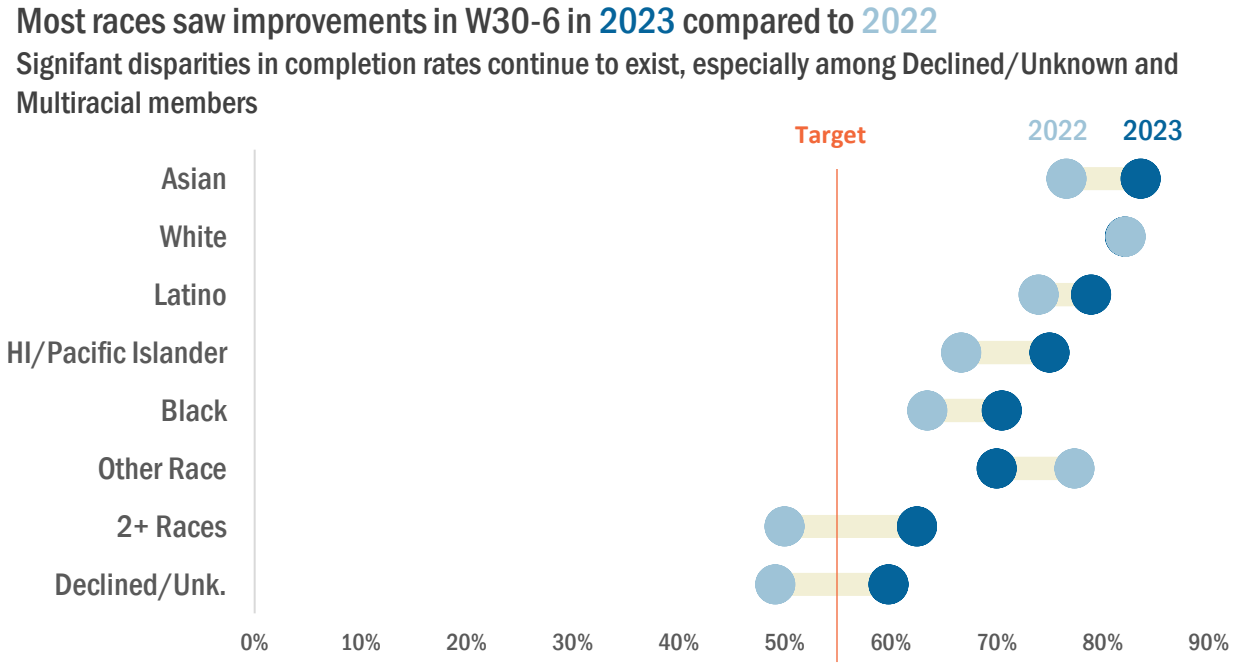
CCHP also completed a DHCS Strengths, Weaknesses, Opportunities and Threats assessment for the CCHP pediatric population after both MY2021 W30-6 and W30-2 rates were below the MPL. After conducting the assessment, CCHP focused on strategies to improve Well Child Visits for Black youth, improve flu vaccination rates, and to improve lead screening rates. CCHP piloted mailing a letter to Black members aged 18-21 who were unengaged with their PCP in the past 18 months, piloted a flu vaccination MyChart messaging campaign, created social media posts for well child visits and lead screening, and created the lead outreach toolkit. The letter and MyChart campaigns, as well as the social media posts, were not as impactful as traditional phone outreach methods.

For the 2023-2026 Performance Improvement Cycle, DHCS assigned CCHP a clinical PIP to improve the W30-6 Measure Among Black Members. DHCS also required a nonclinical PIP topic that supports efforts in building an infrastructure that links members to county mental health and providers for coordinated services. CCHP will focus on Improving the Percentage of Members Enrolled in Care Management within 14 Days of SMH/SUD Diagnosis.

4.4.1.1 Improving W30-6 Measure Rate Among Black Members

The COVID-19 pandemic impacted children's ability to adhere to the recommended periodicity schedule for well-child visits. CCHP saw a decline in the W30-6 measure, from 70.32% in 2019 to a low of 54.35% in 2022. There are significant racial disparities in the W30-6 rate. Notably, in 2023, the total difference between the group with the highest W30-6 rate and Black members was 13.1%. Targeted gift card outreach in 2023 in the RMC network saw some successes in bringing members to the clinic for well care visits, but disparities remain. CCHP will continue to work on this project in 2024.

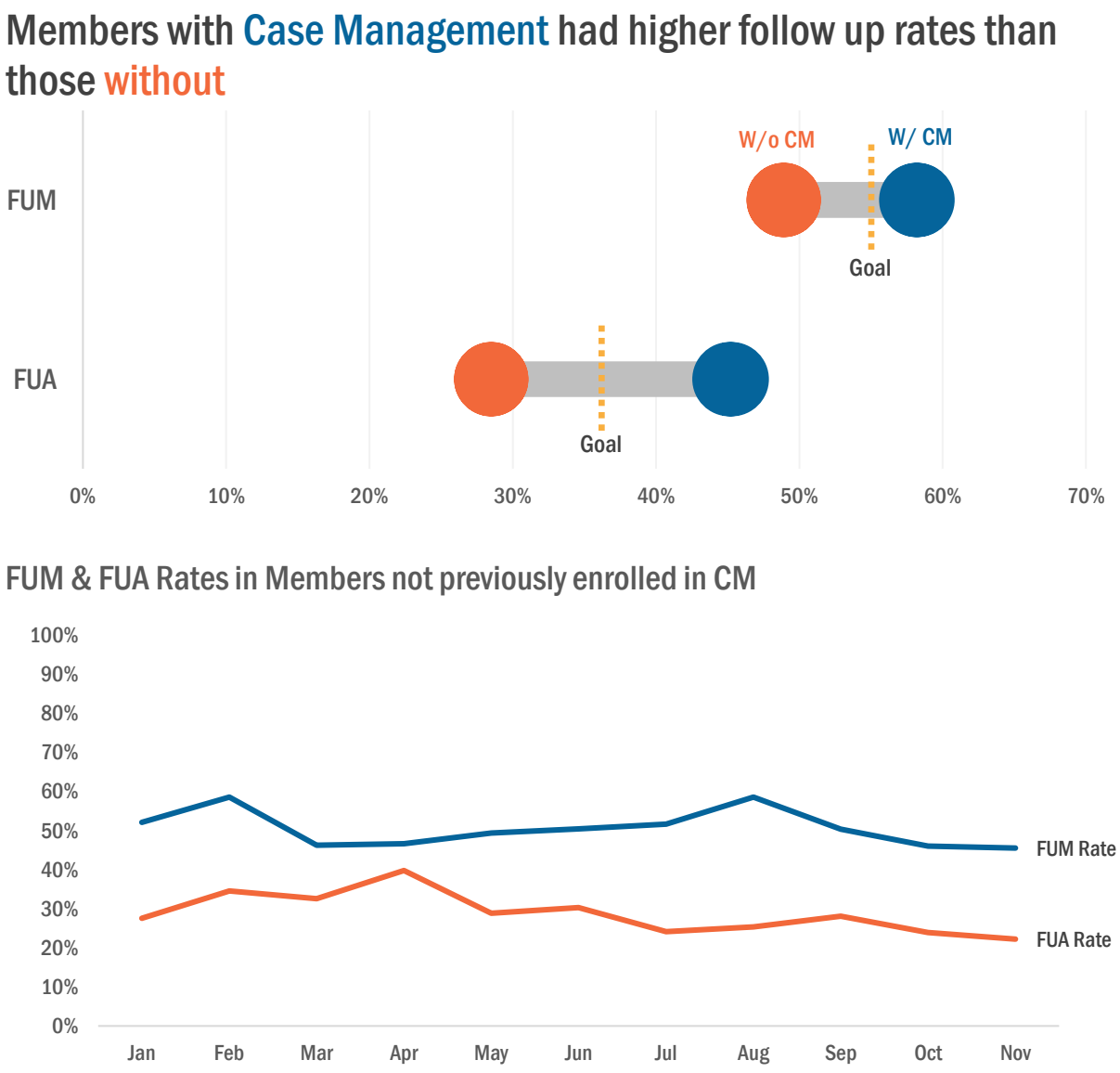
Figure 7



4.4.1.2 Improving the Percentage of Members Enrolled in Care Management within 14 Days of SMH/SUD Diagnosis

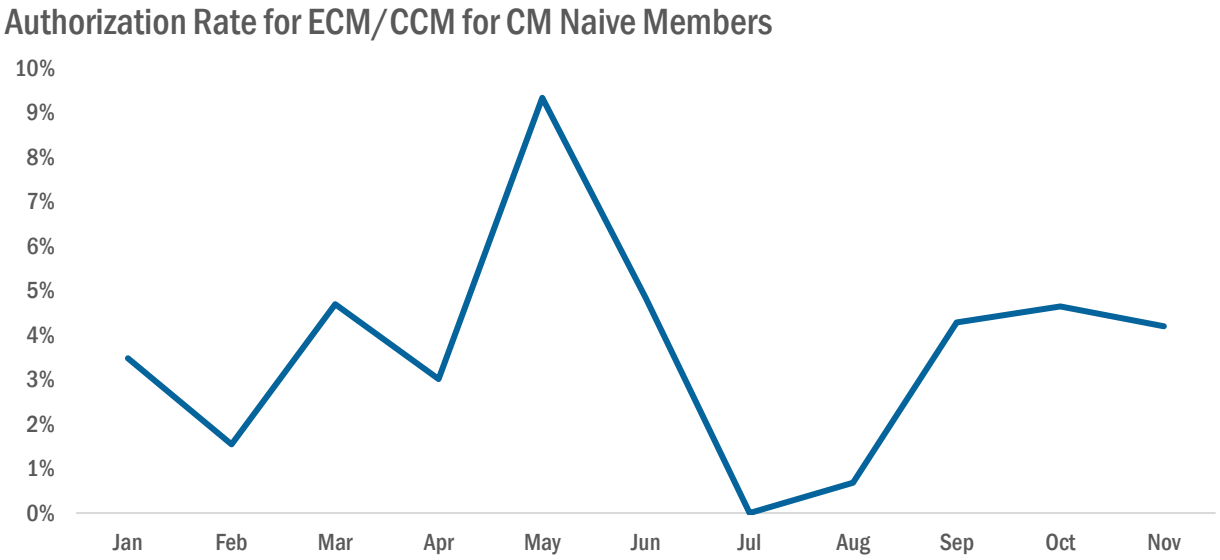
CCHP's non-clinical PIP is focused on improving enrollment in case management following an emergency department visit for mental health or substance use. Members who were previously enrolled in Enhanced Care Management (ECM) or Complex Case Management (CCM) were more likely than members not enrolled in care management (CM) to receive a clinical follow up visit after their ED visit for mental health or substance use. For members in care management, Follow Up within 30-days after ED for Mental Illness was 58.2% compared to 48.9% for members not enrolled in care management. For Follow Up within 30-days after ED for AOD, the rate for members enrolled in care management was 45.2% compared to 28.5% for members not enrolled.

Figure 8



According to baseline data, between 0-10% of members are authorized for case management within 14 days of an emergency department visit for behavioral health. One reason for this is claims lag, which prevents CCHP from identifying individuals for case management in a timely fashion and establishing workflows to trigger authorizations for needed services. These are all areas of opportunity in 2024 as CCHP looks to address and improve linkage to services after emergency department visits for behavioral health. Some possible techniques include expanding usage of Admit, Discharge, and Transfer (ADT) feeds and establishing automated processes to authorize and triage potentially eligible members for services.

Figure 9



4.4.1.3 PIPs for Low Performing MCAS Measurement

CCHP regularly monitors HEDIS and MCAS measures and develops improvement plans based on low performing measures. In MY 2022 (reported in 2023) CCHP identified lead screening and follow-up for ED visits for mental health as low performing measures.

