Healthcare Quality Committee

November 17, 2023

mMeeting Name:	Quality Improvement Health Equity Committee		
Date of Meeting:	11/17/2023	**Time:**	9:00am – 11:00 AM
Meeting Coordinator:	Ashley Asejo	**Location:**	**Microsoft Teams** **Alameda Alliance for Health HQ**
Webinar: Meeting ID:	Meeting ID: 294 215 030 69 Passcode: 7tcxVw		

IMPORTANT PUBLIC HEALTH AND SAFETY MESSAGE REGARDING PARTICIPATION AT ALAMEDA ALLIANCE FOR HEALTH COMMITTEE MEETINGS

YOU MAY SUBMIT COMMENTS ON ANY AGENDA ITEM OR ON ANY ITEM NOT ON THE AGENDA, IN WRITING VIA MAIL TO "ATTN: ALLIANCE HCQC COMMITTEE" 1240 SOUTH LOOP ROAD, ALAMEDA, CA 94502; OR THROUGH E-COMMENT AT aasejo@alamedaalliance.org YOU MAY WATCH THE MEETING LIVE BY LOGGING IN VIA COMPUTER AT THE LINK PROVIDED ABOVE. IF YOU USE THE LINK AND PARTICIPATE VIA COMPUTER, YOU MAY, THROUGH THE USE OF THE CHAT FUNCTION, REQUEST AN OPPORTUNITY TO SPEAK ON ANY AGENDIZED ITEM, INCLUDING GENERAL PUBLIC COMMENT. YOUR REQUEST TO SPEAK MUST BE RECEIVED BEFORE THE ITEM IS CALLED ON THE AGENDA.

PLEASE NOTE: ALAMEDA ALLIANCE FOR HEALTH IS MAKING EVERY EFFORT TO FOLLOW THE SPIRIT AND INTENT OF THE BROWN ACT AND OTHER APPLICABLE LAWS REGULATING THE CONDUCT OF PUBLIC MEETINGS, IN ORDER TO MAXIMIZE TRANSPARENCY AND PUBLIC ACCESS. DURING EACH AGENDA ITEM, YOU WILL BE PROVIDED A REASONABLE AMOUNT OF TIME TO PROVIDE PUBLIC COMMENT. THE BOARD WOULD APPRECIATE, HOWEVER, IF COMMUNICATIONS OF PUBLIC COMMENTS RELATED TO ITEMS ON THE AGENDA, OR ITEMS NOT ON THE AGENDA, ARE PROVIDED PRIOR TO THE COMMENCEMENT OF THE MEETING.

Meeting Objective
To improve quality of care for Alliance members by facilitating clinical oversight and direction.

Members	
Name	**Title**
Steve O'Brien, MD Chair	Chief Medical Officer, Alameda Alliance for Health, Internal Medicine
Sanjay Bhatt, MD Vice Chair	QI Medical Director, Alameda Alliance for Health, Emergency Medicine
Aaron Chapman, MD	Alameda County Behavioral Health Care Services
Wesley Lisker, MD	Kaiser Permanente

Tri Do, MD	Community Health Center Network
Felicia Tornabene, MD	Alameda Health System
James Florey, MD	Children First Medical Group
Donna Carey, MD	CM Medical Director, Alameda Alliance for Health, Pediatrics
Rosalia Mendoza, MD	UM Medical Director, Alameda Alliance for Health, Family Practice
Peter Currie, PsyD	BH Senor Director, Alameda Alliance for Health
Michelle Stott	Senior Quality Director, Alameda Alliance for Health

Meeting Agenda				
Topic	**Time**	**Document**	**Responsible Party**	**Vote to approve or Informational**
Call to Order/Roll Call:	1 min	Verbal	S. O'Brien	Informational
1. CMO Update and New Member – Paul Lao Vang • Alison Lam – Sr. Director of Health Care Services	5 min	Verbal	S. O'Brien	Informational
2. Chief Health Equity Officer Update	5 min	Verbal	P. Vang	Informational
3. Policies and Procedures • Listed below.	2 min	Document	S. O'Brien	E-Vote
4. Approval Committee Meeting Minutes • HCQC – 08/18/2023 • IQIC – 10/11/2023 • A&A Meeting – 08/02/2023 • UMC– 8/25/2023 10/27/2023	2 min	Document	S. O'Brien	E-Vote
5. QIHEC Charter	5 min	Document	M. Stott	Vote
6. Kaiser Permanente • Trilogy Document – 2022 QI Evaluation	10 min	Document	M. Hamon	Vote
7. CFMG - HEDIS Performance Improvement Program in an Independent Practice Association without an Enterprise EMR	15 min	Document	J. Florey B. Kelly	Informational
8. Quality Improvement Financial Investment • Quality Impact on Rates	5 min	Document	M. Stott S. Bhatt	Informational

Meeting Agenda				
Topic	**Time**	**Document**	**Responsible Party**	**Vote to approve or Informational**
9. Provider Pay for Performance Program	10 min	Document	S. Bhatt T. Cheang F. Zainal	Informational
10. Population Health Management	8 min	Document	G. Duran	Informational
11. Non-Utilizer Pilot	7 min	Document	F. Zainal	Informational
12. Compliance Update	5 min	Document	G. St. Clair	Informational
13. Behavioral Health GA Report	5min	Document	J. Karmelich	Informational
14. Clinical Practice Guidelines	2 min	Document	S. Bhatt	Informational
15. Quality Improvement Workplan	1 min	Document	M. Stott	Informational
16. Public Comment	1 min	Document	S. O'Brien	Informational
17. Adjournment	1 min	Verbal	S. O'Brien	Next Meeting February 16, 2024

Americans with Disabilities Act (ADA): It is the intention of the Alameda Alliance for Health to comply with the Americans with Disabilities Act (ADA) in all respects. If, as an attendee or a participant at this meeting, you will need special assistance beyond what is normally provided, the Alameda Alliance for Health will attempt to accommodate you in every reasonable manner. Please contact Ashley Asejo aasejo@alamedaalliance.org at least 48 hours prior to the meeting to inform us of your needs and to determine if accommodation is feasible. Please advise us at that time if you will need accommodations to attend or participate in meetings on a regular basis.

Policies & Procedures

Quality

QI-XX: Clinical Practice Guidelines .

QI-101: Quality Improvement and Health Equity Program

QI-104: Potential Quality Issues (PQIs)

QI-107: Appointment Access and Availability Standards

QI-114: Monitoring of Access and Availability Standards

QI-135: Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)

UM

UM-018: Targeted Case Management and Early and Periodic Screening, Diagnosis and Treatment

UM-036: Continuity of Care

UM-057: Authorization Service Request

UM-059: CoC for MCal Beneficiaries Who Transition into MCal Managed Care

HED

HED-XX: Doula Services

HED-001: Health Education Program

PH

PH-004: Community Health Workers

CLS

CLS-002: Community Engagement

CLS-011: CLS Program - Compliance Monitoring

CMDM

CM-004: Care Coordination of Services

Policies & Procedures Updates

Policy	Department	Policy #	Policy Name	Brief Description of Policy	Description of Changes/Current Revisions	Policy Update	New Policy	Annual Review or Formattin
1	QI	TBD	Clinical Practice Guidelines	Describes how the Alliance adopts, disseminates, and monitors theuse of preventive care and other clinical practice guidelines.	New Policy		X	
2	Quality	QI-101	Quality Improvement and Health Equity Program	Describes the Alliance Quality Improvement and Health Equity program as required by the Medi-Cal Contract	Added health diparity language to comply with the 2024 Medi-Cal Contract (R.0048) Added ICF/DD quality monitoring per APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities	X		
3	Quality	QI-104	Potential Quality Issues (PQIs)	Describes the system and process for identifying any PQI and the process of identifying severity of the issue identified.	Based on the DMHC comment letter for APL 22-026 1)Added definition "Subtantial Harm" to reflect APL 22-026 2) Updates Quality of Care (QOC) severity level 3 and 4 equate to substantial harm	x		
4	Quality	QI-107	Appointment Access and Availability Standards	Describes how the Alliance implements and maintain procedures for members to obtain appointments for routine (non-urgent) and urgent care from all applicable provider types.	Based on the DHCS Audit CAP-reformatted Timely Access Standard table for First Prenatal appointment "within 2 weeks of request"	X		
5	Quality	QI-114	Monitoring of Access and Availability Standards	Describes how the Alliance has established a mechanism for ongoing monitoring of its provider network to ensure timely access to and availability of quality health care services for all members within the Alliance and delegae network.	1)Based on the DHCS Audit CAP-revised QI-114 to ensure members receive timely access to first prenatal visits "within two week upon request" 2)Based on the DMHC J-13A comment Letter - revised P&P to describe our process to improve our provider respository when ineligible provider is found as a result of PAAS 3)DMHC J13A comment letter - added "pattern of non copliance" as part of our monitoring/CAPs process	x		
6	QI	QI-135	Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)	To define Alameda Alliance for Health's (Alliance) responsibility to provide Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) to all Medi-Cal eligible members under the age of 21.	Added the following wording to meet 2024 DHCS Contract: The Alliance regularly reviews encounter and administrative data as necessary, and may be as frequently as quarterly, for appropriateness, utilization, timeliness of child preventive care services, and completed screenings. This includes and not limited to HEDIS/MCAS quality measures, Facility Site Reviews/Medical Record Reviews, or chart reviews, etc. See P&P QI-101 Quality Improvement Health Equity Program	x		

7	UM	UM-018	Targeted Case Management and Early and Periodic Screening, Diagnosis and Treatment	TCM and EPSDT	Addition of details on LGAs and information exchange with LGAs	X		
8	UM	UM-036	Continuity of Care	Policy that governs continuity of care procedures for newly enrolled members or members with a terminated/OON provider	Addition of language that reflects processes to adhere the 2024 MCal MCP Transition Policy Guide regulatory requirements for the transition to a Single Plan Model county, including management of Special Populations.	X		
9	UM	UM-057	Authorization Service Request	Policy that governs the overall processes for authorizing care.	Addition of language that reflects processes to adhere the 2024 MCal MCP Transition Policy Guide regulatory requirements for the transition to a Single Plan Model county, including management of Special Populations.	X		
10	UM	UM-059	CoC for MCal Beneficiaries Who Transition into MCal Managed Care	Policy specifically governing the CoC requirements to manage members transitioning into AAH from other coverage or are newly enrolled.	Addition of language that reflects processes to adhere the 2024 MCal MCP Transition Policy Guide regulatory requirements for the transition to a Single Plan Model county, including management of Special Populations.	X		
11	HED	TBD	Doula Services	Describes how the Alliance implements the doula services benefit to eligible members.	New Policy		X	
12	HED	001	Health Education Program	Descibes Alliance Health Education Program elements.	Updated to align with 2024 Contract requirements, connect to the Population Health Management program, connecting members to preventive services and community health worker.	X		
13	PH	004	Community Health Workers	Describes how the Alliance implements the community health worker benefit and how CHWs are integrated into the Population Health Management program.	Updated policy to expand how the Alliance assesses member needs and determine priority popuations for services, conducts outreach, communicates with providers and members regarding availability of services, and monitors the services.	X		
14	CLS	002	Community Engagement	Describes role, function and policies for Alliance Community Engagement and the Alliance Member Advisory Committee.	Updated to comply with the 2024 MCP Contract including member feedback on health equity, documentation and integration of member feedback, selection of MAC members, role of CHEO, topics MAC members advise on, and reporting structure of the MAC. Updated Subcommittee approval to QIHEC.	X		

15	CLS	011	CLS Program - Compliance Monitoring	Describes how the Alliance ensures quality lanuage assistance services through monitoring of staff, providers and language services vendors.	Updated to comply with the 2024 MCP Contract and DMHC statutory compliance with CRR 1300.67.2.2., including soliciting member and provider feedback on interpreter services through surveys. Updated Subcommittee approval to QIHEC.	X		
16	CMDM	CM-004	Care Coordination of Services	Structure of Plan's Care Coordination Services	Addition of language to ensures no duplication of services information sharing processes IHSS referrals Children with Special Health Care Needs (CSHCN) Direct Observed Therapy for TB Addition of language to ensure regular communication with IHSS regarding open medical issues and related social issues. BPHM reqs.	X		

QIHEC Charter

Michelle Stott

ALAMEDA Alliance FOR HEALTH

ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (QIHEC)

Purpose

Quality Improvement Health Equity Committee, (QIHEC) is a standing advisory committee of the Board of Governors (BOG) and is responsible for the implementation, oversight, and monitoring of the Quality Improvement Health Equity (QIHE) Program and Utilization Management (UM) Program for Alameda Alliance for Health ("Alliance"). The structure, functions, and scope of the QIHEC, as outlined in this charter, shall be in accordance with the regulatory requirements of the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and National Committee for Quality Assurance (NCQA).

Policy/Scope

The QIHEC oversees the development, implementation, and effectiveness of the QIHE Program and is accountable to the BOG. The QIHEC is chaired by the Chief Medical Officer (CMO), in collaboration with the Chief Health Equity Officer.

The QIHEC is responsible for the following activities:

1) Approves and recommends policy and procedure decisions to ensure compliance with QIHE standards
2) Analyzes, evaluates and provides feedback on the results of QIHE activities, including annual review of the results of the performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other subcommittees, such as the Member Advisory Committee
3) Institute actions and ensure appropriate follow-up to address performance deficiencies
4) Monitor whether the provision and utilization of services meets professionally recognized standards of practice.
5) Ensures practitioner participation in the QIHE Program through planning, design, implementation or review
6) Reviews the QIHE Trilogy documents, such as the annual plan, program description, and program evaluation
7) Maintains signed and dated meeting minutes

Structure

1) Membership of QIHEC

The QIHEC shall consist of voting members (including the chair and vice-chair) and standing members of the committee. The committee shall endeavor to include multiple provider network providers including at minimum, those who provide services to members affected by health disparities, limited English proficiency (LEP), children with special health care needs (CSHCN), seniors and persons with disabilities (SPDs), and persons with chronic conditions. The number of voting members may be limited if they are in the same clinical practice sub-specialty (unless the committee member has a specialty in multiple areas).

Voting committee members shall work primarily in an institution within the coverage area of Alameda Alliance (Alameda County) or work for a clinic/hospital/practice/pharmacy that often serves Alameda Alliance members if outside of Alameda County (e.g., University of San Francisco Hospital or affiliated clinic).

Committee members shall not allow affiliations with outside interests to impair the responsible exercise of his or her duties as an QIHEC member.

1) **Voting Members**:

The Committee shall be comprised of the following members:

a) Alliance Chief Medical Officer (*Chair*) or designee
b) Alliance QI Medical Director (Vice-*Chair*)
c) Practicing provider representing Internal Medicine
d) Practicing provider representing Family Practice
e) Practicing provider representing Pediatrics
f) Practicing provider representing Behavioral Health
g) Practicing physician(s) representing common medical specialties
h) Alliance Chief Health Equity Officer
i) Alliance UM Medical Director
j) Alliance Case Management Medical Director
k) Alliance Senior Director, Quality

2) **Regular Guests (non-voting)**

Regular guests shall not be counted towards a quorum or be subject to term limits, but they shall be allowed to participate fully in discussion, and shall be required to complete a Conflict of Interest (COI) Form annually. Non-voting guests may include:

a) Chief Executive Officer
b) Designated Alliance Pharmacist(s) / Pharmacy Director
c) Designated Alliance personnel representing Provider Relations
d) Designated Alliance personnel representing Case Management
e) Designated Alliance personnel representing Quality Improvement
f) Designated Alliance personnel representing Utilization Management
g) Clinician guests who practice in a medical specialty being discussed at that meeting.

3) **Officers of the QIHEC**

a) **Chairman of the QIHEC – Chief Medical Officer (CMO)**

The CMO shall be responsible for, but not limited to, the following:

i. Serve as Chair
ii. Appoint a medical director to serve as the Vice Chair of the QIHEC.

iii. Preside at all meetings of the committee and report on QIHEC matters at regular meetings of the Board of Governors.
iv. Be a voting member of the committee and count toward determining whether a quorum is present.
v. Collaborate with the CHEO on supervision of QIHE activities

b) **Vice Chair of the QIHEC – QI Medical Director**

The QI Medical Director shall serve as Vice-Chair to the committee and shall be responsible for developing the agenda and materials to be reviewed by the QIHEC.

Other Officers Other officers may be appointed by the QIHEC by a majority vote as needed.

c) The Officers shall be voting members of the committee and shall be counted toward determining whether a quorum is present at each QIHEC meeting.

d) If both the Chair and Vice Chair of the QIHEC are absent or unable to act at a meeting where a quorum is present, the Chair will select one of the attending committee members to act as Chair pro tempore, with all the authority appurtenant thereto, if the Chair has not selected a committee member to preside at the meeting.

4) **Closed Sessions**

a) Prior to meeting in closed session, the Chair or Vice-Chair of the committee must orally announce the items to be discussed in closed session (§ 54957.7(a).).
b) At the conclusion of each closed session, the agency must reconvene into open session (§ 54957.7(b).).
c) If any final decisions have been made in the closed-session meeting, a report may be required (§ 54957.1.).
d) Closed Sessions will be based on California Government Code Title 5, §54954.5(h) – REPORT INVOLVING TRADE SECRET and the agenda shall contain a description of what the discussion will concern and the estimated date of public disclosure (month/year).
e) The results and actions taken by the committee during the closed session shall be summarized and disclosed, but not trade secrets.

5) **Meeting Agendas and Minutes**

a) At least 72 hours prior to a regular meeting, an agenda shall be posted containing a brief general description of the topics to be discussed, including items to be discussed in closed session. (§ 54954.2(a).)
b) The agenda shall be posted at the main entrance of the Alliance's principal offices and/or any other location freely accessible to members of the public.
c) Agenda and materials will be sent to the QIHEC committee members at least five (5) days before a regular meeting.

d) When minutes of the QIHEC have been approved, copies of the minutes shall be retained by the Alliance and be made available for inspection and copying according to applicable law.
e) The minutes, including any QIHEC activities of any fully delegated subcontractors and downstream fully delegated subcontractors, findings, recommendation and actions are submitted to the Alliance's Board of Governors.
f) The written summary of the QIHEC activities are publicly available on the Alliance's website at least on a quarterly basis
g) Compliance Department will submit signed QIHEC meeting minutes to the Department of Health Care Services (DHCS) for all meetings.

6) **Non-Agenda Items**

a) Prior to discussing a matter which was not previously placed on an agenda, the item must be publicly identified so that interested members of the public can monitor or participate in the consideration of the item in question.
b) The body may discuss a non-agenda item at a regular meeting if, by simple majority vote, the body determines that the matter in question constitutes an emergency pursuant to §54956.5. (§ 54954.2(b)(1).) or that it should be discussed at a future meeting.
c) Any discussion held pursuant to non-agenda items must be conducted in open session, since emergency meetings held pursuant to §54956.5 cannot be conducted in closed session.

7) **Voting**

a.) All official acts of the committee shall require the affirmative vote of the majority of the members present and voting, at a regular or special meeting with a quorum present.
b.) A simple majority (50% of voting members + 1) shall constitute approval of the proposed action.
c.) A tie vote is a lost vote, as a majority was not obtained.
d.) Absent members may not vote by proxy.
e.) Electronic voting approval may be an option in lieu of a regular or special meeting if a quorum is not present or other circumstances as directed by the CMO

8) **Quorum**

a) A quorum, defined as a simple majority (50% + 1) of voting members, must be present for the QIHEC to vote on any matter.
b) If a quorum is present but members are prohibited from voting because of conflicts of interest, then official acts shall require the majority of those present who are not so prohibited from voting.
c) If a quorum is not met at a regular scheduled meeting, the meeting shall be postponed to a future date or cancelled.

9) **Meeting Schedule and Special Meetings**

a) The QIHEC shall hold regular meetings at least quarterly, at minimum four times per year.
b) The QIHEC may hold special meetings at any time and place as may be designated by the Officers or a majority of the members of the committee. The provisions of applicable open meeting laws with respect to special meetings of the full Board shall apply to special meetings of the QIHEC.

10) **Public Comment:**

a) Every agenda for a regular meeting shall provide an opportunity for members of the public to directly address the QIHEC on any item under the subject matter.
b) Where a member of the public raises an issue which has not yet come before the committee, the item may be briefly discussed but no action may be taken at that meeting (§ 54954.3(a).).
c) The QIHEC may establish procedures for public comment as well as specifying reasonable time limitations on particular topics or individual speakers.

Membership Terms of Service

Members of the QIHEC may be dismissed from the committee (in alignment with the BOG procedures) if:
(1) in the opinion of the majority of the other committee members, a member fails to carry out his or her duties appropriately;
(2) the member fails to attend three consecutive, properly noticed regular and/or special meetings of the committee without having secured prior authority to do so from a majority of the governing committee members;
(3) the member ceases to be employed by or be a member of the group from which he or she was appointed to the committee;
(4) the member fails to attend fifty-percent (50%) or more properly noticed regular and/or special meetings.

New Voting QIHEC members are appointed by the Board of Governors, with all current active members having the right to nominate potential members. The Chair or Vice-Chair shall notify the Board of Governors of the vacancy at the next regular Board of Governors meeting and submit nominations at that time.

If a voting QIHEC member loses eligibility for serving on the committee, the member must immediately notify the Officers. To be eligible as a qualified voting member of the Alliance QIHEC, the provider must:

1. Meet ONE of the following criteria:

a. Be employed by the Alliance as the Chief Medical Officer, QI Medical Director, UM Medical Director, Case Management Medical Director, Senior Director of Quality
b. Be an active member of the Alliance Board of Governors

OR

2. Meet ALL of the following criteria
    a. Work primarily within Alameda County or for an organization that regularly serves Alameda Alliance members;
    b. Has an appropriate clinical background commensurate with the duties of the committee;
    c. Maintain an active medical or pharmacy license in good standing as appropriate;
    d. Complete a non-disclosure agreement and conflict of interests form annually; and
    e. Update their employment and licensure status annually and immediately after any changes.

Voting Member and Regular Guest Qualifications

Committee members should be highly qualified, with a proven dedication to the health and welfare of the Medi-Cal and other populations, and must have a combination of the following qualifications:

1. A thorough familiarity with the health care delivery structure in Alameda County, and the needs of the Medi-Cal population;
2. A demonstrated working knowledge of the Medi-Cal program;
3. A thorough understanding of the multitude of issues facing the implementation of a managed care system;
4. A commitment to the creation of a publicly funded health care system for the good of the public, rather than for the benefit of special interests;
5. An ability to be an active and contributing participant throughout the process; and
6. Sensitivity for patient concerns.

Duties and Rights of All Committee Members

1. Attend all meetings of the committee
2. Contribute to the discussion during committee meetings
3. Make a motion
4. Vote or abstain on any motion

Any committee member may resign, effective upon the giving of written or oral notice to the Chair or Vice Chair of the QIHEC, unless the notice specifies a later time for the effectiveness of such resignation. The acceptance of a resignation shall not be necessary to make it effective. The Chair or Vice Chair shall notify the QIHEC in writing of an oral notice of resignation.

Appendix List:

Appendix A: Annual Conflict of Interest Disclosure Form

APPENDIX A

Confidentiality and Conflict of Interest

Confidentiality

As a member of this committee, you recognize that you owe a fiduciary duty of care to Alameda Alliance for Health (AAH). This includes a duty of confidentiality. In connection with your service, you may be given or have access to confidential information of AAH or third parties. Confidential information is all information that AAH considers to be confidential or proprietary information of AAH or third party sources.

Confidential information may include, but is not limited to, information regarding the organization, operations, programs, activities, policies, procedures, practices, financial condition, trade secrets, membership lists, and standards of AAH, its members, or third parties. Confidential information also may include, but is not limited to, unpublished or pre-release versions of AAH standards, white papers, and other documents and information, or internal use only or limited circulation documents and information.

You covenant and agree that you will not disclose or permit to be disclosed any confidential information, and that you will not appropriate, photocopy, reproduce, or in any fashion replicate any confidential information without the prior written consent of AAH.

You agree that any disclosure of confidential information in violation of this agreement shall cause immediate and substantial damage to AAH and to any parties that provided the confidential information to AAH.

You agree to use reasonable efforts to maintain the confidentiality of the confidential information. You also agree not to use any confidential information for your own benefit unless authorized in advance in writing by AAH. Confidential information shall not include information that you rightfully obtain from a third party without comparable restrictions on disclosure or use.

Conflicts of Interest

All Committee members must act at all times in the best interests of AAH and not for personal or third-party gain or financial enrichment. When encountering potential conflicts of interest, committee members shall identify the potential conflict and, as required, remove themselves from all discussion and voting on the matter. If you believe you have a potential conflict please contact the Compliance department immediately. Specifically, members of the committee shall:

- Avoid placing (and avoid the appearance of placing) one's own self-interest or any third-party interest above that of AAH.
- Not make any health care or medical decisions based on financial incentives.
- Not engage in any outside business, professional or other activities that would directly or indirectly materially adversely affect AAH.

- Not engage in or facilitate any discriminatory or harassing behavior directed toward AAH staff, members, officers, directors, meeting attendees, exhibitors, advertisers, sponsors, suppliers, contractors, or others in the context of activities relating to AAH.
- Not solicit or accept gifts, gratuities, free trips, honoraria, personal property, or any other item of value from any person or entity as a direct or indirect inducement to provide special treatment.

Acknowledgement

I understand and agree that my failure to comply with the terms of this agreement will have consequences and may result in disciplinary action up to immediate termination and criminal prosecution, depending upon the infraction's severity, evidence of my intentions, and the sensitivity and scope of the information compromised.

By signing and dating this agreement in the spaces provided below, I certify that I have read this agreement, and that I agree to its terms.

Signature_____ Date_____

Name (please print) _____

Kaiser Permanente Presentation

Melinda Hamon

ALAMEDA Alliance FOR HEALTH

Kaiser Foundation Health Plan Quality Structure and Program Overview

November 2023

Presentation to Alameda Alliance For Health Quality Committee

Melinda Hamon, Managing Director Hospital/Health Plan Quality

KAISER PERMANENTE®

Entities, Subsidiaries and Affiliated Corporations

Kaiser Permanente is comprised of three entities:

Kaiser Foundation Health Plans (KFHP)

- Nonprofit regional health plans that provide its members with prepaid comprehensive health care benefit plans.

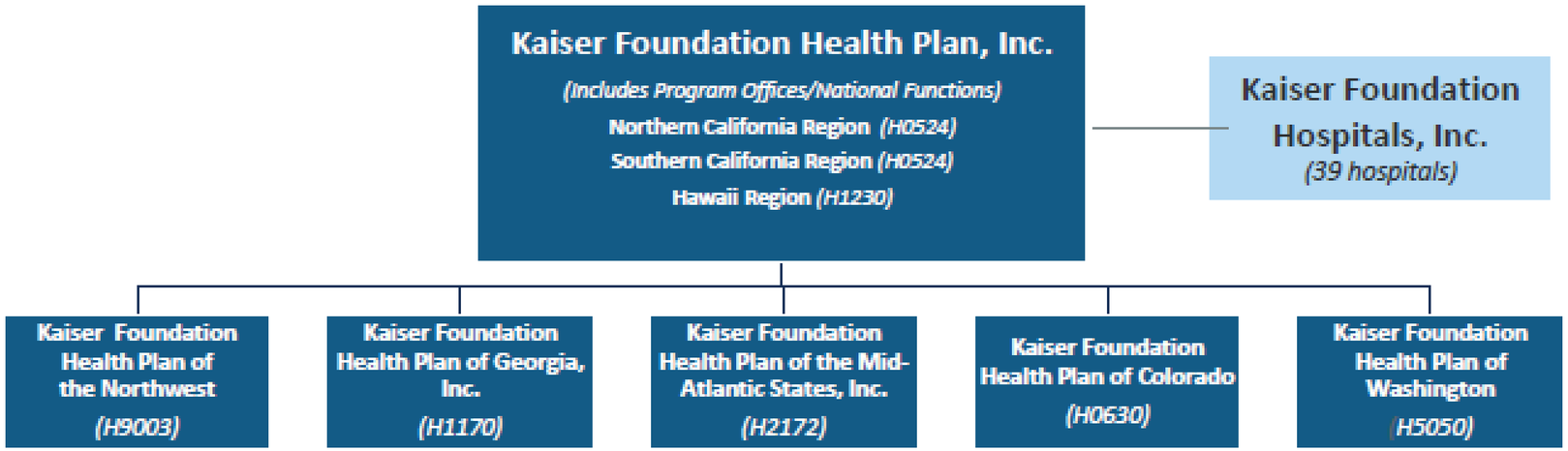
Kaiser Foundation Hospitals (KFH)

- Nonprofit corporation that owns and operates or contracts for hospital facilities and services.

Permanente Medical Groups (PMG)

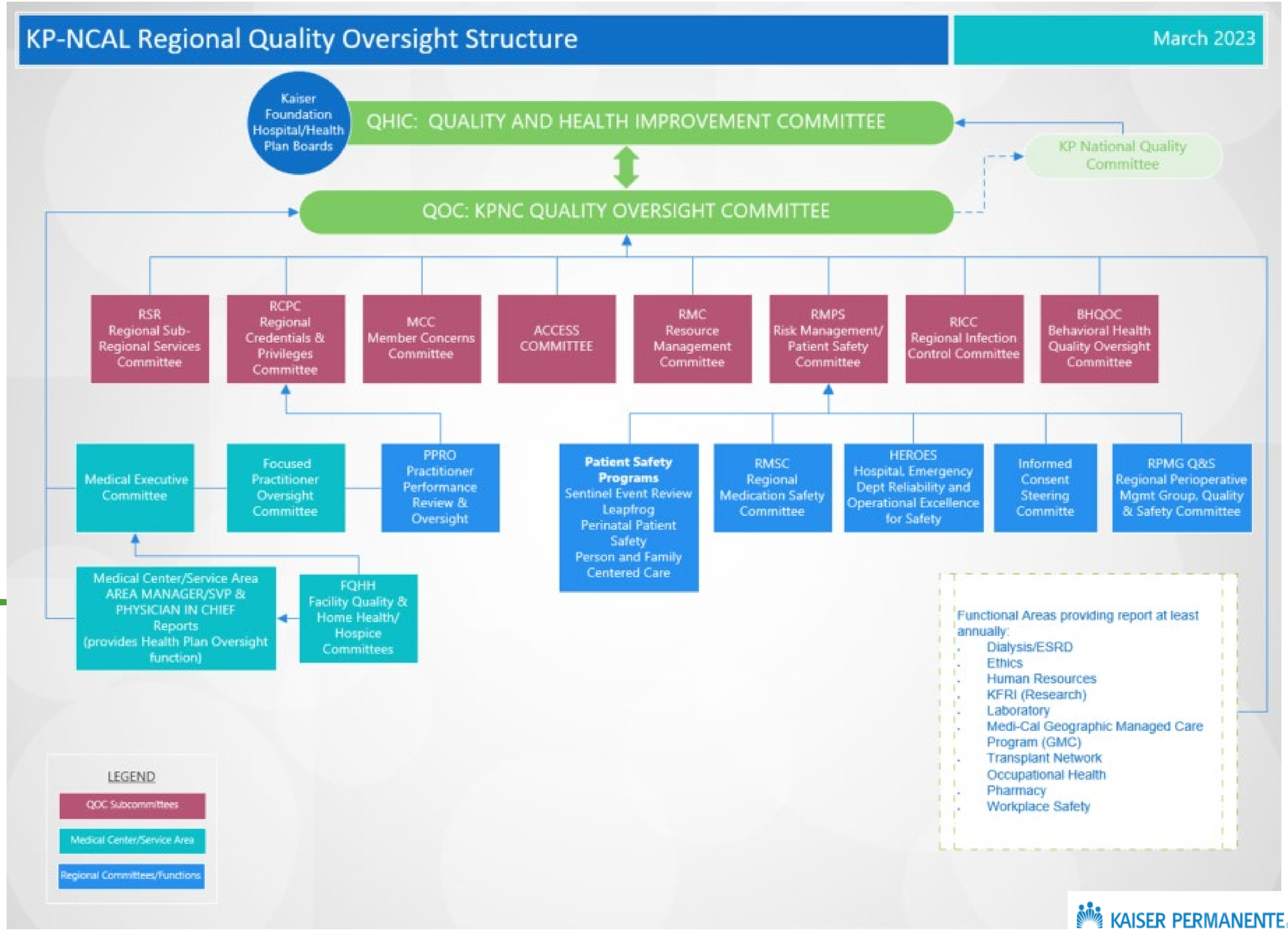
- Regional Medical Groups, represented nationally by The Permanente Federation, which contract exclusively with KFHP to provide medical services to Kaiser Permanente members.

Kaiser Foundation Health Plan Subsidiaries and Affiliated Corporations:



KAISER PERMANENTE®

KPNC Regional Quality Oversight Structure



KAISER PERMANENTE

Regional Quality Oversight Committee

The Purpose of the Regional QOC is to:

- evaluate the quality of care and services provided to KP members and patients in Northern California in all settings,
- support continuous improvement in these areas,
- establish Quality Program direction by identifying and addressing strategic opportunities to establish and maintain KP NCAL healthcare leadership,
- ensure that the quality priorities are aligned and integrated with other key organizational strategic priority areas of work, and
- ensure that the organization meets the standards established by regulatory agencies and accreditation organizations and meets public expectations.

Regional Credentialing and Privileging

The RCPC Committee is a peer review subcommittee that:

- makes credentialing decisions on behalf of KFHP in NCAL concerning practitioners and organizational providers
- oversees credentialing policies, procedures and processes;
- promotes uniformity and consistency in the application of those policies, procedures and processes; and
- oversees the Practitioner Performance Review and Oversight (PPRO) program.

Member Concerns Committee

The MCC provide oversight of member satisfaction processes across the continuum of care through:

- review of regional and statewide reports from departments with a role in patient/member satisfaction work
- analysis of Complaints and grievances data
- review of member experience data
- Receiving reports from each medical center on their member experience work

Resource Management Committee

The RMC Committee serves as the utilization management committee in NCAL that:

- identifies and promotes utilization strategies and activities,
- oversees Health Plan Utilization Management
- monitors utilization across the health care continuum, and
- consults with Medical Centers on Utilization Management (UM) issues

Access Committee

The Access Committee's function is to oversee

- adherence to health plan and regulatory body requirements around timely access and wait times for appointments,
- proactively addressing areas at risk for not meeting these requirements,
- Approving policies, procedures and processes for access oversight

KFHP Quality Plan Documents - “Trilogy”

- Quality Program Description, Evaluations, and Workplans
- Updated Annually
- Approved by the Regional Quality Oversight Committee (QOC)
- Approved by the KFHP Board of Directors

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

2023 Quality Program Description

2023 Utilization Management (UM) / Resource Management (RM) Program Description

2022 Quality Program Evaluation

2023 Quality Program Workplan

Quality Oversight Committee Approval Date: April 12, 2023

The Focus of Workplans

Performance improvement activities

New work or programs

Improve lagging indicators

Measurable goals – SMART

- Specific
- Measurable
- Attainable
- Realistic
- Time-bound

- Actions are not goals; take actions to meet a goal.
- Differentiate actions from monitoring
  - Reviewing reports is monitoring, not an action.

New in 2023:

Program Description:

- Membership and Membership Diversity Numbers were updated
- The KP-NCAL Regional Quality Oversight Structure image was updated to reflect subcommittee reporting
- Sections of the Program Description were updated as needed in Risk Management and Patient Safety Committee, Performance Improvement Methodology, and Equity, Inclusion, and Diversity (EID) sections
- The Culturally and Linguistically Appropriate Services (CLAS) Program Description (attachment V) was added to the Program Description to reflect the partnership between the Regional EID department and Regional Language and Access Program to meet the CLAS Standards of the National Committee for Quality Assurance (NCQA).

Workplan

- The Pharmacy Operations team updated their workplan titles to better align with Health Plan terminology and their quality oversight reporting.
- Focus areas that achieved 2022 targets updated 2023 target outcomes for continuous performance improvement efforts, while some targets remained the same as they are bound to internal metrics.
- Reforming of goals to ensure they are SMART (Specific, Measurable, Achievable, Relevant, and Time-Bound) goals.

Utilization Management

- Addition of the Visiting Member section
- Addition of the Standard Referral section to align with our Southern California UM partners to meet standards posed by the Department of Health Care Services (DHCS).
- Additional footnotes were added to address the Medi-Cal carve outs for Specialty Mental Health and Substance Use disorders.

2022 Evaluations

Positive Outcomes

- The focus areas were able to achieve 60% the total listed goals and exceed the expected outcomes in 2022.
- Focusing on technology system opportunities to enhance workflows to support teams meeting goals

Barriers

- COVID-19 pandemic-related impact continues, such as staffing challenges and returning to pre-pandemic workflows and procedures

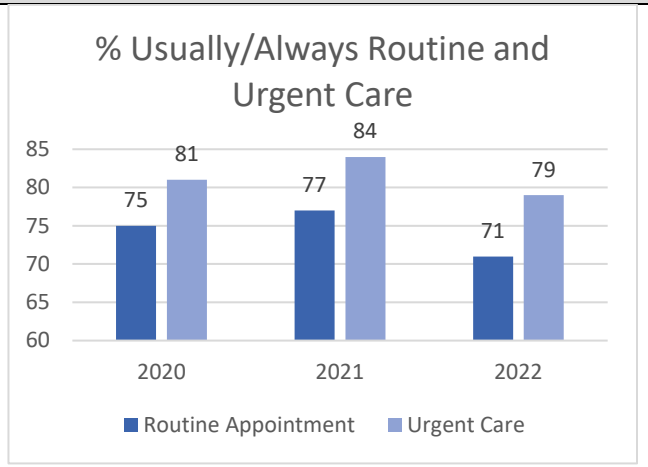
Any questions or feedback?

Kaiser Foundation Health Plan, Inc.
Northern California Region

2022 Quality Program Evaluation

Quality Oversight Committee Approval Date: April 12, 2023

Table of Contents

Accessibility of Services (NET 2)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Primary & Specialty Care Access			
Access to Routine and Urgent Care <u>Routine & Regular Appointments</u> CAHPS Goal: 77% of members will report either usually or always (u/a) getting a routine appointment when needed **Access to Urgent Care** <u>Urgent Care Appointments</u> CAHPS Goal: 84.29% of members will report either usually or always (u/a) getting urgent care as soon as needed	• Monitor CAHPS results and report findings to the Member Concerns Committee (MCC) • Monitor and report access to appointment complaint findings to the MCC. • Obtain action plans from facilities not meeting regional goal through local evaluations and work plans. • Monitor CAHPS results and report findings to the Member Concerns Committee (MCC) • Monitor and report access to appointment complaint findings to the MCC. • Obtain action plans from facilities not meeting regional goal through local evaluations and work plans.	TPMG AED **Annual**: October 2022	 **Results:** KPNC member satisfaction scores related to routine and urgent access to care decreased in 2022 and did not meet the established target. **Analysis:** In 2022, NCQA allowed commercial CAHPS vendors to implement changes to their data collection protocol and the 2022 survey was fielded successfully. Appointment access data is monitored on an ongoing basis by the Access Committee and KPNC has maintained access to routine and urgent appointments in primary care. The ongoing pandemic is still impacting members ability to get care and results should be considered in that context. **Barriers:** The COVID-19 pandemic continues to influence demand for appointments, impacting normal operations.

Accessibility of Services (NET 2)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			Next Steps: Continue to monitor CAHPS/METEOR survey results and report findings to the MCC. Continue to monitor and report access to appointment complaint findings to the MCC. Continue focus on improving access to primary care.
Access to After-Hours Care <u>After Hours Call Center (AACC) Annual Report</u> • Average Speed of Answer (ASA) is within 60 seconds • Less than 3% of calls will be	• Monitor and report after- hours access to care complaint findings to the MCC. • Monitor and report after-hours access metrics, and report to AOC. • Obtain action plans from facilities	TPMG AED **Annual**: October 2022	***Refer to 2022 AACC Report Section***

<table>
<tr><th colspan="4">Accessibility of Services (NET 2)</th></tr>
<tr><th>Goal (including Metric)</th><th>Planned Actions to Meet Goal</th><th>Accountable Team and Due Date</th><th>2022 Evaluation
1. Analysis of results including metrics
2. Barriers
3. Next steps</th></tr>
<tr><td colspan="4"></td></tr>
<tr><td>abandoned</td><td>not meeting regional goal through local evaluations and work plans.</td><td></td><td></td></tr>
<tr><td>BH Telephone Access
<u>Psychiatry After Hours Call Center (PACC) Telephone Service Report</u>
• 85% or more of calls will be answered within 30 seconds
Less than 5% of calls will be abandoned</td><td>• Monitor PACC telephone service and report to IUS and BHQOC.
• Within existing space constraints, actively recruit PACC staff to meet increasing call volume demands.
• Provide PACC call abandonment trends to Chiefs of Psychiatry.</td><td>Regional Director of Inpatient Psychiatry and Continuing Care
Quarterly:
Jan 2022
April 2022
July 2022
October 2022</td><td>Psychiatric After Hours Call Center Telephone Access
<table><tr><th colspan="5">Calls Answered within 30 seconds</th></tr><tr><th></th><th>Q3 2021</th><th>Q4 2021</th><th>Q1 2022</th><th>Q2 2022</th></tr><tr><td>Target 85%</td><td>95.0%</td><td>94.3%</td><td>94.1%</td><td>93.6%</td></tr><tr><th colspan="5">Abandonment Rate</th></tr><tr><th></th><th>Q3 2021</th><th>Q4 2021</th><th>Q1 2022</th><th>Q2 2022</th></tr><tr><td>Target <5%</td><td>2.9%</td><td>3.3%</td><td>3.6%</td><td>4.0%</td></tr></table>Results: The PACC met both targets in all quarters.