4.4.1.3.1 Lead Screening in Children

Lead Screening in Children (LSC) was a new MCAS measure in MY 2022 and DHCS expects CCHP to perform above the 50th percentile nationally. While LSC rates increased from 44.23% in MY 2021 to 51.51% in MY 2022, CCHP was at the 10th percentile nationally and therefore, did not meet the MPL. As part of CCHP's efforts to increase LSC in 2023, CCHP purchased 5 LeadCare II Point of Care Testing machines for FQHC providers. Overall LSC screening rates at the FQHC providers with LeadCare II machines rose from 40.2% at the beginning of 2023 to 47.4% by 12/31/2023. As these machines were put into use in Fall 2023, it is expected this will have more impact in 2024. Additionally, CCHP developed a Lead Outreach Toolkit with example SMS, phone call, and email outreach messages about the importance of lead screening and Contra Costa Health branded posters for provider waiting rooms. The outreach toolkit also included a social media campaign with sample tweets/captions for social media posts to encourage providers to participate in the National Lead Poisoning Prevention Week.

Preliminary MY 2023 HEDIS results for CCHP demonstrate increased improvement in LSC to 52.58%, which corresponds to 25th percentile nationally. This is still below the MPL and CCHP will continue to implement improvement activities to increase performance in 2024. Proposed improvement activities include targeted provider education for providers with low screening rates and gap in care lists to ensure providers are aware of which members need screening.

4.4.1.3.2 Follow-Up for Emergency Department for Mental Health

Follow-Up for Emergency Department for Mental Health is not a new MCAS measure, but it was not previously held to an MPL. While CCHP did not perform at the MPL in MY 2022,

performance on this measure has been steadily improving since MY 2019. To further increase performance on this measure, CCHP partnered with Contra Costa Behavioral Health Services to conduct a Performance Improvement Project. Detailed data analysis revealed that a high percentage of patients who were failing this measure were being seen at a particular network ED. CCHP, CCBHS, and the ED worked together to implement a hidden prompt in the Access Line, the county's centralized Behavioral Health phone line. This hidden prompt allows the ED providers to complete a warm handoff of the patient to the Access Line to schedule follow-up care. CCHP and CCBHS expanded this effort to an additional ED in the network in late 2023 and is exploring other mechanisms for providing expediated follow-up appointments to people upon discharge.

4.5 Population Health Management

Population Health Management (PHM) at CCHP is dedicated to maximizing health by collaboratively designing services with members and providers. This involves delivering primary and secondary evidence-based interventions for illness prevention and management within our assigned population. In 2023, the Department of Health Care Services (DHCS) introduced Population Health Management as a pivotal component of CalAIM. This initiative aims to establish a unified, statewide approach ensuring that Medi-Cal members benefit from a comprehensive program promoting longer, healthier, and happier lives, improved health outcomes, and health equity.

In 2023, CCHP embarked on an enhancement of its existing PHM program. This involved a comprehensive series of meetings engaging key CCHP leadership and collaborating with provider, county, and community partners. Working groups were strategically formed to delve into crucial topics, including transitional care services, risk identification, and new member assessment/identification, setting the stage for effective implementation. Given the transformative nature of these changes, CCHP created a tiered, multi-year plan to ensure effective implementation of these initiatives. The ongoing collaboration with stakeholders demonstrates CCHP's dedication to advancing population health initiatives and adapting to the evolving landscape of healthcare services.

4.5.1 Population Needs Assessment, Strategy, and Impact Report

Annually, CCHP conducts a Population Needs Assessment, leveraging diverse data sources to identify disparities and trends. The outcomes guide the formulation of the Population Health Management Strategy—an annual document approved by the Quality Council, delineating the programs CCHP will implement to address population needs. Concurrently, CCHP conducts an annual Population Health Impact report to evaluate the effectiveness of the implemented programs.

CCHP achieved a milestone in finalizing the Population Health dashboard and Quality Dashboard, providing a consolidated view of key indicators from various data sources. Collaborative efforts with the Public Health Department's epidemiologist and quality team were initiated to align with Contra Costa's Community Health Assessment and Community

Health Improvement Plan. CCHP will be an active stakeholder in Contra Costa County's next Community Health Assessment, scheduled to begin planning in 2024.

Utilizing these various data sources, CCHP responded proactively to population needs, expanding programs for patients with complex needs (patients experiencing homelessness, patients with avoidable emergency room and hospitalizations, patients with experience of incarceration, and members with substance use and severe mental health), diabetes management, and asthma services. Furthermore, CCHP bolstered programs in homeless services, long term support services, doula services, and behavioral health.

As part of continuous improvement, CCHP acknowledges the complexity of evaluating these programs due to regression to the mean and is actively developing a framework and evaluation methodology for program impact assessment. Propensity score matching and other methodologies are being explored to comprehensively assess program effectiveness, ensuring a data-driven approach to population health management.

4.5.2 Improved Member Information

Leveraging its integration within the county delivery system, CCHP utilizes comprehensive data systems, centralizing data from claims, clinical data, detention health, EMS, social services, homeless systems, and public health into one unified member record. While CCHP's data infrastructure is robust, initial new member screening and assessment processes presented an area of improvement.

To address this opportunity, CCHP initiated a comprehensive overhaul of the new member workflow, streamlining activities for improved alignment. A revamped Health Insurance Form/Medical Evaluation Tool (HIF/MET) and Health Risk Assessment (HRA) were designed, featuring specific questions tailored for adults, children, seniors, and persons with disabilities. Questions were aligned with standard queries available in the Electronic Health Record (EHR) to enhance interoperability.

These screenings were seamlessly integrated with the Race, Ethnicity, Age, and Language (REAL) data collection survey, Primary Care Physician (PCP) assignment letter, and a reminder to schedule an Initial Health Appointment. The information from these screenings was incorporated into the electronic health records, ensuring accessibility for all providers on the Epic platform through CareEverywhere and the provider portal.

This refined process was implemented in December 2023, and its impact will be systematically measured and assessed in 2024 to ensure ongoing enhancement of member information for effective Population Health Management.

4.5.3 Risk Stratification, Segmentation and Tiering

CCHP employs a comprehensive approach to risk stratification, segmentation, and tiering by harnessing data from diverse sources. Utilizing claims and encounter data, DHCS-provided data, screening and assessments, electronic health records, referral and authorization data, behavioral health data, pharmacy data, utilization data, and social

services data including homelessness data, criminal justice data CCHP establishes the foundational data for its risk stratification and tiering methodologies.

This diverse dataset enables CCHP to create individual member records based on risk, segmenting them into different risk categories and tiering based on acuity. The incorporation of a broad range of data points facilitates the identification of interventions and eligibility criteria, allowing for the triaging of individuals to services.

In 2023, significant work was done to create an infrastructure for risk identification and program eligibility, combining both risk tiering with program eligibility and exclusion data. These data have then been leveraged to automatically identify and refer people to services, without the need of a practitioner referrals. In sum, over 80% of referrals to enhanced care management were from data-driven authorizations.

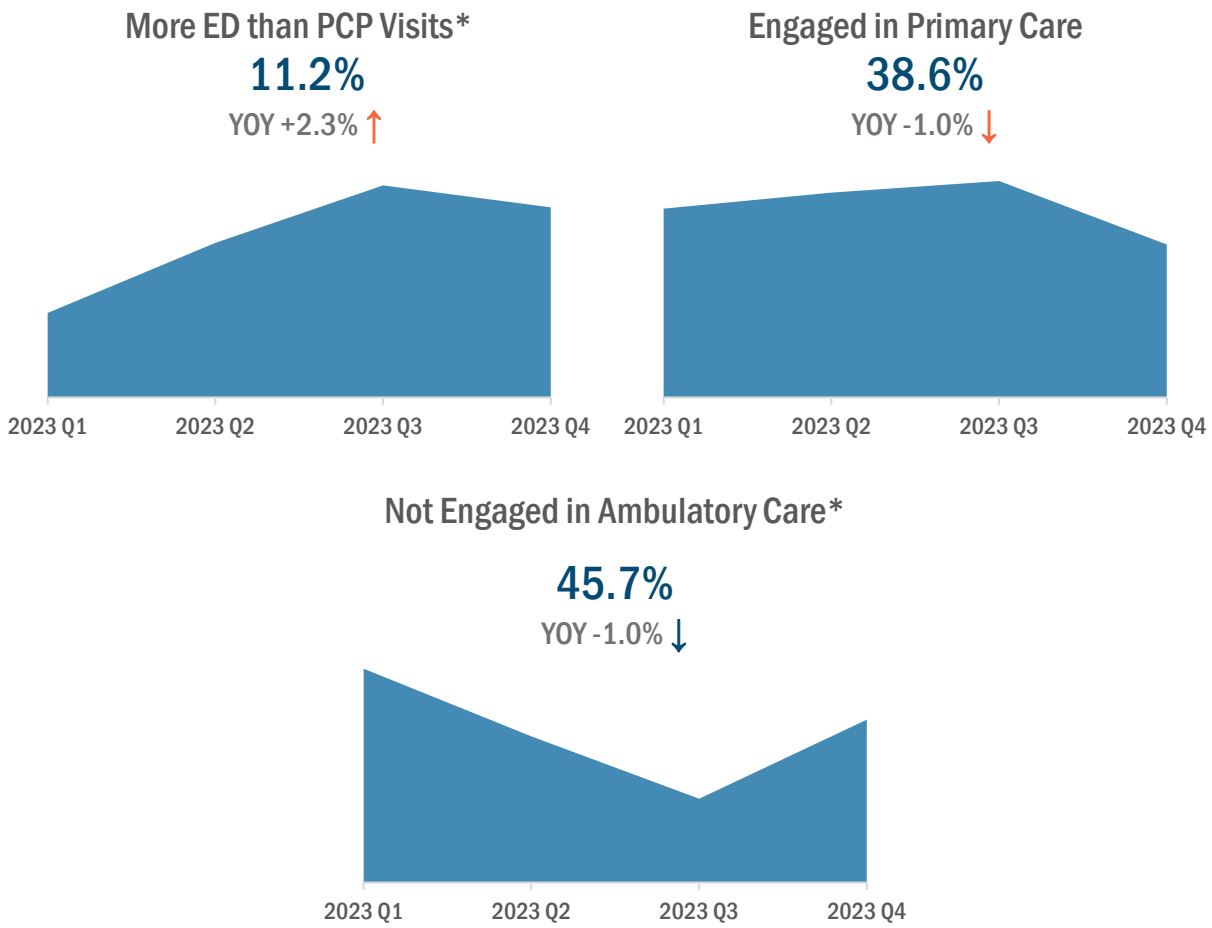
4.5.4 Services

CCHP has introduced programs to cater to the diverse health needs of its members. These initiatives aim to maintain the well-being of individuals already in good health, offer self-management resources to those with well-controlled chronic conditions, extend specialized services to members dealing with poorly controlled chronic diseases, and provide case management services. These include Enhanced Care Management for individuals with the most complex needs, Complex Case Management for those requiring ongoing support for chronic conditions, and Transitional Care Services for individuals in need of assistance during care transitions. Additionally, basic population health management services have been implemented to provide health education, wellness programs, and preventive services accessible to all members.

4.5.4.1 Basic Population Health Management Services

Basic population health management ensures timely access to essential programs and services for all members, irrespective of their risk tier. Unlike care management, which targets populations with specific needs, basic population health management is provided to all members, emphasizing equity. It encompasses primary care access, care coordination, navigation, cultural and linguistic services, and referrals across health and social services. The program includes services by community health workers, wellness and prevention, chronic disease management, maternal health programs, and services covered for children under early and periodic screening, diagnostic, and treatment (EPSDT).

The evaluation of basic population health management primarily relies on HEDIS and MCAS measures, detailed in Table 1. These measures encompass critical aspects such as well care visits for children, immunizations, preventive screenings, and prenatal and postpartum visits. In alignment with DHCS specifications, CCHP introduced a set of population health Key Performance Indicators (KPIs) in 2023, specifically focusing on engagement with primary care. While these metrics are relatively new, with ongoing methodology refinement and no established benchmarks, CCHP has initiated trend analysis to gauge progress and effectiveness.