Barriers: None

Next Steps: Continue to monitor performance and identify opportunities to improve.</td></tr>
<tr><td>Access to Care for Life-Threatening and Non-Life-Threatening Emergencies
<u>Psychiatry After Hours Call Center (PACC) ED Referral and Emergent BH Drop In Clinic Audit Reports Goal:</u>
• Behavioral health access to care for non-life-threatening emergencies is within 6 hours
• PAAC is appropriately referring members to the closest ED for life threatening and non-life-</td><td>Monitor access to BH clinicians for life threatening and non-life-threatening emergencies</td><td>Chair, Chiefs of Psychiatry

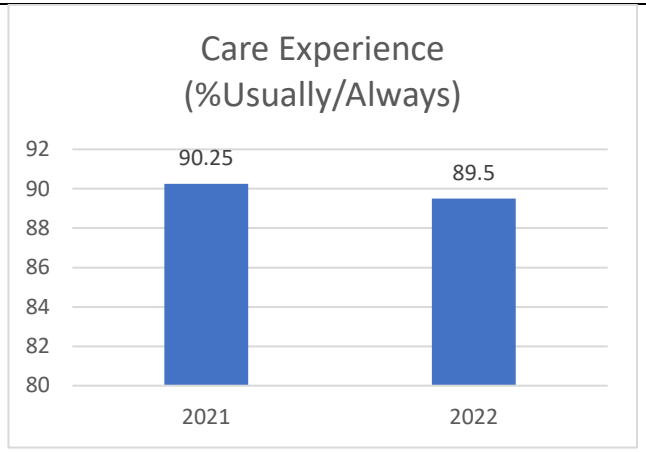
Annual:
October 2022</td><td><table><tr><th colspan="5">PACC Referrals to ED</th></tr><tr><th></th><th>2019</th><th>2020</th><th>2021</th><th>2022</th></tr><tr><td># Referred & Seen in KPHC ED</td><td>365</td><td>244</td><td>299</td><td>284</td></tr><tr><td>% Seen in <6 hours</td><td>100%</td><td>96.3%</td><td>96%</td><td>97%</td></tr></table>Results:
A total of 195,002 incoming calls were received at the PACC from 7/1/2021 to 6/30/2022. This represents a decrease of <0.1% from the previous year’s volume of 195,178.</td></tr>
</table>

Accessibility of Services (NET 2)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
threatening emergency situations			All calls with the Referral Code H/Referred to an ED for services were pulled from the PACC tracking system. This amounted to 340 calls from 338 patients. The 340 calls referred to an ED account for 0.17% of all calls received at the PACC during the reporting period studied. • The top 3 volume categories in 2022 are suicidal ideation, psychosis, and depression/agitation. • The top 3 volume categories comprise approximately 78.52% of the calls referred to an ED, compared to 73.46% last year. • These high-volume categories are emergent in nature and referrals to the ED for these calls are considered appropriate. Several other categories indicate non-emergent situations; however, following established protocols, if a caller who is not in an emergent situation feels s/he needs to be seen immediately, the caller is referred to an emergency department. • Life-threatening and non-life-threatening calls received at the PACC are appropriately being referred to the nearest ED **Barriers**: None **Next Steps**:

<table>
<tr><th colspan="4">Accessibility of Services (NET 2)</th></tr>
<tr><th>Goal (including Metric)</th><th>Planned Actions to Meet Goal</th><th>Accountable Team and Due Date</th><th>2022 Evaluation
1. Analysis of results including metrics
2. Barriers
3. Next steps</th></tr>
<tr><td></td><td></td><td></td><td>Continue to monitor access to BH clinicians for life threatening and non-life-threatening emergencies annually.</td></tr>
<tr><td>Access to Routine and Urgent Care Visits
<u>Access standards:</u>
• Urgent Mental Health Visits within 48 hours
• Nonurgent Mental Health visits within 10 business days
• Urgent Chemical Dependency visits within 48 hours
• Nonurgent Chemical Dependency visits within 10 business days.</td><td>• Monitor quarterly results to determine if distribution to Non-Urgent Physician Services persists after the global public health emergency
• As needed, recruit and hire BH clinicians.
• Facility specific access action plans to be submitted and monitored by Chair of the Chiefs of Psychiatry when targets not met.</td><td>Chair, Chiefs of Psychiatry

Quarterly:
Jan 2022
April 2022
July 2022
Oct 2022</td><td>
<table>
<tr><th colspan="7">2022 NCQA Appointment Access</th></tr>
<tr><td></td><td colspan="2">BH Urgent</td><td colspan="4">BH Non-Urgent</td></tr>
<tr><td></td><td colspan="2">All</td><td colspan="2">MD</td><td colspan="2">Non-MD</td></tr>
<tr><td></td><td>% of Appts w/in 48 hrs</td><td>Avg. days wait</td><td>% w/in 10 Bus. Days</td><td>Avg. Days Wait</td><td>% w/in 10 Bus. Days</td><td>Avg. Days Wait</td></tr>
<tr><td>Thresh old</td><td>80%</td><td></td><td>80%</td><td></td><td>80%</td><td></td></tr>
<tr><td>Jan</td><td>100%</td><td>0.28</td><td>74%</td><td>7.05</td><td>98%</td><td>4.13</td></tr>
<tr><td>Feb</td><td>98%</td><td>0.40</td><td>71%</td><td>7.10</td><td>98%</td><td>4.95</td></tr>
<tr><td>Mar</td><td>98%</td><td>0.53</td><td>66%</td><td>7.71</td><td>96%</td><td>5.85</td></tr>
<tr><td>Apr</td><td>98%</td><td>0.29</td><td>65%</td><td>7.66</td><td>96%</td><td>6.15</td></tr>
<tr><td>May</td><td>94%</td><td>0.61</td><td>68%</td><td>7.56</td><td>95%</td><td>5.89</td></tr>
<tr><td>Jun</td><td>100%</td><td>0.33</td><td>73%</td><td>7.25</td><td>96%</td><td>5.66</td></tr>
<tr><td>Jul</td><td>95%</td><td>0.49</td><td>74%</td><td>6.88</td><td>97%</td><td>5.48</td></tr>
<tr><td>Aug</td><td>99%</td><td>0.44</td><td>75%</td><td>6.33</td><td>95%</td><td>5.43</td></tr>
<tr><td>Sep</td><td>96%</td><td>0.43</td><td>85%</td><td>5.44</td><td>94%</td><td>5.45</td></tr>
<tr><td>Oct</td><td>97%</td><td>0.44</td><td>90%</td><td>5.15</td><td>96%</td><td>4.36</td></tr>
<tr><td>Nov</td><td>97%</td><td>0.53</td><td>83%</td><td>5.76</td><td>98%</td><td>3.21</td></tr>
<tr><td>Dec</td><td>94%</td><td>0.63</td><td>81%</td><td>5.98</td><td>98%</td><td>3.14</td></tr>
</table>
Results:
<u>Urgent Services:</u>
The access standard was met

<u>Non-Urgent Physician Services:</u>
The access standard was not met in 8 of 12 months.</td></tr>
</table>

Accessibility of Services (NET 2)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			<u>Non-Urgent Non-Physician Services</u> The access standard was met. **Barriers**: Facility specific access action plans in place addressing barriers. Non-Urgent services were significantly impacted in 2022 due to the COVID-19 pandemic. **Next Steps**: BHQOC will continue to monitor NCQA access performance and request action plans from facilities that don't meet performance standards.
MPS Survey Care Experience Measure: Continue to demonstrate improvement in the Care Experience Composite Score, which includes: • MPS Q#16 Personal and responsive service • MPS Q#17 Convenient and easy access	• Monitor MPS results and report findings to regional and local quality committees. • Continue to implement service and access process improvements to increase member satisfaction.	TPMG AED **Annual:** Jan 2022 April 2022 July 2022 Oct 2022	 **Results:** KPNC's performance decreased from 2021 by 0.75 percentage points. **Barriers:** None identified. **Next Steps:** Continue to monitor.

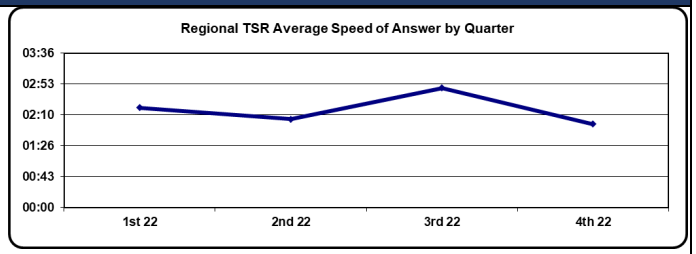
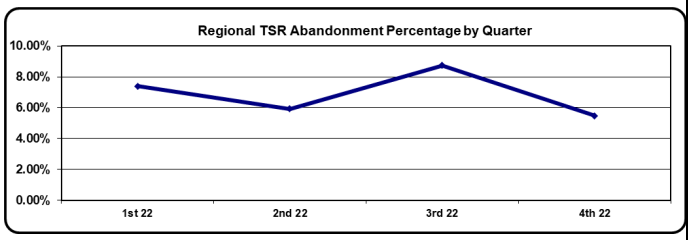
Accessibility of Services (NET 2)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
MD Communication: Continue to demonstrate improvement in CAHPS/METEOR personal doctor communicate composite score. **METEOR and CAHPS - Personal Doctor Communication Composite Score Definition:** % that indicated the doctor usually or always: • explained things in a way they could understand • listened carefully to them • showed respect for what they had to say • spent enough time with them	• Analyze and monitor METEOR and CAHPS results. • Continue to educate MDs on member/patient communication skills and personalization of care • TPMG Consulting Services continue to provide consultative services to improve planning for service and access and improve member's care experience.	TPMG AED **Annual:** December 2022	***See CAHPS Report Below***
Staff Communication: Continue to demonstrate improvement in CAHPS/METEOR customer service composite score. **CAHPS Customer Service Composite Score Definition:** % that indicated they usually or always: • Got needed information from written materials/internet • Got needed help from customer service • Were treated with courtesy and respect by Customer Service Staff	• Analyze and monitor METEOR and CAHPS results. • Continue to educate staff on member/patient communication skills and personalization of care • TPMG Consulting Services continue to provide consultative services to improve planning for service and access and improve member's care experience.	TPMG AED **Annual:** December 2022	***See CAHPS Report Below***

Accessibility of Services (NET 2)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Improve CAHPS Results: Monitor CAHPS results and report to regional and local quality committees and all staff (health plan rating, health care rating, PCP rating, specialist rating)	• Survey results reported to MCC • CAHPS and METEOR results are also presented to other regional and local quality committees.	TPMG AED **Annual:** December 2022	

	Measure	Score		2022 National Percentile*
		Spring 2021 CAHPS	**Spring 2022 CAHPS**	
Rating	Health Plan Rating	52%	47%	50th
Rating	Health Care Rating	55%	50%	33rd
Rating	PCP Rating	61%	62%	10th
Rating	Specialist Rating	70%	65%	25th
Composite	Getting Needed Care	85%	80%	10th
Composite	Getting Care Quickly	81%	75%	5th
Composite	MD Communication	92%	91%	<5th
Composite	Care Coordination	85%	82%	25th
Composite	Customer Service	85%	84%	10th
Composite	Claims Processing	N/A	N/A	N/A

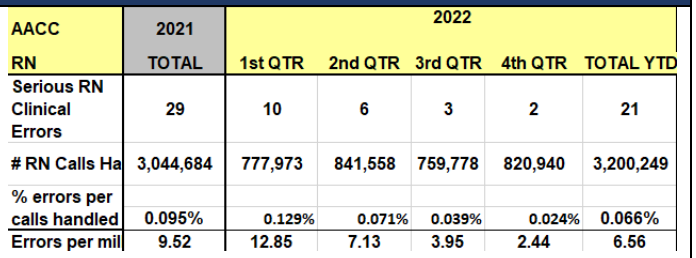
Rating Scores = % 9 or 10 score

Accessibility of Services (NET 2)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			Composite Scores = % Usually or Always **Analysis:** CAHPS scores decreased overall from spring 2021 to spring 2022. MD Communication and Customer Service scores decreased by one percentage point from 2021 to 2022 **Barriers:** Member experiences were less than favorable, overall, on survey questions that ask members about access, Specialist Rating, and Health Care rating. **Next Steps:** Continue to monitor CAHPS and METEOR survey results and report to regional quality committees.

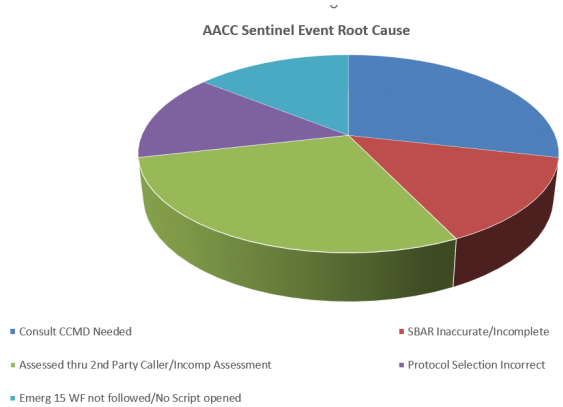
Appointment and Advice Call Center (AACC)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Goal: To ensure that members receive service in a timely manner. Metric: Internal goal for ASA (Average Speed of Answer) for the Regional Tele Service Representatives (TSRs) is less than or equal to 1 minute; Abandonment Levels are less than 3%.	Monitor and report Average Speed of Answer and abandonment levels to improve member satisfaction. Ongoing 30-minute monitoring process for timeliness of service. Adjust staffing levels in response to COVID call surge due to infection and/or vaccine demand Evaluate staffing on a monthly basis to determine new hire plan and adjust accordingly based on attrition levels. Implement technology solutions to mitigate any potential clinical or environment call volume surges.	AACC Medical Director AACC Operations Director Annual – January to December 2022	  1. Average speed of answer (ASA) and abandonment continued to improve from the peaks of 2021. ASA ended the year at 1:57, with abandonment rate ending at 5.48%, the best rate in two years. 2. ASA and abandonment rates are impacted by longer wait times. Barriers to meeting the abandonment target were fluctuating COVID related call volume in the first and third quarters as well as staff attrition. 3. Continue to monitor and report ASA and abandonment levels for 2023.
Goal: Ensure patient safety by focused review of Advice Registered Nurse	Focused monthly review of Advice Registered Nurses (ARNs) calls	AACC Medical Director	Metric 1:

Appointment and Advice Call Center (AACC)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
(ARN) calls using symptomatic and/or high-risk protocols Metric 1: Maintain average clinical quality scores for all three AACC sites above 95% across all questions. Metric 2: Decrease serious clinical errors.	Trends and learnings from serious clinical errors will be shared with staff and training to enhance clinical content for new hires.	AACC Operations Director Annual – January to December 2022	See table below 1. Review of RN calls in 2022 indicated clinical quality scores continuing to average greater than 95% in all three sites as well as a significant drop in serious clinical errors. 2. No barriers identified. 3. Continue to monitor, continue 2022 target to maintain average clinical quality scores greater than 95%. Metric 2:

2022 Triage Scores by Question	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	2022 Wtd Ave
Talked to Patient	99.2%	99.6%	99.3%	99.5%	99.4%
Service Line and Protocol best fit for symptoms	99.4%	99.3%	99.3%	99.2%	99.3%
Pertinent medical history obtained	99.5%	99.4%	99.4%	99.5%	99.5%
Nursing Assessment	98.9%	99.1%	98.9%	98.5%	98.9%
MySBAR	99.4%	99.2%	99.4%	99.0%	99.3%
Critical Thinking & Outcome	98.6%	98.5%	98.3%	97.5%	98.3%
Clinical Advice/Clinical information given	97.7%	97.8%	97.5%	97.7%	97.7%
Care documented appropriately	99.2%	99.3%	99.3%	99.0%	99.2%
Clinical follow up instructions given	98.3%	98.4%	98.4%	98.6%	98.4%

Appointment and Advice Call Center (AACC)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			 1. Strategies to decrease serious clinical errors included a continued partnership with the Training Department in creation of computer-based trainings (CBTs) and a robust remediation process to address individual RN clinical learning opportunities, and heightened monitoring of new hire RNs, resulting in a 28% reduction of errors from 2021 totals. 2. No barriers identified. 3. Continue Training partnership and monitoring of new hire RNs, and the creation of CBTs addressing the most common reasons for serious clinical errors. Continue to monitor.
Goal: If Sentinel Events occur, review, and analyze each event for trends and learning. Metric 1: Achieve Sentinel Event error rates less than 3 clinical errors/1,000,000 calls	Monthly review of potential sentinel events by AACC Regional Quality Committee	AACC Medical Director AACC Operations Director	Metric 1:

<table>
<tr><th colspan="4">Appointment and Advice Call Center (AACC)</th></tr>
<tr><th>Goal (including Metric)</th><th>Planned Actions to Meet Goal</th><th>Accountable Team and Due Date</th><th>2022 Evaluation
1. Analysis of results including metrics
2. Barriers
3. Next steps</th></tr>
<tr><td></td><td>Analysis of events to identify trends related to educational needs for AACC staff</td><td>Annual – January to December 2022</td><td>
<table>
<tr><th>AACC 2022</th><th>1st Qtr</th><th>2nd Qtr</th><th>3rd Qtr</th><th>4th Qtr</th><th>Total</th></tr>
<tr><td>Sentinel Events</td><td>3</td><td>0</td><td>2</td><td>2</td><td>7</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td># Calls Handled</td><td>3,842,996</td><td>4,041,287</td><td>3,769,959</td><td>3,933,364</td><td>15,587,606</td></tr>
<tr><td>SE Errors per mil calls</td><td>0.78</td><td>0.00</td><td>0.53</td><td>0.51</td><td>0.45</td></tr>
</table>
1. In 2021 the AACC had 0.36 Sentinel Event errors per Million calls, achieving the goal of less than 3 clinical errors/1,000,000 calls.
2. No barriers identified.
3. Continue to monitor and address identified trends (see Metric 2).
</td></tr>
</table>

Appointment and Advice Call Center (AACC)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Metric 2: Trends and learnings from Sentinel Events will be shared with staff.			Metric 2:  1. Analysis of sentinel events identified trends related to second party callers, incomplete assessment, CCMD consult needed and inaccurate/incomplete SBAR in emergent calls, protocol selection errors, and warm transfer to RN needed. 2. No barriers were identified. 3. Continue the development and distribution of Computer Based Training Modules as indicated by the identified trends. Continue to monitor

<table>
<tr><th colspan="4">Assessment of Network Adequacy (NET 3)</th></tr>
<tr><th>Goal (including Metric)</th><th>Planned Actions to Meet Goal</th><th>Accountable Team and Due Date</th><th>2022 Evaluation
1. Analysis of results including metrics
2. Barriers
3. Next steps</th></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Non-Behavioral Health Network Adequacy</td></tr>
<tr>
<td>Process Measure Goal:
1. Assess network adequacy using access and availability data and member experience data
2. Prioritize access opportunities for KPNC</td>
<td>• Conduct an assessment of network adequacy using member complaint data.
• Identify opportunities to improve member experience.
• Implement at least one opportunity and measure effectiveness</td>
<td>TPMG Consulting Services

Annual:
December 2022

Data Collection Period:
Q3 2020 - Q2 2021, Q3 2021-Q2 2022</td>
<td>Network Adequacy Assessment completed Q3 2022 and reported to the Member Concerns Committee.

<table>
<tr><th></th><th colspan="2">Q3’21 – Q2’22</th><th>Target</th></tr>
<tr><th></th><th>Access Complaint Volume</th><th>Per 10K Rate</th><th>Per 10k</th></tr>
<tr><td>Commercial</td><td>5,862</td><td>18.53</td><td>8.13</td></tr>
<tr><td>Covered CA</td><td>666</td><td>17.84</td><td>8.11</td></tr>
<tr><td>Medicare</td><td>3,748</td><td>57.67</td><td>30.11</td></tr>
<tr><td>Medi-Cal</td><td>597</td><td>16.11</td><td>10.49</td></tr>
</table>
Analysis/Barriers:

<u>Commercial/QHP Exchange</u>

The commercial and QHP exchange network opportunities for improvement are being combined for this analysis.

Opportunity: The ability to schedule timely appointments was identified by members as an opportunity for improvement through complaint issues, appeal requests, and member experience surveys. Specifically, members identified the following areas of focus.
• <u>Provider Groups:</u> Internal Medicine and OBYN have the highest level of complaints, but also represent the highest utilized services; Specialty Care Services – Radiology and Orthopedics
• <u>Service Areas:</u> Diablo Service Area and Roseville

<u>Medicare</u></td>
</tr>
</table>

<table>
<tr><th colspan="4">Assessment of Network Adequacy (NET 3)</th></tr>
<tr><th>Goal (including Metric)</th><th>Planned Actions to Meet Goal</th><th>Accountable Team and Due Date</th><th>2022 Evaluation
1. Analysis of results including metrics
2. Barriers
3. Next steps</th></tr>
<tr><td colspan="4"></td></tr>
<tr><td></td><td></td><td></td><td>Opportunity: The ability to schedule timely appointments was identified by members as an opportunity for improvement through complaint issues, appeal requests, and member experience surveys. Specifically, members identified the following areas of focus.
• Provider Groups: Internal Medicine and OBGYN have the highest level of complaints, but also represent the highest utilized services; Specialty Care Services – Optometry
• Service Areas: Diablo Service Area, Roseville, and East Bay

Next Steps: Continue to Monitor</td></tr>
<tr><td colspan="4">Behavioral Health Network Adequacy</td></tr>
<tr><td>Process Measure Goal:
1. Assess network adequacy using access and availability data and member experience data for Behavioral Health
2. Prioritize access opportunities for KPNC</td><td>• Conduct an assessment of network adequacy using member complaint and appeal data, and member experience surveys.
• Identify opportunities to improve member experience with BH and non-BH network adequacy.
• Implement at least one opportunity and measure effectiveness</td><td>TPMG Consulting Services

Annual:
December 2022

Data Collection Period:
Q3 2020 – Q2 2021, Q3 2021 – Q2 2022</td><td>Report created Q2 2022

<table>
<tr><th></th><th colspan="2">Q3’20 – Q2’21</th><th colspan="2">Q3’21 – Q2’22</th></tr>
<tr><th></th><th>Access Complaint Volume</th><th>Per 10K Rate</th><th>Access Complaint Volume</th><th>Per 10K Rate</th></tr>
<tr><td>Commercial</td><td>1,263</td><td>3.96</td><td>1,894</td><td>5.99</td></tr>
<tr><td>Covered CA</td><td>159</td><td>4.43</td><td>228</td><td>6.11</td></tr>
<tr><td>Medicare</td><td>178</td><td>2.83</td><td>286</td><td>4.40</td></tr>
<tr><td>Medi-Cal</td><td>165</td><td>5.06</td><td>284</td><td>7.66</td></tr>
</table>
Analysis:

• Overall, NCAL received 2,692 behavioral complaints related to network adequacy between Q3’21 and Q2’22 which increased 53% from the previous period. Between Q3’21 and Q2’22, there were 1,894 Commercial complaints, 228 Marketplace complaints, 286 Medicare complaints, and 284 Medi-Cal complaints.</td></tr>
</table>

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<tr><td></td><td></td><td></td><td>
In addition, there was a total of 24.16 behavioral complaints per 10k members related to network adequacy which comprised of 5.99 Commercial complaints per 10k members, 6.11 Marketplace complaints per 10k members, 4.40 Medicare complaints per 10k members, and 7.66 Medi-Cal complaints per 10k members.
Barriers:
<table>
<tr><th>LOB</th><th>Top Access to Care Issue Type</th><th>Top Access to Care Issues & Requests</th></tr>
<tr><th colspan="3">Complaints</th></tr>
<tr><td>Commercial</td><td>Appointments</td><td>Unable to schedule timely appointment</td></tr>
<tr><td>Covered CA</td><td>Appointments</td><td>Unable to schedule timely appointment</td></tr>
<tr><td>Medicare</td><td>Appointments</td><td>Unable to schedule timely appointment</td></tr>
<tr><td>Medi-Cal</td><td>Appointments</td><td>Unable to schedule timely appointment</td></tr>
</table>
Next Steps/Actions:

Connect to Care (C2C): KPNC implemented the Connect to Care Telepsychiatry Center (“C2C”) located adjacent to the Kaiser Permanente San Leandro Medical Center. Appointments with C2C providers are separate from and supplemental to services provided at local medical centers’ mental health/psychiatry departments. The goal of the center is to provide virtual non-urgent initial assessment and will allow the therapist to evaluate and begin treatment for the member sooner, enhancing patient preference and convenience.
Consistency in Appointing: KPNC RMHA developed and implemented a template for a triage and appointing workflow to improve efficiency and support consistency in member service expectations

</td></tr>
</table>

Assessment of Network Adequacy (NET 3)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**

<table>
<tr><th colspan="4">Availability of Practitioners (NET 1, DMHC)</th></tr>
<tr><th>Goal (including Metric)</th><th>Planned Actions to Meet Goal</th><th>Accountable Team and Due Date</th><th>2022 Evaluation
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<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Primary Care Practitioners</td></tr>
<tr>
<td>Ensure adequate availability of providers within target ratios and geoaccess standards

<u>Geoaccess:</u> 95% of members will be within 15 miles OR 30 minutes of a PCP

<u>Ratios:</u>
• 1 PCP per 2,000 all members (MD head count)
• 1 PCP per 2,000 adult members (MD head count)
• 1 PCP per 2,000 pediatric members (MD head count)
• 1 PCP FTE per 2,000 members
• 1 pediatric practitioner per 2,000 members
• 1 family medicine practitioner per 6,000 members
• 1 internal medicine practitioner per 2,500 Members</td>
<td>• As needed and subject to changes in membership and staff turnover, increase physician staffing by hiring new primary care physicians.
• Recruit bilingual PCPs as needed.
• Expand and remodel facilities.</td>
<td>Annual:
September 2022

TPMG AED of Adult & Family Medicine

TPMG AED of Women’s Health & Pediatrics</td>
<td>
<table>
<tr><th colspan="3">Primary Care Geoaccess Performance</th></tr>
<tr><td>Standard</td><td>Performance Target</td><td>2022 Performance</td></tr>
<tr><td>15 miles to a PCP</td><td>95%</td><td>99.4%</td></tr>
<tr><td>30 minutes to a PCP</td><td>95%</td><td>99.9%</td></tr>
</table>

<table>
<tr><th colspan="3">Primary Care Practitioner Ratio Performance
The PCP/Member ratios include individual headcounts of TPMG MDs and contracted/affiliated MDs. The PCP FTE ratio is based on physician’s clinical time spend with patients. Pool MDs are not included.</th></tr>
<tr><td>Standard Category</td><td>Standard</td><td>2022 Performance</td></tr>
<tr><td>All PCP: Member</td><td>1/2,000</td><td>1/1,052</td></tr>
<tr><td>Pediatric PCP: Member</td><td>1/2,000</td><td>1/961</td></tr>
<tr><td>Adult PCP: Adult Member</td><td>1/2,000</td><td>1/1,080</td></tr>
<tr><td>PCP FTE: Member</td><td>1/2,000</td><td>1/2,286</td></tr>
</table>

Analysis: KPNC met the established targets, regionally, in all but PCP FTE. Upon review of Timeliness of Access reporting there were no notable concerns with regional access performance in Primary Care during this time period. Additionally, PCP headcount ratios were met during the time period. Will continue to monitor.

Barriers: None

Next Steps: As needed, continue to increase physician staffing by hiring new primary care physicians. Continue recruitment of bilingual PCPs as needed. Continue to expand and remodel facilities.
</td>
</tr>
</table>

<table>
<tr><th colspan="4">Availability of Practitioners (NET 1, DMHC)</th></tr>
<tr><th>Goal (including Metric)</th><th>Planned Actions to Meet Goal</th><th>Accountable Team and Due Date</th><th>2022 Evaluation
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<tr><td colspan="4"></td></tr>
<tr>
<td>Ensure that all members are linked to a primary care provider

<u>PCP Member Linkage:</u>
85% of members will be linked with a PCP.

Monitor and improve the ability of members to see own PCP

<u>PCP Matching Rates:</u>
• 80% of Medicine visits will be with their own PCP
• 70% of OB/GYN visits will be with their own PCP
• 70% of Pediatric visits will be with their own PCP</td>
<td>• Monitor the transition of young adults from pediatrics to adult medicine and ensuring that PCP member linkage remains above 85%.
• Ensure process in place so that members are appropriately linked to a PCP.
• Monitor PCP Member Linkage reports.
• Monitor PCP matching reports, to ensure the Medicine matching rates performance improves after the public-health emergency by increasing physician staffing, increasing physician retention rates, and decreasing physician burnout.
• Ensure process in place so that members are appropriately linked to a PCP.</td>
<td>Annual:
September 2022

TPMG AED of Adult & Family Medicine

TPMG AED of Women’s Health & Pediatrics</td>
<td>PCP Member Linkage with PCP
<table>
<tr><th></th><th>Target</th><th>Q3 2022</th></tr>
<tr><td>Medicine</td><td>85%</td><td>97.8%</td></tr>
<tr><td>OB-GYN</td><td>85%</td><td>94.3%</td></tr>
<tr><td>Pediatric</td><td>85%</td><td>99.4</td></tr>
</table>
Analysis: Targets have been exceeded for this measure in all quarters.

Barriers: None

Next Steps: Continue to ensure that all members are linked to a primary care provider

Matching Rates Unavailable in 2022</td>
</tr>
<tr><td colspan="4">Specialty Care Practitioners</td></tr>
<tr>
<td>Ensure adequate availability of high volume and high impact SCP providers within target ratios and geoaccess standards

High Volume SCPs: Dermatology, General Surgery, Head & Neck Surgery, OBGYN, Ophthalmology, Orthopedics
High Impact SCPs: Oncology

Geoaccess: 80% of members will be</td>
<td>• As needed and subject to membership change and staff turnover, increase physician staffing by hiring new specialty care physicians.
• Recruitment of bilingual SCPs.
• Expand and remodel facilities.</td>
<td>September 2022

Access Committee

Member Concerns Committee</td>
<td>Results:

<table>
<tr><th colspan="3">High-Volume Specialty Care Geoaccess Performance</th></tr>
<tr><td>Standard</td><td>Performance Target</td><td>2022 Performance</td></tr>
<tr><td>30 Miles to a SCP</td><td>80%</td><td>99.9%</td></tr>
<tr><td>60 Minutes to a SCP</td><td>80%</td><td>100%</td></tr>
</table>
Specialty Care Practitioner Ratio Performance
High Volume Specialists: The high-volume specialist</td>
</tr>
</table>

<table>
<tr><th colspan="4">Availability of Practitioners (NET 1, DMHC)</th></tr>
<tr><th>Goal (including Metric)</th><th>Planned Actions to Meet Goal</th><th>Accountable Team and Due Date</th><th>2022 Evaluation
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<tr><td colspan="4"></td></tr>
<tr><td>within 30 miles OR 60 minutes of a high-volume SCP

High Volume SCP Ratios –
• 1 Dermatology MD per 40,000 Members
• 1 General Surgery MD per 35,000 Members
• 1 Head & Neck MD per 40,000 Members
• 1 OB/GYN MD per 10,000 Members
• 1 Ophthalmology MD per 28,000 Members
• 1 Orthopedic MD per 26,000 Members</td><td></td><td></td><td>definition is based on volume of visits by “Functional Cost Center.” The high-volume specialist definition includes the following specialties: Dermatology, General Surgery, Head & Neck, OB/GYN, Ophthalmology and Orthopedics. All KNPC members are included in the analysis.

<table>
<tr><th>Standard Category</th><th>Standard</th><th>2022 Performance</th></tr>
<tr><td>Dermatology</td><td>1:40,000</td><td>1:19,235</td></tr>
<tr><td>General Surgery</td><td>1:35,000</td><td>1:21,930</td></tr>
<tr><td>Head and Neck</td><td>1:40,000</td><td>1:20,448</td></tr>
<tr><td>OBGYN</td><td>1:10,000</td><td>1:4,420</td></tr>
<tr><td>Ophthalmology</td><td>1:28,000</td><td>1:10,732</td></tr>
<tr><td>Orthopedics</td><td>1:26,000</td><td>1:14,503</td></tr>
</table>

<table>
<tr><th colspan="3">High-Impact Specialty Care Geoaccess Performance</th></tr>
<tr><th>Standard</th><th>Performance Target</th><th>2022 Performance</th></tr>
<tr><td>30 Miles to a SCP</td><td>80%</td><td>99.5%</td></tr>
<tr><td>60 Minutes to a SCP</td><td>80%</td><td>100%</td></tr>
</table>

KPNC’s 2022 ratios for each type of high volume and high-impact SCP meet the established targets.</td></tr>
</table>

<table>
<tr><th colspan="4">Availability of Practitioners (NET 1, DMHC)</th></tr>
<tr><th>Goal (including Metric)</th><th>Planned Actions to Meet Goal</th><th>Accountable Team and Due Date</th><th>2022 Evaluation
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<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td>Barriers: None

Next Steps: As needed, continue to increase physician staffing by hiring new specialty care physicians. Continue recruitment of bilingual SCPs. Continue to expand and remodel facilities.</td></tr>
<tr><td colspan="4">Behavioral Health Practitioners</td></tr>
<tr><td>Ensure adequate availability of high volume and high impact SCP providers within target ratios and geoaccess standards
• BHP FTE/Member Ratio: 1 BHP per 3,200 members, 1 CD specialist per 40,000
• Types of High-Volume BHP: 1 Psychiatrist per 20,000 members and 1 Psychologist per 20,000 members.
• Geographic distribution or driving time to BHP: 80% of members will be within 30 miles OR 60 minutes of a BHP.</td><td>• As needed and subject to membership change and staff turnover, increase BH practitioner staffing.</td><td>September 2022

Behavioral Health Quality Oversight Committee</td><td>Results/Analysis:

KPNC behavioral health geoaccess and practitioner ratio performance as of 6/30/2021 is included in this analysis.

Behavioral Health Geoaccess Performance
Behavioral Health Practitioner (BHP) includes all Mental Health and Chemical Dependency providers in the following categories: psychiatrists, psychologists, nurse practitioners, clinical social workers, marriage/family therapists, and Chemical Dependency Recovery Program counselors.

<table><tr><th>Standard</th><th>Performance Target</th><th>2022 Performance</th></tr><tr><td>30 Miles to a BHP</td><td>80%</td><td>100%</td></tr><tr><td>60 Minutes to a BHP</td><td>80%</td><td>100%</td></tr></table>
Behavioral Health Practitioner Ratio Performance
Analysis excludes contracted and affiliated practitioners
<table><tr><th>Standard Category</th><th>Standard</th><th>2022 Performance</th></tr><tr><td>All BHP</td><td>1:3,200</td><td>1:2,167</td></tr><tr><td>Psychiatrist</td><td>1:20,000</td><td>1:13,770</td></tr><tr><td>Psychologist</td><td>1:20,000</td><td>1:7,223</td></tr></table></td></tr>
</table>

<table>
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<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td>Chemical Dependency</td><td>1:40,000</td><td>1:16,902</td></tr>
</table>

KPNC’s 2022 ratios for each type of BHP meet the established targets.

Barriers: None

Next Steps: Continue to increase BH practitioner staffing as needed. Report annual findings to MCC/QOC.</td></tr>
<tr><td colspan="4">Facility Standards</td></tr>
<tr><td>Ensure adequate availability of facilities within target geoaccess standards
• Hospital/Emergency Room Geographic Distribution Standard: Geographic distribution or driving time to hospitals/emergency rooms: 100% of members will be within 15 miles OR 30 minutes of a KP or contracted hospital with an emergency department.
• Other Facility Standards: Geographic distribution or driving time to Skilled Nursing Facilities and Home Health Agencies: 100% of Members will be within 30 minutes of a KP or contracted facility.
• Psychiatric Inpatient Hospitals and Behavioral Health Residential Facility Standards: 80% of Members will be within 50 miles OR 75 minutes of a KP or contracted facility.</td><td>• Annual analysis and monitoring of Geoaccess</td><td>Annual:
September 2022

Access Committee</td><td>Results/Analysis:

<table>
<tr><th colspan="3">Other Standards - Geoaccess Performance</th></tr>
<tr><th>Standard</th><th>Performance Target</th><th>2022 Performance</th></tr>
<tr><td colspan="3">Hospital/Emergency Room</td></tr>
<tr><td>15 miles</td><td>100%</td><td>97%</td></tr>
<tr><td>30 minutes</td><td>100%</td><td>99.5%</td></tr>
<tr><td colspan="3">Skilled Nursing Facility</td></tr>
<tr><td>30 minutes</td><td>100%</td><td>99.3%</td></tr>
<tr><td colspan="3">Home Health Agency</td></tr>
<tr><td>30 minutes</td><td>100%</td><td>98.7%</td></tr>
<tr><td colspan="3">Inpatient Psychiatric Facility</td></tr>
<tr><td>50 miles</td><td>80%</td><td>99.7%</td></tr>
<tr><td>75 minutes</td><td>80%</td><td>99.5%</td></tr>
<tr><td colspan="3">Residential Behavioral Health Facility</td></tr>
<tr><td>50 miles</td><td>80%</td><td>100%</td></tr>
<tr><td>75 minutes</td><td>80%</td><td>100%</td></tr>
</table>
</td></tr>
</table>

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<tr><td colspan="4"></td></tr>
<tr><td>• Ambulatory Surgical Centers, Mammography/Radiology clinics and other Ambulatory Clinics (including Behavioral Health): 80% of Members will be within 30 miles OR 60 minutes of a KP or contracted facility.</td><td></td><td></td><td>
<table>
<tr><td colspan="3">Ambulatory Behavioral Health</td></tr>
<tr><td>30 miles</td><td>80%</td><td>99.3%</td></tr>
<tr><td>60 minutes</td><td>80%</td><td>99.9%</td></tr>
<tr><td colspan="3">Ambulatory Surgery</td></tr>
<tr><td>30 miles</td><td>80%</td><td>99.9%</td></tr>
<tr><td>60 minutes</td><td>80%</td><td>100%</td></tr>
<tr><td colspan="3">Mammography/Radiology</td></tr>
<tr><td>30 miles</td><td>80%</td><td>99.8%</td></tr>
<tr><td>60 minutes</td><td>80%</td><td>100%</td></tr>
<tr><td colspan="3">Ambulatory Clinic</td></tr>
<tr><td>30 miles</td><td>80%</td><td>99.7%</td></tr>
<tr><td>60 minutes</td><td>80%</td><td>99.9%</td></tr>
</table>
KPNC met the established targets, regionally, in most reported categories.

Barriers: In the Fresno and Central Valley areas, longer distances are considered the typical geographic pattern of travel for members living in those areas.

Next Steps: Any complaint regarding travel distance will be resolved at the facility level with support from the KPNC Regional Continuum Administrator, as needed. Continue to monitor and report AAR annually to MCC and Access Committee.
</td></tr>
</table>

Behavioral Health			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Intensive Community Treatment (ICT) Program Enhance the quality of life to or a small population of very high acuity and complex behavioral health members who do not benefit from traditional outpatient treatment by providing targeted treatment and interventions specific to each patient's needs. **Metrics**: 1. Expand ICT enrollment to meet demand (approx. 20%) 2. Clinically appropriate reduction in inpatient psychiatric hospital readmissions, psychiatric hospital rates and ED visits. 3. Pre/Post analysis of discharged patients' linkages to KP services (outpatient visits, intensive outpatient programs) 4. Pre/Post analysis of quality indicators (kept appointments in psychiatry, life ability scales alcohol and drug use, quality of life measurement)	Working with the contracted vendor to provide: • Focused telecare to provide community support including assistance in accessing other relevant health services, such as drug and alcohol rehabilitation resources, and community-based programs such as housing, nutrition, transportation, and social support. • Teach the targeted members through self-management coaching and development of life skills, such as grooming, cleaning, cooking, and use of public transportation • Coordinate care with their KP psychiatrist, primary care physicians, and other treatment providers and programs in preparing for and keeping appointments, completing lab work, and other applicable services.	Regional Director of Behavioral Health, TPMG Regional Director of Behavioral Health, KFHP Vice President of Behavioral Health & Specialty Services, KFHP Chair of Chiefs of Psychiatry & Behavioral Medicine, TPMG 12/31/2022	**<u>Results for Metrics 1 & 2</u>** ▪ Expanded the ICT enrollment (referral capacity) by 20% ▪ Patient Day Rate decreased from 22k to 12k (48%). ▪ ED admission rate decreased from 7K to 5K (29%) ▪ Psych Inpatient days decreased from 21K to 7K (66%) **<u>Results for Metrics 3 & 4</u>** ▪ The active patients performed better in a 30-day period on HEDIS measures such as the Follow -up after emergency department visit {FUM (89%)} and Follow -up after hospitalization mental illness {(FUH (87%)} ▪ Observed Lower "no-show" appointments during ICT (31.06%) **<u>Next Steps:</u>** Planning to expand the referral capacity to meet the demands of the service areas.

Claims			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Maintain timeliness at the required compliance targets for each line of business. **Medicare**: • 95% within 30 Calendar Day TAT (Non-Contracted Clean) • 99% within 60 Calendar Day TAT (Non-Contracted Unclean) **Commercial**: DMHC Regulatory Metric • 95% within 45 working days **Medi-Cal**: • 95% within 45 working days • 99% within 90 calendar days • 90% within 30 calendar days	Continue to monitor on a monthly basis and remediate when/if necessary.	National Claims Administration - California Region Annually	2022 Analysis **Medicare**: 99.5%[1] within 30 Calendar Day TAT (Non-Contracted Clean) 99.6%[1] within 60 Calendar Day TAT (Non-Contracted Unclean) **Commercial**: DMHC Regulatory Metric 99.82% within 45 working days **Medi-Cal**: 97.81% within 30 calendar days 99.96% within 45 working days 99.98% within 90 calendar days
Maintain industry standards for financial accuracy, payment accuracy and overall accuracy. **Turnaround Time Targets:** 30 Day Clean 95% **Accuracy Targets (for claims and encounters end-to-end):** Financial Accuracy 99.3% Payment Incident Accuracy 98.0% Overall Accuracy 95.0%	NCA has a robust QA process inclusive of configuration and claims processing audits. The audits are conducted daily and feedback provided to claims operations for resolution. QA results are reported monthly to claims leadership.	National Claims Administration Monthly	2022 results for timeliness for all lines of business. **Turnaround Time Results:** Actual TAT = 99.6%1 **Accuracy Results:** Financial Accuracy =99.95%1 Payment Incident = 99.92%1 Overall Processing = 99.83%1

[1] Figures provided are based upon January through November 2022

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Continuity and Coordination of Care – Med/BH 1. Exchange of Clinical Information NCQA standard requires a process goal. Goal: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to exchange of information.	Continue to annually assess exchange of clinical information between medical care providers and behavioral healthcare practitioners.	TPMG Consulting Services Annually	<u>Analysis</u> Successful. Receive automatic credit for use of fully integrated electronic medical record (EPIC). <u>Next Steps</u> Continue to annually assess exchange of clinical information between medical care providers and behavioral healthcare practitioners.
2. Appropriate Diagnosis, Treatment, and Referral for BH Disorders NCQA standard requires a process goal. Goal #1: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care. Goal #2: Measure members for >= 50% improvement over a 5-month period, based on PHQ-9 depression screening tool. Goal target: 45%	Ongoing promotion of processes to improve the screening, diagnosis, and referral of depression in primary care through the KP MOOD initiative. Improve PHQ-9 capture through use of mobile technology, automatic distribution of screening tool, and piloting a PHQ-9 reminder alert system.		<u>Analysis</u> Goal #1: Successfully measured opportunities to improve collaboration between medical care and behavioral healthcare related to appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care, by monitoring progress on the Depression Response measure, as well as improvement with “Last PHQ-9” capture. Goal #2: Successful. KPNC met the 45% mood target as of December 2022. Note: KPNC is transitioning away from the MOOD measure and the 45% target for improvement over a 5-month period based on the PHQ-9 depression screening tool. The new measure is Depression Response, with significant improvement defined as having a PHQ-9 within a 4-8-month period post-IESD with a >=50% improvement over baseline. 2022 target and performance are below:

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			Depression Response Measure Goal: 17% 2022 performance (as of Sept 2022): 15% KPNC performance on “Last PHQ-9” capture within 4-8 months after IESD dipped slightly from 40% in Oct. 2021 to 39% in Sept. 2022. <u>Barriers</u> Although NCAL achieved significant improvement in PHQ-9 completion in recent years, response rates and intervals for questionnaire completion have become more inconsistent during the pandemic. Preventive screenings have decreased, resulting in fewer touchpoints with patients to provide comprehensive care. In addition, PHQ-9 completion may have been impacted by At Home Assessment work flow changes related to COVID-19 response. <u>Next Steps</u> • Ongoing promotion of processes to improve the screening, diagnosis, and referral of depression in primary care through the KP Depression Monitoring and Depression Response initiatives. • Improve PHQ-9 capture through use of mobile technology, automatic distribution of screening tool, and piloting a PHQ-9 reminder alert system. • Increase use of the Tridiuum tool by our external contracted providers. We are now able to monitor the use of the tool by these external providers and receive alerts when

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			members may need more intervention or are ready for discharge.
3. Appropriate Use of Psychotropic Medications NCQA standard requires a process goal. Goal #1: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to appropriate use of psychotropic medications. Goal #2: Achieve 2022 NCQA HEDIS 90th percentile targets for: ADHD Meds Initiation ADHD Meds Continuation	Continue collaborative efforts between psychiatry and pediatrics, exploring inreach and outreach strategies to make sure patients are scheduling follow-up visits by phone and video within the HEDIS specified timeline. Continue to monitor HEDIS ADHD measure.		<u>Analysis</u> Goal #1. Successfully measured opportunities to improve collaboration between medical care and behavioral healthcare related to appropriate use of psychotropic medications. Goal #2: KPNC achieved the HEDIS ADHD Initiation and ADHD Continuation targets (based on the most recently reported for MY2021). ADHD Initiation Goal: HEDIS 90th percentile: 48.1 ADHD Initiation Performance: 74.15 ADHD Continuation Goal: HEDIS 90th percentile: 59.09 ADHD Continuation Performance: 76.05 <u>Next Steps</u> • Continue collaborative efforts between psychiatry and pediatrics, exploring inreach and outreach strategies to make sure patients are scheduling follow-up visits by phone and video within the HEDIS specified timeline. • Continue to monitor HEDIS ADHD measure.
4. Treatment Access for Coexisting Medical and Behavioral Disorders NCQA standard requires a process goal.	Continue programs to ensure access to members with co-existing medical and behavioral disorders Monitor toxicology screening rate for Early Start program		<u>Analysis</u> Successfully measured treatment access and follow-up for members with coexisting medical and behavioral disorders, by measuring toxicology screening volumes for the Early Start program.