CCHP works with providers on getting members into primary care and addressing care gaps. Two main initiatives in 2023 were enhanced CCHP's birthday letter to pull in more information regarding outstanding health maintenance and improving FIT kit distribution. Prior to 2023, FIT kits were bulk ordered and mailed in conjunction with the birthday letter, which meant members likely only got kits ever other year due to members not being overdue at the time of their birthday. FIT kit distribution was decoupled from the birthday letter so it was sent out directly after someone became due, resulting in increased colorectal cancer screening rates.

In alignment with CalAIM, CCHP has expanded its service offerings aimed to address the comprehensive well-being of individuals. This broader spectrum of services includes doula services, community health worker assistance, care coordination services provided by CCHP's social workers and nurses, and community support services, covering a diverse array of needs for the homeless, individuals requiring long-term support, and those managing chronic conditions that could benefit from specialized interventions such as medically tailored meals or asthma services.

Table 3 outlines the number of individuals who received these services in 2023. Given the novelty of these services, understanding their efficacy and impact on health and utilization requires an extended evaluation period. A comprehensive analysis, scheduled for completion later in 2024 as part of the Population Health Impact Report, will provide

insights into the effectiveness of these programs and their influence on overall health outcomes.

Table 3

Program	Enrolled
Community Supports	
Housing Transition/Navigation Services	719
Medically-Supportive Food/Medically Tailored Meals	600
Housing Tenancy and Sustaining Services	105
Asthma Remediation	86
Short-Term Post-Hospitalization Housing	84
Recuperative Care (Medical Respite)	48
CCHP Care Coordination Services	1,537
Members Receiving CHW Services	920

4.5.4.1.1 Cultural and Linguistic Services

CCHP is dedicated to providing culturally and linguistically appropriate services, ensuring equitable healthcare access for its diverse membership. CCHP actively facilitates REAL data collection to identify health disparities and offers linguistic services to members in need. Through training programs, CCHP fosters cultural awareness and sensitivity among its staff and contracted providers. CCHP aims to prevent discrimination, educate stakeholders on language services and cultural humility, offer technical assistance to providers, collaborate with community agencies, and address health disparities.

In 2023, CCHP conducted a Language Access survey incorporating supplemental CAHPS questions, revealing positive member feedback on interpreter services, with 81.4% stating they could access an interpreter when needed, and 83.9% rating their interpreter positively. The survey also emphasized the need for improvements in the health plan's website for health education, as only 6.8% of respondents used it for information.

Looking ahead to 2024, CCHP plans to enhance the understanding of members' race and ethnicity data by integrating information from the Medi-Cal 834 file. Additionally, recognizing the significance of Sexual Orientation and Gender Identity (SOGI) information in promoting health equity, CCHP is exploring the implementation of a data collection process with its members.

4.5.4.1.2 Wellness, Prevention and Health Education

Contra Costa Health Plan provides health education resources that meet the needs of members as identified in the Population Needs Assessment and other sources such as HEDIS, Community Advisory Committee feedback, and member surveys. CCHP ensures members have access to low-literacy health education and self-management resources in all threshold languages. Resources are available on the CCHP website and through providers. CCHP provides classes, articles, videos, interactive tools for self-management, and links to community resources. CCHP maintains a directory of resources online and publishes this as least annually in the member and provider newsletters. Additionally, CCHP sends out via mail and email a member newsletter three times a year covering a range of topics.

CCHP's health education website currently provides static resources, such as articles and fact sheets, to support our members in making informed healthcare decisions. However, through ongoing evaluation and feedback from our members, we have identified a need for more interactive, engaging, and mobile-friendly content to enhance the overall user experience and promote greater engagement with health education materials. To address this need, CCHP has identified Krames to provide health education materials. Krames offers a comprehensive library of interactive and dynamic health education resources, including videos, interactive quizzes, animations, and personalized health content. By integrating Krames materials into the CCHP health education website, CCHP aims to provide our members with more engaging and interactive resources that cater to diverse learning styles and preferences. In 2023 contract negotiations began, with an aim for implementation in 2024. This initiative underscores CCHP's commitment to delivering high-quality health education that empowers CCHP members to take control of their health and well-being.

4.5.4.1.3 Behavioral Health

CCHP assumes responsibility for mild to moderate behavioral health services for Medi-Cal members and comprehensive behavioral health services for commercial members. Collaborating with Contra Costa County Behavioral Health Services, CCHP triages patients to determine severity levels and delivers appropriate treatment. FQHCs in the community often handle triage and treatment for their members, with some offering embedded behavioral health services. Telehealth providers are contracted to augment access. Quality initiatives focus on HEDIS measures, outpatient behavioral health continuity, coordination of care, and practitioner availability. The Quality Council receives updates, with a Behavioral Health clinician actively participating.

In 2023, CCHP utilized the Agency for Healthcare Research and Quality (AHRQ) Experiences of Health Outcomes (ECHO) survey to gather feedback from members who had utilized behavioral health services. Overall, members' ratings of counseling and treatment were high, as well as clinician communication. Areas for improvement centered around educating members about different treatment options and members' abilities to obtain urgent treatment appointments.

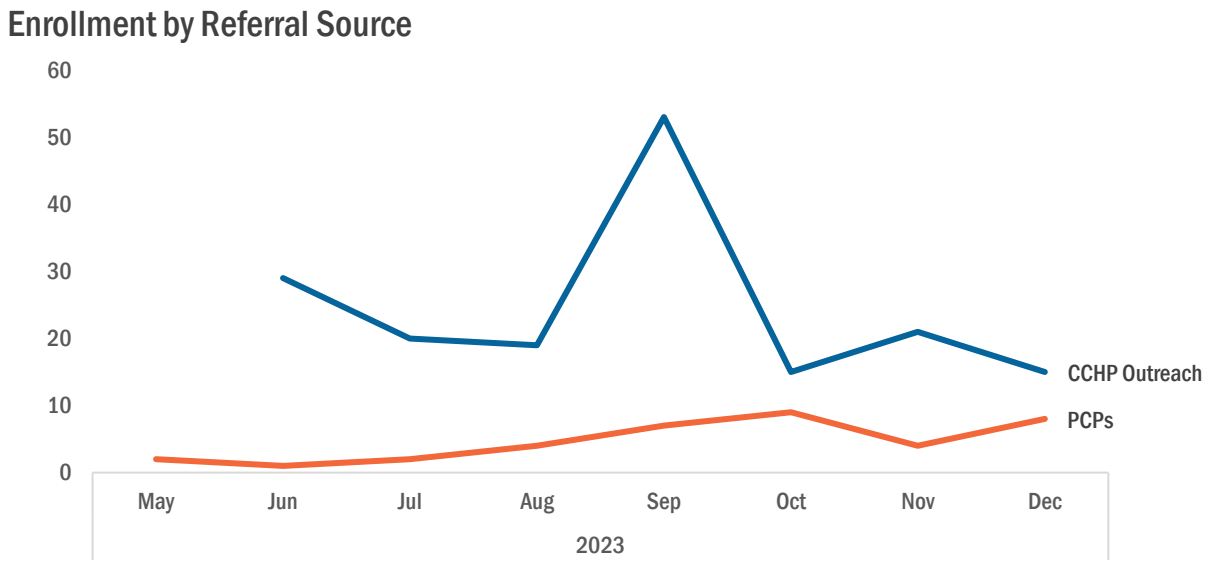
4.5.4.2 Programs Addressing Chronic Disease

4.5.4.2.1 Remote Patient Monitoring for Diabetes and Hypertension

After completing a successful Performance Improvement Project, CCHP expanded our partnership with Gojji Pharmacy to provide remote patient monitoring for patients with uncontrolled diabetes. In 2023, CCHP built out infrastructure to prospectively identify and outreach eligible patients for referral to Gojji. CCHP also expanded eligibility to allow providers to refer any member with uncontrolled diabetes to the program.

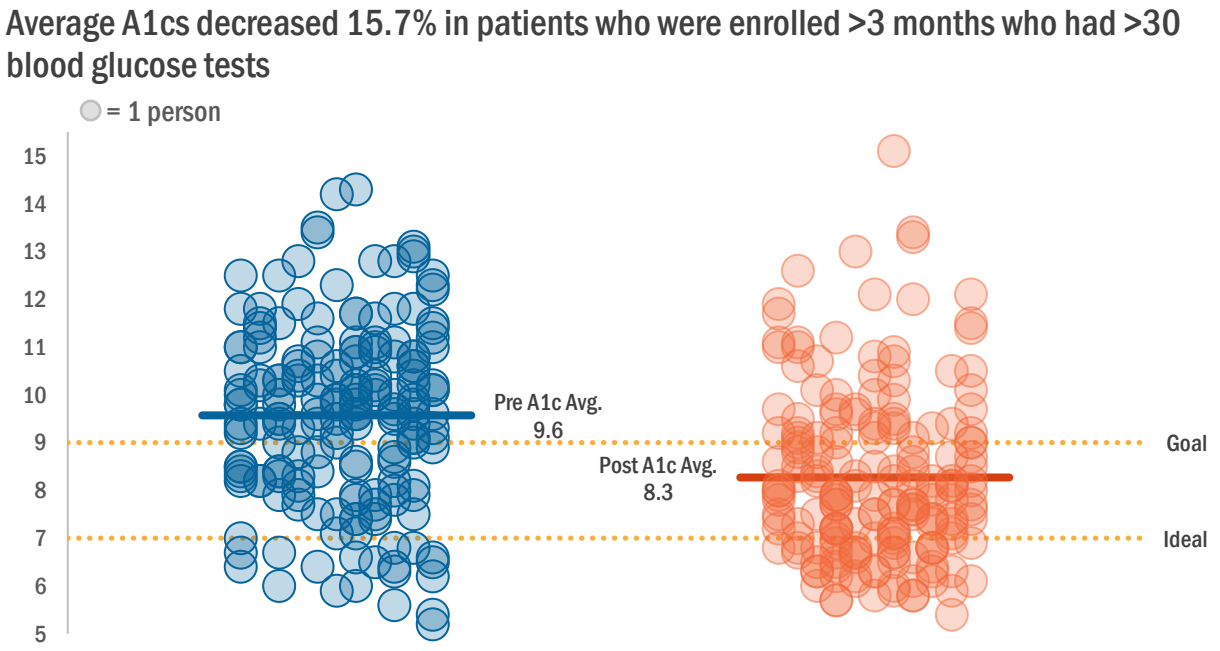
CCHP outreached 1,611 members for referral to Gojji and 324 (20.1%) members consented, while 185 (57.1% of referred) enrolled. Additionally, 100 members were referred to Gojji by their PCP and 55 (55.0%) successfully registered. Figure 10 illustrates the enrollment trends. CCHP plans to continue outreaching to patients in 2024 and continue to monitor this program.

Figure 10



For members who were enrolled with Gojji for at least 3 months and who had registered at least 30 blood glucose tests, average A1cs decreased from 9.6% prior to enrollment to 8.3% at most recent measurement, as depicted in Figure 11. Additionally, 45 members had their most recent A1c below 7.0%, compared to 19 at enrollment. The 1.3 difference between pre and post A1c was significant at p<.0001 (t=7.9397, df=180). More importantly, when matched to a similar cohort of members who did not participate in the Gojji RPM program, Gojji participants were more likley to see an improvement in their A1c, with the results even more pronounced in members with a history of obesity.