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Goal: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to management of treatment access and follow-up for members with coexisting medical and behavioral disorders.			Toxicology Screening Measure Goal: 90% 7/1/2021 to 6/30/22 performance: 90.3% <u>Next Steps</u> • Continue programs to ensure access to members with co-existing medical and behavioral disorders. • Monitor toxicology screening rate for Early Start program.
5. Primary and Secondary Prevention Programs NCQA standard requires a process goal. Goal: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to primary or secondary preventive behavioral healthcare program implementation.	Continue to monitor access to the behavioral health education programs to understand impact.		<u>Analysis</u> Successfully measured opportunities to improve collaboration between medical care and behavioral healthcare related to primary or secondary preventive behavioral healthcare program implementation. The NCQA standard requires choosing an area of opportunity that would benefit from primary and secondary prevention; identifying appropriate preventive services; and measuring access to those preventive services. KPNC chose anxiety and depression, measuring the prevalence of these conditions both within and outside of KPNC, and monitoring access to a set of Behavioral Health Education programs focused on anxiety, depression, couples communication, insomnia, emotional wellness, and stress. Due to COVID-19, Behavioral Health Education classes now take place in an all-virtual format using video. The goal is to see year-over-year reductions in the length of time it takes to book patients in Behavioral

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			Health Education classes, as measured in the Initiated to Triage and Triage to Book columns below. As of September 2022: • # of Referrals Submitted to Behavioral Health Education classes: 1,661 • Initiated to Triage* (days): 0.6 • Triage to Book** (days): 0.56 * Number of days between initial submission of eConsult and when Health Education staff responds (if direct booked by physician or self-booked by patient, then 0 days) ** Number of days between triage of eConsult and when staff or patient self-books appointment (if direct booked, then 0 days). <u>Next Steps</u> Continue to monitor access to the behavioral health education programs to understand impact.
6. Special Needs of Members with Severe and Persistent Mental Illness NCQA standard requires a process goal. Goal: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to special needs of members with severe and persistent mental illness.	Continue to assess the effectiveness of the ICT program throughout the region. Continue to monitor the percentage of members with SPMI diagnosis who had a medicine appointment within 30, 60, 90, and 120 days, and identify additional improvement opportunities as needed to improve performance on this measure.		<u>Analysis</u> Successfully measured opportunities to improve collaboration between medical care and behavioral healthcare related to special needs of members with severe and persistent mental illness. Through the Intensive Community Treatment (ICT) program, KPNC partners with a local community-based organization (CBO) to provide 24/7 services to a select group of members with SPMI who have been identified as high risk. Results of the ICT program continue to be encouraging. Between September 2021 and August 2022, an expanded cohort of 992 ICT patients had 371 fewer visits to the

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			E.D., and 108 fewer psychiatric hospital admits. These results continue to represent a reduction greater than the goal of 5%. NCAL is also monitoring the ICT program to assess improvement on several different quality measures. Based on August 2022 data looking at all current ICT patients, there has been a decline in the number of appointment no-shows, from 85 no-shows pre-ICT, to 52 during ICT. <u>Next Steps</u> • Continue to assess the effectiveness of the ICT program throughout the region. • Monitor the percentage of members with SPMI diagnosis in the ICT program who had a primary care appointment within 30 days of hospital discharge, and who had a primary care follow-up appointment made on discharge.

Care Coordination – Readmissions			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Standardize patient identification and outreach across our 13 Excellent Transitions Programs implementing a patient benefit model and leveraging automated outreach for patient engagement. Overall objective is to reach Readmission O/E of 0.91.	<u>Patient Benefit Model</u> 1. Standardize KPHC registry usage via patient benefit model implemented with support from DOR. a. Covid registry to only have current Covid patients b. TSL Low Elevated registry to only have social transition concerns c. TP Other registry to be minimized d. TSL High/Medium registry to be part of patient benefit model (with DOR) <u>Automated Outreach</u> 1. Introduce IVR platform for automated member outreach and engagement 2. Redesign and implement standard tools, processes, and documentation 3. Train existing Transitions staff	Care Coordination Due Date 7/2022 for tactics 12/31/22 for overall readmission O/E	Performance for 2022 was 0.91. 1. Target O/E of 0.91 was reached for FY2022 2. Barriers: a. Patient Benefit Model – DOR was supposed to have full analysis completed by mid-January. This is being pushed to mid-February. b. Automated Outreach – ACD telephony issues non-related to the IVR platform impacted overall program effectiveness due to increased drop calls and call freezing resulting in decreased patient satisfaction 3. Next Steps: a. Patient Benefit Model – Project work to move to new Readmissions Standard Work Phase II (Optimize Transitions Model of Care). b. Automated Outreach – Develop and deploy patient satisfaction survey to improve patient experience with IVR outreach. Partner with CCSTI to implement identified ACD optimization workflows to decrease volume of dropped calls.

Continuity and Coordination of Medical Care (QI 3)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Continuity and Coordination of Medical Care NCQA standard requires a process goal, to ensure members receive coordination of care across the continuum. Metric: • Identify four opportunities for improvement of coordination of medical care by collecting data on movement of members across settings of care, and conducting quantitative and causal analysis • Act on at least three opportunities • Measure the effectiveness of at least three improvement actions The following opportunities and actions were identified for 2022, based on results of the 2021 Physician Satisfaction Survey: *Opportunity and Action 1:* To continue to improve ease of access to DME information, there will be a collaborative initiative in the Continuum to streamline the education for our providers and staff who order DME. The project will create educational tools available through a regionally accessible technology platform and aims to increase	• Administer 2022 Provider Satisfaction Survey to TPMG network and contracted physicians to identify opportunities to improve coordination of care across the continuum • Collaborate with Continuum leadership to identify actions to improve coordination of care • Measure effectiveness of action taken on three opportunities	TPMG Consulting Services Annually	<u>Analysis</u> Results of the 2022 Physician Satisfaction Survey were used to measure the effectiveness of opportunities and actions identified based on the 2020 survey, and to identify opportunities and improvement actions for 2023. *Opportunity and Action 1:* To continue to improve ease of access to DME information, there will be a collaborative initiative in the Continuum to streamline the education for our providers and staff who order DME. The project will create educational tools available through a regionally accessible technology platform and aims to increase knowledge of the DME ordering and tracking process. *Results:* Survey remeasurement of satisfaction with ease of access to clinical information: DME: +1% change compared to 2021 The new educational tools and interventions were implemented as planned in 2022. DME launched a comprehensive SharePoint site in April 2022, which includes ordering information, job aids including how to view DME order status, as well as a detailed FAQ section. The site averages 400 visits per week. In addition, numerous high-volume DME orders in KP HealthConnect (including wheelchairs, oxygen, walkers, beds, insulin pumps and nebulizers) were redesigned to clarify criteria and streamline the ordering process for providers.

Continuity and Coordination of Medical Care (QI 3)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
knowledge of the DME ordering and tracking process. *Opportunity and Action 2:* The project to implement Health Information Exchange (HIE) with contracted Skilled Nursing Facility providers will continue in 2021. A HIE will facilitate sharing of information including care plans and reduce reliance on paper-based processes. Relevant clinical information from the SNFs will be available in KPHC. The number of SNF buildings with HIE increased from 5 in 2020 to 85 in 2021, and information from the SNF stay is now available in KPHC for patients discharged from those buildings. Deployment to additional buildings as well as enhancement to the format of content of clinical information will continue in 2022. *Opportunity and Action 3:* A number of technical improvements were implemented in 2021 to improve ease of access to Advance Health Care Directives in KP HealthConnect, including documentation of effective date for POLST in KPHC, as well as the ability for patients to share their terminal care wishes through ePOLST completion with an e-signature, and by uploading their AHCDs on kp.org. Heading into 2022, there is an opportunity to raise physician awareness and knowledge of these			*Opportunity and Action 2:* The project to implement Health Information Exchange (HIE) with contracted Skilled Nursing Facility providers will continue in 2021. A HIE will facilitate sharing of information including care plans and reduce reliance on paper-based processes. Relevant clinical information from the SNFs will be available in KPHC. The number of SNF buildings with HIE increased from 5 in 2020 to 85 in 2021, and information from the SNF stay is now available in KPHC for patients discharged from those buildings. Deployment to additional buildings as well as enhancement to the format of content of clinical information will continue in 2022. *Results:* Survey remeasurement of satisfaction with the transition process: Skilled Nursing Facilities: -1% change compared to 2021 KP continued to monitor new buildings that sign on to HIE throughout the year, and two new SNFs were added in 2022. Enhancements to the format of clinical information did not occur because the SNF EMR vendor is not prioritizing such efforts. In 2022, optimizations to KP HealthConnect were made to inform physicians that a patient was in a SNF. This included enhancing an icon to make a SNF stay more visible in the EMR. *Opportunity and Action 3:* A number of technical improvements were implemented in 2021 to improve ease of access to Advance Health Care

Continuity and Coordination of Medical Care (QI 3)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
tools. A communication strategy is in place which will include cascading written information on ePOLST completion through the physician leadership structure and attending existing meetings and forums to share that information. A positive impact on physician satisfaction is expected as awareness and knowledge of these tools spreads. *Opportunity and Action 4:* In an effort to improve the transition process for patients who are receiving home health services from a contracted home health agency, there is an IT project evaluating the expansion of features of the AffiliateLink Epic module. This project aims to investigate the feasibility of communication from contracted Home Health agencies to physicians via KPHC in basket messaging rather than the current use of faxes. The technology enhancement could provide greater insight into the patient's care during the home health episode of care. This project was scheduled for 2021 but was not implemented due to technology challenges. Plans are in development to improve the onboarding of new agencies and to test sending orders and documents using AffiliateLink.			Directives in KP HealthConnect, including documentation of effective date for POLST in KPHC, as well as the ability for patients to share their terminal care wishes through ePOLST completion with an e-signature, and by uploading their AHCDs on kp.org. Heading into 2022, there is an opportunity to raise physician awareness and knowledge of these tools. A communication strategy is in place which will include cascading written information on ePOLST completion through the physician leadership structure and attending existing meetings and forums to share that information. A positive impact on physician satisfaction is expected as awareness and knowledge of these tools spreads. *Results:* Survey remeasurement of satisfaction with ease of access to clinical information: Advance Health Care Directives: -2% change compared to 2021 The communication strategy was implemented in 2022 as planned. There were spots of success in certain areas – e.g. small tests of change that increased physician documentation of planning work – but more work needs to be done to scale and raise physician awareness and knowledge of these tools region-wide. *Opportunity and Action 4:* In an effort to improve the transition process for patients who are receiving home health services from a contracted home health agency, there is an IT project evaluating the

Continuity and Coordination of Medical Care (QI 3)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			expansion of features of the AffiliateLink Epic module. This project aims to investigate the feasibility of communication from contracted Home Health agencies to physicians via KPHC in basket messaging rather than the current use of faxes. The technology enhancement could provide greater insight into the patient's care during the home health episode of care. This project was scheduled for 2021 but was not implemented due to technology challenges. Plans are in development to improve the onboarding of new agencies and to test sending orders and documents using AffiliateLink. *Results:* Survey remeasurement of satisfaction with the transition process: Contracted Home Health Agencies: -1% change compared to 2021 This project was reevaluated in 2022. After evaluation, Affiliate Link was not a viable option and additional scoping was done in 2022 to design a more streamlined solution. Funding for this alternative solution has been approved for 2023. <u>Next Steps</u> The following opportunities and actions were identified for 2023, based on results of the 2022 Physician Satisfaction Survey: *Opportunity and Action 1:* In an effort to improve the transition process for patients who are receiving home health services from a contracted home health agency, a redesigned IT project has been

Continuity and Coordination of Medical Care (QI 3)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			funded which will evaluate electronic order signatures, leveraging Adobe Sign functionality. The project will investigate the feasibility of communication from contracted Home Health agencies to physicians via KP HealthConnect in basket messaging rather than the current use of faxes. The technology enhancement could provide greater insight into the patient's care during the home health episode of care. This project was scheduled for 2021 but was not implemented due to technology challenges. After reevaluation, Affiliate Link was not a viable option and additional scoping was done in 2022 to design a more streamlined solution. Funding for this alternative solution has been approved for 2023 and the project is expected to move forward. *Opportunity and Action 2:* TPMG physicians document notes and care plans for patients in a SNF in KPHC. However, this clinical information is not always obvious to other care providers. Additional technical improvements are being evaluated to facilitate awareness of patient's SNF admission and the availability of this documentation in KPHC. These include color changes, banners, hovers and additional text. At least one of these options will be implemented in 2023. *Opportunity and Action 3:* To continue to improve ease of access to DME information, there will be efforts in 2023 to optimize DME orders in KP HealthConnect, including ensuring relevant clinical information is available from the order. In addition, educational offerings designed for ordering clinicians will be developed.

Continuity and Coordination of Medical Care (QI 3)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			Opportunity and Action 4: A communication strategy was implemented in 2022 with the aim of raising physician awareness and knowledge of new tools and technical improvements implemented in 2021 to improve ease of access to Advance Health Care Directives (AHCD) in KP HealthConnect. Because there was no corresponding increase in physician satisfaction with ease of access to this type of clinical information in 2022, there will be additional focused training/strategies in 2023 that go beyond AHCD into the role of the physician in the goals of care conversation. There will be a more intentional approach to connecting with each specialty in 2023, as well as efforts to scale up the learnings/successes from small tests of change carried out in 2022 that increased physician documentation of planning work. Lastly, work will continue on the ongoing communication strategy of spreading education through physician groups. A positive impact on physician satisfaction is expected as awareness and knowledge of the AHCD tools continues to spread.

Credentialing and Privileging			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Develop and implement a region-wide electronic tracking system for Focused Professional Practice Evaluation (FPPE). Metric: Roll out FPPE tracking system	• Identify platform • Program to align with FPPE plans across all specialties • Pilot in one service area by 3Q 2022	Health Plan Quality Credentialing & Privileging December 2022	FPPE plans across all specialties and service areas were programmed to align with current privilege forms in MSOW. The following barriers caused by platform limitations prevented piloting: • MSO staff must assign reviews to proctors • Inability to combine PDFs • Emails sent from platform allow only 1 attachment • Requires duplicative programming of FPPE forms for each service area to account for practitioners who are experienced versus newly trained • Requires an evaluation to be entered for each condition, even during instances where one evaluation accounts for multiple conditions • Platforms outside of MSOW were explored, but demos revealed that the functionality is the same as MSOW Future considerations for an electronic FPPE tracking system will require platform customization or programming flexibility to align with current practice and complexity of existing privilege form build.
Develop training program for MSOs and credentialing stakeholders on best practices. Metric: Implement region-wide training program	Training program to include: • Confidentiality • Documentation standards • Committee facilitation	Health Plan Quality & Regional Credentialing and Privileging December 2022	On November 29, 2022, a region-wide training program was held. Attendees included Medical Staff Office leads and support staff from each medical center, Regional Credentialing and Health Plan Quality staff. Training content included confidentiality, documentation standards, and committee facilitation

Credentialing and Privileging			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			with an emphasis on maintaining peer review protections, transmitting and storing documents, and committee minutes. No barriers were identified. Next step is to engage with the Chair of Chiefs to expand education.
Credentialing application refresh. Metric: Roll out application refresh	• Update language to support portal interface • Attestation disclosures	Regional Credentialing, RCPC approval December 2022	Completed. RCPC approved updates to the application and attestation disclosures on 1/27/22 which were communicated to all stakeholders. All language was integrated into the Practitioner Portal and validated on 5/27/22. Deployment was delayed due to technology challenges which was remediated with the 10/14/22 MSOW upgrade.

Cultural & Linguistic Diversity			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
LMP Bilingual Program Ongoing Competency – Reassessing staff for language competency using a validated language assessment. 100% completion of reassessment efforts of in-scope Qualified Bilingual Status (QBS) employees for Spoken and ASL language competency.	Complete language proficiency reassessment process of Bilingual Qualified employees at 14 KP facilities to demonstrate their ongoing language competency and to meet interpreter services regulatory requirements for provision of verbal interpreter services to non-English speaking and deaf members/patients. • Reassess QBS Level 1s for Spoken language competency using existing Spoken language assessment • Reassess QBS Level 1s & Level 2s for Sign Language competency using the new American Sign Language (ASL) language assessment	NCAL LMP Bilingual Program Partners - NCAL Language Access September 2022	Goal met for 100% completion of reassessment efforts of in-scope Qualified Bilingual Status (QBS) employees for Spoken and ASL language competency. • QBS Level 1 staff (used for non-clinical Interpretation) were reassessed for their language competency using the new validated language assessment test. Reassessment of about 1,163 employees was completed in July 2022. • Reassessment of QBS Level 1s & Level 2s for Sign Language competency using the new American Sign Language (ASL) language assessment was completed in July 2022. There are now 3 employees with ASL QBS designation. • Additionally, the Qualified Bilingual Status (QBS) Refresher Training for Level 2 QBS (Used for basic clinical interpretation) was developed in early 2022 and was deployed to KP Learn in January 2023. The training will be tracked for completion in 2023. The QBS Level 2 Refresher Training is designed to reinforce, support and assist QBS Level 2 employees in maintaining their skills and demonstrate their ongoing language proficiency to meet regulatory requirements. Beginning January 2023, all QBS Level 2 employees will be offered and

Cultural & Linguistic Diversity			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			are required to take QBS Level 2 Refresher Training every 3 years.
Roll-out the 2022 Providing Culturally & Linguistically Appropriate Services training to all Health Plan depts/depts performing a health plan function to meet operational and regulatory compliance.	Update/rollout 2022 Providing Culturally & Linguistically Appropriate Services training to educate KFHP departments on how to effectively access, offer, use, and document language assistance services and how to provide culturally sensitive care for limited English proficient persons, including diverse members and patients who are deaf or hard of hearing.	NCAL Language Access Program December 2022	Goal met as the training was successfully rolled out. • The 2022 Providing Culturally & Linguistically Appropriate Services training was successfully deployed to KP Learn in November 2022 and was assigned to NCAL and statewide Health Plan employees as a required course. The training will be tracked for completion in 2023. The training supports regulatory requirements designed to improve access to health care services for Limited English Proficient (LEP) population and persons with disabilities and to increase our capacity to address the language and cultural variations of our members and patients. The training curriculum includes the following topics: • Understand and endorse KP's Equity Principles and commitment to Equity, Inclusion, & Diversity. • Identify and overcome Unconscious Bias to build strong diverse teams to provide more equitable care • Recognize the concept of culturally competent care and the importance of providing it

Cultural & Linguistic Diversity			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			• Access and apply Kaiser Permanente's Language Assistance and Equal Access Program Policies and Procedures • Work effectively with LEP members and patients and persons with disabilities by considering their cultural differences

Cultural Diversity Needs Assessment (NET 1)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Annually, create a Cultural Needs Assessment that includes: • Assessment of the cultural, ethnic and linguistic needs of KPNC membership • Make adjustments to provider network	• Complete Cultural Needs Assessment in March 2022. • Monitor mechanisms used for diversity outreach and recruitment to ensure KPNC is able to provide TPMG Medical Center leaders with the broadest cross section of excellent physicians and that placement of minority physicians is meeting the needs of the membership.	March 2022 Director for Regulatory Compliance, Accreditation and Provider Network Reporting, TPMG Consulting Services	GOAL MET. Cultural needs assessment completed in March 2022. Results as of March 31, 2022: **Language** • 3,935,422 KPNC members listed English as their spoken language preference • 10,139 KPNC physicians speak English • 5,618 physicians have language skills other than English • 737 new physicians have been hired, all of whom speak English • 324 new physicians were hired with language skills (1 or more) other than English • 77 different languages are spoken by the KPNC membership • 48 different languages are spoken by new physician hires • 118 different languages are spoken by KPNC physicians **Race/Ethnicity** The majority of the KP population identifies as White and Asian/Pacific Islander (43% and 24%, respectively), and the physician population reflects that. However, Hispanic/Latino and African American populations are also substantially represented in KPNC's membership population, and

Cultural Diversity Needs Assessment (NET 1)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			we have an opportunity to increase the numbers of African American and Hispanic/Latino physicians to reflect this. **2022 Network Adjustment** In 2022, KPNC engaged in a two-pronged approach to recruiting more diverse practitioners, including direct outreach through meetings, events and conventions, as well as through direct mail, website marketing, and publications. During this reporting period, recruitment efforts resulted in 7.1% of new hires having a Hispanic background and 2.7% of new hires having an African American background which resulted in the Black (3.1%) and Hispanic (5.1%) workforces remaining stable. KPNC continues to maintain a diverse practitioner network to meet the needs of its membership.

DMHC Timeliness Initiated to Seen (ITS) Average Days Wait (ADW) Appointment Access Report

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2022 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Monitor compliance with DMHC California State timely access standards through the KPNC Access Committee ITS per Average Days Wait standards: • Urgent care within 48 hours • Nonurgent primary care within 10 business days • Nonurgent specialty care within 10 business days • Nonurgent ancillary services within 15 business days • Nonurgent Nonphysician mental health care within 10 business days • Nonurgent physician mental health care within 15 business days	• Implement action plans when departments/service areas exceed the standard.	KFHP Vice President of Quality and Co-Chair of Quality Oversight Committee TPMG Operational AEDs and Co-Chair of Quality Oversight Committee Quarterly: February 2022 May 2022 August 2022 November 2022	Department of Managed Health Care (DMHC) Initiated to Seen/Average Days Wait Appt Access Report

Threshold: 80%		Q1 2022		Q2 2022		Q3 2022		Q4 2022	
		%	ADW	%	ADW	%	ADW	%	ADW
Primary Care - Medicine									
Urgent	<=48h	90%	1.0	87%	0.8	88%	1.2	92%	1.0
Non-Urgent	<=10 bus day	94%	4.2	90%	5.0	93%	4.3	94%	4.6
Primary Care – Pediatrics									
Urgent	<=48h	98%	0.5	96%	0.6	96%	0.6	95%	0.8
Non-Urgent	<=10 bus day	97%	2.4	97%	5.2	96%	2.6	97%	3.5
Specialty Care (NCQA High Volume and High Impact Specialties)									
Urgent	<=48h	90%	1.38	89%	1.53	88%	1.31	89%	1.29
Non-urgent									
Derm	<=15 bus day	94%	6.31	91%	7.47	89%	7.47	93%	6.4
General Surg	<=15 bus day	94%	5.56	92%	6.75	88%	7.23	90%	6.88
OBGYN	<=15 bus day	93%	4.99	93%	6.3	91%	5.68	93%	7.25
Head/ Neck Surg	<=15 bus day	96%	4.97	94%	5.89	93%	6.32	93%	6.52
Opthalmology	<=15 bus day	86%	7.22 `	84%	7.88	85%	7.8	86%	7.07
Orthopedics	<=15 bus day	94%	5.45	90%	6.83	83%	8.09	90%	6.92
Oncology*	<=15 bus day	96%	N/A	93%	N/A	91%	N/A	87%	N/A
Adult Physician MH Care									
Non-urgent	<= 15 bus day	97%	7.98	97%	7.88	97%	6.9	97%	5.89
Adult Nonphysician MH Care									
Non-urgent	<=10 bus day	98%	4.87	96%	5.91	95%	5.7	98%	3.16

*Oncology data sourced from ITS dashboard
All other data sourced from Timeliness of Access ITS report to Access Committee

KPNC met the established targets, regionally, in all reported categories.

DMHC Timeliness Initiated to Seen (ITS) Average Days Wait (ADW) Appointment Access Report			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			Barriers: None **Next Steps**: Continue monitoring of ITS/ADW Access Reports and other compliance reports via quarterly reporting to the QOC and monthly reporting to the Access Committee. Continue to implement action plans when Medical Centers do not meet the standard.

Durable Medical Equipment			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Improve member service by reducing DME Dept. contact center call abandonment from current rate of 40.13% to less than 30%.	Develop and build reporting structure that will allow monitoring and analysis of dept. telephony performance. Review prioritization of staffing assignments and allocate additional resources to assist the contact center when available Provide additional training to DME clerks to improve telephony etiquette and efficiency.	NCAL DME Continuum Clarity Reporting Technical Team End of Q4 2022	1. 2023 call abandonment rate 39%. 2. Covid surge volume and several large scale manufacturer product recalls (which increased member call volume) prevented Q1 and Q2 goals being met. Q4 abandonment rate 25.6%. 3. Continue with current strategy and progress workflow improvement for 2023 to include qualitative metrics. Progress will be reported to executive leadership through the Executive Continuum Steering Committee.
Improve time to process all incoming DME orders from current average of 1.4 days by reducing volume of incomplete and unclean DME orders received.	Work with technical teams to improve KPHC DME order search functionality Work with PMG KPHC team to improve DME order questions and clarity	NCAL DME KPHC Technical team End of Q4 2022	1. Average time to process all referrals 2022 = 0.9 days. 2. Barriers to further improvement are systems limitations, physician support staff unclean ordering practices. 3. KPHC order improvement has been transitioned to a National project expected to be implemented in 2024.

Emergency Prospective Review Program (EPRP)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Monitoring of success at compliance with direct admission guidelines for EPRP repatriations. Maintain the Direct admission rate within +/- 5% of 19% for EPRP repatriations.	Continue to monitor compliance with use of direct admission guidelines.	NCAL EPRP Quality Department 12/31/22	Goal was met in 2022. No unexpected barriers. Next steps: business as usual to maintain success. Results / 2021 / 2022 / Grand Total DIRECT ADMIT: 3637, 50%, 3671, 50%, 7308

End State Renal Disease (ESRD) and Dialysis Center Oversight			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Dialysis Unit Quality Monitor dialysis unit quality: 1. Adequacy of dialysis: Hemodialysis units Kt/V ≥ 1.2 achieved > 90%, Peritoneal Dialysis units Kt/V ≥ 1.7 achieved > 85%. 2. BSI- Positive Blood Cultures 3. Peritonitis rates	Review clinical quality indicators and any corrective action or performance improvement plans.	Renal Quality and Performance Improvement Committee Chiefs of Nephrology Continuum Administrators Monthly monitoring	1. Adequacy (data from Q1 2022- Q3 2022) - Analysis of results/metrics: # of facilities with Kt/V ≥ 95% (for in-center= 90/106 centers met goal), (home= 17/37 met goal) - Barriers: access to HD, patient's preference, poor adherence, transportation issues - Next Steps: Engage dialysis unit SW to encourage patients to adhere to prescribed dialysis. 2. BSI (data from Q1 to Q3 2022) - Analysis of results/metrics: 80 positive blood cultures - Barriers: education, engagement, competency of staff and patients' adherence to vascular access care. - Next Steps: Improve patient acceptance of permanent vascular access placement. 3. Peritonitis- data from Q1 to Q3 2022 - Analysis of results/metrics: # of facilities with peritonitis rate ≤ 0.33 = 32/37 facilities - Barriers and Next Steps: additional education for staff and patients to maintain correct connection/reconnection of tubing to cycler to decrease infections.
Home Dialysis [Peritoneal Dialysis (PD) + Home Hemodialysis (HHD) incidence • Monitor the home dialysis incidence (peritoneal dialysis and home hemodialysis) and share practices and workflows of the highest performing medical centers. Target: ≥ 33%	Partner with Surgery and Interventional Radiology Champions to enhance workflows and guidelines to support consistent peritoneal dialysis catheter placement and repair.	Chiefs of Nephrology and Home Dialysis Workgroup Monthly monitoring	1. Analysis of results/data: YTD avg regional data= 35% 2. Barriers: patient preference to start treatment, inability or inconsistency to perform treatments, lack of caregiver support, and social issues, housing challenges. 3. Next Steps: Start patients early on PD or HHD. Education to patients about benefits and available resources- such as home assistance and increase utilization of transitional care units.

End State Renal Disease (ESRD) and Dialysis Center Oversight			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Hemodialysis central venous catheter (CVC) prevalence • Continue to monitor hemodialysis patients with a CVC in place for more than 90-days Target: ≤ 12% of Hemodialysis patients have a CVC in use for more than 90-days	• Partner with Vascular Surgery for consistent implementation of referral guidelines • Development of workflows for challenging CVCs • Utilize tools to monitor timeliness of appointment and OR access for vascular surgery	Chiefs of Nephrology Chiefs of Vascular Surgery Monthly monitoring	1. Analysis of results/metrics: Rolling YTD data until Dec. 2022= 19% 2. Barriers: some patients are unable to get an AV fistula or graft due to poor vascular access, OR and Vascular Surgery access. 3. Next Steps: create and leverage weekly reports to monitor patients with CVCs, continue to educate RCMs and nephrologists about documentation for surgical exclusion (when applicable), continue to collaborate with surgeons to prioritize patients requiring permanent vascular access.
Optimal Starts • Promote home dialysis through "Options" patient education resources Target: ≥ 68%	• Encourage consistent utilization of reporting tools and playbooks. • Partnership with vascular, general surgery and interventional radiology champions. • Strengthen shared decision making and supportive care services	Chiefs of Nephrology Chiefs of Vascular Surgery Chiefs of Surgery Monthly monitoring	1. Analysis of results/metrics: YTD avg regional data= 60% 2. Barriers: Vascular Surgery and OR access, lack of knowledge or pt denial about need for dialysis 3. Next Steps: improve access to Vascular Surgery OR surgery for dialysis pts to get AVF or graft, early identification and education for pts who would benefit from dialysis, and improve throughput via POM and Anesthesia selection criteria
Complaints and Grievances To ensure the overall contracted providers are providing adequate care. Target: ≤ 1% of KP members who receive care at a contracted dialysis provider submit a complaint or grievance during the year.	• Review the complaints and grievances filed by KP members regarding service, quality and care received at contracted dialysis providers and assess for trends. • In addition to the standard resolution process at the medical centers, complaints and grievances regarding care and services at contracted providers are reviewed monthly during Renal quality and performance improvement committee meetings to identify trends. The committee to inform the	Renal Quality and Performance Improvement Committee Chiefs of Nephrology Continuum Administrators Monthly monitoring	1. Analysis of results/metrics: YTD 2022 complaints/grievances= 4 2. Barriers: staff education to improve care delivery and experience, national dialysis staffing shortages 3. Next Steps: Address concerns and provide timely feedback to members and staff about complaints/grievances. Report findings during Renal QuPI meetings and monitor trends.

End State Renal Disease (ESRD) and Dialysis Center Oversight			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
	local Continuum Administrators to ensure issues are addressed.		

Health Engagement Consulting Services			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Local Health Ed Services support: Health Engagement Consulting Services supports medical center infrastructure to provide a standard set of services and ensure fidelity to the model of care and assure highest quality and care experience for members.	• Pilot implementation of Motivation Interviewing Excellence at 5 sites • Implement regional model for all online classes in Health Education • Finalize standard documentation template for 1:1 encounters.	Health Engagement Consulting Services 12/31/22	• Pilot of Motivational Interviewing Excellence is ongoing and showing improvement in MITI scores for all participants. Next steps are to begin discussions for providing this training to all Health Educators. • We have implemented a regional model for online classes in the priority clinical topic areas. This has allowed patients access to more schedules, improving convenience and timeliness to online classes. • One barrier we are addressing is a new booking technology that is rolling out across all medical centers this year, requiring additional steps to provide access to schedules. • Next steps are to analyze class availability and adjust schedules as needed to meet patient needs. • Documentation template for 1:1 encounters was put on hold due to competing priorities.
Patient Communication Consulting for Quality Goals: Continue outstanding consulting for patient messaging around chronic health conditions including: • Asthma • Diabetes, Type I & Type II • Depression • Colorectal Cancer Screening • Cervical Cancer Screening • Hypertension	**Asthma** • Promote and integrate Asthma on a Page clinical tool among MD asthma champions • Update the quality tools button in KPHC to integrate updated quality tools into care delivery. • Conduct systematic review of all asthma patient-facing content to align	Health Engagement Consulting Services 12/31/22	**Asthma** • The Asthma on a Page clinical tool was published and promoted across the NCAL asthma champions for implementation of new asthma clinical guidelines. • This tool was also integrated into the Quality Tools Button for quick access when providers are seeing patients. • A systematic review of all asthma patient-facing content was completed and updated

Health Engagement Consulting Services			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
	with national clinical guideline changes. **Diabetes** • Finalize 1:1 content guide for Type 2 DM and disseminate to Clinical Health Educators (CHEs) • Promote and integrate redesigned My Doctor Online diabetes package (kpdoc.org/diabetes) to AFM, PHASE, and HED • Update the quality tools button in KPHC to include diabetes medication titration instructions • Establish support and workflow for continuous glucose monitoring (CGM) **Depression** • Conduct a systematic review of all depression content to ensure clinical accuracy and reduce redundancy.		to align with clinical guideline changes. This included the creation of new health education material for patients on SMART asthma therapy. Barriers did not prevent us from completing all planned activities for 2022. • Next steps will include continuing to develop and facilitate provider and patient education on the new asthma care guidelines. **Diabetes** • The 1:1 content guide for Type 2 DM was postponed in favor of redesigning the diabetes package (kpdoc.org/diabetes). The content guide revision is reprioritized for Q4 in 2023. • Kpdoc.org/diabetes was finalized, promoted and integrated across KPNC. • Quality tools button in KPHC was updated throughout the year to ensure most relevant and updated content was integrated and shared with appropriate stakeholders. • Developed and implemented CGM HED service across KPNC in partnership with AFM/Quality/HED. **Depression** • The 2022 goals were reprioritized for 2023 to develop a depression and anxiety E-visit, the development of two new products

Health Engagement Consulting Services			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
	• Include antidepressant medication adherence messaging in MDO articles and print content **Colorectal Cancer Screening** • Implement outreach messaging for age 45-49. • Redesign in-reach materials for CRC screening. **Cervical Cancer Screening**		and updating existing content in related topic areas. • Online health guides were created for Adverse Childhood Experiences and Attention Deficit Hyperactivity Disorder. Both sites launched in 2022. • Additionally, content around abuse, anxiety and sleep was reviewed and updated. Updating these content areas supports depression. They are closely related and often lead to or exacerbate depressive symptoms. • An E-visit for depression, anxiety and stress was developed last year and is being piloted in Q1 2023. HECS supported the development of the resource end nodes for the E-visit. **Colorectal Cancer Screening** • Outreach messaging for age 45-49 was implemented. • In-reach materials are in the final stages of design. • Barriers to completion sooner were the added complexity of reconciling patient and staff feedback with lab processing needs. • Next steps are to complete and implement the in-reach materials and replace the existing instructional video

Health Engagement Consulting Services			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
	• Design and pilot educational materials and instructions for home HPV screening. **Hypertension** • Promote and integrate "PHASE on a Page" clinical tool among MD CVD champions. • Update the quality tools button in KPHC to integrate updated quality tools into care delivery. • Conduct systematic review of all CVD prevention patient-facing content to align with national clinical guideline changes. • Finalize 1:1 content guide for CVD Risk Reduction and disseminate to Clinical Health Educators (CHEs)		**Cervical Cancer Screening** • Educational materials for home screening were designed and tested. • Pilot was paused to resolve electronic medical record integration issues with the vendor. • Next steps are to pilot the program in 2023. **Hypertension** • Continued to promote and integrate "PHASE on a Page" clinical tool among MD CVD champions. • Integrated updated and new patient-facing content into KP systems including quality tools button, to facilitate delivery of CVD-prevention education to patients. • Reviewed 32 patient-facing materials in alignment with the latest national clinical guidelines on CVD prevention. • Completed 1:1 CVD Risk Reduction guide and disseminated to CHEs across KP's 15 service areas. Each Health Education department continues to utilize the guide in patient encounters.
Communications Consulting on Patient Facing Tech Tools: Continue outstanding consulting support for TPMG technology strategy to support patients with online engagement as defined by AED Sponsors	• Consultants will work with TPMG Technology leadership, clinical leaders and IT consultants to develop new content on the My Doctor Online web site to support patient care paths, with a focus on virtual care resources.	Health Engagement Consulting Services 12/31/22	• Products supporting navigating to care, getting COVID-19 vaccination and preparing for and recovering from surgery developed.

Health Engagement Consulting Services			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
	• We will further enhance these digital products with new outreach channels and personalized, relevant information.		• Outreach and other integration strategies resulted in over 30M sessions on My Doctor Online.

Regional Health Plan Quality			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
To meet NCQA requirements, the NCAL 2022 Quality Program's workplans will be evaluated at the end of the year. Metric: meet the NCQA standard for identifying the review of the 2022 workplans in the 2023 workplan and then evaluating the documents at the end of the year and early in the following year.	Add a specific line item to the 2022 NCAL Quality Program's workplan stating that the documents will be evaluated (see column one). At the end of the year, evaluate the 2022 workplans per current practice. Prepare and present the evaluation to the Regional Quality Oversight Committee (QOC) during its routine review of the workplans in 2023 and for the KFHP Board of Directors Quality and Health Improvement Committee.	Regional Hospital Health Plan Quality team April 2023 – QOC September 2023 – QHIC	This goal was added to this workplan in 2022 to demonstrate the oversight of the Health Plan Quality Program Description and supporting documents are reviewed and evaluated annually. The NCAL Regional QOC approved the overall Health Plan Quality Program description and supporting documents that included 2021 evaluations and 2022 workplans in April 2022. The Health Plan Quality Program description and supporting documents were approved by Kaiser Foundation Health Plan Board of Directors at their June 17, 2022 Quality and Health Improvement Committee meeting. The Health Plan Quality Program description and supporting documents will continue to be reviewed and evaluated annually.
Receive NCQA accreditation for the Health Equity Program Metric in 2022: application for survey filed with NCQA by December 2022 Metric for 2023: accreditation received by December 2023	Key Actions in 2022: • Identify key stakeholders • Prepare gap analysis • Submit application to NCQA • Plan for a mock survey	Regional Hospital Health Plan Quality team December 2022 for key actions	The application for the Health Plan Equity Program accreditation survey was submitted in February 2023. Application submission was modified based on Program Office submission timeline recommendations. NCAL Quality is on track to receive NCQA accreditation by December 2023.

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
HEDIS Measures			
The organizational goals for reporting year 2022 for all HEDIS Measures 1. Exceed or maintain the 75th or 90th percentile for all measures. • Internal targets per individual measure are based on a number of factors including past performance trends and comparison to national benchmarks such as HEDIS percentiles 2. Link HEDIS measures to quality goal activities. 3. Identify areas for improvement which link to strategic goals.	Planned Activities for all HEDIS Measures: Report: • HEDIS results to the Quality Oversight Committee Annually • Exceed or maintain the national percentile for HEDIS measures • Distribute the “Crossing the Quality Chasm” performance indicator report to medical centers monthly (some HEDIS measures are also CQC measures) Data: • All clinical leads to work with HealthConnect staff to ensure data collection remains consistent Outreach: • Provide member outreach through appointment reminder mailings, invitations to health classes, and phone calls. Inreach: • Refer to the CQC and PHM sections (HEDIS measures highlighted) attached below for additional interventions for select measures • Clinical Practice Guidelines (CPGs) are developed to assist clinicians by providing an evidence-based analytic framework for the evaluation and treatment of selected common problems in patients, and to support clinical decisions by practitioners at the point of	Regional Medical Director Outpatient Quality Annual June 2022	<u>Analysis of Results</u>: The organizational goals for reporting year 2022 for all HEDIS Measures (Note: Individual measure goals can be found in the HEDIS Measure Table in the Workplan Summary): 1. Exceed or maintain the 75th or 90th percentile for all members. 2. Link HEDIS measures to quality goal activities 3. Identify areas for improvement which link to strategic goals. The organization closely tracks and monitors the performance on all HEDIS measure and targets those critical measures on which the organization has not performed well for inclusion on the Crossing the Quality Chasm (CQC) dashboard. Inclusion on the dashboard ensures the focus of the entire organization in strategic efforts to improve performance for that performance year. National benchmarks are used to set internal targets for performance and improvement. <u>Barriers/ Next Steps:</u> Refer to the CQC sections attached below for Barriers/Next Steps by measure. Planned Activities for all HEDIS Measures: Report: • HEDIS results to the Quality Oversight Committee Annually • Exceed or maintain the national percentile for HEDIS measures. • Distribute the “Crossing the Quality Chasm” performance indicator report to medical centers

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
	care in the provision of acute, chronic, preventive care, and behavioral health services. The use of CPGs by practitioners assists KFHP by ensuring that the care provided to members is evidence-based and consistent with professionally recognized standards of care. Development of CPGs is prioritized based on established criteria, which include: number of patients affected by a particular condition/need, quality of care concerns and/or excessive variation in clinical practice, regulatory issues, payor interests, cost, operational needs, leadership priorities and prerogatives. CPGs are not used to make utilization management determinations regarding the medical necessity of a member's care. Reducing Variation: • The regional team is assessing common practices among top five NCAL performers; spreading these techniques to achieve more standardization.		monthly (Some HEDIS measures are also CQC measures) • Data: HealthConnect staff to ensure data collection remains consistent

HEDIS - Commercial			
Measure/Data Element	**Reporting Year 2021**	**Reporting Year 2022**	**Change**

Effectiveness of Care			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	68.81%	90.51%	21.70%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	70.09%	85.00%	14.91%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	70.1%	84.92%	14.82%
Childhood Immunization Status (CIS)			
Childhood Immunization Status - DTaP	92.89%	90.99%	-1.90%
Childhood Immunization Status - IPV	97.08%	94.61%	-2.47%
Childhood Immunization Status - MMR	95.54%	92.80%	-2.74%
Childhood Immunization Status - HiB	96.88%	94.51%	-2.37%
Childhood Immunization Status - Hepatitis B	97.13%	95.12%	-2.01%
Childhood Immunization Status - VZV	94.54%	92.70%	-1.84%
Childhood Immunization Status - Pneumococcal Conjugate	92.65%	89.69%	-2.96%
Childhood Immunization Status - Hepatitis A	95.63%	92.88%	-2.75%
Childhood Immunization Status - Rotavirus	90.44%	91.00%	0.56%
Childhood Immunization Status - Influenza	80.82%	78.30%	-2.52%
Childhood Immunization Status - Combo 3	88.08%	87.17%	-0.91%
Childhood Immunization Status - Combo 7	83.47%	84.81%	1.34%
Childhood Immunization Status - Combo 10	72.48%	72.90%	0.42%
Immunizations for Adolescents (IMA)			
Immunizations for Adolescents - Meningococcal	89.51%	89.08%	-0.43%
Immunizations for Adolescents - Tdap	93.44%	93.31%	-0.13%
Immunizations for Adolescents - HPV	62.18%	62.27%	0.09%
Immunizations for Adolescents - Combination 1	88.36%	87.95%	-0.41%
Immunizations for Adolescents - Combination 2	60.84%	60.89%	0.05%
Breast Cancer Screening (BCS)			
Breast Cancer Screening	74.41%	75.63%	1.22%
Cervical Cancer Screening (CCS)			
Cervical Cancer Screening	88.7%	85.89%	-2.81%
Colorectal Cancer Screening (COL)			

Colorectal Cancer Screening	69.99%	76.16%	6.17%
Chlamydia Screening in Women (CHL)			
Chlamydia Screening in Women (16-20)	48.38%	51.58%	3.20%
Chlamydia Screening in Women (21-24)	59.75%	67.21%	7.46%
Chlamydia Screening in Women (Total)	54.71%	60.44%	5.73%
Appropriate Testing for Pharyngitis (CWP)			
Appropriate Testing for Pharyngitis (3-17)	81.06%	16.15%	-64.91%
Appropriate Testing for Pharyngitis (18-64)	47.04%	10.83%	-36.21%
Appropriate Testing for Pharyngitis (65+)	26.89%	5.00%	-21.89%
Appropriate Testing for Pharyngitis (Total)	56.32%	11.69%	-44.63%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	37.77%	25.19%	-12.58%
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	90.56%	86.03%	-4.53%
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	92.09%	91.59%	-0.50%
Asthma Medication Ratio (AMR)			
Asthma Medication Ratio (5-11)	96.62%	93.07%	-3.55%
Asthma Medication Ratio (12-18)	95.35%	90.08%	-5.27%
Asthma Medication Ratio (19-50)	88.93%	85.17%	-3.76%
Asthma Medication Ratio (51-64)	93.4%	90.09%	-3.31%
Asthma Medication Ratio (Total)	91.77%	87.90%	-3.87%
Controlling High Blood Pressure (CBP)			
Controlling High Blood Pressure	49.9%	71.12%	21.22%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)			
Persistence of Beta-Blocker Treatment After a Heart Attack	93.59%	93.89%	0.30%
Statin Therapy for Patients With Cardiovascular Disease (SPC)			
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (M 21-75)	89.62%	90.67%	1.05%
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (M 21-75)	83.19%	83.25%	0.06%

Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (F 40-75)	83.19%	84.01%	0.82%
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (F 40-75)	79.29%	81.84%	2.55%
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	88.13%	89.17%	1.04%
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	82.34%	82.95%	0.61%
Comprehensive Diabetes Care (CDC)			
Comprehensive Diabetes Care - HbA1c Testing	84.91%	93.29%	8.38%
Comprehensive Diabetes Care - Poor HbA1c Control	30.9%	24.45%	-6.45%
Comprehensive Diabetes Care - HbA1c Control (<8%)	57.18%	62.38%	5.20%
Comprehensive Diabetes Care - Eye Exams	59.85%	69.77%	9.92%
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	52.31%	69.42%	17.11%
Kidney Health Evaluation for Patients With Diabetes (KED)			
Kidney Health Evaluation for Patients With Diabetes (18-64)	68.57%	80.85%	12.28%
Kidney Health Evaluation for Patients With Diabetes (65-74)	76.35%	87.29%	10.94%
Kidney Health Evaluation for Patients With Diabetes (75-85)	41.17%	79.27%	38.10%
Kidney Health Evaluation for Patients With Diabetes (Total)	68.88%	81.47%	12.59%
Statin Therapy for Patients With Diabetes (SPD)			
Statin Therapy for Patients With Diabetes - Received Statin Therapy	75.14%	76.46%	1.32%
Statin Therapy for Patients With Diabetes - Statin Adherence 80%	78.1%	78.91%	0.81%
Antidepressant Medication Management (AMM)			
Antidepressant Medication Management - Effective Acute Phase Treatment	79.1%	81.38%	2.28%
Antidepressant Medication Management - Effective Continuation Phase Treatment	61.3%	59.98%	-1.32%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	66.2%	74.15%	7.95%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	68.14%	76.05%	7.91%
Follow-up After Hospitalization for Mental Illness (FUH)			
Follow-Up After Hospitalization For Mental Illness - 30 days (6-17)	89.74%	79.18%	-10.56%

Follow-Up After Hospitalization For Mental Illness - 7 days (6-17)	74.52%	52.74%	-21.78%
Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)	80.88%	74.75%	-6.13%
Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)	62.47%	50.30%	-12.17%
Follow-Up After Hospitalization For Mental Illness - 30 days (65+)	79.17%	82.50%	3.33%
Follow-Up After Hospitalization For Mental Illness - 7 days (65+)	62.5%	50.00%	-12.50%
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)	83.56%	76.30%	-7.26%
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)	66.13%	51.11%	-15.02%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)	87.04%	79.85%	-7.19%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)	81.28%	72.24%	-9.04%
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)	66.78%	68.64%	1.86%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)	57.86%	60.60%	2.74%
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (65+)	58.54%	54.05%	-4.49%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (65+)	46.34%	51.35%	5.01%
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)	71.94%	71.23%	-0.71%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)	63.78%	63.39%	-0.39%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)	31.43%	47.06%	15.63%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)	13.14%	19.61%	6.47%
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)	62.55%	62.71%	0.16%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	38.43%	42.55%	4.12%
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (65+)	42.11%	NA	NA

Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)	15.79%	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	59.37%	61.76%	2.39%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	35.78%	41.04%	5.26%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (13-17)	16.09%	32.47%	16.38%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (13-17)	10.34%	25.97%	15.63%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)	26.95%	37.00%	10.05%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)	17.72%	26.28%	8.56%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)	26.4%	36.87%	10.47%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)	17.35%	26.27%	8.92%
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (18-64) (16-64 in MY 2021)	13.03%	21.90%	8.87%
Pharmacotherapy for Opioid Use Disorder (65+)	0%	34.21%	34.21%
Pharmacotherapy for Opioid Use Disorder (Total)	12.74%	22.21%	9.47%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	64.91%	69.59%	4.68%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11)	52.8%	64.26%	11.46%
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11)	49.07%	59.67%	10.60%
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11)	49.07%	58.69%	9.62%
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17)	56.7%	65.69%	8.99%
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17)	53.03%	59.19%	6.16%

Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17)	51.69%	57.65%	5.96%
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)	55.94%	65.44%	9.50%
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)	52.26%	59.27%	7.01%
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	51.18%	57.83%	6.65%
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.11%	0.07%	-0.04%
Appropriate Treatment for Upper Respiratory Infection (URI)			
Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)	98.04%	98.48%	0.44%
Appropriate Treatment for Upper Respiratory Infection (18-64)	88.97%	95.73%	6.76%
Appropriate Treatment for Upper Respiratory Infection (65+)	87.51%	93.38%	5.87%
Appropriate Treatment for Upper Respiratory Infection (Total)	92.51%	96.50%	3.99%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 -17 Years)	94.86%	98.48%	3.62%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	65.75%	95.73%	29.98%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)	59.38%	93.38%	34.00%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	72.33%	96.50%	24.17%
Use of Imaging Studies for Low Back Pain (LBP)			
Use of Imaging Studies for Low Back Pain	87.57%	85.00%	-2.57%
Use of Opioids at High Dosage (HDO)			
Use of Opioids at High Dosage	2.69%	2.39%	-0.30%
Use of Opioids From Multiple Providers (UOP)			
Use of Opioids From Multiple Providers - Multiple Prescribers	22.35%	24.85%	2.50%
Use of Opioids From Multiple Providers - Multiple Pharmacies	1.76%	1.68%	-0.08%
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies	1.04%	1.10%	0.06%
Risk of Continued Opioid Use (COU)			

Risk of Continued Opioid Use - >=15 Days (18-54) (18-54 in MY 2021)	4.31%	3.74%	-0.57%
Risk of Continued Opioid Use - >=31 Days (18-54) (18-54 in MY 2021)	1.36%	1.23%	-0.13%
Risk of Continued Opioid Use - >=15 Days (65+)	9.67%	8.05%	-1.62%
Risk of Continued Opioid Use - >=31 Days (65+)	3.47%	2.50%	-0.97%
Risk of Continued Opioid Use - >=15 Days (Total)	4.52%	3.92%	-0.60%
Risk of Continued Opioid Use - >=31 Days (Total)	1.45%	1.28%	-0.17%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
Adults' Access to Preventive/Ambulatory Health Services (20-44)	91.45%	91.96%	0.51%
Adults' Access to Preventive/Ambulatory Health Services (45-64)	94.25%	94.21%	-0.04%
Adults' Access to Preventive/Ambulatory Health Services (65+)	95.76%	95.47%	-0.29%
Adults' Access to Preventive/Ambulatory Health Services (Total)	92.97%	93.17%	0.20%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)			
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17)	55.97%	51.15%	-4.82%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17)	15.72%	16.67%	0.95%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (13-17)	85%	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (13-17)	20%	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17)	67.39%	58.86%	-8.53%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17)	26.62%	19.62%	-7.00%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17)	64.93%	57.16%	-7.77%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17)	24.93%	19.16%	-5.77%

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)	61.03%	48.60%	-12.43%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)	31.18%	24.49%	-6.69%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)	69.48%	58.30%	-11.18%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)	43.32%	33.39%	-9.93%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)	51.16%	41.66%	-9.50%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)	19.64%	18.41%	-1.23%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)	59.58%	46.24%	-13.34%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)	28.81%	22.73%	-6.08%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)	60.95%	55.58%	-5.37%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)	30.93%	28.28%	-2.65%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)	69.69%	64.13%	-5.56%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)	43.01%	39.36%	-3.65%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)	52.59%	46.68%	-5.91%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)	20.26%	16.57%	-3.69%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)	59.82%	52.99%	-6.83%

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)	28.64%	25.13%	-3.51%
Prenatal and Postpartum Care (PPC)			
Prenatal and Postpartum Care - Timeliness of Prenatal Care	97.25%	95.39%	-1.86%
Prenatal and Postpartum Care - Postpartum Care	89.7%	94.77%	5.07%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11)	75%	76.67%	1.67%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17)	78.49%	76.92%	-1.57%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	78.01%	76.89%	-1.12%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
Well-Child Visits in the First 30 Months of Life (First 15 Months) (MY 2022 - 6 or more)	81.1%	56.78%	-24.32%
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months) (MY 2022 - 2 or more)	66.35%	59.47%	-6.88%
Child and Adolescent Well-Care Visits (WCV)			
Child and Adolescent Well-Care Visits (3-11)	41.9%	59.55%	17.65%
Child and Adolescent Well-Care Visits (12-17)	34.11%	57.27%	23.16%
Child and Adolescent Well-Care Visits (18-21)	14.87%	24.29%	9.42%
Child and Adolescent Well-Care Visits (Total)	33.45%	51.05%	17.60%
Electronic Clinical Data Systems			
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)			
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)	8.39%	12.55%	4.16%
Depression Screening and Follow-Up for Adolescents and Adults - Follow-up on Positive Screen (Total)	66.21%	84.09%	17.88%
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)			
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period1 (Total)	46.13%	58.73%	12.60%
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period2 (Total)	44.97%	58.56%	13.59%
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period3 (Total)	49.69%	59.42%	9.73%

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)	46.86%	58.90%	12.04%
Depression Remission or Response for Adolescents and Adults (DRR-E)			
Depression Remission or Response for Adolescents and Adults - Follow-up PHQ-9 (Total)	49.43%	41.99%	-7.44%
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)	3.92%	8.34%	4.42%
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)	8.42%	16.27%	7.85%
Prenatal Immunization Status (PRS-E)			
Prenatal Immunization Status - Influenza	72.9%	68.39%	-4.51%
Prenatal Immunization Status - Tdap	90.96%	90.06%	-0.90%
Prenatal Immunization Status - Combination	70.7%	65.75%	-4.95%

HEDIS - MEDICARE			
Measure/Data Element	**Reporting Year 2021**	**Reporting Year 2022**	**Change**
Effectiveness of Care			
Breast Cancer Screening (BCS)			
Breast Cancer Screening - Non-LIS/DE Nondisability	80.18%	82.28%	2.10%
Breast Cancer Screening - LIS/DE	75.2%	75.92%	0.72%
Breast Cancer Screening - Disability	75.23%	75.16%	-0.07%
Breast Cancer Screening - LIS/DE and Disability	70.26%	68.65%	-1.61%
Breast Cancer Screening - Other	80.21%	83.86%	3.65%
Breast Cancer Screening - Unknown	74.42%	82.86%	8.44%
Breast Cancer Screening - Total	79.08%	80.73%	1.65%
Colorectal Cancer Screening (COL)			
Colorectal Cancer Screening - Non-LIS/DE Nondisability	84.96%	88.12%	3.16%
Colorectal Cancer Screening - LIS/DE	80.88%	85.30%	4.42%
Colorectal Cancer Screening - Disability	79.52%	83.00%	3.48%
Colorectal Cancer Screening - LIS/DE and Disability	72.93%	77.64%	4.71%
Colorectal Cancer Screening - Other	85.41%	88.97%	3.56%
Colorectal Cancer Screening - Unknown	82.14%	85.15%	3.01%
Colorectal Cancer Screening - Total	83.77%	87.12%	3.35%

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	41.77%	26.89%	-14.88%
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	87.65%	82.05%	-5.60%
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	93.51%	92.94%	-0.57%
Controlling High Blood Pressure (CBP)			
Controlling High Blood Pressure	60.15%	78.80%	18.65%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)			
Persistence of Beta-Blocker Treatment After a Heart Attack	95.9%	95.29%	-0.61%
Statin Therapy for Patients With Cardiovascular Disease (SPC)			
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (M 21-75)	90.42%	90.77%	0.35%
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (M 21-75)	90.99%	91.99%	1.00%
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (F 40-75)	86.41%	87.73%	1.32%
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (F 40-75)	89.59%	90.50%	0.91%
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	89.13%	89.81%	0.68%
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	90.55%	91.53%	0.98%
Comprehensive Diabetes Care (CDC)			
Comprehensive Diabetes Care - HbA1c Testing	92.66%	97.08%	4.42%
Comprehensive Diabetes Care - Poor HbA1c Control	14.18%	11.68%	-2.50%
Comprehensive Diabetes Care - HbA1c Control (<8%)	75.19%	76.56%	1.37%
Comprehensive Diabetes Care - Medical Attention for Nephropathy	96.46%	97.69%	1.23%
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	63.04%	79.13%	16.09%
Comprehensive Diabetes Care - Eye Exams - Non-LIS/DE Nondisability	72.67%	83.96%	11.29%
Comprehensive Diabetes Care - Eye Exams - LIS/DE	72.3%	83.89%	11.59%
Comprehensive Diabetes Care - Eye Exams - Disability	67.41%	77.87%	10.46%

Comprehensive Diabetes Care - Eye Exams - LIS/DE and Disability	68.61%	77.33%	8.72%
Comprehensive Diabetes Care - Eye Exams - Other	56.7%	62.60%	5.90%
Comprehensive Diabetes Care - Eye Exams - Unknown	66.67%	84.09%	17.42%
Comprehensive Diabetes Care - Eye Exams - Total	71.56%	82.60%	11.04%
Kidney Health Evaluation for Patients With Diabetes (KED)			
Kidney Health Evaluation for Patients With Diabetes (18-64)	74.71%	82.29%	7.58%
Kidney Health Evaluation for Patients With Diabetes (65-74)	80.41%	89.26%	8.85%
Kidney Health Evaluation for Patients With Diabetes (75-85)	43.46%	83.46%	40.00%
Kidney Health Evaluation for Patients With Diabetes (Total)	67.02%	86.79%	19.77%
Statin Therapy for Patients With Diabetes (SPD)			
Statin Therapy for Patients With Diabetes - Received Statin Therapy	85.52%	86.87%	1.35%
Statin Therapy for Patients With Diabetes - Statin Adherence 80%	89.11%	89.87%	0.76%
Osteoporosis Management in Women Who Had a Fracture (OMW)			
Osteoporosis Management in Women Who Had a Fracture	81.66%	82.56%	0.90%
Antidepressant Medication Management (AMM)			
Antidepressant Medication Management - Effective Acute Phase Treatment	87.14%	86.39%	-0.75%
Antidepressant Medication Management - Effective Continuation Phase Treatment	74.41%	65.03%	-9.38%
Follow-up After Hospitalization for Mental Illness (FUH)			
Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)	78.67%	84.87%	6.20%
Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)	61.77%	68.77%	7.00%
Follow-Up After Hospitalization For Mental Illness - 30 days (65+)	77.84%	73.12%	-4.72%
Follow-Up After Hospitalization For Mental Illness - 7 days (65+)	60.54%	53.23%	-7.31%
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)	78.35%	79.98%	1.63%
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)	61.3%	62.30%	1.00%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)	70.12%	81.82%	11.70%

Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)	59.75%	74.83%	15.08%
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (65+)	62.07%	66.07%	4.00%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (65+)	55.49%	58.63%	3.14%
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)	65.54%	73.31%	7.77%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)	57.32%	66.08%	8.76%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)	26.89%	54.22%	27.33%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)	15.11%	45.24%	30.13%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	75.97%	80.76%	4.79%
Transitions of Care (TRC)			
Transitions of Care - Notification of Inpatient Admission (Total)	94.65%	94.00%	-0.65%
Transitions of Care - Receipt of Discharge Information (Total)	74.45%	79.00%	4.55%
Transitions of Care - Patient Engagement After Inpatient Discharge (Total)	98.46%	97.64%	-0.82%
Transitions of Care - Medication Reconciliation Post-Discharge (Total)	85.16%	97.04%	11.88%
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)			
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (18-64)	90.55%	82.55	8164.45%
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (65+)	89.47%	78.55	7765.53%
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (Total)	89.57%	78.89	7799.43%
Non-Recommended PSA-Based Screening in Older Men (PSA)			
Non-Recommended PSA-Based Screening in Older Men	9.09%	14.36	1426.91%
Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)			

Potentially Harmful Drug-Disease Interactions in Older Adults - DDI Falls + Anticonvulsants, Nonbenzodiazepine hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines or Tricyclic Antidepressants	41.28%	29.13%	-12.15%
Potentially Harmful Drug-Disease Interactions in Older Adults - DDI Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine hypnotics or Anticholinergic Agents	23.98%	22.51%	-1.47%
Potentially Harmful Drug-Disease Interactions in Older Adults - DDI Chronic Kidney Disease + Cox-2 Selective NSAIDs or Nonaspirin NSAIDs	2.88%	2.98%	0.10%
Potentially Harmful Drug-Disease Interactions in Older Adults - Total	27.68%	20.73%	-6.95%
Use of High-Risk Medications in Older Adults (DAE)			
Use of High-Risk Medications in Older Adults - High Risk Medications to Avoid (MY 2022: Two Dispensings from Same Drug Class)	5.61%	5.68%	0.07%
Use of High-Risk Medications in Older Adults - High Risk Medication to avoid except for Appropriate diagnosis (Two Dispensings - Except Appropriate Diagnoses)	3.01%	2.83%	-0.18%
Use of High-Risk Medications in Older Adults - Total	8.21%	8.09%	-0.12%
Use of Opioids at High Dosage (HDO)			
Use of Opioids at High Dosage	3.52%	3.23%	-0.29%
Use of Opioids From Multiple Providers (UOP)			
Use of Opioids From Multiple Providers - Multiple Prescribers	20.92%	22.38%	1.46%
Use of Opioids From Multiple Providers - Multiple Pharmacies	1.12%	1.01%	-0.11%
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies	0.7%	0.64%	-0.06%
Risk of Continued Opioid Use (COU)			
Risk of Continued Opioid Use - >=15 Days (18-64)	9.49%	8.30%	-1.19%
Risk of Continued Opioid Use - >=31 Days (18-64)	4.81%	4.56%	-0.25%
Risk of Continued Opioid Use - >=15 Days (65+)	8.81%	7.29%	-1.52%
Risk of Continued Opioid Use - >=31 Days (65+)	3.62%	3.22%	-0.40%
Risk of Continued Opioid Use - >=15 Days (Total)	8.89%	7.39%	-1.50%
Risk of Continued Opioid Use - >=31 Days (Total)	3.75%	3.34%	-0.41%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
Adults' Access to Preventive/Ambulatory Health Services (20-44)	94.46%	96.55%	2.09%

Adults' Access to Preventive/Ambulatory Health Services (45-64)	96%	97.18%	1.18%
Adults' Access to Preventive/Ambulatory Health Services (65+)	94.27%	95.69%	1.42%
Adults' Access to Preventive/Ambulatory Health Services (Total)	94.34%	95.75%	1.41%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)			
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)	49.73%	47.97%	-1.76%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)	11.63%	12.77%	1.14%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)	49.46%	48.09%	-1.37%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)	10.6%	14.31%	3.71%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)	47.11%	41.74%	-5.37%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)	7.71%	7.35%	-0.36%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)	48.79%	46.43%	-2.36%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)	10.52%	11.61%	1.09%

Crossing the Quality Chasm			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **4. Analysis of results including metrics** **5. Barriers** **6. Next steps**
Breast Cancer • 2022 target 84%	• Radiology and Quality are partnering to identify and address any areas of opportunity to improve access given extraordinary levels of demand • Backsweep outreach was piloted in Q4 to encourage members to complete their screening – further additional outreach reminders planned for 2022	Medical Director for Quality Monthly	<u>Analysis</u> 84% of patients screened within the past 24 months as of December 2022 <u>Next steps</u> • Continue monitoring performance • Continue partnering with Radiology and Quality to ensure access needs • Continue supporting inreach efforts • Identify and share best practices for access
Cervical Cancer • 2022 target: 84%	• Team to continue partnering with local sites to ensure good access • Convening special workgroup to tackle issues of COVID-related backlog to try and right-size appointments and hours to demand • Initial pilots are underway to scope home HPV self-collection which will help alleviate any barriers around transportation, perceived COVID exposure risk and access	Medical Director for Quality Monthly	<u>Analysis</u> 81% of patients screened within the past 36 months as of December 2022 <u>Barriers</u> • Severe backlog accumulation due to COVID shelter in place and the suspension of regional outreach (March 2020-September 2020) • Limited in-person appointment capacity to address backlog due to staffing (e.g., hiring and ongoing effects of COVID/flu/RSV outbreaks) <u>Next steps</u> • Anticipated increased appointment access (March 2023-September 2023) to focus on backlog reduction. There will be

Crossing the Quality Chasm			
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			coordination of regional and local outreach efforts to address this backlog. • Regional support of inreach view adjustments to maximize backlog reduction and simultaneously continue screening the coming due population • Identify and share best practices for access
Colorectal Cancer • 2022 target 81% (for 51-75 year olds)	• Work with Regional Lab to improve workflows and create efficiencies in the process • Offering Cologuard to members who have not responded to FIT • Reduce Colonoscopy backlog by providing alternative routes for screening when appropriate (i.e. FIT, Cologuard, Interval Change) • Provide training for new physicians, MAs, and managers on cancer inreach. • Educate new physicians on CRC screening options, especially the ease and effectiveness of FIT. • Use Latino and African-American optimized outreach materials when appropriate. • Use non-English language outreach materials when appropriate. • Partner with MGA/AMGAs to improve inreach success by improving infrastructure, communication, education, and celebration.	Medical Director for Quality Monthly	<u>Analysis</u> 78% of 51-75 yr old patients screened as of December 2022 <u>Barriers</u> • In 2021 we experienced a large number of Test Not Done results due to a staff shortage at the Regional Lab. This led to members having to re-do their FIT kits (sometimes up to 3 times). This may have led to reduced screening rates in 2022. • In order to not have a repeat TND issue, we asked local sites to only focus on local outreach for members that have completed regional outreach to reduce FIT kit volumes to Regional Lab. This may have impacted screening rates. • We hypothesize that there were less in-person visits in 2022 compared to before COVID, so there were less opportunities for Inreach.

Crossing the Quality Chasm			
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	• Set an expectation that every department is accountable for closing CRC care gaps on DOV. • Share patient and staff stories to inspire staff and clinicians. • Share best practices from most successful sites across other medical centers.		Next steps • Conduct a current state assessment of how local outreach is conducted across the region to help identify solutions to improve local outreach. • Implement new FIT kit instruction sheet designed to make instructions clearer for members. • Hold a training for Inreach best practices for Medical Assistants. • Pilot and implement new Small Media postcard during Regional Outreach for the general population (similar to tailored material currently used for African American and Latino American populations).
Cardiovascular Health			
Diabetes A1C ≤ 9 • 2022 target 83%	• A1c testing PROMPT – inreach in all specialties • Use medical center A1c outreach lists • Health Education to support targeted outreach • Lab drop in access for member convenience • Pilot new outreach channels	Medical Director for Population Care Monthly	Analysis 80% of patients tested and in control as of December 2022 Barriers • Staffing shortages across Diabetes care team • Patients with increasing COVID-impacted health disparities • Disengaged patients and resourcing issues due to tripledemic (flu, RSV, COVID)

Crossing the Quality Chasm			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **4. Analysis of results including metrics** **5. Barriers** **6. Next steps**
			Next steps • Continue to explore new outreach channels • Increase remote glucose monitoring/continuous glucose monitoring adoption and utilization • Partner with low-performing medical centers to remove barriers and offer regional support
Diabetes A1C < 8 • 2022 target 71%	• A1c testing PROMPT – inreach in all specialties • Use medical center A1c outreach lists • Health Education to support targeted outreach • Lab drop in access for member convenience • Pilot new outreach channels	See above	Analysis 67% of patients tested and in control as of December 2022 Barriers • Staffing shortages across Diabetes care team • Patients with increasing COVID-impacted health disparities • Disengaged patients and resourcing issues due to tripledemic (flu, RSV, COVID) Next steps • Overcome therapeutic inertia by engaging with patients at risk of flipping out of glycemic control earlier • Continue to explore new outreach channels • Increase remote glucose monitoring/continuous glucose monitoring adoption and utilization

Crossing the Quality Chasm			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **4. Analysis of results including metrics** **5. Barriers** **6. Next steps**
			• Partner with low-performing medical centers to remove barriers and offer regional support • Explore expanded access to Thrive Local resources to address social determinants of health
Diabetes Latino A1C < 8 • 2022 target 71% Note: For 2022, the patient denominator will be expanded to 18-75 years.	• A1c testing PROMPT – inreach in all specialties • Use medical center A1c outreach lists • Health Education to support targeted outreach • Lab drop in access for member convenience • Pilot new outreach channels	See above	<u>Analysis</u> 60% of Latino patients tested and in control as of December 2022 <u>Barriers</u> • Staffing shortages across Diabetes care team • Patients with increasing COVID-impacted health disparities • Disengaged patients and resourcing issues due to tripledemic (flu, RSV, COVID) • New emphasis on Latino A1c disparity has had delayed uptake operationally <u>Next steps</u> • Create Latino Taskforce • Offer cultural training to Diabetes Care Managers • Conduct root cause analysis on high 'fail to keep appointment' (FTKA) rates for Health Education classes

Crossing the Quality Chasm			
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Diabetic Retinopathy/DM Eye Screening • 2022 target 79%	• Review CQC performance monthly. Use monthly DM Eye reports to identify high performing departments and to share best practices. • Managers should review the missing documentation report (monthly). • Provide training to AFM MAs with suboptimal image quality (> 8% inconclusive photo rates). • AFM, Eye, and Quality teams should meet regularly to discuss workflows and PI opportunities. • Provide ongoing training for all new physicians, MAs, and managers on PROMPT DM eye. • All MAs should use PROMPT to review DM Eye status and complete needed DM eye photos. • Ensure effective local infrastructure and leadership • Optimize camera resources • Ensure effective inreach strategies within all departments • Ensure regular outreach to overdue members	Medical Director for Quality Monthly	Analysis 80% of patients screened as of December 2022 Next steps • Enhance current regional outreach methods through improved tracking capability • Test new outreach messaging and evaluate which is most impactful (i.e., results with highest follow up screening rate) • Ensure camera resources are located based on population needs • Support local medical centers with outreach through best practice dissemination
Hypertension (HTN) control all population • 2022 target 83%	• Ensure that all members have their BP checked (improve on 20% gap to reach 100%). • Continue to monitor and explore opportunities for BP Cuff coverage for all members.	Medical Director for Population Care Monthly	Analysis 81% of patients screened as of December 2022. In 2022, we improved our HTN measure, maintained our 2021 gains and furthered our

Crossing the Quality Chasm			
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	• Pharmacy to promote BP cuffs. • Enhance capture of remote BP during virtual care. • Ongoing partnerships with health education and health engagement teams. • MindRay data integration with KPHC to increase efficiency and decrease transcription errors. • Maintain changes and workflows introduced in 2021. • Monitoring monthly and weekly performance reports to identify opportunities for improvement.		improvements incrementally. Areas of success included: • Enhanced KPHC in-reach and outreach tools • Increase virtual bp collections • Yearend Regional Outreach to 116k members • Updated Regional HTN Member Resources • Engage and provide ongoing trainings to multidisciplinary teams • Conducted a HTN Pharmacy PDSA <u>Barriers</u> • Due to COVID, many patients have deferred their care, resulting in lower screening • Adjustments in operations to shifting to post-pandemic to ensure we have multiple BP collection opportunities • Lack of sufficient staff to support BP specific appointments • Competing priorities within AFM-tripledemic • Cost barrier for BP cuff <u>Next steps</u> • Ensure all members have their BPs checked (improve on 2% to close goal gap)

Crossing the Quality Chasm			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **4. Analysis of results including metrics** **5. Barriers** **6. Next steps**
			• Continued communication of tech updates to smooth transition of updated tools (e.g. BP Due Banner) • Conduct bi-annual regional outreach to support local outreach efforts • Ongoing partnership with health education and health engagement teams to promote importance of BP collection and lifestyle modifications • Continue to monitor and explore regional best practices to scale and spread • Monitor monthly and weekly performance reports to identify opportunities for improvement • Identify opportunities to collaborate with specialty depts to collect BPs
HTN in Black/African-American • 2022 target: 83% Note: For 2022, the patient denominator will be expanded to 18-85 years.	*Same as above*	Medical Director for Population Care Monthly	<u>Analysis</u> 76% of patients screened as of December 2022. In 2022, the AAHTN measure achieved a 3% increase from previous year. <u>Barriers</u> • See above <u>Next steps</u> • Identify medical sites who have developed programs/best practices that may be scaled and spread across the organization

Crossing the Quality Chasm			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **4. Analysis of results including metrics** **5. Barriers** **6. Next steps**
			• Review of improvement work done to date and results for purposes of lessons learned • Eliciting patient voice to find best practice around engagement • Explore Thrive Local for social determinants of health resources
Diabetes Blood Pressure • 2022 target 83%	*Same as above*	Medical Director for Population Care Monthly	<u>Analysis</u> 78% of patients screened as of December 2022. In 2022, the DMBP measure improved 2% from previous year. <u>Barriers</u> • See above <u>Next steps</u> • Ensure all members have their BPs checked (improve on 2% to close goal gap) • Continued communication of tech updates to smooth transition of updated tools (e.g. BP Due Banner) • Conduct bi-annual regional outreach to support local outreach efforts • Ongoing partnership with health education and health engagement teams to promote importance of BP collection and lifestyle modifications

Crossing the Quality Chasm			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **4. Analysis of results including metrics** **5. Barriers** **6. Next steps**
			• Continue to monitor and explore regional best practices to scale and spread • Monitor monthly and weekly performance reports to identify opportunities for improvement • Identify opportunities to collaborate with specialty depts to collect BPs
Statin Appropriate Fill/Adherence Combined Fill • 2022 targets: Statin Fill ASCVD: 92% Statin fill DM: 83%	• Optimized automated outreach to reduce secondary nonadherence • Promote mail order pharmacy and two-way texting to refill medications • Monitor weekly performance reports among care managers to identify and spread best practices • Convert 90-day statin supplies to 100 day supply prescriptions	Medical Director for Population Care Monthly	Analysis *Statin Fill ASCVD:* 89% of members in the ASCVD subset of the PHASE registry had at least one dispensing event of an appropriate statin as of December 2022. *Statin Fill Diabetes:* 82% of members in the diabetes subset of the PHASE registry had at least one dispensing event of an appropriate statin, as of December 2022. Barriers for Statin Fill ASCVD: • Patient statin hesitancy • Outside fills • Staffing turnover ○ Lack of focused APM time on Statin reminders Barriers for Statin Fill Diabetes: • Patient statin hesitancy • Outside fills • Staffing turnover

Crossing the Quality Chasm			
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			○ Lack of focused APM time on Statin reminders <u>Next steps</u> • Technology enhancements to provide efficiency and organization in Statin outreach • Development of new statin patient-facing educational materials that addresses patient hesitancy and informs them of the benefits to their health • Training opportunities to adjust medication instructions to reflect correct statin usage • Provide high-yield lists for targeted live outreach • New patient-facing Heart Health Guide on MDO • Exploring THRIVE local to address SDOH needs
ASCVD Adherence • **See above** • 2022 target 92%	See above	Medical Director for Population Care Monthly	<u>Analysis</u> 87% of members in the ASCVD subset of the PHASE registry remained on a high or moderate intensity statin for at least 80% of the time since the first fill, as of December 2022. <u>Barriers for Statin Adherence ASCVD</u> • Post-Q1 dip in adherence • Outside fills • Patients have additional supply of medications <u>Next steps</u>

Crossing the Quality Chasm			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **4. Analysis of results including metrics** **5. Barriers** **6. Next steps**
			• Technology enhancements to provide efficiency and organization in Statin outreach • Training opportunities to adjust medication instructions to reflect correct statin usage • Provide high-yield lists for targeted live outreach • Patient voice analysis to determine root cause of post-Q1 adherence dip • New patient-facing Heart Health Guide on MDO • Exploring THRIVE local to address SDOH needs
DM Adherence • **See above** • 2022 target 86%	See above	Medical Director for Population Care Monthly	<u>Analysis</u> 83% of members in the diabetes subset of the PHASE registry remained on a high or moderate intensity statin for at least 80% of the time since the first fill, as of December 2022. <u>Barriers for Statin Adherence Diabetes</u> • Post-Q1 dip in adherence • Outside fills • Oversupply of medications <u>Next steps</u> • Technology enhancements to provide efficiency and organization in Statin outreach

Crossing the Quality Chasm			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **4. Analysis of results including metrics** **5. Barriers** **6. Next steps**
			• Training opportunities to adjust medication instructions to reflect correct statin usage • Provide high-yield lists for targeted live outreach • Patient voice analysis to determine root cause of post-Q1 adherence dip • New patient-facing Heart Health Guide on MDO • Exploring THRIVE local to address SDOH needs
Tobacco Cessation			

Tobacco Quit Rate
• 2022 target 90%
	• Goal remains unchanged for Quitters Campaign at 30,000 quitters in 2022.
	• Focus on teachable moments:
	  ○ Quit/Counseling/Medication upon admission to hospital
	  ○ Encourage Periop quits
	• Continue to hardwire previous efforts:
	• APICQ, Tobacco consultants, quality leaders review CQC monthly for Quit Rate.
	• AMGAs and Managers review MA Rooming Tool Report monthly for tobacco status completions
	• Teach/monitor for warm handoffs between MAs & PCPs during DOVs
	• Remind physicians and staff that all KP NCAL members can be prescribed over-the-counter (OTC) nicotine replacement therapies (NRT) at no cost share.
		Medical Director for Quality
		
		Monthly
			<u>Analysis</u>
			• Achieved regional quit rate of 90% as of December 2022, with all medical centers reaching target
			
			<u>Next steps</u>
			• Goal remains unchanged for Quitters Campaign at 30,000 quitters in 2023, with the 2023 quit rate target remaining at 90%.
			
			• Focus on teachable moments:
			  ○ Quit/Counseling/Medication upon admission to hospital
			  ○ Encourage Periop quits
			• Continue to hardwire previous efforts:
			  ○ APICQ, Tobacco consultants, quality leaders review CQC monthly for Quit Rate.
			  ○ AMGAs and Managers review MA Rooming Tool Report monthly for tobacco status completions
			  ○ Teach/monitor for warm handoffs between MAs & PCPs during DOVs

Crossing the Quality Chasm			
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	• Multi-disciplinary tobacco team (with designated team lead) meets regularly (recommend monthly). • Ensure ongoing training -- MAs: Accurately document tobacco use in the social hx and alert physicians about current smoker status. Physicians: Trained in effective conversations, uses SmartRx for NRT Rx and referrals to wellness coaching. • Promote the Quality Tools button to review Tobacco guidelines and to share information with patients. • Use My Panel Manager and other tools to outreach to targeted smoking populations (i.e., recent quitters, current smokers). Use a small number of centralized MAs or PrAs to run outreach for a module or facility vs PCPs personal MAs. • Sustain communication structure to ensure tobacco performance data is shared with providers and staff (i.e., posted on huddle boards & shared during dept meetings).		○ Remind physicians and staff that all KP NCAL members can be prescribed over-the-counter (OTC) nicotine replacement therapies (NRT) at no cost share. ○ Multi-disciplinary tobacco team (with designated team lead) meets regularly (recommend monthly). ○ Ensure ongoing training -- MAs: Accurately document tobacco use in the social hx and alert physicians about current smoker status. Physicians: Trained in effective conversations, uses SmartRx for NRT Rx and referrals to wellness coaching. ○ Promote the Quality Tools button to review Tobacco guidelines and to share information with patients. ○ Use My Panel Manager and other tools to outreach to targeted smoking populations (i.e., recent quitters, current smokers). Use a small number of centralized MAs or PrAs to run outreach for a module or facility vs PCPs personal MAs. ○ Sustain communication structure to ensure tobacco performance data is shared with providers and staff (i.e., posted on huddle boards & shared during dept meetings).
ESRD			
Optimal Start 2022 Targets: • Optimal Starts ≥ 68%	• Continue monitoring performance, identify trends and opportunities for	Medical Director for Quality Monthly	<u>Analysis</u> 59% of ESRD patients started renal-replacement therapy optimally as of December 2022. <u>Barriers</u>

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• Percent of Hemodialysis patients who start with a central venous catheter (CVC) ≤ 50% • Home Dialysis [Peritoneal Dialysis (PD) + Home Hemodialysis (HHD) incidence ≥ 33%	standardization and optimization of care across NCAL		<u>Optimal Start:</u> • 90-day data lag due to exclusion criteria • IR and OR availability for AV fistula/graft • Adequate predictive tools for Nephrologists PD Home Dialysis: currently at 38% as of December 2022 • Need to get additional data about PD churn to HD in the first 30-60-90 days. <u>Next steps</u> • Create weekly report to identify New Start patients for timely access for root cause analysis and problem solving for managers • Creating managers tools for process mapping for New Starts • Create report for PD churn to do root cause analysis
Hemodialysis patients with Central Venous Catheter (CVC) in use for ≥ 90 days • 2022 target =<12%	• Continue monitoring performance, identify trends and opportunities for standardization and optimization of care across NCAL Partner with Vascular Surgery to ensure consistent care across the Region (including but not limited to consistent referral guidelines, OR/surgery access and challenging access workflow).	Medical Director for Quality Monthly	<u>Analysis</u> 19% of prevalent in-center hemodialysis patients dialyzed with a central venous catheter for more than 90-days or unknown as of December 2022. <u>Barriers</u> • IR and OR availability for AV fistula/graft • Pts undecided about whether to have dialysis • Knowledge of front-line staff about CVC exclusion criteria • Developing case conferences for Vascular Surgery and Nephrology to verify CVC exclusion

Crossing the Quality Chasm			
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			Next steps • Continue conversations with Vascular Surgery • Creation of weekly tracking reports for dialysis prep patients and may need permanent access
Asthma Care			
Asthma Med Ratio • 2022 target 92%	The regional asthma team will lead implementation of the Asthma care clinical guideline changes including provider and patient education: • Develop a PowerPoint talk for local asthma champions to present to their AFM and Pedi teams. • Develop a CME opportunity • Develop patient-facing content to help support medication changes for patients put on SMART therapy • Develop Asthma SmartRx in KP healthconnect to support prescribers.	Medical Director for Quality Monthly	Analysis 87% of members compliant with AMR of 0.5 or greater as of December 2022. Barriers • PCP time constraints – Asthma quality is PCP-centric and we're seeing a burden on primary care and prescribing providers, who are overwhelmed with competing priorities and limited bandwidth. Next steps • Looking into new internal reporting that can help local teams prioritize patients for outreach • Will conder simplifying our active asthma registry to only include the HEDIS defined patient population
Behavioral Health			
MOOD Significant Improvement • 2022 target 45%	• Analyze results of BPA pilot and make revisions based on performance data • Explore further technological tools to assist clinicians in identifying patients in need of AOQ • Explore and form partnerships with depression supporting groups, such as	Medical Director for Quality Monthly	Analysis 45% of members with a new episode of major depression significantly improved in the 5 month period following their diagnosis as of December 2022. Barriers

Crossing the Quality Chasm			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **4. Analysis of results including metrics** **5. Barriers** **6. Next steps**
	Project Chamai. Socialize new adopted avenues with depression co-consultants		• Technology tools needed for easier identification and tracking of patients Next steps • Transition to new Depression Monitoring and Depression Response measures • Creation of tools and adjustment of workflows for new depression population
Alcohol and Other Drugs – Initiation and Engagement in Treatment (AOD IET) • 2022 target 60%	• Maintain performance in 2022 through partnership with AMRS, AFM, MH, and ED.	Medical Director for Quality Monthly	Analysis 69% of adolescents age 13 -17 and adults age 18+ members with an episode of alcohol or other drug (AOD) dependence initiated treatment through an inpatient AOD admission, outpatient visit, telehealth visit, intensive outpatient encounter, Medication Assisted Treatment (MAT) or partial hospitalization within 14 days of diagnosis as of December 2022. Next steps Maintain performance in 2023 through partnership with AMRS, AFM, MH, and ED.
Immunization			
Childhood Immunization – COMBO 10 • 2022 target 76%	• PROMPT for Pediatric Well Check + IZs (0-2-year-olds) launched in December 2021; will complement regional childhood immunization status outreach lists to support outreach and focused inreach • Consistently monitor monthly rates reported to TPMG Pediatric Quality Dashboard for **Combo 10 (2022 target = 76%)**; engage service areas drifting off	Medical Director for Quality Monthly	Analysis 76% of members age 2 had the following vaccines by their second birthday: all from Combo 3, one hepatitis A (HepA), two or three rotavirus (RV), and two influenza (flu) as of December 2022. Barriers • Pediatric influenza is primary opportunity area impacting overall Combo 10 rates. Operational transition to post-pandemic workflows and onset of triple virus threat

Crossing the Quality Chasm			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **4. Analysis of results including metrics** **5. Barriers** **6. Next steps**
	target trend for consultation and support with performance improvement plan as needed • Extend regional secure message outreach campaign in 2022 for parents/guardians of 1-year-olds overdue for routine Well Child Visit		(COVID, flu and RSV) impacted Pediatric influenza vaccination rates. Next steps Patient outreach/inreach workflows (supported via Regional Outreach Lists and PROMPT patient views), education and ongoing focus on overall Combo 10 rates, including flu. Initiate collaboration with Pediatric Quality and Immunization leadership and Regional Flu Outreach leadership on development/implementation of outreach strategy tailored to Pediatrics.
Childhood Immunization – Flu • 2022 target 79%	• Consistently monitor monthly rates reported to TPMG Pediatric Quality Dashboard for **Child Flu (2022 target = 79%)**; engage service areas drifting off target trend for consultation and support with performance improvement plan as needed • TBD: develop new PROMPT Pediatric list for flu outreach for 2-year-old pediatric patients	Medical Director for Quality Monthly	Analysis 73% of members age 2 had two influenza (flu) vaccines by their second birthday as of December 2022. Barriers • Operational transition to post-pandemic workflows and onset of triple virus threat (COVID, flu and RSV) impacted Pediatric influenza vaccination rates. Next steps Please see above
Adolescent Immunization – Adol. COMBO 2 (replacing Adol. Combo 1) • 2022 target 62%	• PROMPT for Pediatric Well Check + IZs (5-17-year-olds) launched in December 2021; will complement regional adolescent medicine immunization outreach lists to support outreach and focused inreach • HPV Outreach Pilot: partnership with American Cancer Society on	Medical Director for Quality Monthly	Analysis 66% of adolescent members who turned 13 years of age during the measurement year were numerator compliant for all three indicators (meningococcal, Tdap, HPV) as of December 2022. Next steps Pediatric Quality & Immunization leadership will continue to maintain focus on timely and appropriate administration of meningococcal, Tdap,

Crossing the Quality Chasm			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **4. Analysis of results including metrics** **5. Barriers** **6. Next steps**
	performance improvement initiative to develop/test/refine targeted outreach list for adolescent/teen patients eligible for HPV dose (#1, #2, and in some cases, #3); pilot started October 2021 at four KPNC service areas (KP NSA, KP SCL, KP SRO, KP SSF); learning from pilot and development of data-driven best practices anticipated for spread across all KPNC pediatric clinics ~Q4 2022 • Consistently monitor monthly rates reported to TPMG Pediatric Quality Dashboard for **Adolescent Combo 2 (2022 target = 62%)**; engage service areas drifting off target trend for consultation and support with performance improvement plan as needed • TBD: launch new regional outreach campaign focused on 11-year-old pediatric patients due for 11-year Well Child Care Visit and/or adolescent immunizations (meningococcal, Tdap and HPV)		and HPV to our eligible pediatric adolescent patients.
Fracture Prevention: Treat or Scan			
Fracture Prevention: Treat or Scan • 2022 target 87%	• Maintain changes and workflows introduced in 2021.	Medical Director for Quality	<u>Analysis</u> 84% of women members who suffered a HEDIS defined fracture received either a bone mineral

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	• Strengthening partnership with Orthopedics to ensure that patients receive consistent messaging for fracture/fracture prevention care. • Adding preventative screening measure (Osteoporosis Management in Women Who Had a Fracture) to CQC reporting. • Continuing to partner with Imaging team to identify opportunities to improve access to DXA screenings.	Monthly	density test or a RX for HEDIS approved osteoporosis therapy (except calcitonin) in the 6 months since fracture as of December 2022. <u>Barriers</u> • Bone Density Access • Patient perception of treatment options <u>Next steps</u> • Creating effective communication materials • Developing personalized workflow for "Unable to Schedule" members • We will see the 2023 target become 82%

Population Health Management			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation (to be completed in 2023)** **7. Analysis of results including metrics** **8. Barriers** **9. Next steps**
Childhood Immunization – COMBO 10 • 2022 target 76%	• PROMPT for Pediatric Well Check + IZs (0-2-year-olds) launched in December 2021; will complement regional childhood immunization status outreach lists to support outreach and focused inreach • Consistently monitor monthly rates reported to TPMG Pediatric Quality Dashboard for **Combo 10 (2022 target = 76%)**; engage service areas drifting off target trend for consultation and support with performance improvement plan as needed Extend regional secure message outreach campaign in 2022 for parents/guardians of 1-year-olds overdue for routine Well Child Visit	Medical Director for Quality Monthly	Analysis 76% of members age 2 had the following vaccines by their second birthday: all from Combo 3, one hepatitis A (HepA), two or three rotavirus (RV), and two influenza (flu) as of December 2022. Barriers • Pediatric influenza is primary opportunity area impacting overall Combo 10 rates. Operational transition to post-pandemic workflows and onset of triple virus threat (COVID, flu and RSV) impacted Pediatric influenza vaccination rates. Next steps • Patient outreach/inreach workflows (supported via Regional Outreach Lists and PROMPT patient views), education and ongoing focus on overall Combo 10 rates, including flu. Initiate collaboration with Pediatric Quality and Immunization leadership and Regional Flu Outreach leadership on development/implementation of outreach strategy tailored to Pediatrics.
Colorectal Cancer • 2022 target 81% (for 51-75 year olds)	• Work with Regional Lab to improve workflows and create efficiencies in the process • Offering Cologuard to members who have not responded to FIT • Reduce Colonoscopy backlog by providing alternative routes for	Medical Director for Quality Monthly	Analysis 78% of 51-75 yr old patients screened as of December 2022 Barriers • In 2021 we experienced a large number of Test Not Done results due to a staff shortage at the

Population Health Management			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation (to be completed in 2023)** **7. Analysis of results including metrics** **8. Barriers** **9. Next steps**
	screening when appropriate (i.e. FIT, Cologuard, Interval Change) • Provide training for new physicians, MAs, and managers on cancer inreach. • Educate new physicians on CRC screening options, especially the ease and effectiveness of FIT. • Use Latino and African-American optimized outreach materials when appropriate. • Use non-English language outreach materials when appropriate. • Partner with MGA/AMGAs to improve inreach success by improving infrastructure, communication, education, and celebration. • Set an expectation that every department is accountable for closing CRC care gaps on DOV. • Share patient and staff stories to inspire staff and clinicians. Share best practices from most successful sites across other medical centers.		Regional Lab. This led to members having to re-do their FIT kits (sometimes up to 3 times). This may have led to reduced screening rates in 2022. • In order to not have a repeat TND issue, we asked local sites to only focus on local outreach for members that have completed regional outreach to reduce FIT kit volumes to Regional Lab. This may have impacted screening rates. • We hypothesize that there were less in-person visits in 2022 compared to before COVID, so there were less opportunities for Inreach. <u>Next steps</u> • Conduct a current state assessment of how local outreach is conducted across the region to help identify solutions to improve local outreach. • Implement new FIT kit instruction sheet designed to make instructions clearer for members. • Hold a training for Inreach best practices for Medical Assistants. • Pilot and implement new Small Media postcard during Regional Outreach for the general population (similar to tailored material currently used for African American and Latino American populations).
Diabetes A1C < 8 • 2022 target 71%	• A1c testing PROMPT – inreach in all specialties	See above	<u>Analysis</u>

Population Health Management			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation (to be completed in 2023)** **7. Analysis of results including metrics** **8. Barriers** **9. Next steps**
	• Use medical center A1c outreach lists • Health Education to support targeted outreach • Lab drop in access for member convenience Pilot new outreach channels		67% of patients tested and in control as of December 2022 <u>Barriers</u> • Staffing shortages across Diabetes care team • Patients with increasing COVID-impacted health disparities • Disengaged patients and resourcing issues due to tripledemic (flu, RSV, COVID) <u>Next steps</u> • Overcome therapeutic inertia by engaging with patients at risk of flipping out of glycemic control earlier • Continue to explore new outreach channels • Increase remote glucose monitoring/continuous glucose monitoring adoption and utilization • Partner with low-performing medical centers to remove barriers and offer regional support • Explore expanded access to Thrive Local resources to address social determinants of health
Asthma Med Ratio • 2022 target 92%	The regional asthma team will lead implementation of the Asthma care clinical guideline changes including provider and patient education: • Develop a PowerPoint talk for local asthma champions to present to their AFM and Pedi teams. • Develop a CME opportunity	Medical Director for Quality Monthly	<u>Analysis</u> 87% of members compliant with AMR of 0.5 or greater as of December 2022. <u>Barriers</u> • PCP time constraints – Asthma quality is PCP-centric and we're seeing a burden on primary care

Population Health Management			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation (to be completed in 2023)** **7. Analysis of results including metrics** **8. Barriers** **9. Next steps**
	• Develop patient-facing content to help support medication changes for patients put on SMART therapy • Develop Asthma SmartRx in KP healthconnect to support prescribers.		and prescribing providers, who are overwhelmed with competing priorities and limited bandwidth. <u>Next steps</u> • Looking into new internal reporting that can help local teams prioritize patients for outreach • Will conder simplifying our active asthma registry to only include the HEDIS defined patient population
Kaiser Permanente medical centers across Northern California maintain a C. diff standardized infection ratio (SIR) of 0.55 or below.	• Members targeted for the C. diff program care bundle receive close monitoring of any loose stools to determine cause and identify cases of C. diff infection (vs. carriers) • Members with confirmed cases of C. diff infection are acted upon quickly, including isolation and treatment with antibiotics.	TPMG Consulting Services and PHM/Quality Director 12/31/2022	• At year-end 2022, regional performance for the C.diff metric had a standardized infection ratio (SIR) of 0.47, which met the target of below 0.55. • Going forward, members will continue to receive the program care bundle and close monitoring as appropriate to maintain program performance.
Over 90% of members in the Special Needs Plan program and Complex Chronic Conditions program affirm through a feedback survey that the interdisciplinary care team successfully assists them in achieving their goals.	Complex Chronic Conditions • Intensive case management conducted by nurses and social workers consisting of face-to-face clinic visits, telephone appointments, family conferences, and home visits if indicated. • During these visits, nurse/social worker teams develop a personalized care plan designed to be completed in the limited time span intended for the program (no more than 6 months) • Nurse/social worker teams	TPMG Consulting Services and Complex Needs Director 12/31/2022	• The Special Needs Plan program had year-end performance of 96.7%, which met this PHM program goal of 90% performance. • The Complex Chronic Conditions program, however, had year end performance of 100%, which met the PHM program goal of 90% • In 2023, we plan to seek insight from program staff to help understand members' perceived lack of utility of each program. In addition, we plan to continue to deliver program services as outlined in the relevant program descriptions.