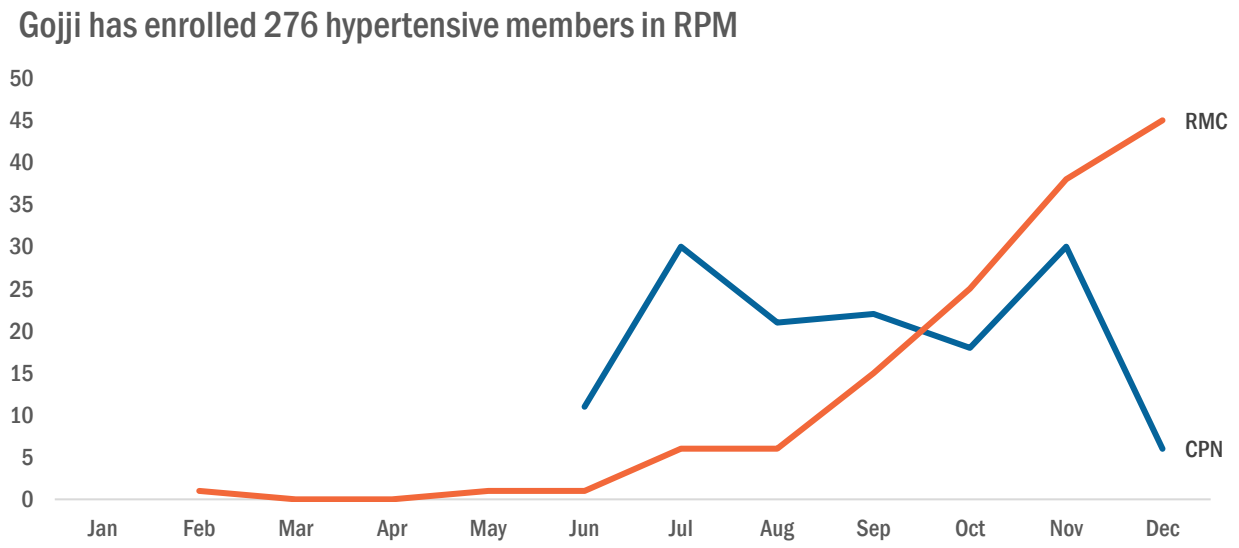
Figure 11



In addition to the diabetes RPM, Gojji also offers a hypertension program. Currently, CCHP providers can enroll members by prescribing a blood pressure cuff and sending the prescription to be filled by Gojji pharmacy. CCHP is monitoring the number of prescriptions

filled by Gojji and is working to update the contract to allow for more robust data sharing. In 2023, Gojji enrolled 276 members in the hypertension RPM program (Figure 12).

Figure 12



4.5.4.2.2 Asthma Education and Remediation Services

Prior to the launch of DHCS' Asthma Preventive Services (APS) and CalAIM Asthma Remediation services, CCHP was awarded two grants to serve members with asthma. CCHP hired two temporary Community Health Workers (CHW) to enroll members into these programs, educate members about medications and environmental triggers, and provide them with consumer supplies to reduce environmental triggers. These CHWs also coordinated more in-depth environmental assessments and home modifications provided by the grant partner. In 2023, CCHP successfully completed enrollment for these grants and transitioned to serving members eligible for APS and CalAIM Asthma Remediation via a contracted provider. The reporting and health education infrastructure developed to identify members for the grant will continue to be utilized to identify members for to services. CCHP's Asthma Medication Ratio (AMR) was 75.23% in MY 2022, placing CCHP in the top 90th percentile nationally.

4.5.5 Care Management

Contra Costa Health Plan (CCHP) prioritizes the needs of its most vulnerable members through two essential programs, Enhanced Care Management (ECM) and Complex Case Management (CCM). ECM, designed for the most complex patients offers community-based case management, offering personalized, in-person interactions. This program targets diverse populations with unique needs, including homeless individuals, those at risk for avoidable hospitalizations, individuals with severe mental illness and substance use, those with a history of incarceration, children with a welfare background, and adults transitioning from skilled nursing facilities. Recognizing these intricate needs, ECM enrollment is for one year, with the option to extend based on individual requirements. In contrast, CCM supports higher and medium-risk members not served by ECM, providing

chronic care disease management and episodic interventions. The fluid transition between ECM and CCM ensures comprehensive care management.

In 2023, CCHP made significant investments to direct qualified individuals to ECM, leveraging the robust data infrastructure discussed in the risk stratification section above. The implementation of automated authorizations streamlined service access. The capacity of ECM providers increased from two to eight by year-end, showcasing CCHP's commitment to expanding capacity. The inclusion of children in mid-2023 prompted targeted efforts, identifying and enrolling the most at-need children with experienced public health nurses. CCHP stands out as the leading health plan in the state for ECM provision, surpassing others in overall ECM enrollment relative to assigned Medi-Cal lives.

Table 4

Care Management Program	Enrolled
ECM Population of Focus	6,488
Adult Homelessness Individual	1,081
Adult High Utilizer	836
Adult SMI/SUD	806
Adult Incarceration Transition	490
Child/Youth High Utilizer	453
Child/Youth CCS/WCM	149
Child/Youth SED/CHR	138
Child/Youth Homelessness Family	71
Adult Homelessness Family	56
Child/Youth Welfare Hx	48
Child/Youth Incarceration Transition	32
Adult LTC	30
Adult Nursing Facility Transition	30
Child/Youth Homelessness Unaccompanied	30
Case Management	981
Hospital Transitions	634
Complex Case Management	200
CCS Transitions	147

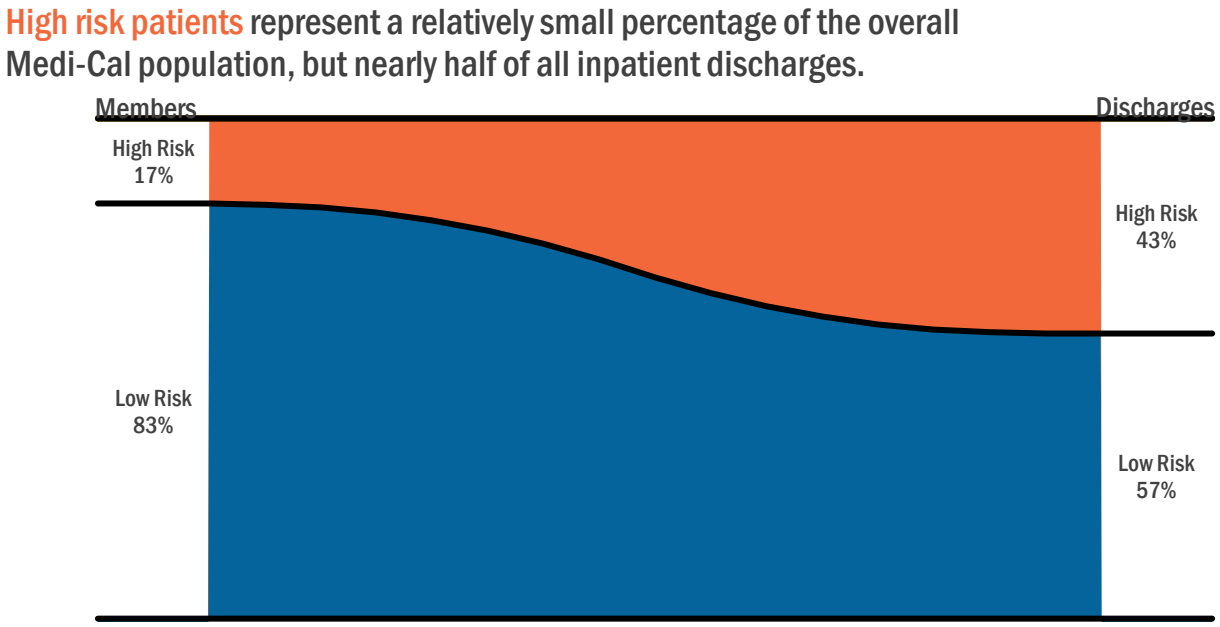
To assess impact of ECM, a broader evaluation will be undertaken as part of the Population Health Impact assessment, addressing complexities in evolving enrollment, selection bias, and regression to the mean. In the interim, as part of the CalAIM Incentive Payment Program, CCHP has begun trending several HEDIS measures for the ECM enrolled population: Emergency Department Visits / 1000 member months, Follow-up for ED with Mental Health, Follow-up for ED with AOD, Adult Access to Preventive/Ambulatory Health Services, Well Care Visits of Children and Adolescents, and Follow-up to Hospitalization for Mental Health.

4.5.6 Transitional Care Services

Transitional Care Services (TCS) at CCHP focuses on facilitating the movement of members across different care settings, ensuring a smooth transition from hospitals to home-based or community settings. Essential services include comprehensive medication reconciliation

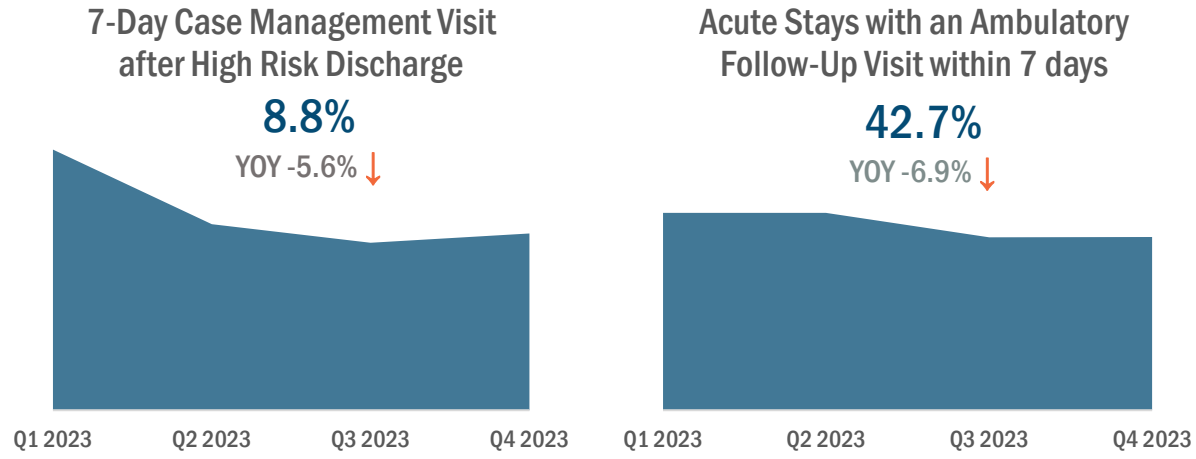
upon discharge and post-discharge, linkage to a primary care appointment post discharge, review of discharge paperwork, and coordination of any post-discharge needs, which may include durable medical equipment, coordination of services, transportation, and other supports. High-risk individuals receive personalized care management, while low-risk individuals have direct access to coordination services.

Given the annual volume of nearly 18,000 inpatient admissions, CCHP, in alignment with DHCS guidelines, conducted risk tiering in 2023 for all admissions to distinguish high-risk and low-risk individuals. Those classified as high-risk were intended to be linked to a care manager, necessitating collaboration with hospital social work and discharge teams for effective case management referrals. In 2023, 634 individuals were successfully linked to CCHP case managers for transitional care services, in addition to those members that had a pre-identified case manager through ECM or CCM at the time of discharge.



In 2023, DHCS released Population Health Monitoring KPIs, two of which were related to transitional care services. As newer metrics, with ongoing methodology refinement and no established benchmarks, CCHP has initiated trend analysis to gauge progress and effectiveness. Throughout 2023, the analysis of KPIs indicated that only 8% of individuals had a asynchronous case management visit within 7-days post-hospitalization and 42% of individuals had an ambulatory visit within 7-days post-discharge. The identified barriers to achieving this target include timely identification of admissions, assigning a case manager promptly, and ensuring effective member engagement within a limited timeframe. To overcome these challenges and enhance efficiency, CCHP is proactively exploring the use of admit, transfer, and discharge data (ADT) data feeds. The aim is to automate referrals for transitional care services, drawing experience from the successful approach implemented for ECM. Furthermore, the dedicated CCHP transitions team is actively focused on augmenting staff capacity and streamlining workflows to deliver comprehensive follow-up services. These initiatives align with a key objective for 2024,

introducing transitional care services for the lower-risk population, with the ultimate goal of reducing all-cause readmissions and improving the overall health of members.



4.6 Patient Safety Activities and Projects

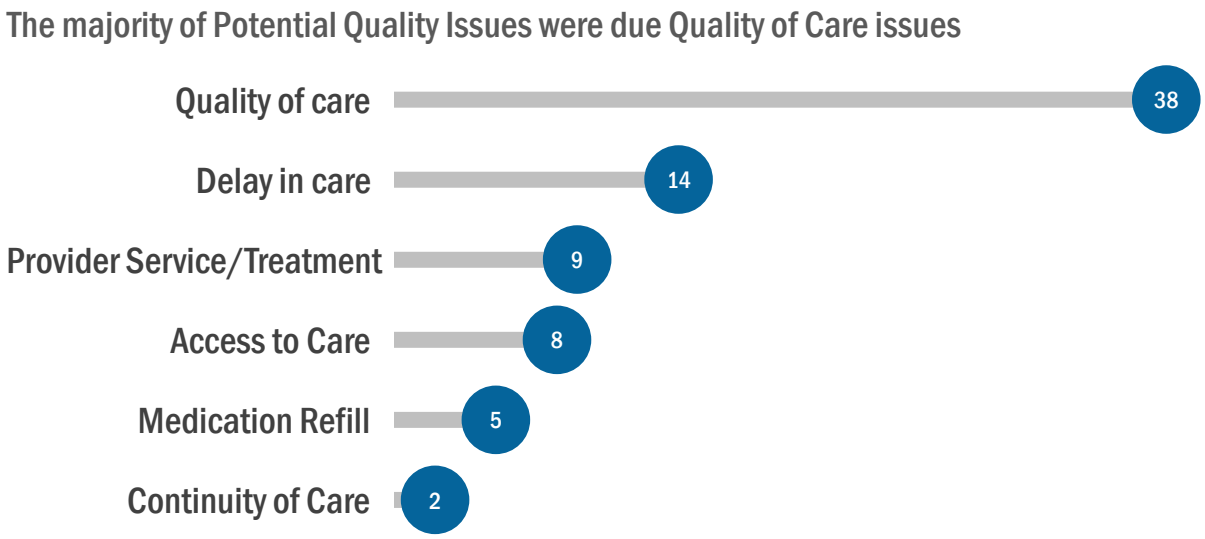
Patient safety is a top priority at CCHP, and various departments collaborate to address this critical aspect of healthcare. Routine reviews of data from sources such as grievances, appeals, access and availability metrics, claims, medical record review, HEDIS measures, satisfaction surveys, utilization and case management records, as well as studies on adherence to clinical guidelines, contribute to the identification of potential risks to members' safety. The findings from these reviews are regularly presented to the Quality Council, allowing for comprehensive oversight and continuous improvement in patient safety measures.

4.6.1 Potential Quality Issues and Provider Preventable Conditions

Any department, provider or member can identify and report a potential quality issue (PQI) which will then undergo an investigation and resolution. Additionally, a quality nurse reviews a report that identifies Provider Preventable Conditions (PPCs) according to diagnosis codes. All PPCs are entered in the system as a PQI and undergo an investigation. The PQI committee, consisting of the Chief Medical Officer, Medical Director, and Director of Pharmacy, evaluates and categorizes PQIs from level 0 (no confirmed issue) to level 3 (a significant concern). Level 3 PQIs prompt a Corrective Action Plan (CAP) and potential escalation to the Peer Review and Credentialing Committee (PRCC). Provider Relations further identifies any trends at the provider level where intervention is warranted. Trends, recommendations, and updates on PPCs and PQIs are provided to the Quality Council bi-annually.

During 2023, CCHP reviewed 150 cases, primarily referred through grievances, followed by utilization review. Of those cases 74 were determined to have quality no quality issue (level 0), 47 had minor issues (level 1), 17 moderate issues (level 2), and 12 presented significant quality issues (level 3). PQIs predominantly centered around Quality of Care. Through diligent follow-up, corrective action plans (CAPs) were initiated, empowering

providers to enhance services and elevate overall care quality. All PQIs are protected under California Evidence Code 1157.



Compared to 2022, there was a slight increase in PQI cases. This trend was partly due to an increase in overall clinical services post-COVID, and part due to new health plan benefits requiring additional oversight.

Structural changes in 2023 meant PQIs were overseen by the Clinical Quality Auditing Department at CCHP, allowing a more experienced clinical team with a wider variety of backgrounds to address PQIs according to the specific topic.

4.6.2 Pharmaceutical Safety

CCHP actively addresses pharmaceutical safety concerns through targeted over/under-use activities. These initiatives encompass the review of members with fifteen or more prescriptions, potential case management referrals, assessments of members with potentially unsafe medication regimens, and review of prescription trends to detect possible fraud, waste, and abuse. Proactive measures include notifying providers about medication safety issues and educating patients.

Throughout the reporting period, CCHP executed the outlined pharmaceutical safety activities to ensure the ongoing safety and appropriateness of medication regimens. For example, CCHP tracked, communicated with and provided education to 75 members being treated for Hepatitis C to ensure completion of therapy. Additionally, 65 letters were sent to providers alerting them of their patients who were currently taking the dangerous drug therapy combination of opioids and benzodiazepines. Continuous efforts in provider communication and patient education underscore CCHP's commitment to pharmaceutical safety, aligning with best practices in healthcare quality management.

4.6.3 Facility Site Review and Medical Record Review

CCHP prioritizes the adherence of primary care provider sites to local, state, and federal regulations to uphold patient safety standards. Stringent protocols ensure medical records comply with legal standards, documenting the provision of preventive care and effective coordination of primary care services. Facility Site Review nurses conduct periodic full-scope reviews, addressing deficiencies through corrective action plans.

In 2023, CCHP completed 13 Facility Site Reviews, with 10 providers undergoing medical record reviews, totaling 125 records. This comprehensive assessment process identified areas for improvement, resulting in the formulation of 9 corrective action plans. Additionally, Physical Accessibility Review Surveys (PARS) were conducted for PCP sites, high volume specialists, ancillary providers, and community based adult services providers, with 49 PARS completed during the year. The identified corrective actions and PARS contribute to an ongoing cycle of improvement, reinforcing CCHP's dedication to fostering a healthcare environment that prioritizes patient safety and regulatory compliance.

4.7 Provider Collaboration

CCHP is dedicated to fostering collaborative relationships with provider stakeholders, including the CCRMC system, Federally Qualified Community Health Centers (FQHCs), Community Provider Network providers, Behavioral Health, Public Health, Skilled Nursing Facilities, Hospitals, and Community Support and Enhanced Care Management providers. Joint Operations Meetings (JOM) provide a platform for leadership discussions, facilitating communication across diverse entities. CCHP actively participates in the Safety Net Council structure, engaging with FQHCs and regional clinical consortiums. The commitment to collaboration extends to various operational, quality, and provider-focused meetings, underscoring the shared goal of enhancing healthcare quality and delivery.

In 2023, CCHP completed Joint Operations Meetings with hospitals and established a new framework for JOM meetings with Skilled Nursing Facilities (SNF), Enhanced Care Management (ECM), and Community Support (CS) providers. Four quarterly provider network trainings and newsletters successfully provided updates and a forum for direct community with providers. Regular round meetings occurred between the Utilization Management (UM) and Case Management teams and hospitals to refine member transitions and discharge processes. Notably, the UM and Case Management team restructured their approach, organizing efforts by hospital, fostering consistent interactions for improved coordination. The Quality Department's established new bi-monthly quality meetings with individual FQHC quality teams, emphasizing focused discussions on quality improvement activities. Over 20 dedicated meetings transpired, focusing on reviewing quality measures and crafting active improvement initiatives.

In 2023, leveraging enhanced provider engagement, CCHP has successfully strengthened its coordination and service delivery to members through effective partnerships. The year was marked by structured engagements, strategic meetings, and proactive communications,

fostering collaborative initiatives, transparent communication channels with providers, and a steadfast commitment to continuous quality improvement.

4.8 Delegation

Delegated activities at CCHP are governed by a comprehensive delegation agreement, defining specific functions and responsibilities assigned to delegated entities. Among the delegated providers, Kaiser Permanente is the only entity that delegated to for Quality functions. To ensure compliance and quality standards, the Quality Department collaborates with other health plans in conducting an annual audit of Kaiser Permanente.

As a sister organization, CCHP extends its delegation to the Contra Costa Health, Behavioral Health Division, for utilization management. The Behavioral Health Division reports activities to the Utilization Management (UM) committee and it is the responsibility of CCHP's Behavioral Health Department to conduct delegation oversight. Regular reviews take place at the Quality Council to maintain transparency and oversight.

In 2023, CCHP actively engaged in the Kaiser regional audit, revealing no findings during the comprehensive assessment. For the Behavioral Health Division's delegated UM responsibilities, detailed reviews were conducted at the UM Committee and Quality Council, encompassing data on turnaround times, annual work plans, evaluations, and other UM functions. DHCS annual audit identified a repeat finding related to the inclusion of language taglines and non-discrimination notices. This matter promptly addressed and corrected in 2023.

5 Conclusion

5.1 Barriers

In 2023, CCHP successfully completed and met a large majority of the ambitious goals and objectives outlined in the 2023 Quality Work Plan. There were, however, some barriers to successfully meeting all objectives in the year.

One of the more challenging barriers stemmed from the complex regulatory landscape coupled with the rollout of simultaneous ambitious initiatives by DHCS. Navigating through the requirements associated with the implementation of the Single Plan Model and additional CalAIM initiatives, such as ECM, Community Supports, doula services, Community Health Worker benefits, Population Health Management, and behavioral health enhancements with school districts, proved to be demanding. These project rollouts required meticulous execution amidst competing priorities while ensuring ongoing compliance with existing statutes and organizational goals.

Additionally, barriers related to data integration and completeness were identified. Notably, CCHP recognized a larger-than-expected proportion of members with an unknown race, prompting efforts to enhance data reliability, crucial for health equity initiatives.

Another data barrier is the lack of interoperability between the remote patient monitoring vendor and providers electronic health records. The RPM vendor is working with a consortium of FQHCs to integrate RPM data into their instance of Epic and CCHP is hoping to use the information learned to share with others in the network.

Addressing access and availability concerns, CCHP is actively engaged in expanding the provider network to improve appointment availability, particularly in specialties facing significant impact. However, challenges persist due to shortages of providers willing to accept Medi-Cal rates, especially in certain specialties. CCHP remains dedicated to the ongoing development of its population health services, with a focus on expanding transitional care services and refining processes to facilitate effective linkage and navigation for individuals at critical junctures.

5.2 Overall Effectiveness

CCHP renewed its NCQA accreditation and achieved 4 stars in NCQA's Health Plan Report Card, the highest rating given to Medi-Cal plans in California. These endorsements are a recognition of CCHP's commitment to quality and patient care.

One of the primary indicators of CCHP's success is improved patient outcomes. CCHP's efforts in preventive care, chronic disease management, and care coordination have contributed to better health outcomes and enhanced overall patient well-being. This is demonstrated by the improvements in A1cs in our RPM program, the improvements seen in the well care visits in first 30-month rates, and improvements in controlling high blood pressure.

CCHP is also proud to report significant enhancements in the patient experience because of quality program initiatives. Patient experience scores improved on the CAHPS survey, with many measures increasing in percentile ranking.

Central to CCHP's quality program is the use of data-driven decision-making to inform our quality improvement efforts. CCHP has established robust data collection, analysis, and reporting mechanisms that provide actionable insights into our performance metrics, outcomes, and areas for improvement. By leveraging data analytics and performance metrics, the quality department can identify trends, track progress, and make informed decisions to drive continuous quality improvement.