Population Health Management			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation (to be completed in 2023)** **7. Analysis of results including metrics** **8. Barriers** **9. Next steps**
	assess the member's needs, provide education and self-care skill building, and link the member to appropriate internal and external resources. Special Needs Plan • Members in the Special Needs Plan program receive a comprehensive health assessment upon enrollment and annually thereafter, as well as during a transition in care venue • Members jointly develop a care plan customized to their specific health needs and preferences with the assistance of a nurse • Members' progress against the individualized care plan is tracked closely by Special Needs Plan teams at each of the medical centers, including nurses and social workers.		
Receive no complaints or grievances related to the Complex Chronic Conditions (CCC) program	Continue to provide service according to the CCC program description	TPMG Consulting Services and Complex Needs Director 12/31/2022	In 2022, CCC program enrollees provided no complaints or grievances that specifically mentioned the CCC program.
Appropriate members are informed about eligibility to participate, how to use program services, and how to opt in or out for the following programs:	Utilize print and secure electronic communications to reach members who are identified for program	TPMG Consulting Services, PHM/Quality	Members in all four of the listed programs received outreach in 2022 as outlined in the Population Health Management Program Description.

Population Health Management			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation (to be completed in 2023)** **7. Analysis of results including metrics** **8. Barriers** **9. Next steps**
• Asthma • Diabetes • Special Needs Plan • Complex Chronic Conditions	participation through registry inclusion, insurance coverage, or referral	Director, and Complex Needs Director 12/31/2022	
Complete population assessment report detailing demographics and disease burden of KPNC member population.	• KP will assess our member population to inform appropriate PHM strategies • KP will plan for the programs/services, goals and metrics that will address the identified strategies. • The assessment and the Strategy Program will be reviewed by the Quality Oversight Committee. • Strategies will be implemented. • Measure the impact of our population management program and identify opportunities for improvement.	TPMG Consulting Services, PHM/Quality Director, and Complex Needs Director 12/31/2022	The annual PHM Population Assessment report was completed in 2022 and approved by the Quality Oversight Committee in December 2022. A 2023 Population Assessment will be completed in 2023 and will be submitted to the Quality Oversight Committee for approval before year end.
Conduct annual analysis of program effectiveness, including the following metrics: • Childhood Immunization Status Combo 10 • Well Child visits in the first 15 months of life • Interactive Voice Response Satisfaction Survey for SNP and CCC programs • CCC complaints and grievances	Complete narrative report and analysis for quality leadership	TPMG Consulting Services, PHM/Quality Director, and Complex Needs Director 12/31/2022	A PHM Impact Report was completed in December 2022; this report is completed annually. In 2023, a PHM Impact Report will be completed before the end of the year.

Home Health and Hospice Member Experience			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Overall Rating of Agency survey performance results for NCAL Home Health will be sustained at 93.7 linear mean for time period October 2021 through September 2022 by December 31, 2022. 2021 Baseline: 93.7 2022 Target: 93.7	1. Area specific education and training will occur based upon identified gaps to goal or requested needs 2. Sharing of best practices at peer groups will be scheduled as a standing agenda item 3. Leadership patient rounding will occur via in-person tracer visits 4. Care experience questions and observation to enable leading indicator data capture will be added within the tracer tool 5. Report and analytics development, training and utilization for data captured within tracer tool will be incorporated to drive targeted efforts	Each Home Health Agency Service Director and Quality Director and their supervisory management staff September 30, 2022	NCAL agency results were 93.8 Successful performance achieved as a region, above target of 93.7 Goal met or exceeded in several agencies. Challenges impacting agencies not achieving target (MTZ, VAL, HAY, OAK) include labor activity, continued pandemic related effects, staffing challenges. For 2023, the same question of Overall rating of agency was chosen to track. Continuity of goal focus will enable teams to continue efforts in place on this high-level question. Individual correlating questions driving to improve overall rating of agency has been analyzed and provided for each agency for performance improvement opportunities.
Overall Rating of Agency survey performance results for NCAL Hospice will be sustained at 82.6 top box score for time period July 2021 through June 2022 by December 31, 2022. 2021 Baseline: 82.6 2022 Target: 82.6	1. Area specific education and training will occur based upon identified gaps to goal or requested needs 2. Sharing of best practices at peer groups will be scheduled as a standing agenda item 3. Leadership patient rounding will occur via in-person tracer visits 4. Care experience questions and observation to enable leading indicator data capture will be added within the tracer tool	Each Home Health Agency Service Director and Quality Director and their supervisory management staff June 30, 2022	NCAL agency results were 83.7 Successful performance was achieved as a region, above target of 82.6 Goal met or exceeded in many agencies. Challenges impacting agencies not achieving target (HAY, SFO, SCL) include labor activity, continued pandemic related effects and staffing challenges. For 2023, the same question of Overall rating of agency was chosen to track. Continuity of goal focus will enable teams to continue efforts in place on this high-level question. Individual correlating

Home Health and Hospice Member Experience			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
	5. Report and analytics development, training and utilization for data captured from tracer visit tool will be incorporated to drive targeted efforts 6. Start of Care specific visit experience design completion, education and spread expected by end of Q2 2022 for all RN's completing this visit type.		questions driving to improve overall rating of agency has been analyzed and provided for each agency for performance improvement opportunities.

Kidney Transplant Clinics			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Transplant Wait Times To ensure members are referred in a timely manner for evaluation. **Target** Transplant Referral to Phone Evaluation (wait time in days): ≤ 21 calendar days.	Monitor the wait times from referral to evaluation. When wait time exceeds 21 days, review case to identify reason for the delay and share learning.	Renal Transplant / Kidney Transplant Clinics; Renal Quality and Performance Improvement Committee Quarterly	**Analysis** Met for the University of California San Francisco (UCSF); did not meet for the University of California Davis (UCD) The average wait time target of 21 days was met 86% of the time at UCSF, with an average wait time of 14.2 days, and 62% at UCD, with an average wait time of 25.1 days. UCSF met target in all 4 most recent reported quarters, while UCD met target in 1 of the 4 most recent reported quarters. Please see the tables below for details. **Barriers** UCD took a deliberate pause of processing new evaluations due to COVID-19 in 2020, and as a result, developed a backlog of patients waiting for their triage appointment. KPNC Renal Transplant leaders formally notified UCD on 3/31/21 with a request that UCD develop a plan to address backlog and ensure that patients have timely access to post-referral appointments. In response, UCD dedicated two referral coordinators to outreach patients to schedule appointments and converted their Education First class to a video offering to process new referrals in a timelier fashion. UCD has also introduced a new online based referral portal in Q2 of 2022 to improve transplant referral intake operations. UCSF Wait Time for Pre-Transplant (Measured in Calendar Days) Referral to Triage Appointment Wait Time (Target 21 calendar days) RANGE 2022 Q1: Average Wait Time 19.4, Min 1, Max 169, % of Patients within the Target 84%, Included Patients 97, Excluded Patients[1] 24 2022 Q2: 12.3, 1, 93, 89%, 76, 22 2022 Q3: 13.0, 1, 109, 88%, 72, 16 2022 Q4: 13.8, 1, 74, 84%, 57, 3 UCD Wait Time for Pre-Transplant (Measured in Calendar Days) Referral to Triage Appointment Wait Time (Target 21 calendar days) RANGE 2022 Q1: Average Wait Time 20.3, Min 1, Max 83, % of Patients within the Target 69%, Included Patients 54, Excluded Patients 33 2022 Q2: 24.0, 1, 83, 67%, 51, 20 2022 Q3: 31.2, 4, 64, 54%, 26, 23 2022 Q4: 23.8, 4, 65, 63%, 57, 41 **Next steps**

Kidney Transplant Clinics			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			Continue to monitor results quarterly and work with Transplant Center of Excellence (COEs) to assure patients have timely access to evaluation for transplant.
Patient and Graft Survival Patient and Graft Survival target rates are within expected hazard ratios set by Scientific Registry of Transplant Recipients (SRTR).	Conduct quality review on 1- and 3-year patient and graft survival rates. Compare observed performance with expected and national data from the SRTR. Compare the same metrics as above for KP-specific population by reviewing NTS reports created with the help of UNOS	Renal Transplant / Kidney Transplant Clinics; Renal Quality and Performance Improvement Committee Annually	One and three-year survival rates are calculated by organ, institution, and living versus deceased donor by the Scientific Registry of Transplant Recipients (SRTR). It includes all patients transplanted by the COEs. A hazard ratio above 1 indicates higher than expected graft failure rates (e.g., a hazard ratio of 1.5 would indicate 50% higher risk), and a ratio below 1 indicates lower than expected graft failure rates (e.g., a hazard ratio of 0.75 would indicate 25% lower risk). The observed hazard ratios for UCSF were below the expected ratios for both patient and graft survival and for living and deceased donor at one and three years (1-year graft survival: 0.98 deceased donor; 0.73 living donor. 1- year patient survival: 0.69 deceased donor; 0.54 living donor; 3-year graft survival: 0.84 deceased donor; 0.68 living donor. 3-year patient survival: 0.80 deceased donor; 0.65 living donor). The observed hazard ratios for UCD were at or below the expected ratios for both patient and graft survival for living and deceased donor transplants at one year and three years. (1-year graft survival: 0.92 deceased donor; 0.79 living donor. 1-year patient survival: 0.38 deceased donor; 1.03 living donor. 3-year graft survival: 1.06 deceased donor; 0.61 living donor. 3-year patient survival: 0.94y deceased donor; 0.65 living donor). Cedars Sinai graft survival hazard ratios are higher than expected at three years due to a complicated (highly sensitized) patient population that they serve. Observed hazard ratios were below the expected hazard ratios for patient survival at both one and three years. KP National Transplant Services, in partnership with UNOS, has recently developed a dashboard using Kaiser Permanente

Kidney Transplant Clinics			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			patient records and UNOS data to compute risk-adjusted expected outcomes for transplanted patients. These risk-adjusted outcome models compare outcomes of KP transplant recipients relative to national transplant recipients. The risk-adjusted expected outcomes are based on data as of October 25, 2021, and captures a different cohort of transplant recipients from the observed hazard ratio data presented above: The observed hazard ratio for UCSF for 1 and 3-year patient survival were below the expected ratio (0.95 and 0.87 respectively). The observed hazard ratio for UCD for 1 and 3-year patient survival was also below the expected ratio (0.97 and 0.94 respectively). The observed hazard ratio for UCSF for 1 and 3-year graft survival was above but near the expected ratio (1.06 and 1.11) respectively). The observed hazard ratio for UCD for 1-year graft survival was above the expected ratio, however the observed hazard ratio for 3-year graft survival was below the expected ratio (1.41 and 0.86 respectively). **Next steps** Continue to monitor annually.
Member Complaints and Grievances Complaints and grievances filed by KP members regarding the quality, services and care received at the Transplant COE are reviewed. **Target** ≤ 1% of patients who receive care at a Transplant COE submit a complaint or grievance.	Monitor and review complaints and grievances with the Transplant COEs during monthly conferences and biannual Oversight Joint Meetings.	Renal Transplant / Kidney Transplant Clinics Monthly	**Analysis** There were three complaints filed in 2022, which is below the 1% target. One complaint was filed by a KP member regarding fulfillment of a reasonable accommodation form. Another complaint was regarding COVID-19 vaccination requirement for transplant listing at our contracted centers of excellence, and the last complaint was regarding service provided by KTC RN. **Next steps** Ongoing monitoring of complaints and grievances for trends in the areas of renal transplant access, service, and quality.

<table>
<tr><th colspan="4">Kidney Transplant Clinics</th></tr>
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2. Barriers
3. Next steps</th></tr>
<tr><td colspan="4"></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Patient Satisfaction

≥ 75% favorable rating received from Transplanted Members.</td><td>Send patient satisfaction questionnaire to:
members evaluated for a transplant 30-days after members are denied or listed for transplant
transplanted members 90-days after receipt of transplant
Analyze the results from the patient satisfaction questionnaire and review with the Transplant centers during biannual Oversight Joint Meetings.</td><td>Renal Transplant / Kidney Transplant Clinics; Renal Quality and Performance Improvement Committee

Quarterly</td><td>Patient satisfaction with the Center of Excellence ranged from a low of 86% and 83% (UCSF, UCD respectively) to a high of 97% and 90% (UCSF, UCD respectively) for post-transplant patients – meeting or exceeding target for each recorded quarter. Given the total number of transplants and the response rate, variability per quarter is expected.
<table>
<tr><th colspan="5">Transplant Patient Survey</th></tr>
<tr><th></th><th colspan="2">UCSF</th><th colspan="2">UCD</th></tr>
<tr><th></th><th>Response Rate</th><th>Favorable Rating</th><th>Response Rate</th><th>Favorable Rating</th></tr>
<tr><td>Target</td><td></td><td>75%</td><td></td><td>75%</td></tr>
<tr><td>2021 Q 3</td><td>34%</td><td>90%</td><td>35%</td><td>88%</td></tr>
<tr><td>2021 Q 4</td><td>36%</td><td>87%</td><td>38%</td><td>88%</td></tr>
<tr><td>2022 Q 1</td><td>9%</td><td>86%</td><td>19%</td><td>83%</td></tr>
<tr><td>2022 Q 2</td><td>26%</td><td>97%</td><td>10%</td><td>90%</td></tr>
<tr><td colspan="2">At or Above Target</td><td colspan="2">Within 20% of Target</td><td>20% From Target</td></tr>
</table>
Patient satisfaction with the Center of Excellence ranged from a low of 84% and 67% (UCSF, UCD respectively) to a high of 93% and 100% (UCSF, UCD respectively) for pre-transplant patients. UCSF met or exceed target for each recorded quarter, while UCD partially met goal with two of the four quarters above goal.</td></tr>
</table>

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<tr><td>2021 Q 4</td><td>25%</td><td>84%</td><td>10%</td><td>76%</td></tr>
<tr><td>2022 Q 1</td><td>23%</td><td>88%</td><td>18%</td><td>73%</td></tr>
<tr><td>2022 Q 2</td><td>14%</td><td>93%</td><td>9%</td><td>67%</td></tr>
<tr><td>2022 Q 3</td><td>9%</td><td>88%</td><td>6%</td><td>100%</td></tr>
<tr><td colspan="2">At or Above Target</td><td colspan="2">Within 20% of Target</td><td>20% From Target</td></tr>
</table>

<u>Next steps</u>
Continue to monitor quarterly.</td></tr>
<tr><td>Quality Indicators and Sentinel Events (within 90-days of transplant)

Ensure all complications within 90-day of transplant are captured.

Compare data quarterly to ensure there are no fluctuations in the 90-day quality indicators.</td><td>Monitor quality indicators with Transplant centers at monthly conferences and biannual Oversight Joint Meetings. Address any reported fluctuations in quality indicators with Transplant centers. Report sentinel events to KP Regional Risk Management.

Corrective measures will be taken with the transplant centers to address fluctuations in quarterly quality indicator data.</td><td>Renal Transplant / Kidney Transplant Clinics; Renal Quality and Performance Improvement Committee

Quarterly</td><td><u>Analysis</u>
The Kidney Transplant Clinic monitors quarterly reports for the percent of transplant recipients with complications including delayed graft function and surgical complications. The results at each COE each quarter remain generally consistent, without major outliers.

<u>Next steps</u>
Continue to monitor trends for each Transplant COE. There are no published national benchmarks for this timeframe (within 90-days of transplant).</td></tr>
</table>

Medi-Cal Geographic Managed Care (GMC)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**

Performance Improvement Project #1:
 	
<u>Health Disparity</u>
Focus on hypertension among the African American Medi-Cal Managed Care population in South Sacramento, where there is currently a statistically significant difference in percent with controlled hypertension by race.
 	
Goal: Improve controlled hypertension among African American members in South Sacramento.
 	
Metric: By December 31, 2022, increase the percentage of Controlled Hypertension among African American Members in South Sacramento ages 18-65, from 54.5% to 64.5 %.
 	
Baseline: 54.5%
 	
Target: 64.5%
 	
**** PIPs are required by the DHCS GMC Contract. PIPs are 2-year projects; the overall PIP SMART AIM is based on 2 years and ends in 2022.***
	• Distribution and education of home BP Monitors.
	• Case Management by GMC Pharmacist.
	• Collaboration with South Sacramento African American Disparity Task Force to implement various educational opportunities to African American members with hypertension.
		GMC Department
		
		GMC Managers
		
		GMC Consultant
		
		GMC Department
		
		GMC Pharmacist
		
		GMC Health Care Coordinators
		
		December 2022
			The rate of controlled Hypertension (HTN) among African American adult members in South Sacramento (SSC) as of December 31, 2022, was 60.1%.
			
			PDSAs:
			• Focus on behavior change through face-to-face visit with a Clinical Health Educator for members who have not received a BP home monitor (136 members).
			• Focus on education for members:
			  • Black Heart Health Check
			  • Community Garden
			  • House Call: Ask the Docs Session
			  • Plants Over Pills: A Conversation on
			  • Plant Based Diet
			  • Black Women's Health-Mind & Body
			  • Plans over Pills- Growing Your Own Food
			  • Advocating for your Health
			  • Pre-Diabetes
			
			These PDSAs were implemented in collaboration with the African American Disparities Strategy Team in SSC, which includes Adult and Family Medicine (AFM), Women's health, Quality and PHASE. This group provides regular feedback on our course of action and provides collaboration to ensure the project is meaningful, useful, and culturally appropriate.
			
			All Health Care Coordinators have been trained to order home BP machines for any of their members with Hypertension. All AFM physicians and staff have access to the job aids to enable ordering of home BP machines for any member.

Medi-Cal Geographic Managed Care (GMC)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			Results: The overall rate of controlled HTN among African American adults in SSC is 60.1% as of December 31, 2022. • 494 blood pressure machines have been ordered between July 2020 and December 2022. • 461 members (93.3%) have a blood pressure reading in their chart after the blood pressure order date. • Of those members, 264 (53.4%) have a reading indicating controlled HTN. The Medicaid MPL (Minimum Performance Level) for CBP (Controlled Blood Pressure) is 55.35% and the Medicaid HPL (High Performance Level) is 66.79%, KP NCAL's overall CBP rate was 71.2%. Although we did not meet our disparity goal of 64.5% among African American members, we improved significantly from baseline of 54.5% to 60.1%. Furthermore, our overall CBP MediCal rate of (71.22%) uncharacteristically outperformed our Commercial rates (71.12%). **Barriers:** Reducing uncontrolled hypertension is multi-faceted and complex. The most recent respiratory surge (RSV, flu, and COVID) impacts capacity for blood pressure checks and outreach. Additionally, the public health emergency has weighed on us all, and taking measures to reduce high blood pressure is challenging. **Next Steps:** Continue to engage members who have received a BP Machine to help them get their measurement within healthy range. Continue to order blood pressure machines for members with uncontrolled hypertension. Continue to address healthy behavior changes to

Medi-Cal Geographic Managed Care (GMC)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			reduce risks and refer members back to their PCP for support. Continue to work with the South Sacramento African American Disparity Task Force to address disparities in uncontrolled hypertension. Continue to track progress towards unmet goal.

Performance Improvement Project #2
 	
<u>Child and Adolescent Health</u>
Focus on improving Childhood Immunization Status: Combo 10 (CIS 10) among GMC members in Sacramento.
 	
Goal: Improve Childhood Immunization Status: Combination 10 (CIS-10) rates among children with a Pediatrician in Sacramento.
 	
Metric: By December 31, 2022, increase the percentage of Children completing CIS-10 combo vaccinations among North Valley Pediatric clinics in Sacramento Point West Clinic, Sacramento Railyards, and Rancho Cordova from 57% to 65%.
 	
Baseline: 57%
 	
Target: 65%
 	
**** PIPs are required by the DHCS GMC Contract. PIPs are 2-year projects; the overall PIP SMART AIM is based on 2 years and ends in 2022.***
	#1 Decrease Fail to Keep Well Child Visits through pre-appointment outreach/ reminder calls
	• Assign 2 Member Engagement Specialist (MES) to conduct PDSA
	• Build new KP HealthConnect List of all doctors (23) at Point West, customize columns to include important data regarding upcoming Well Child visits (2W).
	• MES conducts daily searches for all Medi-Cal patients who have an upcoming 4-month WCV through 7-month WCV within the next 3 days.
	• MES calls member and adds "GMC Call" in "Schedule Comment" to track members who've received a call. During the call, the MES offers transportation or to reschedule appointment if patient can't make scheduled appointment.
	• MES will "CC chart" to PCP if there is a problem finding a visit that works for family.
	• Well Care FTK report will be used to track progress for 3 months.
	• MES will keep spreadsheet which includes: 1) Member reached 2) Rescheduled Well Child 3)
		GMC Department
		
		GMC Managers
		
		GMC Member Engagement Team
		
		GMC Care Coordination Team
		
		Sacramento KP TPMG Chief and Staff
		
		December 2022
			PDSAs:
			#1 Decrease Fail to Keep WCV through pre-appointment outreach calls (11/1/2021-1/31/2022)
			• Decreased FTKA (failed to keep appointment) rate among Sacramento Medi-Cal members by between 2.0 - 5.7 depending on baseline comparison date (Jan - Aug and Jun-Aug).
			
			Results:
			Medi-Cal:
			• Baseline Jan – Aug 2022:
			  • FTKA: 13.5%
			  • Delta: -2.0%
			• Baseline Jun – Aug 2022:
			  • FTKA: 17.2%
			  • Delta baseline is -5.7%
			
			Commercial:
			• Baseline Jan – Aug 2022:
			  • FTKA: 3.0%
			  • Delta: +2.9%
			• Baseline Jun – Aug 2022:
			  • FTKA: 3.6%
			  • Delta baseline is +2.3%
			  •
			• Additionally, we experienced an increase in vaccination rates because of decreasing FTKA. We experienced a much higher up to date rate within

Medi-Cal Geographic Managed Care (GMC)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
	Member not reached 4) CC chart to PCP to problem solve patient not being able to come during regular business hours. • Test to run 1/1/2022- 8/31/2022. #2 Focus on identifying children that are behind on their immunizations: • Utilize immunization tracking report to filter patients under 24 months who are behind on immunizations. • Staff assistant will conduct monthly targeted outreach calls to schedule Well Child Visit (WCV). • If contact is unsuccessful, patient's chart will be forwarded to the GMC inbox to aid with outreach.		the <12-month vaccines, even with flu, than in the prior population. #2 Focus on identifying children that are behind on their immunizations – 2/28/2022 **Results:** Tracked immunization (IZ) rates from Jan 2022 (46%) through Aug 2022 (54%). We experienced an increase in IZ rates for the target population. The most recent PDSA to track FTKA was implemented successfully and to this day the Pediatric Department staff continues to outreach Medi-Cal members with a routine well visit who are between ages 2 months and 24 months. December 2022 YTD CIS rate for SAC GMC members is not yet available. Most up-to-date date includes 11/2021 – 10/2022 51.67%. KP is above the 90th percentile for Medicaid for CIS 10 however, we wanted to improve a smaller subset which we intend to continue tracking. **Barriers:** the recent respiratory surge (RSV, flu, and COVID) have been barriers to immunization outreach. In addition, these respiratory conditions reduce well-child attendance due to illness. Lastly, keeping up on a child's first 10 vaccines proves to be problematic with the shut down due to the Public Health Emergency (PHE) because the vaccines must be spaced and given at incremental doses, if a child misses two or more doses it can be nearly impossible to get caught up. In particular, the flu vaccine which must be given in two doses for these younger children can be problematic as there is a shorter window in which to administer the flu vaccine. Recovering from the PHE will take time and

Medi-Cal Geographic Managed Care (GMC)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			unfortunately CIS-10 will not increase immediately but instead will take more time to catch these younger children up on their vaccines. **Next Steps:** Following the respiratory surge, the Pediatric staff will have capacity to pick up their outreach related to FTKA. Although this is not a continued performance improvement project, we intend to follow the data and our physician partners will continue to strive towards this goal. Data is received annually via HEDIS.
Tobacco Initiative Although tobacco use among KP members is lower than the national average, Medi-Cal members in Sacramento Valley are almost double the rate of commercial smokers. **Goal:** Decrease tobacco prevalence in North Valley (Sacramento/Roseville) GMC members by 5% by Q1, 2022 **Baseline:** 12.3% (data obtained from 1/1/2019 – 12/31/2020) (den 28,864, num 3,545) **Target:** 11.68% or less ***This goal was set in early 2020, at the beginning of the pandemic.***	• Implement MES and HCC process for updating tobacco use status in KPHC, which triggers contact from Health Education Dept if member went from current smoker to recent quit. • Advise members to quit tobacco and refer members to Wellness Coaching for one-on-one support. • Wellness Coaches are master's Prepared Health Educators with expertise in brief negotiation and tobacco cessation. • Continue to highlight benefits of tobacco cessation among Health Care Coordinators throughout the year to ensure they keep services for members top of mind during their outreach.	GMC Department GMC Managers GMC Member Engagement Team GMC Care Coordination Team Health Education Team December 2022	**PDSA's:** • During New Member Onboarding (NMO), MES will ask each member about smoking, document in KPHC, and refer to wellness coaching if applicable. **Results:** • Tobacco use prevalence among GMC members as of 10/2/2022 is 9.70% • Wellness Coaching: 238 individuals had tobacco coaching for a total of 338 coaching sessions **Barriers:** None **Next Steps:** Continue to track data. Support Member Engagement Specialists and Health Care Coordinators by ensuring their workflows include asking social history questions related to tobacco use.
KP.org **Goal:** Educate members on how to access online resources and self-service	Member Engagement Specialists and Health Care Coordinators will assist members in registering and re-	GMC Department GMC Managers	**Results:** As of December 31, 2022, 76% of GMC members have activated kp.org and the PMPM (Per Member Per Month) usage is 9.8.

Medi-Cal Geographic Managed Care (GMC)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
tools through kp.org to enhance access to email their doctor, participate in online health education programs, schedule appointments, and order refills for medication. **Metric:** Increase KP.org activation for GMC members 13 years and older by 5% between Q1, 2020 and Q4, 2022 **Baseline:** 54% **Target:** 59%	activating access to kp.org during New Member Onboarding. Leverage kp.org campaigns (Robo Calls, text, and direct mail) implemented by National Medicaid to improve enrollment and usage. Implement provider generated communication regarding kp.org registration and the benefits.	GMC Member Engagement Team GMC Care Coordination Team December 2022	**Barriers:** None **Next Steps:** Continue to track data through the year end 2022. The CalAIM/ECM workflows include Health Care Coordinators providing education and support for members to sign up for kp.org so they can see their Care Plans.

<u>Diabetes Screening</u>
 	
Goal: Improve Diabetes Screening for GMC Medi-Cal Members ages 18-64 with **Schizophrenia or Bipolar Disorder who are using Antipsychotic Medication** in the Sacramento Valley from MCAS 2020 KP baseline of 81.71% to above Medi-Cal benchmark of 82.09% by August 31, 2022.
 	
Baseline: 81.71%
 	
Target: 82.09%
	The Behavioral Health Department will review the 2020 "Fallout List" patients taking medication for Schizophrenia or Bipolar Disorder and who did not have a diabetes screening.	GMC Manager
		
		Behavioral Health Chiefs and Directors in NVLY and SSC
		
		December 2022
			PDSA:
			Review data from 2020 Fallout List report to determine A1C or Fasting Glucose in 2021.
			• Among the 105 members on the 2020 Fallout List in Sac Valley:
			  • 47 members (45%) have not had 2021 screenings:
			  • 30 members (64%) had A1C or Fasting Glucose labs ordered
			  • 17 members (36%) did not have orders
			  • Number of pended labs: 17
			  • Number of outreaches: 39 outreaches occurred (7 for patients with abnormal labs + 30 with no labs in HC)
			  • 56 (53%) had 2021 screenings
			  • 2 (2%) are no longer members
			
			Results: January 2022-December 2022
			86.74%
			
			Barriers: None

Medi-Cal Geographic Managed Care (GMC)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			Next Steps: Behavioral Health Managers to decide if they will continue a similar process in coming months.

Member Experience (ME 7)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Commercial, Medicare, and Marketplace Member Experience (ME 7 C-D)			
ME 7 C-D **Process Goal:** **Develop member experience report to:** • Analyze and monitor Commercial, Medicare, and Marketplace member experience • Identify opportunities for improvement	• Identify trends in Commercial, Medicare, and Marketplace complaint, grievance and appeal data which represent opportunities for improvement • Identify trends in member experience surveys which represent opportunities for improvement	TPMG Consulting Services Member Experience Standard Lead Member Concerns Committee **Annual:** October 2022	Report developed in Q2 2022

	Q3'21 - Q2'22		
Commercial	**Total**	**% of Total**	**Per 10K**
Access	5,862	8%	18.53
Attitude/Service	36,606	50%	115.71
Billing/Financial	17,785	24%	56.22
Quality of Care	12,927	18%	40.86
Quality of Practitioner Office Site	604	1%	1.91

	Q3'21 - Q2'22		
Covered CA	**Total**	**% of Total**	**Per 10K**
Access	666	5%	17.84
Attitude/Service	6,157	46%	164.96
Billing/Financial	4,391	33%	117.65
Quality of Care	1,975	15%	52.92
Quality of Practitioner Office Site	96	1%	2.57

	Q3'21 - Q2'22		
Medicare	**Total**	**% of Total**	**Per 10K**
Access	3,748	6%	57.67
Attitude/Service	36,468	62%	561.17
Billing/Financial	11,395	19%	175.35
Quality of Care	6,627	11%	101.98
Quality of Practitioner Office Site	812	1%	12.50

Member Experience (ME 7)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**

	Q3'21 - Q2'22		
Medi-Cal	**Total**	**% of Total**	**Per 10K**
Access	597	6%	16.11
Attitude/Service	6,148	60%	165.91
Billing/Financial	900	9%	24.29
Quality of Care	2,446	24%	66.01
Quality of Practitioner Office Site	98	1%	2.64

Analysis: Targets not met

Barriers:

<u>Areas of Opportunity</u>

Commercial/Exchange QHP Opportunity: From analysis of member experience complaints, appeals, and surveys, the Commercial LOB has an opportunity to:

1. Improve the quality of communication with members, ensuring that communication is timely, complete, and accurate.
2. Improve member experience with billing for Emergency Services, through transparency and accuracy
3. Improve access to routine specialty care

From analysis of member experience complaints, appeals, and surveys, the Exchange QHP LOB has an opportunity to:

1. Improve the quality of communication with members, ensuring accuracy of information provided

<table>
<tr><th colspan="4">Member Experience (ME 7)</th></tr>
<tr><th>Goal (including Metric)</th><th>Planned Actions to Meet Goal</th><th>Accountable Team and Due Date</th><th>2022 Evaluation
1. Analysis of results including metrics
2. Barriers
3. Next steps</th></tr>
<tr><td colspan="4"></td></tr>
<tr><td></td><td></td><td></td><td>2. Attitude and Service; incorrect information given Billing for Emergency Services

Medicare Opportunity: From analysis of member experience complaints, appeals, and surveys, the Medicare LOB has an opportunity to:
1. Improve member service through reduced telephone hold times
2. Improve access and billing to Durable Medical Equipment (DME)

Next Steps: Continue to monitor</td></tr>
<tr><td colspan="4">Behavioral Health Member Experience (ME 7 E-F)</td></tr>
<tr><td>ME 7 E-F

Process Goal:

Develop member experience report to:
• Analyze and monitor Behavioral Health member experience
• Identify opportunities for improvement</td><td>• Identify trends in behavioral health member experience data which represent opportunities for improvement</td><td>TPMG Consulting Services

Member Experience Standard Lead

Behavioral Health Quality Oversight Committee

Annual:
October 2022</td><td>Report developed in Q2 2022

<table>
<tr><th></th><th colspan="3">Q3'21 - Q2'22</th></tr>
<tr><th>Commercial</th><th>Total</th><th>% of Total</th><th>Per 10K</th></tr>
<tr><td>Access</td><td>1,894</td><td>35%</td><td>5.99</td></tr>
<tr><td>Attitude/Service</td><td>1,985</td><td>36%</td><td>6.27</td></tr>
<tr><td>Billing/Financial</td><td>125</td><td>2%</td><td>0.40</td></tr>
<tr><td>Quality of Care</td><td>1,456</td><td>27%</td><td>4.60</td></tr>
<tr><td>Quality of Practitioner Office Site</td><td>13</td><td>0%</td><td>0.04</td></tr>
</table>

<table>
<tr><th></th><th colspan="3">Q3'21 - Q2'22</th></tr>
<tr><th>Covered CA</th><th>Total</th><th>% of Total</th><th>Per 10K</th></tr>
<tr><td>Access</td><td>228</td><td>30%</td><td>6.11</td></tr>
</table></td></tr>
</table>

Member Experience (ME 7)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**

Attitude/Service	253	34%	6.78
Billing/Financial	27	4%	0.72
Quality of Care	245	32%	6.56
Quality of Practitioner Office Site	1	0%	0.03

	Q3'21 - Q2'22		
Medicare	**Total**	**% of Total**	**Per 10K**
Access	286	27%	4.40
Attitude/Service	444	42%	6.83
Billing/Financial	9	1%	0.14
Quality of Care	311	30%	4.79
Quality of Practitioner Office Site	4	0%	0.06

	Q3'21 - Q2'22		
Medi-Cal	**Total**	**% of Total**	**Per 10K**
Access	284	25%	7.66
Attitude/Service	441	40%	11.90
Billing/Financial	9	1%	0.24
Quality of Care	380	34%	10.25
Quality of Practitioner Office Site	0	0%	0.00

Analysis:

- There was a 21 percent increase in behavioral Commercial complaints between Q3'20 – Q2'21 and Q3'21 – Q2'22, attributed by a 50% increase in Access complaints, 19% increase in Attitude/Service complaints, 73% decrease in Billing/Financial

Member Experience (ME 7)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			complaints, 31% increase in Quality of Care complaints, and a 44% increase in Quality of Practitioner Office Site complaints. • There was a 25 percent increase in behavioral Covered CA complaints between Q3'20 – Q2'21 and Q3'21 – Q2'22, attributed by a 43% increase in Access complaints, 7% increase in Attitude/Service complaints, 53% decrease in Billing/Financial complaints, 64% increase in Quality of Care complaints, and a 50% decrease in Quality of Practitioner Office Site complaints. • There was a 48 percent increase in behavioral Medicare complaints between Q3'20 – Q2'21 and Q3'21 – Q2'22, attributed by a 61% increase in Access complaints, 37% increase in Attitude/Service complaints, 50% increase in Billing/Financial complaints, 59% increase in Quality of Care complaints, and a 50% decrease in Quality of Practitioner Office Site complaints. • There was a 40 percent increase in behavioral Medi-Cal complaints between Q3'21 – Q2'22 and Q3'21 – Q2'22, attributed by a 72% increase in Access complaints, 24% increase in Attitude/Service complaints, 13% increase in Billing/Financial complaints, 45% increase in Quality of Care complaints, and a 100% decrease in Quality of Practitioner Office Site complaints. **Barriers:**

Member Experience (ME 7)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			• Opportunities for Behavioral Health Improvement: Access, Billing/Financial, and Quality of Care **Next Steps/Actions:** 1. Consistency in Communication: Mental Health (MH) and Addiction Medicine Recovery Services (AMRS) Chiefs and Directors are working to standardize local MDO webpages and waiting room flyers and brochures to ensure continuity and consistency in communication about KPNC MH/AMRS programs and services. 2. KPNC RMHA developed and implemented a template for a triage and appointing workflow to improve efficiency and support consistency in member service expectations 3. Service Area Improvements: The BHQOC is providing ongoing tracking of service area performance to support improved member experience performance.

Member Relations			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Complaint, Grievance & Appeals (CGAs) Reduction NCAL Region Metric: Achieve target for joint goal reduction in average number of cases per 1k member per month inclusive of all Complaints/Grievances Target: 3% reduction from baseline period rate of 2.04 cases per 1k member	• Identify grievance trends by location/area/function • Help facilitate creation/execution of action plans to eliminate pain points to reduce complaint, grievance, and appeals volume Approach varies by service area, some examples include: • Sharing dashboards with leaders for visibility and review/discussion during Member Concern Committee meetings • Integration of care experience training (ECX) to improve service experience • Nurse leader rounding debriefs to improve communication on in-patient plan of care • Continuous coaching via observations/validations • Real-time escalation of dissatisfaction to department leadership for immediate resolution of concerns • Partner with departments across the MCA to develop strategies and share best practices	Member Relations (Local Member Services (LMS), Grievance Ops, Data & Reporting and key stakeholders at medical offices / hospitals) 10/2022	Update provided as of 11/23/2022: YTD Performance to Goal: ▪ All MCAs except for South San Francisco are not meeting their goal. ▪ NCAL Combined Region remains higher than the target at **2.58** cases per 1K member for 2022. Examples how we are addressing drivers: • Training events to ensure ongoing education of LMS staff. • Monthly Member Complaints and Grievances Committee reviews concerns to identify trends in the outpatient setting and in the licensed departments; reviewing CGA data and identify strategies to address primary drivers. • Rounding practices emphasizing Compassion Matters and Caring Moments culture.
Medicare 5 Star A. Achieve CMS Medicare 5 Star targets per 2020 Stars Cut points in: Part C Timeliness Target ≥97% B. Achieve CMS Medicare 5 Star	Enable clear line of sight into Health Plan appeals measure performance for Member Relations grievance • Timely delivery of 5 Star report (based on Service Level Agreement (SLA) to create transparency and quickly identify opportunities and risks	Member Relations (Grievance Ops, Data & Reporting, and Quality & Regulatory Ops) 12/31/22	As of 1/6/2023: A. Achieved target for CMS Medicare 5 Star Part C Timeliness at 97%. B. Above target for CMS Medicare 5 Star Part C Upheld at 99%.

Member Relations			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
per 2020 Stars Cut points in: Part C Upheld Target ≥96%	• Ensure action plans are tracked for status updates and mitigation efforts are in place to avoid risk / penalties		
Letter Quality Improvement To improve member experience by improving written communication. Target: Achieve a total score of 88% or higher	Letter Editors to review a minimum of 1,000 letters being sent to members to evaluate the following criteria: • Writing conventions • Readability • Content • Member Experience	Member Relations (Grievance Ops, Data & Reporting, and Business Integration & Governance) 12/31/22	Member Relations finished the year with an 89.28%, exceeding the target metric.
Maintain timeliness results for processing claims member grievances at the required compliance targets. • 95% of grievance cases are acknowledged within 5 calendar days • 95% of grievance cases are resolved within the required compliance targets for each line of business	Continue ongoing monitoring and take actions as indicated to improve performance as needed. • Hiring plan of action being executed to address higher volumes than current staffing case support • Medical center goals to reduce CGAs will positively impact achievement of timeliness goals	CA Grievance Operations Monthly Average	Year-end results –missed the internal targets • Acknowledgement is at 87.2% • Resolution is at 83.9% Volume in 2022 increased 29%, which was beyond our budgeted staffing to complete timely. We communicated and were approved to add resources to address volume and we are working to reduce backlog of outstanding grievances.