CCHP has fostered a culture of excellence, innovation, and continuous quality improvement throughout our organization and provider network. CCHP implemented regular quality meetings with provider groups to work together to identify improvement opportunities, develop solutions collaboratively, and ensure alignment with clinical priorities.

The successes achieved through CCHP's quality program reflect the dedication to delivering exceptional healthcare services and improving patient outcomes. By prioritizing patient-centered care, data-driven decision making, and a culture of continuous improvement, CCHP has made significant strides in enhancing the quality, safety, an efficiency of healthcare delivery.

A critical aspect of our success is the continuous evaluation of our Quality Improvement (QI) program resources. Currently, our QI committee and subcommittee structure are robust, ensuring a comprehensive approach to quality initiatives. Recognizing the importance of diverse perspectives, we are pleased to announce the addition of the Equity Council in 2024, providing an additional layer of insight to our QI efforts. CCHP's practitioner engagement and leadership in the QI program have been commendable, with fruitful meetings and valuable input from providers. This collaboration has further enriched our quality initiatives.

As we reflect on the year, CCHP acknowledges the adequacy of our QI program resources, the effectiveness of our committee structure, and the active practitioner participation and leadership. Looking ahead, the QI program for the subsequent year will maintain its current structure, with no major changes planned for 2024. This decision is grounded in the success and positive outcomes witnessed in our current approach.

The effectiveness of CCHP's quality program is evident in improved patient outcomes, enhanced patient experiences, and the positive impact on key metrics. By fostering a culture of excellence, innovation, and continuous improvement, we remain dedicated to delivering exceptional healthcare services and achieving meaningful improvements in patient well-being. Our commitment to patient-centered care, data-driven decision-making, and a culture of continuous improvement positions CCHP as a leader in enhancing the quality, safety, and efficiency of healthcare delivery.

6 2023 Quality Work Plan and Evaluation of Activities

Item #	Program/Project Area	Goals and Objectives	Planned Actions to Meet Goal	Evaluation of Activities
1. Quality Program Structure				
1.1	***Quality Program Documents***	By March 2023, approve annual quality program documents at March JCC meeting.	Finalize 2023 Quality Program Description	Met. CCHP reviewed approved the annual quality documents at the March Quality Council meeting and Joint Conference Committee Meeting. This annual plan and priorities served as a focal point for meetings with provider groups through the first two quarters for 2023.
1.2			Finalize 2022 Quality Evaluation	
1.3			Finalize 2023 Quality Work Plan	
1.4	***Quality Council***	Ensure quality council oversight of CCHP's quality program through regular meeting schedule	Convene monthly quality council meetings. Convene a minimum of 9 Quality Council meetings annually	Met. CCHP convened 9 Quality Council meetings in 2023. Attendance remained strong. One vacancy arrived, which was promptly filled by a network provider with an interest in population health.
1.5		Ensure program governance of quality council meeting	Revise quality council charter	
1.6		Ensure there are policies and procedures to meet regulatory and operational needs	Review CCHP policies annually and upon any new APL changes	
2. NCQA Accreditation				
2.1	***NCQA Accreditation***	By March 2023, achieve NCQA accreditation status by obtaining a "met" score on all elements.	Complete NCQA survey and respond to preliminary report	Met. CCHP achieved accreditation status on March 1, 2023. CCHP achieved over 80% in all sections and passed all "must pass elements".

Item #	Program/Project Area	Goals and Objectives	Planned Actions to Meet Goal	Evaluation of Activities
				Surveyors commented on strengths being committed staff and the "staying power" in the community.
2.2		Correct any deficiencies identified during the 2020-2022 NCQA accreditation survey by June 2023	Respond to NCQA Corrective Action Plans (if applicable)	Met. Areas of opportunity for the 2025 survey include improving analysis across quality, network adequacy, and member experience. CCHP quality staff underwent training in data visualization and NCQA standard training.
2.3			Modify internal processes for any "not met" or "partially met" areas	
2.4		By May 2023, complete an evaluation with key stakeholders of the 2022 NCQA survey and develop a plan for the 2025 survey	Conduct comprehensive evaluation of 2022 NCQA survey process, including best practices, challenges, and process improvements	Met. CCHP held follow-up meetings and de-brief session with key staff in the organization to plan for the next accreditation cycle. Turnover in key staff, the NCQA accreditation manager, put these efforts on hold in mid-2023. Quality Director is looking to re-hire key positions and improve structure for the next survey round.
2.5			Develop execution strategy for 2025 NCQA survey	
3. Measurement, Analytics, Reporting, and Data Sharing				
3.1	**HEDIS Reporting (DHCS, NCQA)**	1. By June 30, 2023, report HEDIS MY2022 scores for NCQA Health Plan Accreditation and the DHCS Managed Care Accountability	Complete all annual HEDIS activities, including identifying new data sources and completing medical record abstraction.	Partially Met. CCHP achieved high performance (over the 90th percentile nationally) in 8 MCAS measures. However, two measures were under the

Item #	Program/Project Area	Goals and Objectives	Planned Actions to Meet Goal	Evaluation of Activities
3.2		Set (MCAS) 2. Exceed the 50th percentile for all MCAS measures and establish performance improvement plan for those near or at risk 3. Prepare for transition to ECDS by identifying efficiencies in data system measurement 4. Align HEDIS measurements to quality improvement projects and strategic goals for 2023	Complete annual HEDIS MY2022 report, analyzing yearly trends and identifying areas for improvement. Incorporate report into Population Health Needs Assessment.	minimum performance level, lead screening and follow-up for ED visits for mental health. CCHP began improvement projects on both of these measures in 2023 and will continue with these improvement projects in 2024. CCHP prepared for the transition to ECDS by retiring hybrid on three measures, CIS, IMA, and LSC, by accessing external data. CCHP continued to strive to improved data sharing by implement Epic CareEverywhere Population Health Queries. This was implemented in a stepwise fashion throughout 2023, allowing for more real-time monitoring. It is expected this will further improve data quality and prepare for the ECDS transition.
3.3			Identify areas of opportunity for data system for MY2023	
3.4			Develop and implement improvement projects targeting at risk measures and those measures that align with other strategic goals of CCHP	
3.5	**CalAIM Report (DHCS)**	Complete all DHCS CalAIM reporting deliverables and maximize incentive dollars available through continuous	Complete DHCS quarterly CalAIM ECM-CS Quarterly Monitoring Reports, reporting enrollment and utilization of CalAIM services	Met. CCHP developed IT infrastructure to report the multitude of DHCS CalAIM reports. This centralized infrastructure not only is

Item #	Program/Project Area	Goals and Objectives	Planned Actions to Meet Goal	Evaluation of Activities
3.6		improvement in pay for performance measures	Develop measure specifications for reporting on the DHCS Housing and Homelessness Incentive Program (HHIP)	creating a source for reporting, but it is also a vehicle for identifying potentially eligible individuals and creating a framework for population health management by directing those in need to services. CCHP successfully earned incentive dollars through HHIP and IPP and continues to lead California as the health plan with largest penetration rate of ECM enrollees.
3.7			Develop measure specifications and report on the DHCS Incentive Payment Program	
3.8			Develop measure specifications and report on the DHCS Population Health Monitoring Report	
3.9	**Other Quality Reporting (Internal)**	Develop quality measure and monitoring for other health plan programs that are not tied to HEDIS reporting	Develop quality metrics and monitoring system for all Initial Health Appointment	Met. CCHP created a number of individual measurement reports to assess population health programs. Methodology for Initial Health Appointment was revised to reflect PHM changes and align with HEDIS value sets. CCHP will be using the MCAS measures for LTC monitoring and is exploring implementation of the HEDIS LTSS measures in the future. CCHP is utilizing stratified HEDIS measures for ECM (as part of the IPP framework) to evaluate ECM, CCM and Community Supports; however, it is acknowledged a more
3.10			Develop quality measurement system and measure set that supports long-term care quality improvement and a systematic monitoring system for members with long term support services	
3.11			Complete internal quality measures and evaluation for determining efficacy of Enhanced Care Management and Community Supports	
3.12			Develop quality metrics and evaluation for Complex Case Management program	

Item #	Program/Project Area	Goals and Objectives	Planned Actions to Meet Goal	Evaluation of Activities
3.13			Develop quality measurement and monitoring system for pregnant and postpartum individuals	robust framework is needed. CCHP is exploring partnership with UC Berkeley to conduct this analysis. CCHP is utilizing HEDIS to evaluate pregnant and postpartum care and process measures such as receiving doula services.
3.14	**CCHP Quality Measurement Infrastructure**	Create quality dashboard and quality monitoring program with feedback loop to providers to allow for ongoing tracking of all HEDIS MCAS measures, including measuring disparities, trends by year, and current rates	Work with Business Intelligence unit on design and creation of ongoing CCHP quality metric dashboard	Met. CCHP successfully launched a CCHP quality dashboard, collating all official HEDIS measures from 2018, showing historical trends, benchmarks, and key stratifications. Key measures can be reviewed using rolling 12-month measurement for a select number of measures. CCHP can stratify measures by provider groups and rates are shared with provider during meetings. A more robust and automated system is needed for provider groups and this is a key program focus for 2024.
3.15			Create quality scorecards for providers, which will share monthly performance rates by provider group on a CCHP priority measures	
3.16			Develop system of data sharing quality measures with CPN network to allow for ongoing quality improvement	
3.17	**Member Experience (NCQA, DHCS)**	1. By June 30, 2023, gather, analyze, and highlight areas of opportunity using the CAHPS survey	Review and analyze CAHPS survey results stratifying by network and other demographic fields, trending results by year. Incorporate	Met. CCHP completed and analyzed the CAHPS survey, behavioral health survey, and new interpreter services survey. These experience surveys were

Item #	Program/Project Area	Goals and Objectives	Planned Actions to Meet Goal	Evaluation of Activities
		2. Process 95% percent of grievances within required timeframes. 3. Develop member feedback channel through the Community Advisory Committee	into Population Health Needs Assessment.	administered and results analyzed, with trending and comparison to benchmarks. CCHP Medical Director regularly reported grievance data during Quality Council meeting and CCHP quality director presented and gathered input from the Community Advisory Committee during meetings in throughout 2023. These input were incorporated into the Initial Health Appointment workflow improvements.
3.18			Review and analyze behavioral health specific member experience surveys	
3.19			Review and analyze grievance and appeals data according to NCQA methodology. Complete annual report	
3.20			Gather member input on member experience utilizing Community Advisory Committee. Incorporate into annual Population Health Needs Assessment	
3.21	**Access to Care (DMHC, DHCS)**	1. Maintain compliance rate of 90% or above with in-office wait times not to exceed 45 minutes 2.Maintain a compliance rate of 90% or above with	Conduct telephone surveys to members with recent office visits; educate and resurvey non-compliant providers; implement quality monitoring program of non-compliant providers	Partially met. CCHP completed internal monitoring of in-office wait times, telephone answer times, and first prenatal visit, all meeting the 90% compliance rate.

Item #	Program/Project Area	Goals and Objectives	Planned Actions to Meet Goal	Evaluation of Activities
3.22		telephone answer times to not exceed 10 minutes and return call times to not exceed 1 business day as evidenced by monthly secret shopper calls to a sample of providers. 3. Maintain a compliance rate of 90% or above with first prenatal appointment access to not exceed 14 calendar days from day of request. 4. Develop a monitoring program specific to behavioral health access standards and respond to at least one identified area for improvement related to behavioral healthcare access 5. Review results of Provider Appointment Availability Survey MY 2022 and develop and act on at least one opportunity for improvement.	Conduct telephone surveys to providers offices to ensure timely answering and returning of calls; education and resurvey non-compliant providers; implement quality monitoring program of non-compliant providers	CCHP conducted the annual PAAS survey and identified an area of opportunity in educating providers on the standards. Multiple personalize communications were sent out to providers on the appointment time standards, including information about the providers' prior years rates. It also solicited the replies from providers to give information about barriers for the plan.
3.23			Conduct telephone surveys to OB/GYN and midwife providers quarterly; education and resurvey non-compliant providers; implement quality monitoring program of non-compliant providers	
3.24			Develop a process to monitor BH: 1) route care appointments, 2) non-life-threatening emergency care within 6 hours of request, 3) triage does not exceed 30 minute wait time	
3.25			Analyze PAAS results and conducted any needed follow up for routine care appointment deficiencies, if any	
3.26			Conduct analysis on Provider Appointment Availability Survey, implement quality monitoring program, and implement and act upon one identified area for opportunity.	

Item #	Program/Project Area	Goals and Objectives	Planned Actions to Meet Goal	Evaluation of Activities
3.27	**Provider Experience**	Implement standard process for collected provider experience and identify areas for opportunity	Implement Provider Experience Survey; identify at least two areas of improvement	Met. CCHP sent out a provider experience survey at the end of 2023 utilizing a new vendor. Results have not yet been received at time of the evaluation report.
3.28			Develop provider experience survey for all behavioral health providers	
3.29	**REAL Data**	Improve collection of race, ethnicity, preferred spoken and written language data collection	Compile new member survey collection of REAL data into ccLink	Met. CCHP continued to send out the REAL survey to new members and document this in Epic.
3.30	**CLAS Reporting**	Ensure cultural and linguistic needs of population are being met by provider network	Conduct annual CLAS analysis of patient and provider population	Met. The annual CLAS analysis was presented at the Quality Council meeting in Q1.
3.31	**Encounter Data validation (DHCS)**	Implement the encounter data validation study per the timelines and requirements from DHCS	Procure medical records and submit according to auditors deadlines	Met. CCHP successfully completed the encounter data validation study.
4. Performance Improvement Projects				
4.1	**Follow-Up After Emergency Department Visit for Mental Illness (FUM)**	Increase the percentage of members who complete a follow-up appointment within 30-days of an ED visit for mental illness	Conduct comprehensive analysis on FUM data to identify areas of opportunity; collaborate with Contra Costa Behavioral Health on improvement project	Met. While the MY 2023 rates are not yet finalized, the most recent data pull has the FUM 30-day rate increasing from 45.97% in 2022 to 51.56% in 2023, a difference of +5.59% (Percent change: 12.2% difference).

Item #	Program/Project Area	Goals and Objectives	Planned Actions to Meet Goal	Evaluation of Activities
4.2	**Follow-up for Hospitalization after ED Visit Substance Use**	Increase the percentage of members who complete a follow-up appointment within 30-days of an ED visit for substance use	Conduct comprehensive analysis on FUA data to identify areas of opportunity; collaborate with Contra Costa Behavioral Health on improvement project	Met. While the MY 2023 rates are not yet finalized, the most recent data pull has the FUA 30-day rate at 31.5%, an increase of 4.89% points compared to the 2022 rate of 26.61%. (percent change: 18.4%)
4.3	**Blood Lead Screening**	Increase pediatric blood lead screening rates to exceed the DHCS MPL.	Educate providers on Point of Care testing and develop targeted outreach to members with orders that have not been incorporated.	Not Met. The preliminary 2023 data for LSC shows that the rate increased from 51.51% in 2022 to 52.58% in 2023. This increase of 1.07% points was not enough to exceed the DHCS MPL and CCHP is below the 25th percentile in this metric.
4.4	**Well Child Visits in First 6 Months of Life**	1. Improve the completion rate for WCV in the first 6 months of life 2. Narrow the health disparities gap between Black/African American and Asian members	Identify regional and provider level disparities in WCV completion performance and develop targeted improvement project.	Partially Met. 1. MET: The completion rate of WCV for CCHP members 0-15 months increased from 65.88% in 2022 to 72.09% in 2023.* This exceeds the 90th percentile for this metric. 2. NOT MET: The disparities gap widened between Black and Asian members. In 2022, the completion difference was 13.16% and this increased to 14.14% in 2023. However, Black members saw their completion rates raise 10.9% in 2023 compared to 2022 while
4.5			Identify CBO to partner with to develop strategy for targeted outreach to the Black/African American community	

Item #	Program/Project Area	Goals and Objectives	Planned Actions to Meet Goal	Evaluation of Activities
				the percent change for Asian members was only 10.3%.
4.6	**Child and Adolescent Well Care Visit**	Increase WCV rates for 15-17 year old and 18-21 year old members	Outreach and incentive campaign for members to re-engage in primary care Conduct social media campaigns to educate members on the importance of routine health care	Met. The WCV rates for 15–17-year-olds increased from 52.26% in 2022 to 56.0% in 2023, a difference of 3.74. The WCV rate for 15-17-year-olds is above the MPL and slightly below the threshold for 75th percentile. The WCV rates for 18-21-year-olds also increased; from 28.48% in 2022 to 31.95% in 2023, a difference of 3.47. While an improvement was seen in the 18-21-year-old WCV rate, it is below the 25th percentile for this measure.
4.7	**Childhood Immunization**	1 Increase number of children with completed vaccination series 2. Increase flu immunization rate for children	Develop and deploy MyChart message campaigns targeted at overall flu vaccinations and <2 year old flu boosters	Met. The percentage of children who were compliant with all 10 childhood vaccinations by age 2 increased from 44.0% in 2022 to 45.4%* in 2023. Additionally, children compliant in the Combo 7 increased from 61.6% to 65.5%* and Combo 3 increased from 69.2% to 72.7%*. The flu vaccination rate increased slightly from 56.3% in 2022 to 56.6%* in 2023.

Item #	Program/Project Area	Goals and Objectives	Planned Actions to Meet Goal	Evaluation of Activities
4.8	**Cervical Cancer Screening**	Increase Cervical Cancer Screening rates in members ages 18-29	Conduct member outreach and incentive campaign	Met. The rate of cervical cancer screening in the 18-29 age group increased from 47.8% in January 2023 to 50.4% in December 2023.
4.9	**Controlling High Blood Pressure**	Increase the percentage of members with hypertension whose blood pressure is controlled	Explore expanding remote patient monitoring programming to include hypertension	Likely Met. The CBP rate decreased from 67.27% in 2022 to 64.58%* in 2023 preliminary data. However, the preliminary data is based off of administrative data, while the 2022 is based off of a hybrid data pull which provides more accurate information due to blood pressure being in the clinical record. It is expected CCHP will exceed this mark in 2023. It is important to note, in the second half of 2023, many providers had expressed patient difficulty in finding at home blood pressure monitoring cuffs in stock at local pharmacies. CCHP has instructed prescribers to have patients fill their blood pressure cuff prescription with a mail order pharmacy known to have cuffs in stock. The mail order pharmacy has

Item #	Program/Project Area	Goals and Objectives	Planned Actions to Meet Goal	Evaluation of Activities
				substantiated that Northern California pharmacies are not routinely stocking blood pressure cuffs on the Medi-Cal Rx formulary. CCHP will work on increasing the number of patients referred to the mail order pharmacy for blood pressure cuffs and remote patient monitoring.
4.10	**Colorectal Cancer Screening**	1. Increase colorectal cancer screening rates 2. Decrease rates of returned FIT kits that are unable to be processed	Redesign FIT kit mailing procedures, providing FIT kits when patients are due for a FIT.	Met. CCHP increased rate from 38.54 in MY 2022 to 38.75 in MY 2023. CCHP redesigned a FIT kit process with one large provider in the network. Previously, FIT kits were ordered and mailed out with the birthday letter; however, this was resulting in people not receiving a kit annually. CCHP decoupled the birthday letter from the FIT kit and also began pre-stickering tubes. In sum, these improvements have resulted in a 10% increase in rates.
4.11	**Continuity and Coordination of Medical Care (NCQA)**	Improve continuity and coordination of member care between medical providers	Through collaboration, identify project for NCQA 2024 - 2025 and establish baseline data	Met. CCHP has identified FUM, FUA, and PCR as the three measures for continuity and coordination of health care.

Item #	Program/Project Area	Goals and Objectives	Planned Actions to Meet Goal	Evaluation of Activities
		through at least 3 projects that meet NCQA standards.		CCHP has identified process measures to address these needs.
4.12	**Continuity and Coordination Between Medical Care and Behavioral Healthcare**	Improve continuity and coordination of member care between medical providers and behavioral health providers through at least 2 projects that meet NCQA standards.	Through collaboration, identify project for NCQA 2024 - 2025 and establish baseline data	Partially Met. CCHP has been meeting regularly with behavioral health partners to identify 4 potential projects and will be narrowing down to the final 2 in Q1 2024. Baseline data has been collected on all potential measures.
4.13	**Initial Health Appointment**	Increase IHA completion rates	Modifying the measurement strategy to align with the following HEDIS value set metrics: AAP, WCV, WC-30. Update reports and provider training of new measurement.	Partially Met. CCHP aligned the measurement strategy to match HEDIS and completed all quarterly chart audits. CCHP worked with the largest provider network to implement a text message campaign and redesigned its initial outreach campaign. CCHP is waiting for approval from DHCS on a text message campaign to implement further initiatives. CCHP provided education on the provider training.
4.14			Conduct quarterly chart audits and give feedback and education to providers missing IHA elements	
4.15			Replace current member IHA robocalls with a dynamic new member outreach campaign that will educate members on the importance of establishing a relationship with their primary care doctor upon enrollment, and provide additional	

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			outreaches for those that have not yet completed an IHA.	
4.16			Integrate member refusal into electronic health record through documentation of outreach attempts and provide additional provider education on the need to document member outreach and refusal in their electronic health record.	
5. Population Health				
5.1	**Comprehensive Population Health Rollout Plan**	Implement population health strategy engaging delivery system, community, and county partners to implement CalAIM population health goals	Create rollout plan and garner buy-in from key stakeholders	Met. CCHP conducted a series of meetings with key CCHP leadership along with provider partners. Several working groups were established around topics such as transition care services, risk identification, and new member assessment/identification to facilitate implementation.
5.2			Implement population health workgroups on key topics, developing workflows and metrics to align with overall population health goals	
5.3	**Population Needs Assessment**	Understand member needs and health to create a responsive population health program	Complete 2023 PNA utilizing all available data sources to Contra Costa Health Plan	Met. CCHP finalized the CCHP Population Health dashboard to view key indicators, bringing together a variety of data sources. CCHP established meetings with Public Health Department epidemiologist and quality team to discuss collaboration on Contra Costa's
5.4			Develop cross functional team collaborating with Epidemiologists in CCHS in preparation for the 2025 PNA	

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				Community Health Assessment and Community Health Improvement. CCHP reviewed Public Health's RFQ and supports aligning these efforts to best serve the community.
5.5	**Population Health Management Strategy**	Develop population health strategy in alignment with new CalAIM requirements, involving delivery system, county, and community partners	Complete PHM Strategy in alignment with DHCS and NCQA guidelines	Met. Utilizing health plan data, CCHP developed responsive programming to meet the needs of the population. This includes expanding diabetes programming, asthma services, and providing additional services to those complex members that need additional social services. Expanded programs regarding homeless services, long term care services, and behavioral health services were offered through enhanced care management and community support services.