<table>
<tr><th colspan="4">Member Service Contact Centers (MSCC)</th></tr>
<tr><th>Goal (including Metric)</th><th>Planned Actions to Meet Goal</th><th>Accountable Team and Due Date</th><th>2022 Evaluation
1. Analysis of results including metrics
2. Barriers
3. Next steps</th></tr>
<tr><td colspan="4"></td></tr>
<tr>
<td>Monitor and track call quality metrics to objectives based on the MSCC's Quality Assurance Call Standards & Expectations.

• Threshold: 90%
• Target: 92%</td>
<td>• The MSCC's Quality Assurance department monitors phone calls utilizing the Quality Assurance Call Standards & Expectations.
• The Quality Assurance analyst reviews the interaction and assesses the customer service representative's service provided, accuracy of information provided, ability to follow all policies and procedures, and the interaction's documentation in our tracking system.
• The Call Quality Assurance program includes data collection, reporting, analysis, and identification of opportunities to improve overall performance through process improvements, staff training, coaching, and mentoring.</td>
<td>Member Service Contact Center

12/31/2022</td>
<td>1. Analysis of Results including metrics

<table>
<tr><th>Metric</th><th>Goal</th><th>2022 Results</th></tr>
<tr><td>Call Quality</td><td>Threshold: 90%
Target: 92%</td><td>91.4%</td></tr>
</table>

2. Barriers

The MSCC in the California region did not meet our target goal for call quality but did meet our threshold goal in 2022. In general, the MSCCs were challenged by staffing issues that affected overall CSR performance.

3. Next Steps

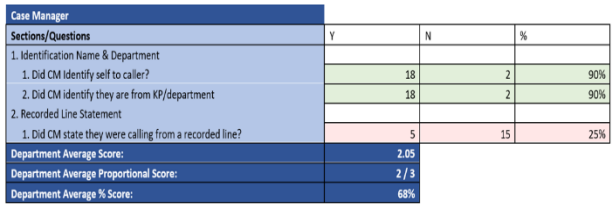
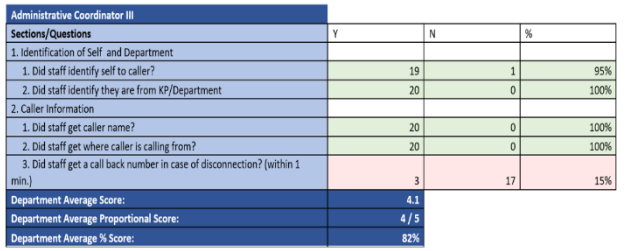
Continue monitoring and analyzing results on a monthly basis to ensure goals are met.</td>
</tr>
<tr>
<td>Monitor and track email quality metrics to objectives based on the MSCC's Email QA Standards & Expectations.

• Threshold: 90%
• Target: 92%</td>
<td>• The MSCC's Quality Assurance department monitors member emails sent after logging into their kp.org account utilizing the Quality Assurance Email Standards & Expectations.
• The Quality Assurance analyst reviews the interaction and assesses the customer service representative's</td>
<td>Member Service Contact Center

12/31/2022</td>
<td>1. Analysis of Results including metrics

<table>
<tr><th>Metric</th><th>Goal</th><th>2022 Results</th></tr>
<tr><td>Email Quality</td><td>Threshold: 90%
Target: 92%</td><td>92.9%</td></tr>
</table>
</td>
</tr>
</table>

Member Service Contact Centers (MSCC)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
	response to the member, the accuracy of information provided, ability to follow all policies and procedures, and the interaction's documentation in our tracking system. • The Email Quality Assurance program includes data collection, reporting, analysis, and identification of opportunities to improve overall performance through process improvements, staff training, coaching, and mentoring.		**2. Barriers** The MSCC in the California region met our target goal for email quality in 2022. **3. Next Steps** Continue monitoring and analyzing results on a monthly basis to ensure goals are met.

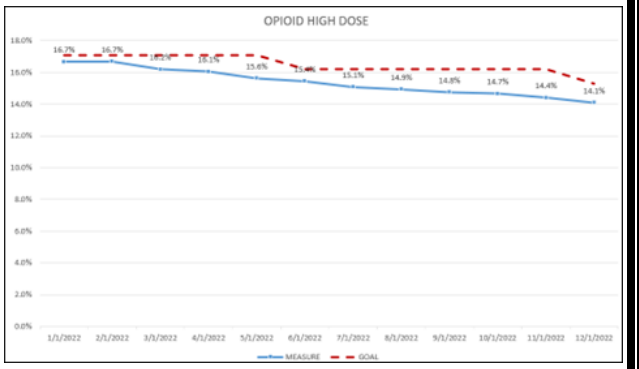
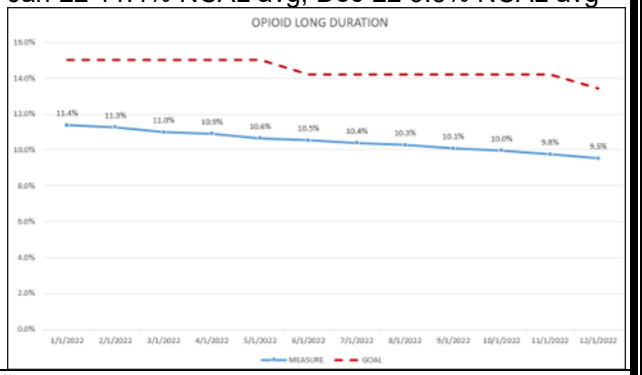
Outside Utilization Review Services (OURS)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Goal - Improve customer service for outbound calls. The % of times that the customer interactions for outbound calls included identification of the case manager by name, the name of the KP/department and that the call is on a recorded line. Methodology: number of compliant in the business telephone analysis program (NICE)/Total number recorded outbound calls monitored Baseline: 2021 was 60% Data Source: NICE business telephone analysis program Measurement Period: 2/01/22 - 12/31/22 Target: 66%	• Include goal in mandatory AB1203 training. • Dept results, progress to goal and reminders to staff during staff meetings. • ANM's to include individual call results during monthly one on one meetings.	OURS Quality and Management Teams Due: 12/31/2022	 **Target:** 66% **Results:** 68% **Barriers:** N/A **Next Steps:** Continue to share progress toward goal and reminders during staff meetings. ANMs will continue to include results during monthly one on one meetings.
Goal - Improve customer service for incoming calls. The % of times that the customer interactions for incoming calls included identification of the operations specialist by name, the name of the KP/department and caller name, and number was obtained prior to the end of the call. Methodology: number of compliant in the business telephone analysis program (NICE)/Total # recorded outbound calls monitored Baseline: 2021 was 75%	• Include goal in mandatory AB1203 training. • Dept results, progress to goal and reminders to staff during staff meetings. • ANM's to include individual call results during monthly one on one meetings.	OURS Quality and Management Teams Due: 12/31/2022	 **Target:** 81% **Results:** 82% **Barriers:** N/A **Next Steps:** Continue to share progress toward goal and reminders during staff

Outside Utilization Review Services (OURS)			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Data Source: NICE business telephone analysis program Measurement Period: 2/01/22 - 12/31/22 Target: 81%			meetings. ANMs will continue to include results during monthly one on one meetings.

Pharmacy Operations			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Continuum of Care			
Home Based Palliative Care (HBPC) Pharmacy Pilot Integrate pharmacists into a transdisciplinary home-based palliative care team to provide expertise in reducing polypharmacy among high-risk and palliative care members **Target:** Assess any Adverse Drug Events (ADE) related to the de-prescribing of medications. Measure will be average rate of ADE related to deprescribing of medications per HBPC service discharges. Goal ADE/HBPC discharges < 2%. **Numerator =** ADEs related to deprescribing in the HBPC pilot population **Denominator =** number of discharges from HBPC service	• Evaluate the current interventions made for the HBPC population • Partner with HBPC leads to discuss opportunities for deprescribing to ensure safe medication practices • Develop standardized approach for deprescribing interventions and tracking (e.g., documentation, interaction with team, etc.) • Train pharmacists on standardized approach	Pharmacy Continuum 2022 Q4	**Analysis of Results:** **Evaluation: Target Achieved** • During 2/1/2022 - 10/31/2022, HBPC pharmacist interventions with focus on deprescribing have been closely monitored • To ensure safe practices in deprescribing, patient charts (n=67) were reviewed for potential ADE within 30 days after discontinuation of medication(s) recommended for deprescribing by HBPC pharmacist • 221 medications were recommended for deprescribing with 141 medication recommendations accepted by providers (64% acceptance rate) • Zero ADEs have been identified during 9-month monitoring period therefore achieving the goal of ADE/HBPC discharges of < 2% **Barriers:** • Standardized approach for deprescribing interventions and tracking (ex. documentation) remains to be a barrier **Next steps**: • In collaboration with HBPC physicians and pharmacists develop the tracking tool to monitor interventions • Defining deprescribing with further analysis if future ADEs identified

Pharmacy Operations			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			• Target achieved. Will continue to carry next steps forward with Pharmacy Continuum Team
Drug Use Management			

Opioid Measures
 	
• Initial Opioid Prescribing- Opioid High Dose
• Initial Opioid Prescribing- Opioid Long Duration
• Avoidance of Concurrent Use of Opioids and Benzodiazepines/Z drugs
 	
Goal is the same for the 3 separate measure (<u>lower is better</u>)
 	
Phase 1: 5% reduction from NCAL baseline (BL) or 5% reduction from medical center (MC) BL
Phase 2: 10% reduction from NCAL BL or 10% reduction from MC BL
Phase 3: 15% reduction from NCAL BL or 15% reduction from MC BL
	• Ongoing partnership with the Regional Opioid Safety team and 13 Chiefs groups to support opioid related initiatives.
	  • Ongoing region wide dissemination of initiative materials such as PowerPoints and cover memos.
	  • Provide monthly physician utilization data performance tracking and academic detailing.
	  • DrUM to support Regional Opioid Safety team as they lead specialty specific KPHC order sets to reduce opioid MME and dispense quantity.
		Drug Use Management Team
		
		Due Date: 12/31/2022
			<u>Analysis of Results:</u>
			
			Initial Opioid High Dose Prescriptions
			
			Evaluation: Target Achieved
			The average NCAL 2022 performance, 15.4% initial opioid high dose prescriptions, did achieve the regional targets outlined to the left. The percent of initial opioid prescription exceeding 50 MMEs has decreased from the regional average by 2.6% (15% change).
			Jan-22 16.7% NCAL avg, Dec-22 14.1% NCAL avg
			▪ Carry forward into 2023 Trilogy workplan

Pharmacy Operations			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
	• Share medical center best practice sharing at Bimonthly McDRUM webinars.		 **Initial Opioid Long Duration Prescriptions (IOP)** **Evaluation: Target Achieved** The average NCAL 2022 performance, 10.5% initial opioid long duration prescriptions, did achieve the regional targets outlined to the left. The percent of initial opioid prescription exceeding a 7 day supply decreased from the regional average by nearly 2% (16% change). Jan-22 11.4% NCAL avg, Dec-22 9.5% NCAL avg 

Pharmacy Operations			
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			IOP Barrier(s): ▪ Ongoing efforts to update all the KPHC order set and preference lists to promote lower quantities and MME of opioids. ▪ Continued partnership with the regional opioid safety team. **IOP Next Steps:** ▪ Continue surgeon/prescriber, physician assistant, nursing, and pharmacist education regarding the initiative. ▪ Ongoing distribution of surgeon/prescriber level data to identify opportunities for focused education if needed. ▪ Enhancing KPHC content (order sets and preference list) to promote decrease quantity and MME. ▪ Carry forward into 2023 Trilogy workplan **Concurrent Opioid / BZD / Z drugs prescriptions (COB)** **Evaluation: Target Achieved** The average NCAL 2022 performance, 0.049 PMPMK concurrent opioid/bzd/z drugs prescriptions, did achieve the regional targets outlined to the left. The reduction of concurrent opioids/bzd/z drugs has decreased regionally by an average of 0.02 PMPMK (41% change). Jan-22 0.052 PMPMK NCAL avg, Dec-22 0.031 PMPMK NCAL avg.

Pharmacy Operations			
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			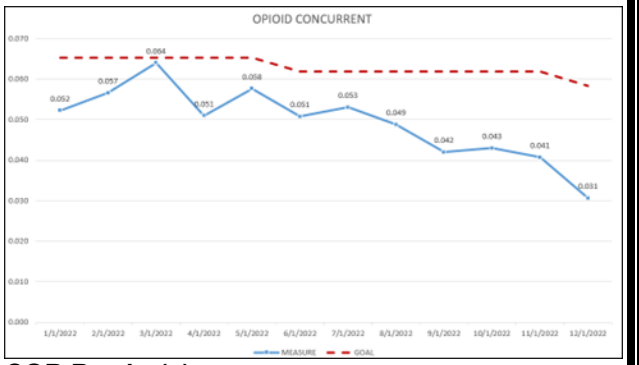 **COB Barrier(s):** ▪ Different prescriber specialties prescribing concurrent medications. **COB Next Steps:** ▪ Continue surgeon/prescriber, physician assistant, nursing, and pharmacist education regarding initiative. ▪ Ongoing distribution of prescriber level data to identify opportunities for focused education if needed. ▪ Carry forward into 2023 Trilogy workplan
High Risk Medications- Polypharmacy: • Reduce use of multiple CNS-active and anticholinergic (ACH) medications in members ≥ 65 years of age	• Update measure to align with latest external measurement specifications from CMS. New CNS-active medication classes such as SNRI, antiepileptics, and anticholinergic medications such as	Drug Use Management Team 12/31/2022	**Analysis of Results:** **Polypharmacy CNS** **Evaluation: Target Achieved** The Jan to Oct-22 avg NCAL performance, 2.7%, did achieve the regional target of either 10%

Pharmacy Operations			
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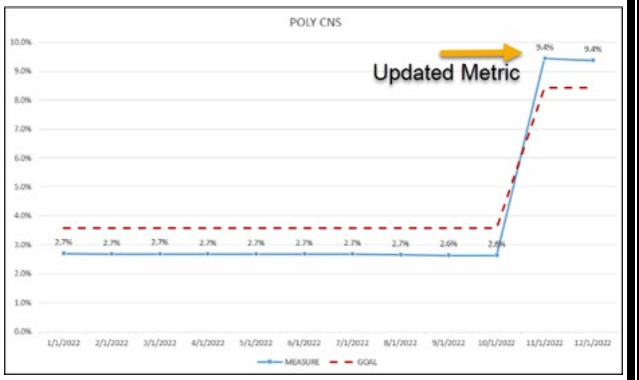
Dual Goal: 10% reduction from medical center (MC) baseline **OR** ≤ NCAL average for both poly CNS- 3.59% and poly ACH 5.41% **Update Goal:** 3Q2022 Both polypharmacy metrics were updated to reflect the latest external quality measurement specifications from CMS. Reset baseline and developed new goals. New baseline effective November 2022. The data is based on a rolling 12 months. The new goal will become effective October 2023, which allows 12 months to see the impact of ongoing efforts with the continuous data methodology. **Dual Goal:** Polypharmacy CNS-active: Phase 1 (10/2023): 10% reduction from MC BL **OR** ≤ NCAL avg (8.4%) Phase 2 (10/2024): 15% reduction from MC BL **OR** ≤ NCAL avg (8%) Polypharmacy Anticholinergic: Phase 1 (10/2023): 5% reduction from MC BL **OR** ≤ NCAL avg (4.5%)	methscopolamine and pyrilamine were added to the measure. • Engage key prescribers: o AFM o Female Pelvic Medicine and Reconstructive Surgery o Neurology o Obstetrics and Gynecology o Psychiatry o Urology o MTM pharmacists o AmCare clinical pharmacists o TPMG quality team • Leverage KPHC support o Best practice alerts o SmartPhrases • Collaborate with Health Engagement Consulting Services (HECS)		reduction from medical center baseline **OR** ≤ NCAL average (poly CNS 3.59%). **Goal Revised starting Nov 2022. Status of current results to update goal:** Data as of Nov to Dec 2022 includes the new medication classes as part of the updated initiative, which resulted in significant increase in utilization and new goals. The Nov-Dec 22 NCAL avg, 9.4% is above the targeted 2023 goal (effective 10/2023). The data is pulled with the continuous data methodology and the impact of the completed work is reflected in 12 months. ▪ Carry forward into 2023 Trilogy workplan  **Polypharmacy Anticholinergic** **Evaluation: Target Achieved** The Jan to Oct-22 avg NCAL performance, 4.8%, did achieve the regional target of either 10% reduction from medical center baseline **OR** ≤ NCAL average (poly ACH 5.41%).

Pharmacy Operations			
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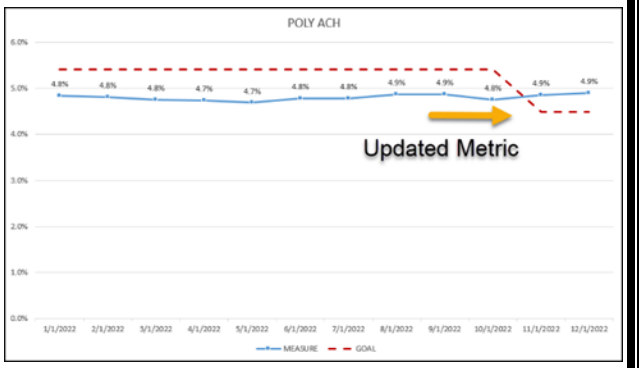
			Goal Revised starting Nov 2022. Status of current results to update goal: Data as of Nov to Dec 2022 includes the anticholinergic new medications and new goals. The Nov-Dec 22 NCAL avg, 4.9% is above the targeted 2023 goal (effective 10/2023). The data is pulled with the continuous data methodology and the impact of the completed work is reflected in 12 months.  **Barrier(s):** ▪ Polypharmacy: Avoidance of Multiple Medications, focuses on the combinations of medications rather than a single agent, and the 2022 updates include high volume medication classes added to the metric. CNS-active medication classes added include SNRIs and antiepileptics commonly used to treat anxiety, depression, insomnia, pain, etc. The addition of these medication classes increases the numerator and

Pharmacy Operations			
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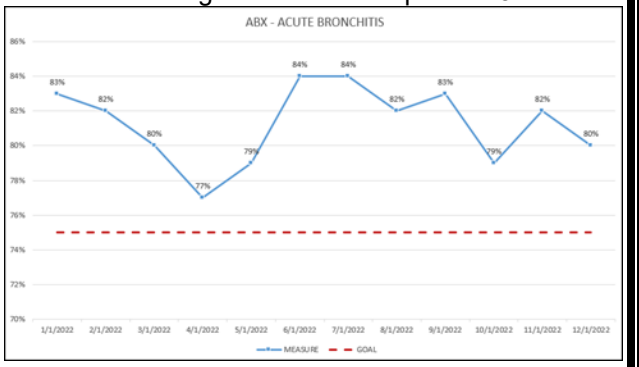
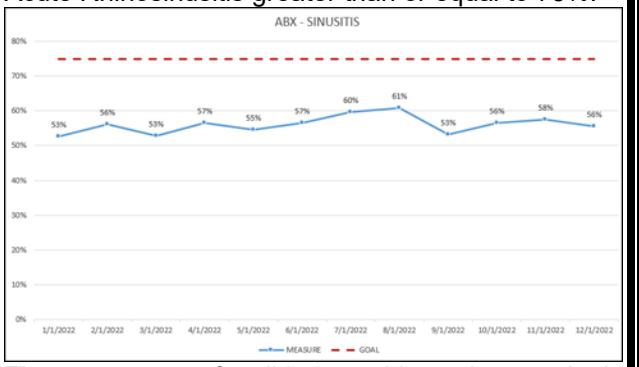
			denominator for the metric, which results in an overall increase of utilization of concurrent CNS-active agents. The anticholinergic medications added to the metric include methscopolamine and pyrilamine (minimal impact to performance). ▪ Due to the backlog of COVID-19, many patients have returned to in-person appointments, minimizing extra time for deprescribing outreach efforts. ▪ Challenging to see real-time progress as the impact of the completed work is reflected in 12 months due to the continuous data methodology determined by CMS. **Next Steps:** ▪ Continue to disseminate initiative performance tracking through the monthly DRUM scorecard and Initiatives Report, which provides physician and pharmacy leadership tools to evaluate the medical center performance and identify areas of opportunity that exist for improving a medical center's performance. ▪ Continue physician education and shared decision-making strategies for deprescribing. ▪ Developed new topic to be presented during the Bimonthly McDRUM webinar to focus on

Pharmacy Operations			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			deprescribing presented by the Regional NCAL Eldercare Champion. ▪ Carry forward into 2023 Trilogy workplan
Appropriate Antibiotic Utilization – Expansion • Avoid use of antibiotics in Acute Bronchitis ≥ 75% • Avoid use of antibiotics in URI ≥ 93% • Avoid use of antibiotics in Acute Rhinosinusitis ≥ 75% *External HEDIS quality measures. DrUM expanded the outpatient antimicrobial stewardship and expanded antibiotic avoidance in acute rhinosinusitis.	• Continue partnership with TPMG Chair of Chiefs o Infectious Disease o Pediatrics o Adult and Family Medicine o Emergency Medicine o Pediatric Infectious Disease Regional Lead • Continue best practice sharing to leverage strategies to improve regional performance • Continue to promote the KPHC technology alerts (SmartRxs), SmartPhrases (patient facing), and supportive educational materials were developed (cover memo, poster, avoidance antibiotics). • Outlier physician education as needed.	Drug Use Management Team Due Date: 12/31/2022	**Analysis of Results:** **Avoid Antibiotics in Acute Bronchitis** **Evaluation: Target Achieved** The average NCAL 2022 performance, 81%, did achieve the regional target of antibiotic avoidance in acute bronchitis greater than or equal to 75%.  **Avoid Antibiotics in URI** **Evaluation: Target Achieved** The average NCAL 2022 performance, 96%, did achieve the regional target of antibiotic avoidance in URI greater than or equal to 93%.

Pharmacy Operations			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			 **Avoid Antibiotics in Acute Rhinosinusitis** **Evaluation: Target NOT Achieved** The average NCAL 2022 performance, 56%, did not achieve the regional target of antibiotic avoidance in Acute Rhinosinusitis greater than or equal to 75%.  The percentage of antibiotic avoidance has gradual changes in performance each month, overall, consistently ranging between 53-61% antibiotic avoidance each month. **<u>Barrier(s):</u>**

Pharmacy Operations			
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			▪ Barriers include population of patients that the use of antibiotics is clinically appropriate such as cases of acute rhinosinusitis with presumed bacterial etiology. **<u>Next Steps</u>** ▪ Continue to disseminate initiative performance tracking through the monthly DRUM scorecard and initiatives report. This report provides physician and pharmacy leadership tools to evaluate the medical center performance and identify areas of opportunity that exist for improving a medical center's performance. ▪ Outlier physician education as needed. ▪ Carry forward into 2023 Trilogy workplan
Medication Therapy Management (MTM)			
Medication Therapy Management (MTM) • Improve patient outcomes related to medication use, per CMS Medicare Stars clinical part D measure on Medication Therapy Management Comprehensive Medication Review (CMR) completion rate. • For Star rating year 2024, (measurement year 2022), Program	• MTM National Group meets every other week. • CMR completion rate report weekly on Tuesdays and Thursdays. • Northern and Southern CA dashboard track metrics more closely.	Clinical Operations 12/31/2022	**Analysis of results:** **Evaluation: Target Achieved** • For measurement year 2022 (2024 Star rating year), Northern CA region achieved a 91% CMR completion rate which exceeded the internally projected 5-star cut point of 90%. This equates to over 25,000 CMRs.

Pharmacy Operations			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Office forecasts the 5 star-cut point at 90% CMR completion rate. This forecast is 1% higher than last year. The projected cut point was adjusted upward 1% in late Oct 2022 after actual cut points for CY 2021 were released in Sept 2022.	• NPA's National MTM Dashboard created by NPA deep-dives into the adherence in the MTM population. • Report available weekly for medication adherence in the MTM population.		• Achieved 5 stars for 2023 (2021 measurement year). 5-star cut point remained the same as the prior year at 89% CMR completion rate. • Updated KP HealthConnect letter template launched in January 2022 to align with new CMS requirements. • New technology implemented in 2022: complete transition to scheduled visits in PARRs booking system across service areas, region-wide batch secure message CMR offer, eConsult patient self-booking, option to send CMR letter electronically, and standardized documentation template. **Barriers:** • Rising CMS 5-star cut point for MTM CMR completion rate (91% for 2023), with eligible population potentially expanding to 140k members (a 467% increase based on 2024 proposed MTM eligibility criteria) • Meeting staffing requirements • KPHC and other technology to meet CMS requirements and support operations (through automated outreach and scheduling, and allowing for patient in-reach) • Extensive documentation requirements **Next steps:** • Continue to explore additional technology in patient outreach, e.g., electronic MTM Questionnaire through KPHC and text CMR offer

Pharmacy Operations			
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			• Integrate diabetes deprescribing flag along with communication trainings • Deploy KPHC Compass Rose for MTM in 2023 • Support data analytics to demonstrate ROI and impact on patient outcomes • Continue to enhance the MTM Clinical Workup Tableau dashboard to assist pharmacist workup • Refine non-responder outreach and target outreach within 60 days of enrollment • Integrate predictive models for patient complexity and no-show for scheduled visits • Continue to leverage outpatient pharmacists to complete targeted medication reviews, specifically related to medication adherence • Change collaborative practice agreement (i.e., pharmacist protocol) from patient-specific authorization to panel management • Carry forward into 2023 Trilogy workplan

Med Adherence
 	
To ensure medication adherence in Medicare patients taking oral diabetes, statin, and RAS agents to improve patient outcomes per CMS Star Rating Measures.
 	
Annual Incentive Plan (AIP) Health Equity sub-scoring: to improve medication adherence in select ethnicities. (The metric was updated during 2022 to include 3 non-White ethnicities, see scoring below.)
	• Maintain interactive texts, batch secure messages, and outreach telephone calls at a level necessary to meet new goals (Pending discussions with SCAL and waiting to see how the score behaves in the first few months. We can put an empiric 80% reach rate to start)
	• Evaluate the need for strategically timed robocalls by Q2 2022, and deploy in Q3-Q4 if needed
		Clinical Pharmacy Team
		
		12/31/2022
			Analysis of results:
			
			Evaluation: Target Partially Achieved
			• For 2022, End of Year Acumen Forecast based on January Analysis, November 2022 Acumen data (Source: Program Office):
			  • STATIN 92.2% (goal 93%) – 4 stars
			  • RAS 92.0% (goal 92%) – 5 stars
			  • DM 92.2% (goal 93%) – 4 stars
			  • SUPD: 92.2% (goal 91%) – 5 stars

Pharmacy Operations			
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2024 Star rating year (2022 measurement year) 5-star cut points internally projected from Program Office: • STATIN: 93% (triple-weighted) • RAS: 92% (triple-weighted) • DM: 93% (triple-weighted) • SUPD: 89% (single-weighted) • Annual Incentive Plan (AIP)/Health Equity targets (based on a calculator from AIP with weighted scores from the following ethnicities: Asian/Pacific Islander, Black/African American, Hispanic/Latino, White): o Below Threshold: < 5.0 o Threshold: 5.0 - 10.9 o Target: 11.0 - 16.9 o Max: ≥ 17.0	• Start and maintain formal peer group meetings to enhance front-line staff communication effectiveness to improve refill rates • Obtain practice protocol approval for remaining Medicare patients on eligible medication by EOY 2022 (goal of >95% of Medicare patients on drug w/ protocol). • Deploy error-fixing/optimization strategies: incorrect days' supply, 90-to-100 days' supply conversions, Med Rec/Low PDC, tablet splitting, tablet consolidation, "as directed"/dose ranges, and hold parameters. Complete remediation for non-adherent patients by end of Q2 2022. • Health equity work: complete social health screening conversation guide and share with other regions by end of Q1 2022. Evaluate other health equity related trainings and build a pharmacy package for deployment by Q2 2022. Continue ongoing partnership with Thrive Local Connections (TLC) team.		• Annual Incentive Plan (AIP) health equity score at 10.3 (at threshold) • The program reached outreach goal with an overall 80% reach rate, as monitored by an expanded productivity dashboard for managers. • Claims remediation was completed by June 2022 • Error-fixing strategies were deployed in Q1-Q2 2022 and will be continued in 2023 • Standardized training and Microsoft Team hosts an informal peer group. In Q3, regular office hours were held for newly trained staff • Piloted a social health awareness training for pharmacy services and recorded into a KP Learn module for spread in 2023 • A Division of Research predictive model that flags patients at higher risk of unmet social needs was replicated and KP Insight/Thrive AI is in process of building the data and score into their databases. A manuscript for the initial pilot was submitted for publication in Nov 2022. • A residency project was started in 2022 to screen for social needs in Spanish-speaking patients by a fluent, Spanish-speaking resident **Barriers:**

Pharmacy Operations			
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			• Rising 5 star cut points, competitor improvements, increasing population sizes, and patient alert-fatigue • Non-dedicated resources resulting in inconsistent coverage as pulled to cover other services • Stationary budget despite rising points over the years • Impact from strike planning, mail order software update, mPulse texting missing replies, and ePIMs data errors **Next steps:** • Develop a mixed central/decentralized seasonal staffing model to ensure an adequate number of weekly outreaches are being completed • Move to new patient list platform called the Member Outreach Management (MOM) tool created by National Pharmacy Analytics • Coordinate with National Pharmacy robocall campaigns and create script and flow for adherence robocalls in 2023 • Continue to integrate Pharmacy Digital Transformation (PDT) features • Continue targeted medication list clean-up, including 90 to 100 day supply conversions and deprescribing • Continue claims remediation • Expand social health with use of the Social Risk predictive model along with

Pharmacy Operations			
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			standardized KP Learn communication trainings • Change collaborative practice agreement (i.e., pharmacist protocol) from patient-specific authorization to panel management • Carry forward into 2023 Trilogy workplan
Deprescribing Polypharmacy increases medication adverse events and hospitalizations and is associated with low medication adherence. Deprescribing medications that no longer provide benefit or is causing harm, can reduce risk and improve quality of life for members. • Final analysis of randomized controlled trial of bundled Hyper polypharmacy (10+ medications) deprescribing in 1,000 patients randomized to pharmacist intervention • Work with specialty medicine to update drug class deprescribing guides and share with KPNC TPMG and Pharmacy. • Integrate targeted deprescribing of diabetes and other drug classes in existing programs, including	• Further develop shared decision-making materials, including patient decision aids. • Finalize Hyper polypharmacy operational playbook and share with interregional pharmacy operations. • Continue outcomes analyses and determine ROI. • Draft and submit 1-2 manuscripts to peer-reviewed journals and/or conferences. • Identify additional research opportunities, including long-term effects of deprescribing and additional drug class opportunities	Clinical Pharmacy Team 12/31/2022	**Analysis of results:** **Evaluation: Study Completed** Whole-patient deprescribing: ▪ A randomized control trial demonstrated no evidence of impact in the targeted population (patients age 76+ on 10+ medications) on top of existing KPNC infrastructure ▪ 40% of patients agreed to discontinue, reduce, or change medication ▪ There was no significant change in prescription med count (-0.4, -0.4; p=0.91) or prevalence of geriatric syndrome (+2.9%, +1.9; p=0.65) in the intervention versus control group ▪ Operational playbook finalized ▪ Manuscript and posters submitted on program implementation and pharmacists' perspectives Continued focus on drug class deprescribing:

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Medication Therapy Management (MTM).			▪ The targeted diabetes deprescribing work from 2016-2017 was handed over for a ROI analysis in partnership with KP Insight for potential spread to other regions. Initial analysis yielded positive ROI but exact amount pending validation. ▪ A pilot integrating targeted diabetes deprescribing in Medicare Medication Adherence patients yielded a 34% deprescribing rate and will be integrated into the annual strategy. ▪ The Diabetes Deprescribing guide was updated late 2022 and is now available on the Clinical Library. **Barriers:** ▪ Need to continue demonstrating deprescribing outcomes and ROI ▪ Clinical guides for deprescribing other drug classes require update (written in 2019) and ones may need to be created for additional drug classes and require regular updates every 2 years ▪ Support integration measures, including incorporating build into KPHC to identify and guide deprescribing. **Next Steps:** ▪ Collaborate with National Optimal Prescribing in Seniors Project

Pharmacy Operations			
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			▪ Operationalize MTM Care Gap flag for diabetes deprescribing ▪ Continue diabetes deprescribing in Medication Adherence and explore additional drug class deprescribing opportunities ▪ Explore targeted populations that may benefit from hyper polypharmacy deprescribing. ▪ Spread shared-decision making and patient-centered care tools ▪ Due to integration into other existing programs, we recommend **removing Deprescribing** as a separate program in future reports. ▪ Study completed and objectives achieved. Will carry work forward with the Clinical Pharmacy Team
Outpatient Pharmacy			
Outpatient Pharmacy Clinical Services • Establish 7 Outpatient Pharmacy Clinical Services HUB's in NCAL to provide MTM services and other identified services. **Target:** Expand clinical activity of OP pharmacist, in partnership with TPMG, establish workflows.	• Identify HUB Sites • Identify and engage stakeholders • Develop workflows for OP pharmacist to work in the HUBS • Develop process for staffing the Clinical HUBS • Train at least 1 pharmacist in the HUB locations to rotate through all	Regional Pharmacy Outpatient Operations Outpatient Pharmacy Director 12/31/2022	**Analysis of results:** **Evaluation: Target NOT Achieved** The HUB model was abandoned with a change of the goal and vision to have all OP pharmacist work in the clinical areas in their respective pharmacy locations using a rotating clinical shift. **Barriers:** Prioritization was moved to member service

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	the clinical services, eg, MTM, med adherence, OPIOID, etc.		Expansion of OPCS was minimized due to staffing constraints in hiring **Next Steps:** Continue to evaluate OP pharmacy core work Continue current OPCS work and evaluate a strategy to expand to provide MTM and Med Adherence services in the OP setting Revamp of staffing models and redesign of OP Clinical Services will be completed in 2023 with the Regional Pharmacy Operations Team.
Naloxone Furnishing Program Expansion • Expand Naloxone Furnishing to 7 additional pharmacies by April 30, 2022. • The remaining 14 medical centers will have one pharmacy furnishing Naloxone by December 31, 2022.	• 7 more sites already identified to roll out Naloxone furnishing by April 2022 • A core group of pharmacists will be trained per pharmacy location to provide the service • Engage TPMG stakeholder leaders in each medical center • Playbook for implementation already developed so work can be standardized	Regional Pharmacy Outpatient Operations 12/31/2022	**Analysis of results:** **Evaluation: Target Partially Achieved** A total of four medical centers are actively furnishing Naloxone, South San Francisco, San Rafael, Martinez, and Manteca. **Barriers:** Minimal patient demand with extensive member access to providers with the system Time required for consultation and cost of medication deterred member interest **Next Steps:** Data demonstrates that naloxone prescriptions are being ordered by providers but not picked up by members. Initiate a new performance improvement project to influence naloxone prescription pickup

<table>
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<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td>New element added to 2023 Trilogy workplan titled: Naloxone Pick up Opportunity</td></tr>
<tr><td colspan="4">Pharmacy Call Center (PCC)</td></tr>
<tr><td>Optimize Centralized Pharmacy New Member program

• Increase Capture rate to 50% or 3% increase over 2021 baseline 35.6%

Background:
Improving new member capture rate will improve new member onboarding experience with KP. Will provide a “Wow” experience for the member by transitioning prescription needs before the 1st PCP appointment creating more time for provider and members to discuss medical needs.</td><td>• Pilot Local Pharmacy NM onboarding in DSA like San Jose’s local pharmacy new member program. SJ providers and AACC refer new members directly to SJ AmCare staff. Proof of concept in DSA could lead to spread in other service areas
• Exploring a partnership with local area new member onboarding program to maximize pharmacy resources
• Work with AACC on robust New Member referral system to Pharmacy like SCal AACC referral model and leverage standardized referral workflow from local new member onboarding areas.</td><td>Centralized Service Team
NCAL Local New Member Onboarding Team
AACC

Q4 2022</td><td>Analysis of results:

Evaluation: Target NOT Achieved
• Final 2022 capture rate: 37.4%
o Goal ≥ 50% or 3 % above 2021 baseline (35.5%).
o Increase from baseline of 1.9% but fell 1.1% short of our goal.
• Number of new members dropped by 3,032(9%)
• Local new member referrals 3,659 (2021) vs 3,215(2022) dropped by 444(12%) which aligns with drop in 9% new member

<table><tr><td>NCAL % Capture Rate</td><td>2021</td><td>2022</td></tr><tr><td>Q1</td><td>40.3</td><td>37.3</td></tr><tr><td>Q2</td><td>33.3</td><td>35.5</td></tr><tr><td>Q3</td><td>32.2</td><td>38.2</td></tr><tr><td>Q4</td><td>32.6</td><td>38.5</td></tr><tr><td>Total</td><td>35.5%</td><td>37.4%</td></tr><tr><td>Transition</td><td>11,367</td><td>10,818</td></tr><tr><td>New Member(N)</td><td>31,993</td><td>28.961</td></tr></table>
Barriers
• Robust referrals to pharmacy
• Short New Member staffing</td></tr>
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<table>
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3. Next steps</th></tr>
<tr><td colspan="4"></td></tr>
<tr><td></td><td></td><td></td><td>• Local DSA pharmacy pilot did not implement due to tech and pharmacist short staffing.

Next steps
• Pharmacy strategic staffing plan for 1st quarter of each year
• Partner with TPMG and Management Strategy consultant improve new member referrals to pharmacy
• Goal not achieved, next steps and plan carried forward to 2023 Trilogy workplan</td></tr>
<tr><td>Improving Customer Service and Self-Service Technology

PCC dashboard targeted goals obtained and sustained as below:
• 80% Calls answered within 3min
• ASA < 3 mins
• AHT < 4 mins
• <10% Abandon Rate

Background: Driver of high ASA, AHT, and Abandon Rate are high call volumes</td><td><u>Technology</u>
• Implement and evaluate member facing IVR voice form.
• Continue to implement KP.org Pharmacy Click-to-Chat program.
• Hire temporary technicians to back fill the clerk vacancies until permanent staff are hired and trained.
• Activate Retention taskforce to explore opportunities to reduce high turnover.
• Implement Nexedia AI software Q2 2022 to better track and monitor clerk performance for improvement opportunities</td><td>Centralized Service Team
Digital Project Solution Team
National Pharmacy Ops Team
Contact Center Technology Team

Q42022</td><td>Analysis of results:

Evaluation: Target Not Met
• Overall call metrics not met.
○ ASA (Goal < 3mins)
○ AHT (Goal < 4mins)
○ Abandon Rate (goal <10%)
• Call volume in 2022 decreased by 6% (133,823) when comparing 2021 vs 2022.

<table><tr><th></th><th>2021</th><th>2022</th></tr><tr><td>ASA mins (goal < 3mins)</td><td>5:42</td><td>6:39</td></tr><tr><td>AHT mins (goal < 4mins)</td><td>4:27</td><td>5:04</td></tr><tr><td>Abd Rate% (goal <10%)</td><td>19%</td><td>23%</td></tr><tr><td>Call Volume</td><td>2,163,076</td><td>2,029,253</td></tr></table>
Barriers</td></tr>
</table>

Pharmacy Operations			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**

			• High turnover of staff (5 clerks/mos) and high vacancy rate throughout 2022 compared to prior year
			• Call handling times increased on average by 37 sec per call leading to overall lower productivity
			
			Next steps
			• Leverage Nexedia AI data to identify barriers to service and improve efficiencies and service
			• Staffing Retention Strategy
			  ○ Convert clerks to technician
			  ○ Optimize PCC staffing model. Consider decentralized and or annex hubs for additional call support.
			  ○ Push for remote work regulation with the CA BOP
			• Enhancements to IVR self-service
			  ○ Natural Language
			  ○ Rx Status
			  ○ Credit Card update
			  ○ Zero copay 1st fill
			• Spread Click to Chat NCal wide
			• Goal not achieved, next steps and plan carried forward to 2023 Trilogy workplan

Special Needs Plan Program			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
Improve Special Needs Plan (SNP) member access to essential services and affordable care: Ensure 100% of members had a health risk assessment completed	Monitoring: monthly and rolled up annually via the Regional Process Report measuring percent of members who had a health risk assessment completed. • Enhance operational tools • Identify enhancements to performance reporting • Identify and share best practices from high-performing teams and provide additional support to lower-performing teams	Regional SNP Leadership and Local SNP Teams 12/31/2022	Following explicit guidance from CMS, SNP programs that choose to focus on assessment completion must set the target at the theoretical maximum of 100%. While we recognize that – due to members who refuse service or are unable to be reached – achieving 100% is practically impossible, we believe this is a critical measure that should receive ample focus. Performance improvement efforts are always conducted with this goal in mind. October 2022 YTD performance of 88.2% this year is an improvement in performance compared to 86.4% recorded in November 2021. Next Steps: Continue to enhance tools and implement enhancements to performance reporting, which support program managers in identifying improvement opportunities in their department. Continue to identify and share best practices from high-performing teams and provide additional support to lower-performing teams.
Improve coordination of care and appropriate delivery of services through the direct alignment of the HRAT (Health Risk Assessment Tool), ICP (Individualized Care Plan), and ICT (Interdisciplinary Care Team): Members answer “yes” to the phone survey question, “Do you think this Care Management program is helpful for you in achieving your goals?” The target is 94.2%.	Monitoring: Monthly and rolled up annually via the IVR phone survey that Care Managers are successfully providing care coordination for our members by making sure that our members feel that the SNP Care Management program is helping them coordinate their needs to help them achieve their goals.	Regional SNP Leadership and Local SNP Teams 12/31/2022	October 2022 YTD performance of 96.7% met the target of 94.2%. Next Steps: Continue to reinforce offering of the survey and encourage care managers to continue their high level of support for patients’ goals.
Provide seamless transitions for SNP members across healthcare settings, care providers, and health	Monitoring: Quarterly Transition Audit	Regional SNP Leadership and Local SNP	Performance of 97.3% exceeded the goal of 95%. Next steps:

Special Needs Plan Program			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
services: Appropriate transition as evidenced in internal randomized chart review audit. The target is 95%.	The regional SNP team will continue to audit transition management on a quarterly basis. • Emphasize Model of Care requirements • Continue to support medical center use of operational and performance reporting • Identify best practices in managing patients who are moving between healthcare settings.	Teams 12/31/2022	Continue to support medical center use of transitions report, monthly performance report, and smart phrases. Identify best practices in managing patients who are moving between healthcare settings.
Ensure appropriate utilization of services for preventive health and chronic conditions: HEDIS Comprehensive Diabetes Control HbA1c < 8 metric. The target is the HEDIS Commercial 90th percentile.	Monitoring: Yearly via HEDIS rates Work with care managers to utilize tools and resources that support the linking of members to appropriate preventative services.	Regional SNP Leadership and Local SNP Teams 12/31/2022	October 2022 performance of 70.2% met target of the HEDIS 90th percentile, which was 66.7%. Next Steps: Continue current operations to meet or exceed HEDIS Medicare 90th percentile.
Ensure appropriate utilization of services for preventive health and chronic conditions: Percent of adults with a designated decision maker and/or Advanced Health Care Directive (AHCD) on file in medical record. The target is 80%.	Monitoring: Monthly Work with care managers to support them in having initial life care planning conversations with members and giving them the tools to have a designated decision maker and/or a AHCD on file in KPHC.	Regional SNP Leadership and Local SNP Teams 12/31/2022	October 2022 performance of 88.6% met target of 80%. Next Steps: Continue to support medical center teams which may include regional or individual training sessions.