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5.6	**Population Impact Report and Evaluation**	Develop framework for evaluating CCHP's population health program and measuring impact to ensure programs are achieved desired outcomes	Complete PHM Impact and Evaluation report	Met. CCHP completed an assessment of several key population health programs, including the remote patient monitoring diabetes program and the medically tailored meals program. Through propensity score analysis both of these services showed drop A1c by a statistically significant margin.
5.7	**New Member Workflow**	Provide streamlined new member experience, with regards to HIF/MET, IHA, LTSS, and other assessments.	Consolidate new member surveys (HIF/MET, HRA, LTSS, REAL) into one survey specific for the patient population	Met. CCHP underwent an overhaul of the new member workflow in order to align activities for new members. A revised HIF/MET and HRA was created, with specific questions for adults/children and seniors and persons with disabilities. Questions aligned with standard questions available in the EHR to extent possible to increase interoperability. These screenings were combined with the REAL data collection survey, PCP assignment letter, and reminder to schedule an Initial Health Appointment. These screenings were included and shared in the electronic health records, so all providers on the
5.8		Develop an new member outreach workflow to maximize Initial Health Appointments and New member survey completion	Implement Epic Campaigns to consolidate outreach into a single flow, documenting all outreaches into a unified EHR that is shared across all Epic networks	
5.9		Ensure system exists so members with positive screenings are identified for the appropriate services Develop data system so screening questions are results are shared across providers	Develop and implement workflows for following up on positive screenings	

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				Epic platform could see these through CareEverywhere and the provider portal. This revised process was implemented in December 2023 and impact will be measured in 2024.
5.10	**DHCS Population Health Service/Risk Stratification, Segmentation, and Tiering**	Implement DHCS Population Health Service into existing workflows	Implement DHCS Population Health Service based on forthcoming guidance upon service launch.	Met. CCHP developed a data infrastructure for RSS and created a tiering system to identify high risk individuals according to CCHP definition. Additionally, CCHP is currently segmenting population according to ECM criteria and CCM criteria.
5.11		Refine CCHP's risk stratification, segmentation, and tiering processes utilizing all available data sources	Modify RSS and Tiering and supporting workflows to incorporate the DHCS Population Health Services	
5.12	**Closed Loop Referrals**	Understand closed loop referral guidelines and implement technical system to support regulations	Develop workplan for implementing closed loop referrals based on DHCS guidance	Partially met. CCHP utilized Findhelp.org, a resource and referral platform, and is working to understand DHCS guidelines and implement a system.
5.13	**Ongoing Engagement with PCP**	Increase regular engagement with PCPs	Develop disengaged member reports and supporting workflows	Met. CCHP developed a report to identify individuals with PCP visit in the prior twelve months.
5.14	**Care Coordination/Navigation with Social Services**	Implement social resources into health education workflows and support referrals to CHW services	Develop referral process for CHW services based on identified social needs	Met. CCHP has begun to expand access to CHW services, with various workflows to refer individuals. Over 900 members accessed CHW services in 2023 and 2100 access care

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				coordination services through CCHP case management unit.
5.15	**Wellness and Prevention programs**	Improve preventive health of members with regards to : Healthy weight, smoking/tobacco, physical activity, healthy eating, managing stress, avoiding at-risk drinking, identifying depressive symptoms	Implement Health Education Krames to have dynamic website that offers self-management tools. Education providers and sat	Not met. Due to contracting delays, this project was delayed until 2024.
5.16			Educate providers and staff on available new health education tools	
5.17	**Chronic Disease Management**	Develop comprehensive chronic disease management program for the following chronic conditions: Diabetes, Cardiovascular Disease, Asthma, Depression, COPD, and CKD/ERSD	Develop program descriptions (including target populations, interventions, and risk tiering) for the following chronic conditions: Diabetes, Cardiovascular Disease, Asthma, Depression, COPD, and CKD/ERSD	Partially Met. CCHP developed a robust program for diabetes, asthma, and CVD (specifically, hypertension). Due to prioritization, other programs were delayed.
5.18	**Chronic Conditions: Diabetes Management Program**	Reduce number of CCHP members with uncontrolled diabetes	Provide medically tailored people to patients with uncontrolled diabetes. Evaluate efficacy of MTM.	Met. CCHP implemented a robust MTM and RPM program for members with diabetes. The percentage of members with uncontrolled diabetes (A1c<9.0%) decreased from 33.99% to 32.53%* in 2023. This puts CCHP above the 75th percentile nationally for the percentage of members with uncontrolled diabetes.
5.19			Expand remote monitoring blood glucose program in partnership with Gojji	

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5.20	**Chronic Conditions: Asthma Mitigation Program**	Reduce the number of CCHP members with acute asthma exacerbations that require emergency department visits and/or hospitalization	Serve at least 70 members in the Asthma Mitigation Program Increase number of contracted CalAIM Asthma Remediation Providers	Not Met. While CCHP met its process goals of implementing the asthma mitigation program and expanding to additional CalAIM providers, this is not impact acute asthma exacerbations for the population. In 2022, there were 0.6 inpatient admissions for asthma per 1,000 CCHP members. This number remained unchanged in 2023 at 0.6 inpatient admissions for asthma per 1,000 CCHP members. In 2022 and 2023, for people who were admitted for asthma, the average number of inpatient admissions was 1.4 per member. In 2022, there were 4.6 ED visits for asthma per 1,000 CCHP members. This increased slightly to 5.2 ED visits for asthma per 1,000 CCHP members. For members who presented to the ED for asthma, the average number of ED visits per member was 1.3 in both 2022 and 2023. This could potentially be due to environmental factors.

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5.21	**Maternal Health Outcomes**	Improve key maternal health outcomes across quality measurement strategy identified in 3.13	Increase number of contracted doulas	Partially Met. CCHP created a Baby Watch program out of its case management program, aiming to increase access to doulas, healthy start, and improve birth outcomes. However, implementation has been delayed.
5.22			Develop comprehensive perinatal program for CCHP members, including increasing access to healthy start and doula benefit	
5.20	**Keeping members healthy: Gaps in Care**	Notify members of gaps in care for needed preventive services	Redesign birthday letter process to incorporate broader gaps in care and offer more targeted calls in action	Partially Met. CCHP redesigned the adult birthday letter to incorporate more health maintenance activities and a more user-friendly format. CCHP deferred the pediatric birthday letter after discussions with provider groups due to duplicative efforts.
5.21			Develop specific pediatric birthday letter that provider more specific information to members in terms of gaps in care	
5.22	**Health Education Materials and Resources**	Assure that members are provided health education materials and are informed on new community and medical services. Develop comprehensive health education program	Annually update health education materials on website	Met. CCHP regularly updated information on the health education website, member newsletter, and developed a high level plan for enhancing health education for members.
5.23			Publish member facing newsletter three times per year	
5.24			Develop health education plan, including the following: classes, provider based strategy, direct patient outreach strategy, including triggering event notifications, community presence at CBOs, churches and school, and referral and request process for members, digital	

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			strategy for health education which may include email campaigns, care pathways, social media calendar, and health education council.	
5.25	**Cultural and Linguistic Access**	Ensure systematic processes in place to promote cultural competency/health equity by making accessible: educational opportunities, current and up-to-date resources, and understanding of CLS needs.	Complete provider trainings and educate providers on interpretation requirements and resources, and reading level requirements	Met. CCHP completed provider trainings, facilitated translation requests and reviewed all grievances related to CLA.
5.26			Facilitate translation request of educational materials, website, forms, and other documents.	
5.27			Review CLA grievances	
6. Patient Safety				
6.1	**Potential Quality Issues (PQIs)**	Review and resolve potential quality issues within 120 days	Issues CAPS according to leveling guidelines, report on trends. Modify ccLink workflow for ease of reporting	Met. CCHP met timeframes on all PQIs. CCHP also developed a specific report to ease administrative burden and enhance tracking.
6.2	**Provider Preventable Conditions (PPCs)**	Review and investigate PPC through the PQI process	Capture all PPCs through accurate reports, Investigate all identified PPCs. Report to DHCS and track all confirmed PPCs, Provide education on PPCs for contracted network	Met. CCHP investigated all PPC. CCHP also improved and automated the reporting to identify PPC and review them in a more timely fashion. Education on PPCs was provided during quarterly network training.

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6.3	**Over/Under Utilization - ED Use**	Develop a standard over-under utilization report and develop standards with how reporting is used to improve care	Define measures to track and identify areas of opportunity for improvement initiatives	Met. CCHP quality department met with UM department on utilization on HEDIS measures for over/under reporting.
6.4	**Medication Safety**	Reduce concurrent prescribing of opiate and benzodiazepine	Provide quarterly reports to providers on patients that are co-prescribed opioids and benzodiazepines	Met. 65 letters were sent to providers alerting them of their patients who were currently taking the dangerous drug therapy combination of opioids and benzodiazepines/anti-psychotics.
6.5		Reduce concurrent prescribing of opioids and anti-psychotic medications	Provide quarterly reports to providers on patients that are co-prescribed opioids and anti-psychotics	
6.6.		Antipsychotic, anti-depressant and mood stabilization prescriptions for children	Quarterly audit to determine if these medications that are being prescribed to children have a qualifying diagnosis	Met. CCHP completed quarterly audit.
6.7		Improve Hepatitis C medication adherence	Review HepC medication to ensure that members are fully completing their course of treatment	Met. CCHP tracked, communicated with and provided education to 75 members being treated for Hepatitis C to ensure completion of therapy.
6.8		Reduce number of members with 15 or more medications	Review CCHP members with 15+ prescriptions, develop personalized recommendations when appropriate and refer members to case management	Met. CCHP pharmacy reviewed medications and referred individuals to CCHP case management.

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6.9		Ensure members can get their prescriptions filled after ED discharge	Audit Emergency Department discharges with prescriptions and confirm that individuals were able to fill their prescriptions; educate pharmacies on prescription benefits. Additionally, this quarterly audit will look for members with 4 or more ED visits in a 6 month period and refer them to case management.	Met. Completed ED visit audit and educated pharmacies on benefits.
6.10		Reduce prescription opiate abuse	Review potential unsafe prescriptions where members have multiple opiate prescriptions from multiple prescribers and pharmacies—refer to case management for potential follow up with members and providers	Met. Reviewed unsafe combinations and referred individuals to case management for review.
6.11	**Facility Site Reviews**	Ensure PCP sites operate in compliance with all applicable local, state, and federal regulations, and that sites can maintain patient safety standards and practices.	Complete an initial Facility Site and Medical Record Review and the Physical Accessibility review Survey for newly contracted PCPs. Conduct periodic full scope reviews for PCPs. Complete corrective action plans for cited deficiencies.	Met. Completed all scheduled FSR, MRR, and PARs. Developed and tracked corrective action plans with providers.

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6.12	**Medical Record Reviews**	Ensure medical records follow legal protocols and providers have documented the provision of preventive care and coordination of primary care services.	Conduct annual MRR of provider office in accordance with DHCS standards.	Met. Completed all scheduled MRR according to DHCS standards. Developed and tracked corrective action plans as necessary.
6.13	**Long Term Care Facility Reviews**	Ensure a members that were recently carved into Medi-Cal are receiving optimal care while they are in skilled nursing facilities	Develop monitoring plan for long term care facilities through regular medical record review	Partially Met. Identified metrics for tracking and plan will be implemented in 2024.
7. Provider Engagement				
7.1	**Provider Training**	1. Increase attendance at provider trainings by 20% from 2021 average 2. 85% of providers will rate their overall experience as very good or excellent	1. Develop and implement four Quarterly trainings covering a range of topics including regulatory changes/updates and topics that matter most to providers; Solicit input from providers on agenda topics through providers	Met. CCHP conducted four provider network trainings. Attendance at meetings was less than optimal, so time was changed to be over lunch time in quarter 3 and 4. This markedly improved attendance. Additional outreach is planned to increase attendance in 2024.
7.2	**Quality Improvement Collaborative**	Foster quality improvement with provider network by facilitating improvement institute	Develop workplan and launch learning collaborative	Not Met. This action item was put on hold in 2023, to be replaced with provider specific meetings that were held bi-monthly with the largest provider groups. These meetings allowed for relationship building and to review and understand

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				provider-specific quality improvement plans.
8. Delegation Oversight				
8.1	**Delegation oversight**	Implement all oversight activities for the Quality portions of the Kaiser delegation	1. Review Kaiser's Quality Program Description, Annual Evaluation, and Work Plan annually 2. Participate in annual joint delegation audit and issue corrective action plans as necessary	Met. CCHP participated in the joint Kaiser delegation and conducted file review of several of Kaiser chart audits. There were no major findings.