Utilization Management			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
DME Process Improvement ➢ Address provider dissatisfaction with DME communication about denials as identified in Provider Satisfaction Survey (PSS) Target: • UM Criteria Communication – Increase from 68% in 2021 to 72% in 2022 • Denial Communication – increase from 56% to 64%	Reconvene PSS Workgroup to: • view outcomes from previous PSS action plans for new improvement opportunities • Develop and communicate new improved processes related to DME denial processing so providers will have better understanding of the alternatives they can suggest to patients	CDSU and PSS Workgroup Q4 2022	UM Criteria Communication fell from 68% in 2021 to 66% in 2022. Denial Communications remained at 56% in 2022 (no increase from 2021). A multifaceted approach to improve DME knowledge base and support for ordering clinicians and support staff was undertaken in 2022: • Revised DME Sharepoint Site designed and built based on Regional Survey from Clinical Staff, Administrators and DME Dept. Staff. • PCC Annual DME Training Module Developed and will be an annual KP Learn Requirement • Weekly Review of DME Avoidable days with feedback, findings provided to facility staff, leaders and Continuum Administrators to promote greater awareness of processes, expectations and ID areas of opportunities in Med Center, DME Dept. and vendor workflows. • Microsoft Teams Site allocated for DME Physician Champions to communicate with DME leadership, ask questions, share knowledge • Microsoft Teams Chat set up between highly impacted medical centers and DME Lead Clerks to allow efficient and rapid communication. • After an analysis of whether question modification(s) to ascertain additional interventions might be indicated, it was determined that those questions are currently in a NCQA look-back period for an action plan, and it would be important to preserve the questions as written to allow a like-for-like comparison. 2024 will be a non-look back year and the possibility of question modifications can be assessed at that time. Potential barriers to improvement: broader dissemination of the new DME Sharepoint site and how to navigate within it may be needed; PCC Annual DME

Utilization Management			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
			Training Module as a KPLearn Requirement not fully implemented in 2022; and an inability to modify some PSS questions delayed until 2024 due to current NCQA Action Plan. Next steps: continue promotion of Sharepoint site, Team chats to promote more efficient communications, and fully implement annual KPLearn Training Requirement. The Resource Management Committee (RMC) will continue to review results of the annual Practitioner Satisfaction Survey at their December meeting.
DME Process Improvement ➢ Conduct a deep dive into the processes and the work that is done between the CDSU and the DME Hub to clarify roles and responsibilities. Metric: Documented accountabilities between DME Hub and CDSU.	A team from CDSU/DME Hub staff will: • identify and act on problem(s) needing resolution • identify/vet proposed accountabilities • Report to Executive Sponsors quarterly	CDSU and DME Hub Q4 2022	A list of shared agreements between DME Hub and CDSU has been created and shared with staff, and it continues to be a work in progress into 2023. The DME Hub-CDSU PI Workgroup was repurposed to a weekly Collaboration Call among DME Hub and CDSU Leadership to discuss and resolve workflow and process issues arising between the two departments. A tracking list of identified issues/questions has been created and the Leadership Collaborative Calls will continue until all issues addressed. Potential barrier to more rapid progress: the SMEs in the Workgroup did not view themselves as decision-makers to agree to changing processes. Next steps: Continue the weekly Leadership Collaboration Calls and continue to cascade out the shared agreements to staff in each department.
Develop new model of delivering InterQual trainings in a timely manner to multiple Medical Centers at time. Metric: train at least 15 medical centers with 2022 InterQual updates with this new model	• Hire and train (as needed) 1-2 InterQual Certified Instructors (IQCI) • Update all presentation materials for virtual trainings in 2022	CDSU Q4 2022	3 IQCIs were trained in 2022. Virtual training materials were updated with latest InterQual information. The InterQual training team leveraged technology and built a self-scheduler for medical centers to sign up for their trainings, eliminating much back-and-forth to pin down training date(s). Approximately 370 Patient Care Coordinator Case Managers from 20 medical centers received training in 2022. All trainings are open to all

Utilization Management			
Goal (including Metric)	**Planned Actions to Meet Goal**	**Accountable Team and Due Date**	**2022 Evaluation** **1. Analysis of results including metrics** **2. Barriers** **3. Next steps**
	• Test scheduling 2-3 medical centers at a time for a single virtual 2022 IQ Update training		medical centers and several sessions had PCCs from 5+ medical centers in attendance. Potential barriers: None identified. Next steps: Refresh training content with 2023 InterQual updates and continue utilization of the self-scheduler to cover trainings for all medical centers in 2023.

Quality Improvement Financial Investment

Michelle Stott

Dr. Sanjay Bhatt

ALAMEDA Alliance FOR HEALTH

Factors Influencing Quality and Quality Investment

Michelle N. Stott, RN, MSN
Sr. Quality Director

Sanjay Bhatt, MD
Sr. Med. Director

ALAMEDA Alliance FOR HEALTH

Agenda

Goals

Factors Influencing Quality Metrics

HEDIS Rates

Investment

HEDIS Goals:

- Improve HEDIS rates to above MPL
- Close Health Care Disparity Gaps
- Promote Quality to the Staff, Providers, and Membership
- Improve Member and Provider Satisfaction

Quality: Financial impact

- Quality Withhold component (includes CAHPS)
- Quality Factor Sanctions
- Value Based Payment Program
  - → FQHC Alternate Payment Method
  - → PCP Value Based Payment Program
- DMHC Equity & Quality Measures
- Dual Eligible Special Needs Plan (D-SNP)
- DPH Quality Improvement Project
- Community Re-investment

Quality Factor Sanctions

- Quality Factor Sanctions
  - Below minimum performance levels (MPLs) for each measure within the four MCAS domains:
    1. Children's Health (2)
    2. Reproductive Health & Cancer Prevention (1)
    3. Chronic Disease Management (1)
    4. Behavioral Health
  - Tiers

Tiers	Green Tier	Orange Tier	Red Tier
Triggers	Below the State median or regional median in **one (1)** of the domains **MCP reporting units in the Green Tier will not be subject to monetary sanctions (TBD)*.*	Below the State median or regional median in **two (2)** of the domains	Below both the State median and regional median in **three (3) or more** domains

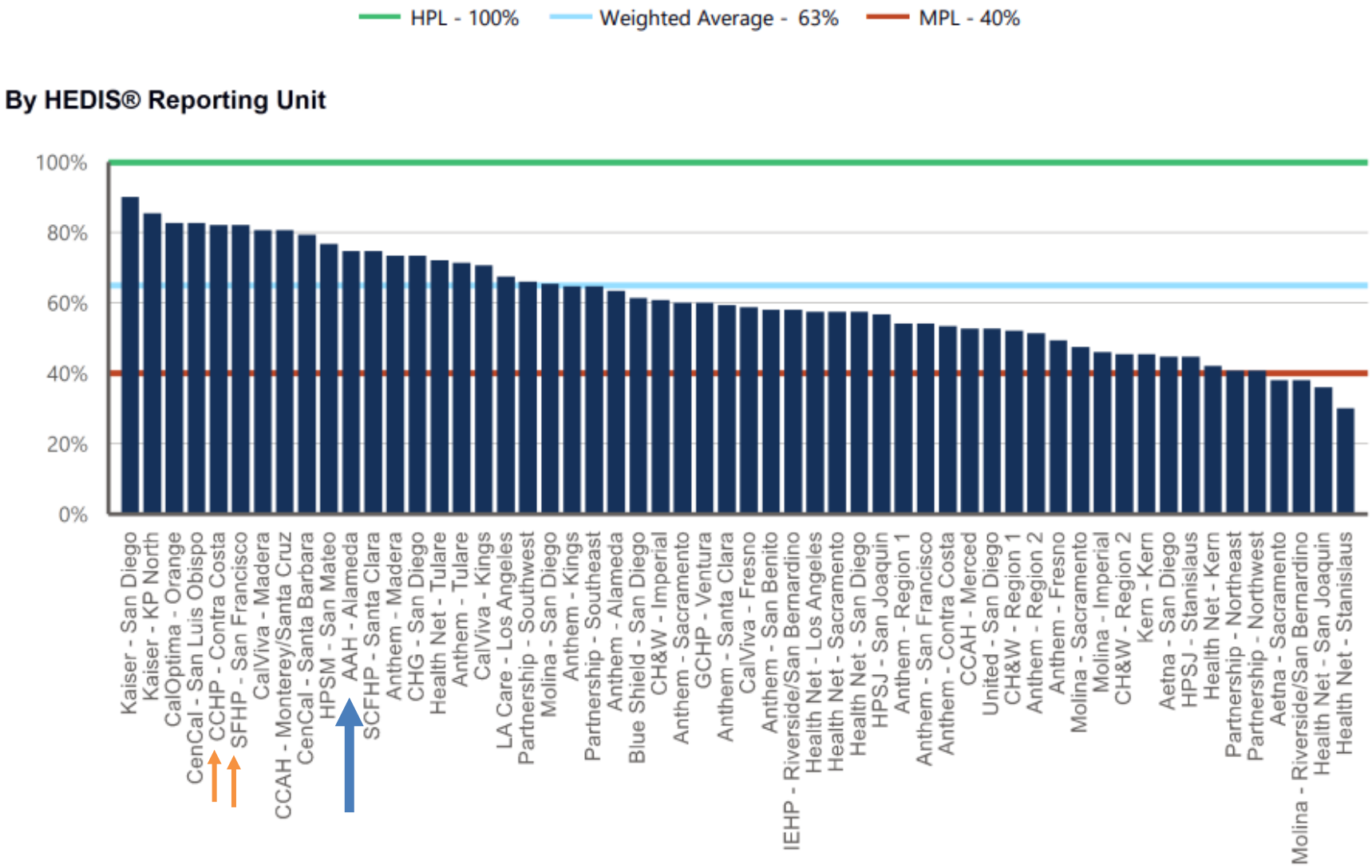
AAH

Quality: Performance impact

- Ongoing / January 1, 2024
  - → Loss of Kaiser Members resulting in decreases in QI scores
  - → Gain of ABC Members resulting in equal / decreases in QI scores
  - → Re-determination impact – TBD
- Comparison to Sister Health Plans / AQFS
- Comparison against regional plans affecting Quality Withhold

Managed Care Performance Monitoring Dashboard Report
Released July 2023

2022 HEDIS® Aggregated Quality Factor Score (AQFS)



Shared Quality Measures (performance)

8 below MPL as of 10/5/23

Measure Sort	Measure Description	2022	2023	Number to Treat to MPL	MPL
FUA1*	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day	29.46%	29.89%	98	36.34%
FUM1*	Follow-Up After Emergency Department Visit for Mental Illness - 30 Day	49.03%	27.09%	376	54.87%
CIS	Childhood Immunization Status - Combo 10	52.80%	37.44%	0	30.90%
IMA	Immunizations for Adolescents - Combo 2	50.61%	47.85%	0	34.31%
LSC	Lead Screening in Children	60.58%	58.20%	185	62.79%
W15*	Well-Child Visits in the First 15 Months of Life - 6 or More Visits	46.56%	45.24%	202	58.38%
W30*	Well-Child Visits for Age 15 Months to 30 Months - Two or More Visits	69.01%	69.28%	0	66.76%
WCV*	Child and Adolescent Well-Care Visits	49.69%	38.69%	9,368	48.07%
HBD2	HbA1c Poor Control (>9.0%)	29.20%	51.26%	2,071	37.96%
CBP	Controlling High Blood Pressure	54.74%	39.23%	4,360	61.31%
PPC1	Timeliness of Prenatal Care	85.42%	83.25%	25	84.23%
PPC2	Timeliness of Postpartum Care	87.50%	79.33%	0	78.10%
CCS	Cervical Cancer Screening	53.83%	49.60%	5,688	57.11%

* Admin

Quality Investment: Summary

1. Provider Engagement
   - **P4P Funding**
   - Value-Based Payment Program
   - On-going Network Development to ensure timely access
2. Member Engagement
   - **3 FTEs** telephonic outreach on care gap lists
   - Explore integrated care management platform (FY 2025)
3. Data collection & sharing
   - **Resources** required for implementation
4. Funding/Resources
   - Community Investment funds
   - QI/Performance Improvement Projects: **3 FTEs**
     - Pediatrics – CFMG
     - Behavioral Health measures
     - Support for VBP, EPT, health disparity projects
   - Practice coaching consultants/training/staff: **vendor**
5. Organizational Alignment
   - Coordinated campaigns**: multi-modal communication methods (i.e. letters, text, flyers, etc.)**
   - Utilize **Alliance staff incentives** to reward HEDIS activities/performance

Questions?

ALAMEDA Alliance FOR HEALTH

2024 Pay For Performance

11/17/2023

ALAMEDA Alliance FOR HEALTH

2023 Pay For Performance Summary

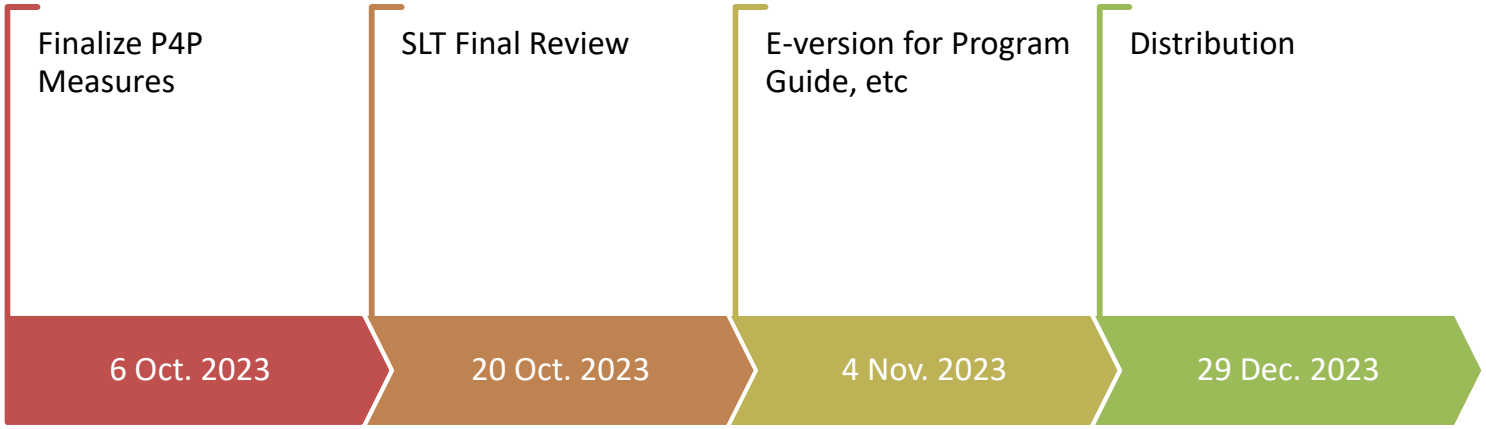
Year	Pool Dollars	% of Pool Dollars Earned	Dollars Left Behind
2022	**$5,000,000.00**	**39.95%**	***$3,021,153.94***
2021	$4,000,000.00	44.57%	*$2,217,007.48*
2020	$4,600,000.00	48.37%	*$2.375,083.34*

MY 2024 Details

- **Correlates with**
  - Managed Care Accountability Set (MCAS) Metrics
  - Promotion of Quality Care and Preventive Care

- **Four Areas of Focus**
  - Preventative Care
  - Access
  - Readmission
  - Member Satisfaction

Timeline


Finalize P4P Measures
6 Oct. 2023
SLT Final Review
20 Oct. 2023
E-version for Program Guide, etc
4 Nov. 2023
Distribution
29 Dec. 2023

HEDIS Rates YTD

Measure Type	Measure Sort	Measure Description	2022 Admin Rate	2022 Hybrid Rate	EP	Num	2023 10/5 Rate	Above MPL	Number to Treat to MPL	MPL	90th Pctl
Behavioral Health											
Admin	FUA1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day	29.82%		1,512	452	29.89%	N	98	**36.34%**	53.44%
Admin	FUM1	Follow-Up After Emergency Department Visit for Mental Illness - 30 Day	49.03%		1,351	366	27.09%	N	376	**54.87%**	73.26%
Well Child											
Hybrid	CIS	Childhood Immunization Status - Combo 10	45.20%	52.80%	4,014	1,503	37.44%	Y	0	30.90%	45.26%
Hybrid	IMA	Immunizations for Adolescents - Combo 2	49.36%	50.61%	5,383	2,576	47.85%	Y	0	34.31%	48.80%
Admin	W15	Well-Child Visits in the First 15 Months of Life - 6 or More Visits	46.56%		1,534	694	45.24%	N	202	**58.38%**	68.09%
Admin	W30	Well-Child Visits for Age 15 Months to 30 Months - Two or More Visits	69.01%		3,923	2,718	69.28%	Y	0	**66.76%**	77.78%
Admin	WCV	Child and Adolescent Well-Care Visits	49.69%		99,837	38,624	38.69%	N	9,368	48.07%	61.15%
Admin	DEV	Developmental Screening in the First Three Years of Life Total	44.24%		9,686	4,527	46.74%	Y	0	34.70%	
Hybrid	LSC	Lead Screening in Children	57.52%	60.58%	4,026	2,343	58.20%	N	185	62.79%	79.26%
Admin	TFLCH1	Topical Fluoride for Children Rate1 - dental or oral health services	10.87%		102,784	1,768	1.72%	N	18,070	19.30%	

HEDIS Rates YTD

Measure Type	Measure Sort	Measure Description	2022 Admin Rate	2022 Hybrid Rate	EP	Num	2023 10/5 Rate	Above MPL	Number to Treat to MPL	MPL	90th Pctl
Behavioral Health											
Disease Management											
Admin	AMR	Asthma Medication Ratio	74.71%		2,025	1,469	72.54%	Y	0	**65.61%**	75.92%
Hybrid	CBP	Controlling High Blood Pressure	41.77%	54.74%	19,741	7,744	39.23%	N	4,360	**61.31%**	72.22%
Hybrid	HBD2	HbA1c Poor Control (>9.0%)	37.06%	29.20%	15,568	7,980	51.26%	N	2,071	**37.96%**	29.44%
Women's Health											
Admin	BCS	Breast Cancer Screening	56.13%		19,330	10,219	52.87%	Y	0	**50.95%**	61.27%
Hybrid	CCS	Cervical Cancer Screening	52.44%	53.83%	75,769	37,584	49.60%	N	5,688	**57.11%**	66.48%
Admin	CHL	Chlamydia Screening in Women	64.14%		7,692	4,582	59.57%	Y	0	**56.04%**	67.39%
Hybrid	PPC1	Timeliness of Prenatal Care	85.36%	87.50%	2,496	2,078	83.25%	N	25	**84.23%**	91.07%
Hybrid	PPC2	Timeliness of Postpartum Care	81.72%	85.42%	2,496	1,980	79.33%	Y	0	**78.10%**	84.59%

P4P Overview

Clinical Quality Measure Goals

Delegates

- → 100% of points awarded per measure if the NCQA 90th Percentile is met.
- → 75% of points awarded per measure if the NCQA 50th Percentile is met.
- → If 50th Percentile isn't met, points awarded based on % of increase from prior year.

Measures

A total of 16 Measures are broken up and aligned with the type of practice: Family, Internal Medicine or Pediatrics

Points

- Clinical Quality Measures: 70 points
- Other Measures: 30 Points

P4P HEDIS Metrics

- **Children**
  - Well-Child Visits in the First 15 Months of Life: Six or More Visits (W30)
  - Well-Child Visits in the First 30 Months of Life: Two or More Visits (W30)
  - Child and Adolescent Well-Care Visits (WCV)
  - Childhood Immunizations: Combo 10 (CIS)
  - Immunizations for Adolescents: Combo 2 (IMA)
  - Lead Screening in Children (LSC)
- **Preventative Care**
  - Breast Cancer Screening (BCS)
  - Cervical Cancer Screening (CCS)
  - Colorectal Cancer Screening (COL-E)*
- Behavioral Health
  - Follow-up After ED Visit for Mental Illness (FUM) - 30 day
- **Chronic Disease**
  - Hemoglobin A1c Poor Control (> 9%) For Diabetics (HBD)
  - Controlling High Blood Pressure (<140/90) (CBP)

Measures Below MPL

* New Measure

Non-HEDIS Metrics

- Access
  - CG-CAHPS Non Urgent Appt
  - CG-CAHPS Urgent Appt
- Preventative Care
  - At least one PCP visit within the measurement year
- Chronic Disease
  - Readmission Rate

Additional Measures

- Manifest Medex Health Information Exchange (HIE) Participation
  - Participation in the Manifest HIE with continuous data submission throughout the measurement year.

Member at the end of the Measurement Year	15-999	1000-4999	5000-14999	15000+
New Participant	$ 2,000	$ 3,000	$ 5,000	$ 10,000
Ongoing Participant	$ 1,000	$ 1,500	$ 2,500	$ 5,000

Monitoring Measures

Avoidable ED visits per 1000 (Using the ED Visit Types per Johns Hopkins of either "Emergent, primary care treatable" or "Non-emergent.")

Percentage of acute hospital stay discharges which had follow-up ambulatory visit within 7 days post hospital discharge (PHM/IPP measure)

CPTII Code Utilization for BP Readings
(Non HEDIS measure that encourages providers to use CPT II codes to document BP ranges for all patients and not just those who are part of the EP for the CBP measure)

Developmental Screening in the First Three Years of Life (DEV): Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E): The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.

- Depression Screening. The percentage of members who were screened for clinical depression using a standardized instrument.
- Follow-Up on Positive Screen. The percentage of members who received follow-up care within 30 days of a positive depression screen finding.

Topical Fluoride for Children (TFL): Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year.

Questions?

ALAMEDA Alliance FOR HEALTH

Population Health Management

QIHE Committee

11/17/2023

ALAMEDA Alliance FOR HEALTH

Why Population Health Management (PHM)?

Our Aim

Optimal health and wellbeing for all members.

The Problem

Not all members need the same care, or receive the care they need, when they need it.

The PHM Solution

- Understanding Alliance members through assessments and identifying groups of members at risk.
- Providing equitable access to necessary wellness and prevention services, care coordination, and care management programs.
- Collaborating with provider and community partners.
- Improved health and equity.

Alliance Member Key Populations

Children and Youth

Older Adults

Birthing Members

Members with Behavioral Health Needs

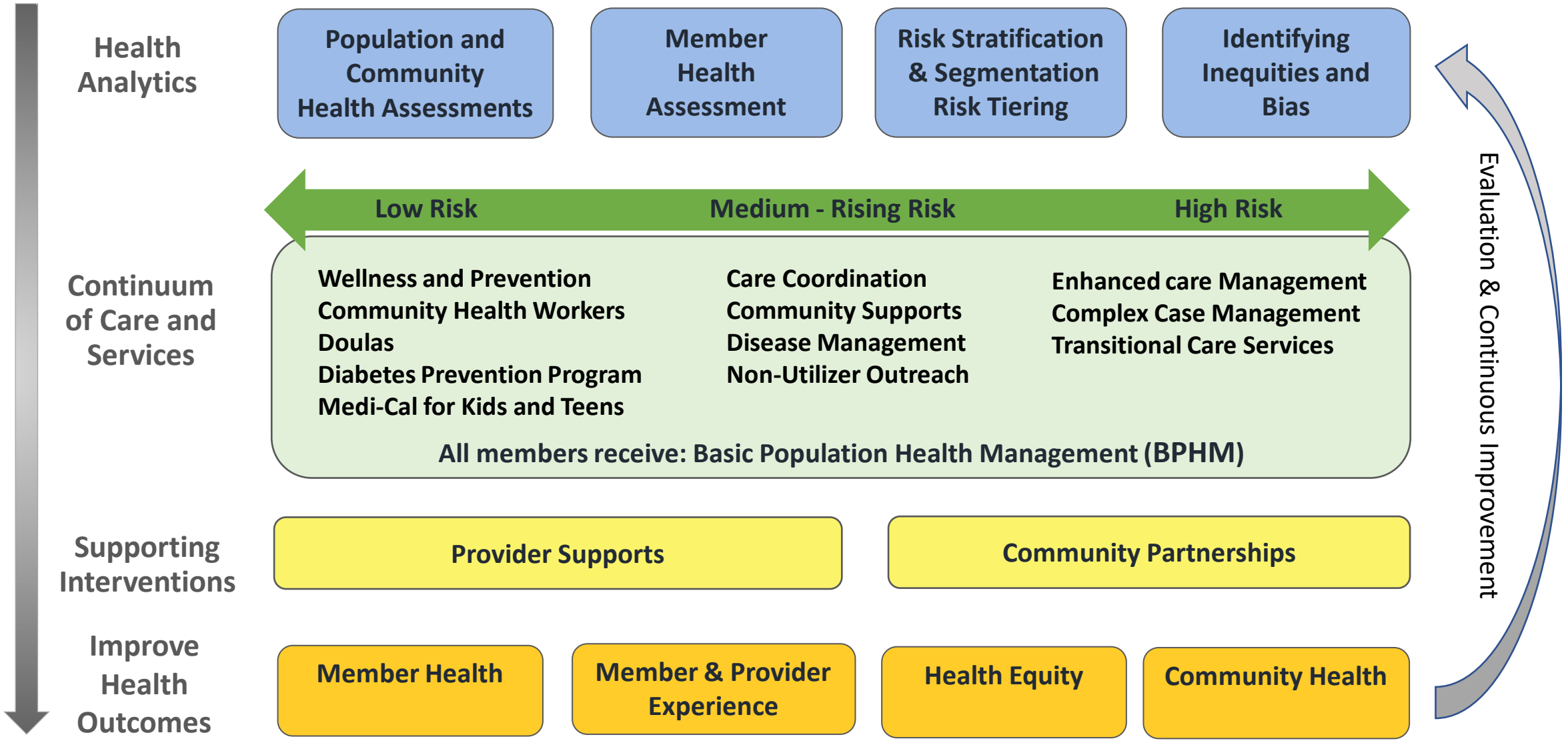
Members with Disabilities

Racial/Ethnic Groups

Members with Limited English Proficiency Needs

Enhanced Care Management Populations of Focus

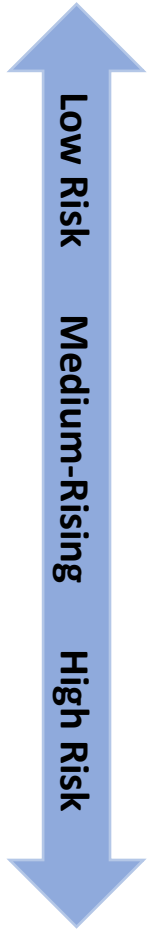
Population Health Management Framework



Addressing social determinants of health to promote health equity.

2023 PHM Strategic Pillars

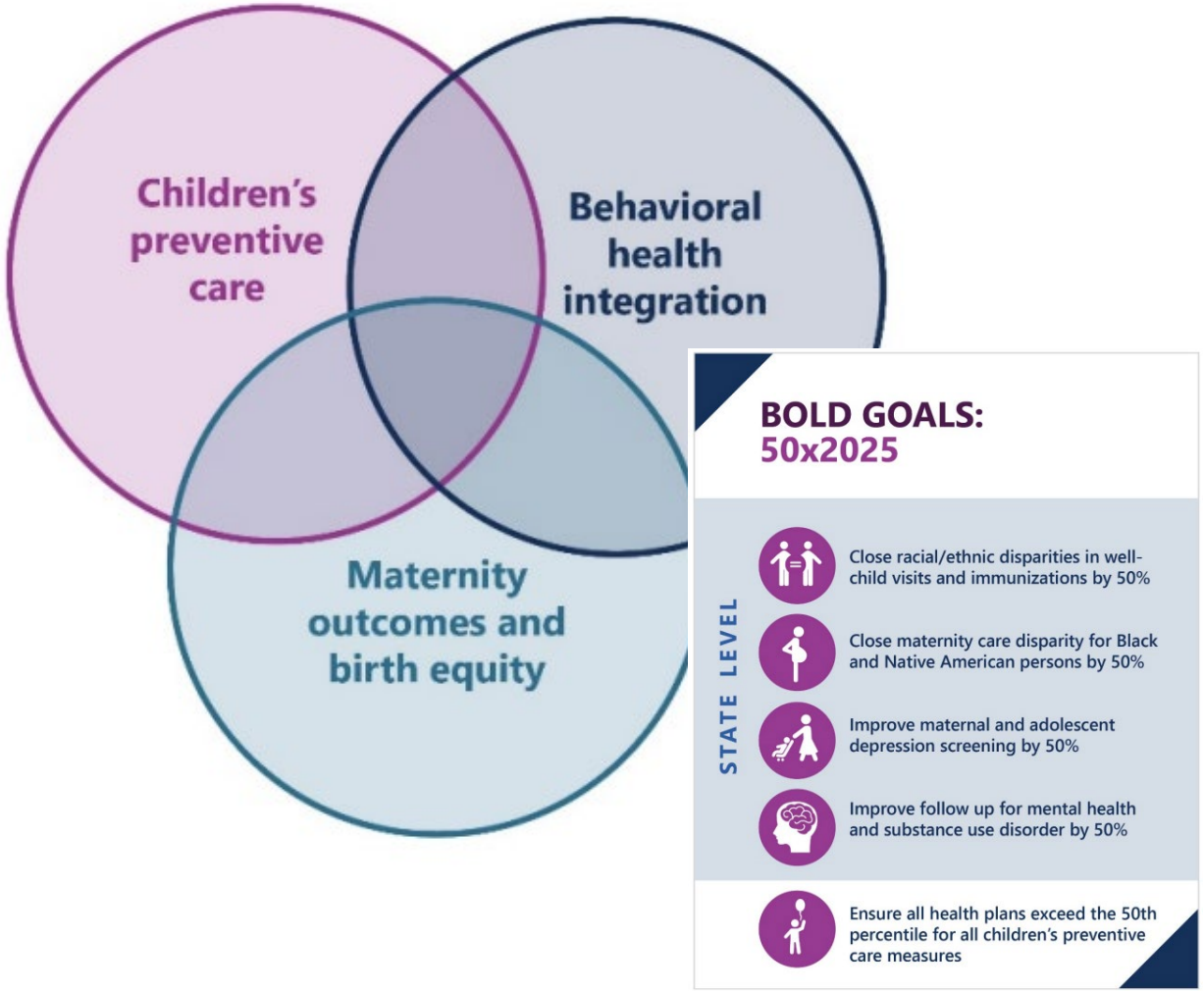
Strategic Pillars	2023 Programs
Address primary care gaps and inequities	• Non-utilizer outreach campaigns • Breast cancer screening - Equity • Under 30 months well visits – Equity
Support members managing health conditions	• Hypertension & diabetes disease management • Maternal mental health • Follow-up after ED visit for mental illness and substance use
Connect members in need to whole person care	• Transitional Care Services • Catastrophic case management • California Children's Services (CCS) referrals



NCQA PHM Areas of Focus

- Keeping Members Healthy
- Managing members with emerging risk
- Managing multiple chronic illnesses
- Patient safety or outcomes across settings

DHCS Quality Strategy Clinical Areas of Focus



Questions?

Gil Duran
Manager, Population Health and Equity
gduran@alamedaalliance.org

Linda Ayala
Director, Population Health and Equity
layala@alamedaalliance.org

ALAMEDA Alliance FOR HEALTH

Non-Utilizer Outreach Campaign

Farashta Zainal
Megan Hils

ALAMEDA Alliance FOR HEALTH

Background and Purpose

- **Organizational goal to address health disparities:**
  - Outreach to at least 20% of non-utilizers over the age of 50, and connect 2% to primary care services
  - Outreach to at least 20% of non-utilizers ages 6 and under, and connect 2% to primary care services
  - Goal is continued for 2023-24
- **Non-utilizer:** continuously enrolled members who have not utilized primary care services in the last 15 months.
  - Some did have claims for prescriptions, ER visits, and/or inpatient admissions
- **Outreach campaign goals:**
  - Primary:
    - → Update the member's assigned PCP.
    - → Transfer the member directly to their provider to schedule an appointment.
  - Secondary:
    - → Identify members with HEDIS measure completion gaps to tailor calls around needed preventive services

Campaign details

- Calls conducted **May 1 – Jun 30**
- Two subgroups:
  - Adults aged 50 and older with an ER visit
  - Children aged 6 and younger
- 3 outreach attempts
- Results of calls (dispositions) were tracked
- Member counts:

	Adults	Children	**Total**
AHS	1398	69	1467
Directs	1994	645	2639
CFMG	-	1821	1821
CHCN	961	799	1760
Total	**4353**	**3334**	**7687**

Results

- 50% overall success rate - 47% for adults, 55% for children

Call Dispositions	Adults	Children	Total
Changed PCP*	**39**	**15**	**54**
Did not want to speak with us	479	220	699
Incorrect or Disconnected #	2980	1080	4060
Left Voicemail*	**4991**	**2898**	**7889**
Member disconnected during call	59	11	70
No Answer-No option for VM	1896	911	2807
No phone number on file	182	353	535
Shared General Information*	**30**	**2**	**32**
Spoke with Member, Parent or Guardian*	**501**	**408**	**909**
Terminated Account	316	76	392
Third Party Answered	299	46	345
Transferred to PCP*	**43**	**17**	**60**
Total	11815	6037	17852

*Dispositions categorized as “successful”

Results

- 44% of calls resulted in a voicemail.
- 41% of members could not be reached due to incorrect/disconnected phone number, no option to leave voicemail or no phone number on file.
- **102 (2.25%) adults** and **97 (1.26%) children** had a PCP visit following a successful contact.
- Agents Feedback:
  - Members reporting coverage under Kaiser.
  - Members reporting they already had or will have an appointment.
  - Xaqt agents experienced challenges connecting with interpreter services; members disconnected before interpreter was on the line.
  - Members stating they did not have time to talk when we called.

Results - Disenrollments

- Due to delay from the time the call list was generated and the campaign began, **71 adults** and **34 children** were ineligible before the campaign began.
- **103 adults** and **88 children** became ineligible during the campaign.
- **251 adults** and **255 children** became ineligible in the 3 months following the campaign (Jul – Sep).
- **3928 adults** and **2957 children** were still enrolled through October.

Barriers and Lessons Learned

- High number of incorrect or missing numbers on file.
- When members are unable to stay on call to transfer, we don't know what happens after that.
  - Ex., do they follow through with calling PCP?
- Voicemail is a successful contact, however it gives us limited information.
- Disposition tracking was not very consistent; need to improve tracking system

Changes to test in Cycle 2

- Track when members request a callback.
- Xaqt agents use a project-dedicated phone line with a California area code.
- Add evening call hours.
- Updated definition of “non-utilizer”: No encounters within the last 12 months
  - Continue to exclude duals or other healthcare coverage.
  - Continue to identify gaps in care.

Thanks!

Questions?

You can contact our team at:

mhils@alamedaalliance.org

fzainal@alamedaalliance.org

Compliance Update

Grace St. Clair

ALAMEDA Alliance FOR HEALTH

Q3 2023 COMPLIANCE ACTIVITY REPORT

(QIHEC) Quality Improvement Health Equity Committee

Presented To: QIHEC (Quality Improvement Health Equity Committee)
Presented By: Richard Golfin III, FACHE, CCO/CPO
Date: November 17th, 2023.

Compliance Audit Updates

- **2023 DHCS Routine Medical Survey**:
    - The onsite virtual interview took place from April 17th, 2023, through April 28th, 2023. An exit interview took place on September 26th, 2023. There were 15 findings and 5 identified repeat findings. On October 20th, 2023, the Plan received the final report from the DHCS. The DHCS Managed Care Quality and Monitoring Division has asked that all corrective action plans be submitted to the Department by November 22nd, 2023.
- **2022 DHCS Routine Medical Survey**:
    - The 2022 DHCS Routine Medical Survey was held on April 4th, 2022, and completed April 13th, 2022. On September 13th, 2022, the Plan received the Final Audit Report which detailed 15 findings, 9 of which were repeat findings from the previous audit year. The DHCS has completed a review of 8 out of the 15 findings. The Plan awaits further guidance from DHCS.
- **2021 DMHC Follow-up Routine Survey**
    - On June 26th, 2023, the Plan received notification from the DMHC that the Department will be conducting a Follow-Up Review (Survey) of the outstanding deficiencies identified in the October 23rd, 2022, Final Report of the 2021 DMHC Routine Survey of the Plan. The review period covered November 1st, 2022, through May 31st, 2023. Initially the Department scheduled an onsite virtual session for October 26th ,2023. On October 12th, 2023, the Department notified the Plan that it no longer needs the virtual interview session, and the meeting was cancelled. The Plan awaits further instructions from the DMHC.

Delegation Oversight Auditing Activities 2023

Delegate	Virtual/On-site Audit Dates
BEACON HEALTH STRATEGIES LLC	1/18/2023 – 1/20/2023
PERFORMRX	5/9/2023 - 5/10/2023
KAISER	7/31/2023 - 8/11/2023
CHILDREN'S FIRST MEDICAL GROUP (CFMG)	10/30/2023 - 10/31/2023
MARCH VISION CARE GROUP, INC.	11/8/2023 - 11/9/2023
TELEDOC (Credentialing only)	12/1/2023
COMMUNITY HEALTH CENTER NETWORK (CHCN)	10/11/2023 – 10/12/2023
CHME	11/2/2023- 11/3/2023
MODIVCARE	11/6/2023- 11/8/2023
LUCILLE PACKARD (Credentialing only)	9/1/2023
PHYSICAL THERAPY PROVIDER NETWORK (PTPN) (Credentialing only)	4/1/2023
UCSF (Credentialing only)	10/1/2023

- **Behavioral Health Insourcing:**

  - Although the Alliance has received approval from the Departments of Managed Health Care (DMHC) and Health Care Services (DHCS), as expected, DMHC's approval was subject to and conditioned upon the Alliance's full performance to the Department's satisfaction of eight Undertakings. Six of the eight Undertakings require deliverables to the DMHC. Compliance is coordinating with internal stakeholders to gather responses for timely and complete submission of the deliverables. All undertakings deliverables have been filed with DMHC. The Alliance has received substantive comments for Undertaking six and is gathering responses.

Outstanding Undertakings Chart:

Undertaking #	Deliverable	Initial Due Date	Progress
No. 2	Submit regular reports detailing the Plan's efforts to recruit and fill positions identified to support the insourcing of MH/SUD services. The initial report is due no later than 30 days following the date of the Order of Approval. Each subsequent report must be submitted within 30 days of the prior report, until all positions have been filled.	By April 28th, 2023, and every 30 days thereafter.	Final Status Report to DMHC 8/8/2023 (see closed Filing No. 20232500).
No. 6	Submit electronically an Amendment filing to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") (42 USC § 300 gg-26) and its regulations (45 CFR § 146.136) and Section 1374.76 of the Act. Before submitting the Amendment, the Plan shall contact the Department's MHPAEA review team by May 28th, 2023, to obtain detailed filing instructions and DMHC MHPAEA template worksheets for completion as part of the MHPAEA compliance filing.	By July 12th, 2023	Received extensive comments to which the Plan will need to respond. Compliance is currently reviewing DMHC's comments and gathering responses.

Behavioral Health Grievance & Appeals Report

Jennifer Karmelich

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Behavioral/Mental Health Grievance and Appeals Report

Date:	September 20, 2023
From:	Alma Pena - Senior Manager, Grievance and Appeals
Reporting Period:	January 2023 to August 2023

Purpose: To track and trend all grievance and appeals resolved during the reporting period in order to identify opportunities for quality improvement.

Standards/Benchmark:

	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	474	30 Calendar Days	95% compliance within standard	451	95.1%	
Expedited Grievance	0	72 Hours	95% compliance within standard	NA	NA	
Exempt Grievances	298	Next Business Day	95% compliance within standard	298	100.0%	
Standard Appeal	0	30 Calendar Days	95% compliance within standard	NA	NA	
Expedited Appeal	0	72 Hours	95% compliance within standard	NA	NA	
Total Cases:	772		95% compliance within standard	749	97.0%	1.03

*Goal is to have less than 1 complaint per 1,000 members, (calculation: the sum of all unique grievances for the quarter divided by the sum of all utilizers for the quarter multiplied by 1000.)

Data/Analysis:

Filed Against:	Grievance Type					Grand Total
	Access to Care	Coverage Dispute	Other	Quality of Care	Quality of Service	
Beacon	**51**	**11**	**2**	**5**	**18**	**87**
Q1 2023	34	5	1	4	6	50
Q2 2023	13	5	1	1	9	29
Q3 2023	4	1	0	0	3	8
Mental Health Facility	**17**	**6**	**0**	**5**	**13**	**41**
Q2 2023	5	4	0	1	1	11
Q3 2023	12	2	0	4	12	30
Mental Health Professional	**18**	**7**	**2**	**7**	**18**	**52**
Q2 2023	6	2	2	2	7	19
Q3 2023	12	5	0	5	11	33
Plan	**73**	**14**	**2**	**0**	**205**	**294**
Q2 2023	34	8	1	0	97	140
Q3 2023	39	6	1	0	108	154
Grand Total	**159**	**38**	**6**	**17**	**254**	**474**

Grievance Type	Q1 2023	Q2 2023	Q3 2023		Grand Total
			Jul	Aug	
Access to Care	**34**	**58**	**33**	**34**	**159**
Authorization	2	4	2	2	10
Continuity of Care	0	12	0	3	15
Geographic Access	1	1	0	0	2
Language Access	0	1	1	0	2
Out-of-Network	3	4	0	0	7
Physical Access	0	1	0	0	1
Provider Availability	7	11	14	16	48
Technology / Telephone	5	12	9	7	33
Timely Access	16	12	7	6	41
Coverage Dispute	**5**	**19**	**6**	**8**	**38**
Benefit	2	4	1	3	10
Denial of Request to Dispute Financial Liability	1	0	0	0	1
Provider Balance Billing	0	4	2	2	8
Provider Direct Member Billing	1	7	1	1	10
Reimbursement	1	4	2	2	9
Other	**1**	**4**	**1**	**0**	**6**
Eligibility	1	2	0	0	3
Enrollment	0	0	1	0	1
Fraud/Waste/Abuse	0	1	0	0	1
PHI/Confidentiality/HIPAA	0	1	0	0	1
Quality of Care	**4**	**4**	**3**	**6**	**17**
Assault/Harassment	0	0	0	1	1
Inappropriate Care	1	2	0	2	5
Provider Denial of Treatment	1	0	0	0	1
Quality of Care	2	2	3	3	10
Quality of Service	**6**	**114**	**77**	**57**	**254**
Authorization	0	0	2	1	3
Case Management/Care Coordination	0	4	0	0	4
Member Informing Materials	0	2	1	1	4
Plan Customer Service	0	75	49	32	156
Provider/Staff Attitude	2	6	7	5	20
Referral	4	27	18	18	67
Grand Total	**50**	**199**	**120**	**105**	**474**

- Quality of Service and Access to Care continue to be the categories with the most complaints. Majority of complaints are related to the following sub-categories:
    - (254) Quality of Service:
        - (156) Plan Customer Service:
            - Members did not receive return phone calls from ABA/BH team.
            - Members were given incorrect contact information for BH/MH providers.
            - Member stated that they have been trying to find a grief counseling provider, but kept getting transferred around to different departments.
        - (67) Referral:
            - Members had difficulty securing BH/ABA services.

        - Members contacted several ABA and BH providers, but they were not accepting AAH insurance, and needed assistance with finding new ABA/BH providers.
        - Members were authorized for services, but never received any follow-up.
- (159) Access to Care:
    - (48) Provider Availability:
        - Members were unhappy that the BH/MH providers that they contacted, were not accepting new patients at the time.
    - (41) Timely Access:
        - Members had difficulty securing timely appointments with BH providers.
        - Member waited 6-8 months to get an evaluation for autism.
        - Member had been on waiting list for ABA services since November 2022.
    - (33) Telephone/Technology:
        - Members had difficulty reaching the BH Department, as well as other BH providers by phone.
        - The online provider directory listed incorrect information stating that the providers were accepting new patients.

Grievances:

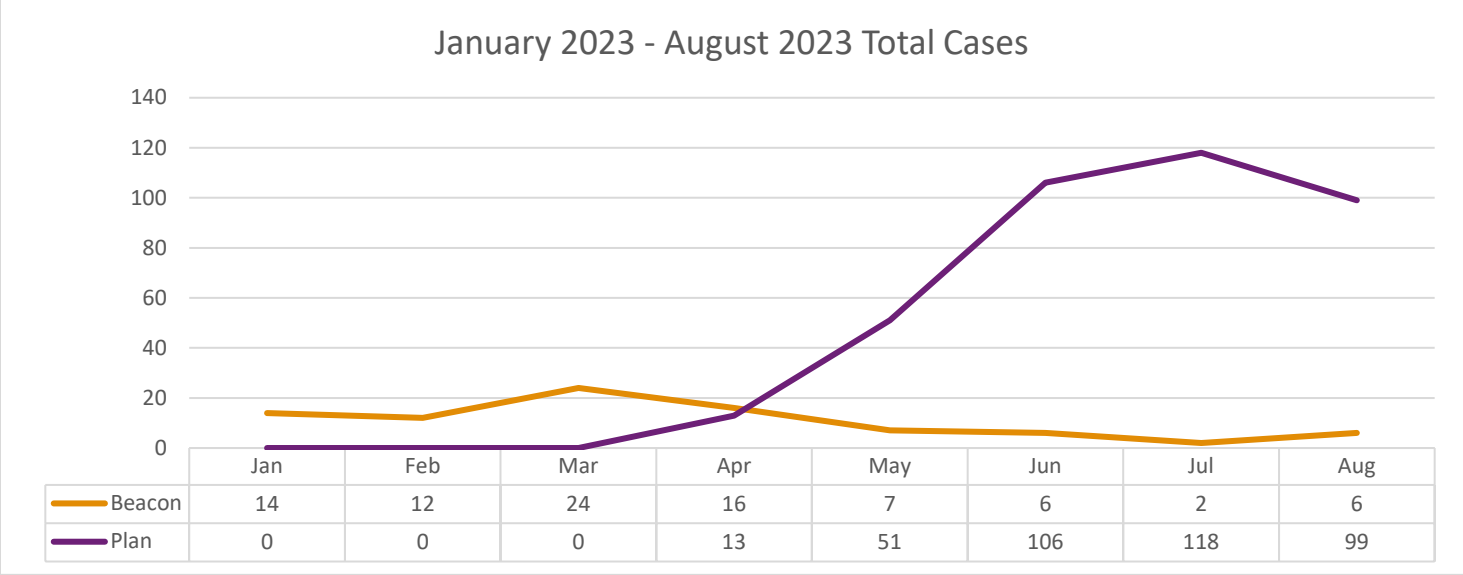
Identified providers/clinics with 2 or more complaints in Q1 2023

Filed Against	Access to Care	Coverage Dispute	Other	Quality of Care	Quality of Service	Grand Total
Beacon Health	33	2	0	2	4	41
Bright Heart Health	0	0	0	1	1	2
Nadirah Stills	1	0	0	1	0	2
Grand Total	**34**	**2**	**0**	**4**	**5**	**45**

Identified providers/clinics with 2 or more complaints in Q2 2023 - Q3 2023

Filed Against	Access to Care	Coverage Dispute	Other	Quality of Care	Quality of Service	Grand Total
Plan	74	15	2	0	206	297
Beacon Health	17	2	1	1	12	33
MindPath Health	2	4	0	0	0	6
Uvaldo Palomares	2	0	0	0	3	5
Davis Street Primary Care Clinic	0	0	0	0	4	4
Array Behavioral Health	0	4	0	0	0	4
Roman Empire ABA Services, Inc.	2	0	0	0	1	3
Schuman-Liles Clinic	2	0	0	0	1	3
Berkeley Therapy Institute	2	0	0	0	1	3
Individualized ABA Services for Families	1	0	0	0	2	3
ACES	2	0	0	0	0	2
Autism Intervention Professionals	1	0	0	1	0	2
Autism Learning Partners	0	0	0	2	0	2
Creative Solutions for Autism	0	0	1	1	0	2
Educational and Therapeutic Services, Inc	0	0	0	0	2	2
John George Pavilion	0	0	0	2	0	2

Lorena Perswain	1	0	0	0	1	2
Willow Rock Telecare	1	0	0	1	0	2
Grand Total	**107**	**25**	**4**	**8**	**233**	**377**



Tracking and Trending: 31.3% of grievances are related to our Behavioral Health Department.

Issues/Recommendations:

- Meeting bi-weekly interdepartmentally to discuss network gaps for contracting opportunities; and customer services issues related to the implementation to improve operational workflows.

Action Items:

Action Item:	Responsible Party:	Completed:
Continue to monitor and meeting on a biweekly basis to discuss specific cases and members with multiple complaints.	J. Karmelich / A. Pena	Ongoing

Clinical Practice Guidelines

QIHEC November 17, 2023

ALAMEDA Alliance FOR HEALTH

Clinical Practice Guidelines

- New policy
- The Alliance **adopts, disseminates, and monitors** clinical practice guidelines
- Support for providers and staff

Criteria for Guidelines

- Based on
  - valid and reliable clinical evidence, or
  - consensus of health care professionals in the field
- Consider the needs of members
- Stem from recognized organizations
- Reviewed by the Quality Improvement Medical Director, subcontractors and other network providers as appropriate
- Approved by IQIC and QIHEC
- Distributed through
  - Alliance website, provider communications, on request

Guidelines for Approval

Guidelines	Organization	Members	Link (if available)
Clinical preventive services "A" and "B"	• U.S. Preventive Services Task Force (USPSTF)	Adults ages 21 and older	uspreventiveservicestaskforce.org
Bright Future Periodicity Schedule	• American Academy of Pediatrics	Children and adolescents under 21 years old	periodicity_schedule.pdf (aap.org)
Perinatal Care	• American College of Obstetrics and Gynecology (ACOG)	Pregnant members	acog.org
Mental and Behavioral Health Guidelines: **Miliman** **LOCUS** **CALOCUS/ECSII**	• Miliman • American Association for Community Psychiatry • American Academy of Child and Adolescent Psychiatry	Members experiencing mental and behavioral health conditions.	Care Guidelines for Evidence-Based Medicine | MCG Health American Association for Community Psychiatry American Academy of Child and Adolescent Psychiatry
Autism Spectrum Disorders	• American Psychological Association Board		APA-Approved Standards and Guidelines

Quality Improvement Workplan

Michelle Stott

ALAMEDA Alliance FOR HEALTH

2023 Quality Improvement Health Equity Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Continued or New?	Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**	**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	The team is in the process of completing the 2022 Annual QI Program Evaluation. The QI 101 Quality Improvement and Health Equity (QIHE) policy was approved at HCQC in March 2023, and ultimately, steps will be taken to evolve the QI program to the QIHE Program in 2023.	Annual QI Program Evaluation was presented at the May 2023 HCQC meeting.	N/A	N/A	All Sub-Committees and HCQC	Q2 2023	AAH will insource BH 4/1/23

Quality of Care

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Continued or New?	Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Manager Name: Farashta Zainal	**HEDIS Rates MY 2023**	**Continuation**	Increase the HEDIS/MCAS below MPL (W30 0-15, LSC, CCS, CBP, FUM) scores to meet or exceed MPL by December 31, 2023	2023 rates as of 5/5/2023 - CBP - 29.28% CCS - 44.48% FUM - 22.48% LSC - 53.0% W15 - 26.51%	2023 rates as of 8/5/2023: CBP - 36.16% CCS - 47.54% FUM - 28.39% LSC - 57.15% W15-38.47%	2023 rates as of 10/5/2023: CBP - 39.23 CCS - 49.60 FUM - 27.09 LSC - 58.20% W15 - 45.24%		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2023	Due to the pandemic AAH saw a decline in HEDIS measures with multiple years of service. Furthermore, state wide insufficient lead screening kits may be a factor in declining lead screening rates.
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**HEDIS Retrieval and Overreads MY 2023**	**Continuation**	Alongside the analytics team, provide HEDIS support related to medical record retrieval, abstraction, and overreads. The goal is to overread 20% of the abstracted charts for the hybrid measures.	Completed record retrievals. Completed Change University training to conduct overreads; providing overread support for HBD measure only. 65% of overreads completed by May 1.	100% of overreads due by May 5. Rates were finalized in June. Project complete.	On Track		Internal Quality Improvement Committee	5/02/2023	The quality analytics team benefits from QI partnership in completing their goal of 100% overreads to reduce errors in the HEDIS data submission
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Lead QI Project Specialist Name: James Burke	**Pay For Performance (P4P) 2023**	**Continuation**	Incentivizes providers to improve care on P4P measures with quarterly QI oversight. Facilitate webinars to discuss P4P updates, best practices and answer questions. - meet with 100% of the delegates by December 31, 2023 - meet with at least 30% of Directs by January 30, 2024	Hosted P4P provider webinars to discuss 2023 measures and program details. Disseminate program guides to providers and delegates.	Begin discussing 2024 P4P program, including payout measures.	QI and Anlytics team continue to meet and discuss measures for 2024. Leadership has approved additional funding for QI and as a result the P4P pool dollars will increase		Quality Improvement Health Equity Committee	12/2023	The P4P program has been a successful tool used to support providers improve HEDIS rates
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**QI PDSA Cycle Training**	**Continuation**	By December 31, 2023, provide support and training to all divisions to utilize the PDSA performance improvement model to develop and evaluate quality improvement projects	On Track	Offered ABCs of QI training to all staff in the Health Care Services division, with over 40 participants in attendance	No updates, will continue in MY24		All Sub-Committees	6/30/2023	As quality improvement (QI) projects spread throughout the Health Care Service team, it is essential that all staff have an understanding of the PDSA model for improvement. The model provides a vehical to drive QI projects
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Priority PIP: Improve FUA/FUM - improve 30 day follow-up rate**	**New**	Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 30 days of emergency department (ED) by December 31, 2025	N/A	PIP submission submitted to HSAG/DHCS on 04/7/23. Received approval on 4/12/23. Attended HSAG PIP overview training 4/26/23.	Steps 1 - 6 submitted 7/7/2023 Aim statement: Does a visit feed based on claims increase the percentage of provider notifications that occur within seven days for member emergency department visits for mental illness and substance use disorder? Indicator: FUA/FUM 7 Day Provider Notification Rate.		Internal Quality Improvement Committee	12/31/2025	This is a newly assigned PIP. PIP topic was assigned by the state based on low performance
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Bob Hendrix	**Equity PIP: Improve Well Child - W15 (6) for African American Children**	**New**	To address the disparity that exists with Well Child visits, by December 31, 2025, increase the percentage of well-child visits (W30-6) amongst African American children between the ages of 0-15 months from 30.54% to MPL.	N/A	PIP submission submitted to HSAG/DHCS on 04/11/23. HSAG approved, DHCS's approval is in progress. Submission included MY22 W30-6 Population: Denominator: 167 Numerator: 51 Rate: 30.54%	Submission form due 9/8. First draft completed, revisions in progress		Internal Quality Improvement Committee	12/31/2025	This is a newly assigned PIP. PIP topic was assigned by the state based on low performance
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**SWOT - Improve Well Child W30-6 & W30-2 rates**	**New**	Increase well child visit rates: The first 30 months of life - 0-15 (6 or more visits The first 30 months of life 15-30 months (2 or more visits)	Strategy Submitted to DHCS on 01/30/23. Strategies: Provider Training: P4P Directs Webiners, W30 Measure Highlight Webinar, and W30 Measure Highlight Cheat Sheet. -Member Education: Alliance sends mailers, and parter w/a Community Agency to provide member handouts. -Data Mining W30-6: Understand gaps in services and increase supplemental data.	Submitted update to DHCS in May. Continuing efforts initially established. Next update submission is due on 10/01/23.	Prepared update to DHCS for October 02, 2023 submission. Continuing efforts initially established. Scheduled Technical Assistance call with DHCS Nurse Consultants is on 10/12/23, where we will learn our next steps for this SWOT.		Internal Quality Improvement Committee	09/30/2023	This is a SWOT assigned by DHCS based on MY21's pefomance rates in these two measures.
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Sangeeta Singh	**PDSA - Improve Breast Cancer Rates**	**New**	Alameda Alliance for Health (AAH) will improve Breast Cancer Screening (BCS) rates for women (50-74 years from MY2021 53.02% to 55.00% by December 31, 2023.	Mobile Mammography has been schedule for three events in May. May 3rd: Lifelong, May 4th : West Oakland, May 5th: Fremont Directs (Ahuja,Nara, Mission Primary.)	Finalizing final edits and ready to submit the PDSA on August 15th on time.	Completed three mobile mammography events for the PDSA. One with West Oakland which included Sutter and one with Life Long which included Alinea's portable units. PDSA is scheduled to		Internal Quality Improvement Committee		
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Sangeeta Singh	**Workgroup - Women's Health**	**New**	The Alliance will improve on women's health measures in the MCAS, by conducting improvement projects to increase the low performing measures to above the MPL and to maintain current rates, by December 31, 2023, as follows: Improve Cervical Cancer Screening rates from 51.70% to minimum performance level 57.64%, by December 31, 2023. Increase Breast Cancer Screening rate for African American Women from 48.22% to meet minimum performance level 51%, by December 31st, 2023	Established a charter and projects for the women's health workgroup. Cervical cancer screening measure proposed 3 new projects and breast cancer screening proposed 4 new projects.	Launched projects include: - CCS Xaqt Outreach calls: Targeting women ages 24-30, CHCN and Alliance Directs. Approx 7,090 members - CCS Birthday Cards expansion, now serving Axis Health, BACH, Lifelong, West Oakland Health Center for Incentive Birthday Cards, (10 directs for non-incentive birthday cards) - provider incentive / extended hours program, - BCS Mobile mammography (upcoming events include 9/29 with Lifelong and Alinea) Multiple events with Sutter at lifelong and West Oakland Health, -BCS African American Flyer Health Educational Flyer	Planning for 2024. Current projects include CCS Birthday cards, CCS Xaqt outreach calls, CCS/BCS Combo project with BACH, BCS flyer, BCS flyer outreach call with Xaqt, mobile mammography. West Oakland Pap a thon		Internal Quality Improvement Committee	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**Workgroup - Well Child**	**New**	The Alliance will improve on well-child measures in the MCAS, by conducting improvement projects to increase the rates from below the MPL to above the MPL and to maintain current rates, by December 31, 2023, as follows: WCV, from 49.24% to 59.34% '22 MPL: 48.93% LSC, from 57.47% to 67.47% (Admin Rate focus) '22 MPL: 63.99% W30-6+, from 46.56% to 56.57% '22 MPL: 55.72%	Established a charter & projects for drive improvement. Projects the workgroup identified: -Electronic Blood Lead Reporting (EBLR) System Provider Training (Measure Focus: LSC) -Newborn Letters for Pregnant Members (Measure Focus: W30-6) -Fluoride Varnish (FV) training for providers (Measure Focus: TFL-CH) -Virtual Town Halls (Measure Focus: W30-6, W30-2, WCV, CIS, IMA, DEV, TFL-CH, LSC)	Worked through planning phase of a few projects and continuing to develop content. New projects include: - Lead Screening Point of Care Testing Funds - HEDIS Crunch expansion for CFMG - Fluoride Varnish Video	Continued to develop a few more projects: -Lead Screening Incentives (9/1/23-12/31/23) -WCV Incentive for BACH targeting 3-17 y/o (10/9/23-12/31/23) -Starting to plan work for MY24		Internal Quality Improvement Committee	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Workgroup - Chronic Disease Management -**	**New**	Alameda Alliance for Health (AAH) will improve or maintain performance on chronic disease management measures in the Managed Care Accountability Set (MCAS) to meet the Minimum Performance Level (MPL), by conducting PDSA (Plan, Do, Study, Act) projects by December 31, 2023, as follows: : - Asthma Medication Ratio (AMR), maintain at least 10% performance above MPL, by December 31, 2023. - Controlling High Blood Pressure (CBP), increase from 38.2% to 60.0%, by December 31, 2023. - Hemoglobin A1c Control for Patients with Diabetes, decrease from 42.2% to 39%, by December 31, 2023	Established a charter and projects to drive improvement. Projects the workgroup identified: Hypertension and diabetes management: partnering with vendor Goji for remote monitoring support and care coordination. CHCN funding to support SMBP implementation. Hypertension education initiative in barbershops with Roots HC. Support access and awareness of health education programs. Increase colorectal cancer screening in partnership with Exact Sciences (Cologuard)	Group explored partnering with vendors for disease management. No contracts at this time, partnership still under exploration with Goji. Working with Magellan to increase pharmacy knowledge of BP monitor covered benefit. Group began brainstorming BP management project ideas.	Health Education team is planning to launch asthma and cardiovascular disease management programs in Q3/Q4; group will provide support. Planning for joint BP control project between QI, Health Ed, Pharmacy, and case management underway		Internal Quality Improvement Committee	12/31/2023	This workgroup supports the goal of creating a culture of quality improvement goals throughout the organization and increases alignment of quality improvement efforts across QI department teams.
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Workgroup - Behavioral Health**	**New**	Alameda Alliance for Health will improve on behavioral health measures in the Managed Care Accountability Set that are held to the Minimum Performance Level (MPL), by conducting PDSA (Plan, Do, Study, Act) projects to increase the rates to meet or exceed the MPL by December 31st, 2023 as follows: -FUM: Maintain 5% or greater performance above MPL (54.51%) -FUA: Maintain 7% or greater performance above MPL (21.24%)	Established a charter and projects to drive improvement. Projects the workgroup identified: Increase provider education of the FUA and FUM measures through webinars and measure highlight documents. Increase provider notifications of member ED visits through use of the ADT report. Monitor rates for the following measures: DSF, DRR, PND, PDS	FUA/FUM webinars delivered to providers and measure highlights distributed. Group continued brainstorming ideas to increase FUM rates.	Group working to develop vendor partnership to conduct FUM follow up. Health Education is planning to launch maternal mental health program; group will provide support.		Internal Quality Improvement Committee	12/31/2023	This workgroup supports the goal of creating a culture of quality improvement goals throughout the organization and increases alignment of quality improvement efforts across QI department teams.

2023 Quality Improvement Health Equity Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiatve	Continued or New?	Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**	**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	The team is in the process of completing the 2022 Annual QI Program Evaluation. The QI 101 Quality Improvement and Health Equity (QIHE) policy was approved at HCQC in March 2023, and ultimately, steps will be taken to evolve the QI program to the QIHE Program in 2023.	Annual QI Program Evaluation was presented at the May 2023 HCQC meeting.	N/A	N/A	All Sub-Committees and HCQC	Q2 2023	AAH will insource BH 4/1/23
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Fairashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**Provider Training on HEDIS measures**	**New**	Provide multiple forms of QI education to the AAH provider network by December 31, 2023	Three education session: P4P for Directs Dates: 1/18/23 & 1/25/23 # Signed Up: 47 # Attended: 49 W30 Measure Highlight Date: 3/8/23 # Signed Up: 18 # Attended: 19 FUA & FUM Measure Highlight Date: 3/15/23 # Signed Up: 18 # Attended: 18	Planning a QI Virtual Townhall for Fall 2023	QI Virtual Town Hall Date: 09/13/2023 # Signed Up: 35 # Attended: 36		Internal Quality Improvement Committee	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Fairashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Under Utilization Outreach**	**Continued**	Member outreach to at least 20% of non-utilizers over the age of fifty, and connect 2% to primary care services; outreach to 20% of non-utilizers ages six and under, connect % to pediatric primary care services by 6/30/24	Provided Xaqt with gap list and outreach script. Completed "train the trainer" session with Xaqt staff. Established regular meetings to discuss campaign logistics.	Campaign calls began May 2. Target population: Adults 50+ with ER visit, children under 6.	Contract was renewed through Jun 30 2024. Non-utilizer outreach paused, CCS gap in care outreach currently taking place. Final results of first non-utilizer campaign received and being analyzed. Results will be reported at DHCS conference and IQIC in November.		Internal Quality Improvement Committee	12/31/2023	More than half of members have not seen a PCP, which contributes to low IHA rates and may contribute to low performance in other indicators, including increased ED use.

Population Health Management

Sponsor	Business Owner		Topic		Goal	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Projected Due Date	Monitoring of Previously Identified Issues

2023 Quality Improvement Health Equity Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Continued or New?	Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**	**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	The team is in the process of completing the 2022 Annual QI Program Evaluation. The QI 101 Quality Improvement and Health Equity (QIHE) policy was approved at HCQC in March 2023, and ultimately, steps will be taken to evolve the QI program to the QIHE Program in 2023.	Annual QI Program Evaluation was presented at the May 2023 HCQC meeting.	N/A	N/A	All Sub-Committees and HCQC	Q2 2023	AAH will insource BH 4/1/23
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management DHCS Readiness**	**New**	5.1 - Develop a robust CalAIM PHM strategy to support population health equity by October 2023.	5.1 - Developed policies and procedures re: PHM APLs.	5.1 - Provided feedback on PNA and PHM Concept paper. Preparation for LHD integration in progress.	5.1 - Ongoing planning meetings with HCSA and City of Berkeley.		Internal Quality Improvement Committee Health Care Quality Committee	9/30/2023	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Equity NCQA Readiness**	**New**	5.3 - Develop a strategic framework and roadmap for NCQA HEQ Accreditation by the end of 2023.	5.3 - Starting in Q4 2023.	5.3 - Strategic framework draft in socialization.	5.3 - Presented PHM framework to IQIC.		Internal Quality Improvement Committee Health Care Quality Committee	12/31/2023	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**PHM Monitoring of KPIs**	**New**	5.2 - Implement PHM monitoring processes and roadmap by September 2023.	5.2 - Developed PHM 2023 strategic goals and objectives to monitor.	5.2 - Coordinating PHM monitoring response by Aug 15.	5.3 - Submitted DHCS KPI Monitoring report.		Internal Quality Improvement Committee Health Care Quality Committee	9/30/2023	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management - PHM Strategy Document**	**Continued**	4.3 - Maintain and conduct yearly update an cohesive plan of action that addresses the Alliance member/population needs across the continuum of care.	4.3 - Developed plan of action (strategy) to address population health needs.	4.3 - Identifying and consolidating lessons learned and process improvements.	4.3 - Updated PHM strategy and reviewed with NCQA consultants.		Internal Quality Improvement Committee Health Care Quality Committee	5/30/2023	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management - PHM Evaluation Document**	**Continued**	4.2 - Conduct yearly impact analysis of the PHM Strategy according to NCQA (Group Care and Meedi-Cal) and DHCS (Medi-Cal) guidelines and implement activities to address findings.	4.4 - Finalized impact evaluation of 2022 PHM Strategy.	4.2 - Implementing activities and monitoring.	4.2 - Developing tools to support leads in reporting and monitoring.		Internal Quality Improvement Committee Health Care Quality Committee	5/30/2023	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management - Population Assessment**	**Continued**	4.1 - Conduct annual population health assessment according to NCQA (Group Care and Medi-Cal) and DHCS (Medi-Cal) guidelines including a gap analysis.	4.1 - Conducted member health assessment and developed gap analysis.	4.3 - Identifying and consolidating lessons learned and process improvements.	4.3 - Refining and understanding NCQA requirements.		Internal Quality Improvement Committee Health Care Quality Committee	5/30/2023	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Linda Ayala	**Population Health Management - DEI Strategic Framework**	**New**	6.1 - Collaborate with the Chief of Health Equity to incorporate the Alliance's Population Health Management strategy into the organization's DEI strategic framework.	6.1 - Socialized Health Ed and PHM programs with CHEO.	6.1 - Developed HEQ/PHM deliverables. Supported CHEO onboarding consultants to support work.	6.1 - Bimonthly coordination meetings held QI/PHM and Chief Health Equity Officer. DEI consultant onboarded by CHEO. First PHM meeting with DEI Consultant held.		Internal Quality Improvement Committee Health Care Quality Committee	12/31/2023	

Quality of Service

Sponsor	Business Owner		Topic		Goal	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Projected Due Date	Monitoring of Previously Identified Issues
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Faiasha Zainal	TBD	**QIP #4: Increase Initial Health Appointment rates**		By 12/31/2023 improve IHA completion rates from MY2022 37.2% to 45% by December 31, 2023	Implemented IVR outreach calls April 2023 First quarter rates - 43.67%	In progress - rates pending claims data	Chart review process underway by QI RNs, results are forthcoming.		Internal Quality Improvement Committee Health Care Quality Committee	12/31/2023	State issued CAP for IHA

Safety of Care

Sponsor	Business Owner		Topic		Goal	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Projected Due Date	Monitoring of Previously Identified Issues
Title: Sr. Director, Pharmacy Services Name: Helen Lee Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Clinical Pharmacist Name: Ramon Tran Tang	N/A	**QIP #5: Opioid / SUD - Continuation**	**Continued**	Goal 1: By 12/31/23, educate chronic opioid users on health habits, management of chronic pain, and alternative therapy and care (>120 MME) daily). Goal 2: By 12/31/23, educate opioid users at risk of becoming chronic users (i.e., 50 to 119 MME/day).	Analytics was working on automating the mailing list for member education.	Analytics completed chronic and rising risk member mailing list. C&O request was also submitted to work in target with analytics request. C&O requested we update the letter language and send to the state for approval.	As of 8/14/23, DHCS approved both member letters. C&O is now proceeding with member translation. C&O mailed member education at end of August	Check to see if mailing was effective by checking member opioid claims.	Internal Quality Improvement Committee Health Care Quality Committee	12/31/23	Staff bandwidth and staffing transistion
Title: Sr. Director, Pharmacy Services Name: Helen Lee Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Clinical Pharmacist Name: Ramon Tran Tang	N/A	**QIP #5: Opioid / SUD - Continuation**	**Continued**	Goal 3: By 12/31/23, educate providers who are assigned members that utilize high dose opioids (>120MME) and who are presenting to the Emergency Department with opioid and / or benzodiazepine overdose.	Analytics was working on automating the mailing list for provider education.	Analytics completed provider mailing list. Pharmacy will mail both member and provider letters at the same time.	C&O mailed provider education at end of August	Check to see if mailing was effective by checking member opioid claims.	Internal Quality Improvement Committee Health Care Quality Committee	12/31/23	Staff bandwidth and staffing transistion
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**Potential Quality Issues (PQIs) Continuation-Quarterly**	**Continued**	Monitor, evaluate, and take effective action with +/- 95% PQI closure within 120 days to address any needed improvements in the quality of care delivered by all providers rendering services on behalf of the Alliance in any setting along with internal data validation.	As of 3/27/23, 2.23% of PQIs exceeded the 5% 120 day TAT benchmark of 120 days.	As of 6/26/23, 1.01% of PQIs exceeded the 5% 120 day TAT benchmark of 120 days.			Internal Quality Improvement Committee Access to Care Sub-Committee Health Care Quality Committee	12/31/23	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**Exempt Grievances Auditing-Biannual**	**Continued**	Ensure clinical monitoring of Exempt Grievances for Quality of Care, Service, Access and Language issues per P&P QI-104 through bi-annual review of 100 randomly selected Exempt Grievances.	This report is performed bi-annually-last done in Jan 2023 with a passing score of 100% and is due in June 2023	N/A	Audit lookback Q4 2022-Q1 2023- passing score of 99.5%		Internal Quality Improvement Committee Access to Care Sub-Committee Health Care Quality Committee	12/31/23	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**Potential Quality Issues (PQIs) Annual Training**	**Continued**	Plan provides documented evidence of ongoing annual training on PQIs by clinical staff for both new and seasoned customer service staff who serve as the front-line entry for the intake of all potential quality of care grievances	Annual training was last performed companywide including MSD in Nov/Dec 2022 and is due in Nov/Dec 2023	Annual training was last performed companywide including MSD in Nov/Dec 2022 and is due in Nov/Dec 2023	Annual training was last performed companywide including MSD in Nov/Dec 2022 and is due in Nov/Dec 2023		Internal Quality Improvement Committee Access to Care Sub-Committee Health Care Quality Committee	End of Q4	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title: Sr. QI Nurse Specialist Name:Kathy Ebido	**Facilty Site Review (FSR) Continuation**	**New**	100% of corrective action plans for periodic (full-scope) site reviews (FSR/MRR) are received within 30 days and closed within 90 days of FSR/MRR Report.	7 CAPs, closed within 30 days*, closed within 90 days *providers were given a grace period of 45 days to comply with APL 22-017	2/10 CAPs (20%), received within 30 days, 7/10 CAPs (70%) closed within 90 days. CAP letter include CAP due dates and APL 22-017 language on new membership hold. Providers are called and/or sent reminder email/fax to return CAP on or before the CAP due date around 20th day from review. FSR team follow escalation process. New membership assignment is placed on hold if CAP is not closed timely. **Full scope reviews completed in Q2** FSR: 0 MRR: 3 **Additional reviews (non Full-scope) in Q2** Interim Monitoring: 27 Focused reviews: 6	1/1 CAP (100%), received within 30 days, 1/1 CAP (100%) closed within 90 days. **Full scope reviews completed in Q3** FSR: 2 PCP, 2 Urgent Care, 4 Dialysis MRR: 1 **Additional reviews (non Full-scope) in Q3** Interim Monitoring: 20 Focused reviews: 8		Access to Care Sub-Committee Health Care Quality Committee	End of Q4	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Ratt	**Inter-rater Reliability (IRR) Continuation-Annual**	**Continued**	IRR is performed annually to ensure >/=90% IRR consistency and accuracy of review criteria applied by all clinical reviewers - physicians and non-physicians - who are responsible for conducting clinical reviews and to act on improvement opportunities identified through this monitoring.	IRR was last performed in Feb 2023 (passing score for all participants) and due again in Feb 2024	N/A	N/A	N/A	Internal Quality Improvement Commite	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. QI Nurse Name: Kathy Ebido	**Skilled Nursing Facility/Long Term Care (SNF/LTC) Quality Monitoring**	**New**	Develop quality monitoring process for SNF/LTC to meet APL 23-004 SNF/LTC Benefit Standardization: CMS SNF QAPI Program, quality and HEDIS measures, and trackfrand monitoring for facilities.	An attestation was drafted to distribute to SNFs to attest and/or acknowledge CMS SNF QAPI requirements. Incorporated quality monitoring in the SNF/LTC TownHall training scheduled in Q2.	A SNF/LTC tracker was developed that incorporated monitoring of CHDP site reviews, Quality Stars, and PQI. Attestations will be distributed following SNF/LTC roster is completed	Fax blast sent to providers to complete SNF attestation. Team is collecting CHDP site review data for review.		SNF/LTC Project Health Care Quality Committee	12/31/2023	

Member Experience

Sponsor	Business Owner		Topic		Goal	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Projected Due Date	Monitoring of Previously Identified Issues

2023 Quality Improvement Health Equity Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Continued or New?	Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**	**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	The team is in the process of completing the 2022 Annual QI Program Evaluation. The QI 101 Quality Improvement and Health Equity (QIHE) policy was approved at HCQC in March 2023, and ultimately, steps will be taken to evolve the QI program to the QIHE Program in 2023.	Annual QI Program Evaluation was presented at the May 2023 HCQC meeting.	N/A	N/A	All Sub-Committees and HCQC	Q2 2023	AAH will insource BH 4/1/23
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Tanisha Shepard	**CG-CAHPS Survey Continuation (Quarterly)**	**Continued**	Ensure that quarterly survey questions align with DMHC timely access and language requirements to evaluate member clinical & group satisfaction/experience with Timely Access Standards - Office Wait Time, Call Return Time, Time to Answer Call. To ensure that the survey results are actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. **"**Starting Q3 2022, the compliance threshold goal was changed from 80% to 70% (with a stretch goal of 80%) for Call Return Time and Time to Answer Call. In Office Wait Time goal remains 80% for 2023.	**Call Return Time 4th Quarter 2022** Numerator: 925 Denominator: 1225 Compliance Rate: 75.5% Goal Met: Y Gap to goal: 0% **In office Wait Time** 4th Quarter 2022 Numerator: 2168 Denominator: 2380 Compliance Rate: 91.1% Goal Met: Y Gap to goal: 0% **Time to Answer Call** 4th Quarter 2022 Numerator: 1383 Denominator: 1897 Compliance Rate: 72.9% Goal Met: Y Gap to goal: 0%	**Call Return Time 1st Quarter 2023** Numerator: 1,204 Denominator: 1,619 Compliance Rate: 74.3% Goal Met: Y Gap to goal: 0% **In office Wait Time** 1st Quarter 2023 Numerator: 2,885 Denominator: 3,135 Compliance Rate: 92% Goal Met: Y Gap to goal: 0% **Time to Answer Call** 1st Quarter 2023 Numerator: 1716 Denominator: 2450 Compliance Rate: 70.0% Goal Met: Y Gap to goal: 0%	**Call Return Time** 2nd Quarter 2023 Numerator: 1,022 Denominator: 1,372 Compliance Rate: 74.5% Goal Met: Y Gap to goal: 0% **In office Wait Time** 2nd Quarter 2023 Numerator: 2,168 Denominator: 2,380 Compliance Rate: 91.1% Goal Met: Y Gap to goal: 0% **Time to Answer Call** 2nd Quarter 2023 Numerator: 1,383 Denominator: 1,1897 Compliance Rate: 72.9% Goal Met: Y Gap to goal: 0%		Access to Care Sub-Committee Health Care Quality Committee	3/31/2022	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Tanisha Shepard	**Provider Satisfaction Survey Continuation (Annual)**	**Continued**	Annually, timely completion of measures for provider and staff satisfaction/experience with the health plan and department services. To ensure that the survey meets NCQA requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. **Fielding Oct - December 2022.** Goal: 88.3% (2% increase from MY 2022)	Results received Feb, 2023. Overall Satisfaction Plan Rating 88.3% up by 9% points from 2021 -73.3%. Met or significantly higher scores compared to SPH Comm. and Aggregate BoB. Results shared with CCO/CEO for review and evaluation of next steps. Provider Services and QI collaborates on the Provider Did you know campaign to increase satisfaction scores. Will share results at May 3, 2023 A&A Sub-committee meeting	C. Gomez from Provider Services presented the MY2022 Provider Satisfaction Survey results at the A&A Sub-Committee Meeting on May 3, 2023. Results will then be presented at the next HCQC on August 18, 2023.	MY2022 results were presented at the HCQC on August 18, 2023. MY2023 On Track		Access to Care Sub-Committee Health Care Quality Committee	01/30/2022	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Fiona Qian	**CAHPS 5.1 (Member Satisfaction Survey) Continuation (Annual)**	**Continued**	Measures member experience with health plan and affiliated providers. To ensure that the annual survey aligns with NCQA standards and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities for member experience. **Fielding: Feb. - May of 2023.** Goal TBD.	MY 2022 Results Highest and Lowest measures for all LOB identified. Met with internal SME to review data to further discuss opportunity for improvement	Survey fielding process with SPH	MY2022 Final report received from SPH. A&A team to review and analyze data to report at QA A&A Sub-Committee meeting. Met with internal SME to review data.		Access to Care Sub-Committee Health Care Quality Committee	12/30/2021	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Tanisha Shepard	**After Hours Care Continuation (Annual)**	**Continued**	Audits provide after hours protocols (Emergency Instructions/Access to Provider) and availability according to DMHC/NCQA methodology/standards for PCP, Spec. and BH providers. To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. Maintains 80% compliance rate for After Hour Survey. **Fielding Oct - Nov 2022**	**Primary Care Providers** Numerator: 71 Denominator: 73 Compliance Rate: 97.3% Goal Met: Y Goal: 80%% **Specialists** Numerator: 192 Denominator: 207 Compliance Rate: 92.8% Goal Met: Y Goal: 80% **Behavioral Health** Numerator: 102 Denominator: 113 Compliance Rate: 90.3% Goal Met: Y Goal: 80%	On Track: According to the SPH JOM on July 20, 2023. The 2023 After Hours Survey is in Engaged through end 9/7/2023 in Amendment 20 and contract pending approval Amendment 22.	On Track		Access to Care Sub-Committee Health Care Quality Committee	12/30/2021	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Fiona Qian	**Initial Pre-Natal Visits Continuation (Annual)**	**Continued**	To ensure that the survey aligns with DHCS requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities related to OB/GYN appts offered according to Timely Access Standards. Reach or exceed 75% compliance rate for First Prenatal appointment. **Fielding Sep - Nov. 2022** **HEDIS Prenatal visits: 85.36 baseline to 85.40 admin (MPL) - increase by 3%**	On Track	Numerator: 20 Denominator: 36 Compliance Rate: 55.6% Goal: 75% Goal Met: N Gap to Goal: 19.4% Establish a workgroup in collaboration with Provider Relations and Data Analytics to conduct a PDSA for the following: 1.Non-Responding providers/delegates: Provider education regarding the First Pre-Natal Visit survey and regulatory requirements. A&A will issue corrective action plans (CAPs) to non-responding providers beginning Q2 2023. 2.Ineligible providers: The list of ineligible providers will be shared with Provider Services and the Data Analytics department with the intent of ensuring optimal provider database integrity to generate a reliable provider sample. 3.Non-Compliant Providers / delegates / groups: Provider education regarding the First Pre-Natal Visit survey and regulatory requirements. A&A will issue corrective action plans (CAPs) to non-compliant providers beginning Q2 2023. 4.Track and trend OB/GYN QOA PQI reports to identify non-compliant providers for education and ongoing compliance.	Non-PAAS for First Pre-Natal Visits is currently in fielding progress.		Access to Care Sub-Committee Health Care Quality Committee	3/31/2022	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Fiona Qian	**Oncology Survey Continuation (Annual)**	**Continued**	To ensure that the survey aligns with DHCS requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities related to timeliness of Oncology routine and urgent care appointments. Maintains a 75% compliance rate for urgent & non-urgent appointment. **Fielding Sep - Nov.**	On Track	**Urgent Appts** Numerator: 18 Denominator: 35 Compliance Rate: 51.4% Goal: 75% Goal Met: N **Non-Urgent** Numerator: 29 Denominator: 35 Compliance Rate: 82.9% Goal: 75% Goal Met: Y establish a workgroup in collaboration with Provider Relations and Data Analytics to conduct a PDSA for the following: 1.Non-Responding providers/delegates: Provider education regarding the Oncology Visit survey and regulatory requirements. A&A will issue corrective action plans (CAPs) to non-responding providers beginning Q2 2023. 2.Ineligible providers: The list of ineligible providers will be shared with Provider Services and the Data Analytics department with the intent of ensuring optimal provider database integrity to generate a reliable provider sample. 3.Non-Compliant Providers / delegates / groups: Provider education regarding the Oncology Visit survey and regulatory requirements. A&A will issue corrective action plans (CAPs) to non-compliant providers beginning Q2 2023. 4.These providers will receive a letter regarding the timely access requirements and a CAP. These CAPs will be issued during Q2 2023.	PAAS for Oncology is currently in fielding progress.		Access to Care Sub-Committee Health Care Quality Committee	3/31/2022	

2023 Quality Improvement Health Equity Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiatve	Continued or New?	Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**	**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	The team is in the process of completing the 2022 Annual QI Program Evaluation. The QI 101 Quality Improvement and Health Equity (QIHE) policy was approved at HCQC in March 2023, and ultimately, steps will be taken to evolve the QI program to the QIHE Program in 2023.	Annual QI Program Evaluation was presented at the May 2023 HCQC meeting.	N/A	N/A	All Sub-Committees and HCQC	Q2 2023	AAH will insource BH 4/1/23
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Fiona Qian	**PAAS (Provider Appt Availability Survey) Continuation (Annual)**	**Continued**	To ensure that the annual survey aligns with DMHC requirements to assess appointment availability is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. Maintains a 75% compliance rate for urgent and non-urgent appointment. **Fielding Aug - Dec. 2022**	MY 2022 Results undergoing analysis and report development	MY 2022 Results undergoing analysis and report development. Results will be presented at the next A&A Sub-Committee meeting on August 2, 2023.	PAAS fielding is in progress.		Access to Care Sub-Committee Health Care Quality Committee	End of Q4	

Health Education

Sponsor	Business Owner		QI Activity/Initiatve		Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Operations**	Continued	1.1 - Maintain a 95% fulfillment rate for health education material requests and referrals withing 2 weeks for threshold languages and within 3 weeks for translated materials through the end of 2023. 1.2 - Sustain member wellness libraries and materials by updating and adhering to the 5 year review cycle. 1.3 - Support coordination and logistics of Member Advisory Committee meetings, monthly and quarterly team meetings through the end of 2023.	1.1 - 97.73% Service Level Target for Fulfillment Rate goal. 1.2 - Carebook updated pending approval by Dr. O'Brien. 1.3 - Supported successful March MAC.	1.1 - 98.33% Service Level Target for Fulfillment Rate goal. 1.2 - Health Ed offerings refresh project started in July. 1.4 - Supported successful June MAC meeting.	1.1 - 85% service level achieved for 10- day fulfillment on materials. 1.2 - Reviewed/approved 11x educational materials. 1.3 - Coordinator supported successful Q3 MAC.		Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2023	Linda Ayala Director of Pop. Healty and Equity
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Programs**	Continued	2.1 - Develop and implement health education program evaluations to drive process and program improvements by Q3 2023.	2.1 - Program evaluation planning begins in July 2023.	2.1 - Completed program evaluations and program audits.	2.1 - Transitioned Diabetes Prevention Program network provider and terminated Weight Watchers.		Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2023	Linda Ayala Director of Pop. Healty and Equity
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Programs**	New	2.2 - Launch Maternal Mental Health Program by July 2023.	2.2 - Developed PHM program objectives.	2.2 - Kicked off Maternal Mental Health planning June. In progress: program deliverables.	2.2 - Submitted DMHC narrative. Developed screening guidelines.		Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	6/30/2023	Linda Ayala Director of Pop. Healty and Equity
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Programs**	New	2.3 - Submit Health Education Program Descriptions to DHCS for approval by the end of Q3 2023.	2.3 - Starting in July 2023.	2.3 - Planned kick off first of Q3.	2.3 - Developing program descriptions for submission to DHCS.		Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Disease Management: Asthma**	New	3.1 - Implement the launch of expanded Asthma Disease Management health education and coaching campaigns in Q2 2023. 3.2 - Implement the expansion of Asthma Remediation services to adults in Q3 2023.	3.1 - Updated workflows and streamlining reporting. 3.2 - Starting in July 2023.	3.1 - Asthma and DM expansion in progress. Updated target date to September 2023.	3.1 - Preparing for launch of DM programs in November/December of 2023. 3.2 - Adult Asthma Remediation expansion pushed out to 2024.		Utilization Management/Quality Improvement and Health Equity Committee	6/30/2023 9/30/2023	Linda Ayala Director of Pop. Healty and Equity
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Disease Management: Diabetes**	New	3.3 - Implement the launch of Diabetes Disease Management health education and coaching campaigns in Q3 2023.	3.3 - Starting in April 2023.	3.4 - Planning in progress. Target go-live in September of 2023.	3.4 - Planning in progress. Target go-live pushed out to Q4 of 2023.		Utilization Management/Quality Improvement and Health Equity Committee	9/30/2023	Linda Ayala Director of Pop. Healty and Equity
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Disease Management: CVD and Depression**	New	3.4 - Implement the launch of Cardiovascular Disease and Depression Disease Managemetn programs in Q4 2023.	3.4 - Starting in Q3 2023.	3.5 - Kickoff held in July. Target go-live in Dec 2023. Planning in progress.	3.5 - Target go-live in January 2024. Planning in progress.		Utilization Management/Quality Improvement and Health Equity Committee	12/31/2023	Linda Ayala Director of Pop. Healty and Equity

Cultural and Linguistic Servcies

Sponsor	Business Owner		QI Activity/Initiatve		Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Member Cultural and Linguistic Assessment**	Continued	Assess the cultural and linguistic needs of plan enrollees.	CLS Needs assessed at 1/23/2023 CLS Committee.	1. CLS needs assessed at 05/02/2023 CLS Committee.	1. CLS needs assessed at 07/26/2023 CLS Committee.		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	1/31/2023	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Language Assistance Services**	Continued	Reach or exceed an average fulfillment rate of ninety-five percent (95%) or more for in-person, video, and telephonic interpreter services.	Q1 - 99.97% Fill rate for all modalities of services.	1. Q2- 96% fill rate for all modalities of services.	1. Q3- 95% fill rate for all modalities of services.		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	4/31/2023	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Provider Language Capacity (Member Satisfaction)**	Continued	Based on the Member CG-CAHPS Survey 81% of adult members and 92% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.	Planned implementation Q2	1. Q4 2022-Adult: 83.7%; Child: 91.5% (Metric Met) 2. Q1 2023-Adult: 84.4%; Child: 95.9% (Metric Met)	Planned implementation Q3		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	7/31/2023	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Provider Language Capacity (Provider Network)**	Continued	Complete NCQA NET 1 A Analysis of Capacity of Alliance Provider Network to meet Cultural and Linguistic needs of members.	Planned implementation Q2	1. NCQA Net 1 A Report was completed and presented at the CLS Committee on 05/02/2023.	1. NCQA Net 1 A Report was completed and presented at the CLS Committee on 05/02/2023.		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	10/31/2023	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Cultural Sensitivity Training - Participation**	Continued	96% of Alliance staff will participate in the annual Cultural Sensitivity training.	Planned implementation Q3 - Q4	1. Planned implementation in Q3-Q4. 2. Put together workgroup to review current training topics and staff input/feedback.	1. CST rolled out on 09/09/2023 to all staff as part of the annual compliance trainings.		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	3/31/2023	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Cultural Sensitivity Training - Enhancements**	New	Facilitate collaborative process to update Cultural Sensitivity Training (s) to meet DHCS 2024 requirements.	Updated P&Ps relevant to DHCS 2024 Contract.	1. Completed analysis of DHCS 2024 Contract requirements, including draft DEI APL. 2. Scheduled meeting with impacted departments to identify department scope/ownership of work. 3. Met with CST workgroup to review staff feedback/input, finalize 2023 training content/outline, and identify speakers.	1. Completed final CST recording. 2. Submitted final CST recording to Compliance for review.		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	6/30/2023	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Member Advisory Committee**	New	Ensure implementation of DHCS 2024 Contract updates to Member Advisory Committee and community engagement.	Updated P&Ps relevant to DHCS 2024 Contract.	1. Planned timeline for analysis by Q3 2023 and planned implementation by Q2 2024.	1. Completed analysis of DHCS 2024 Contract requirements. 2. Outreached to Compliance for clarification on 2024 Contract requirements.		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	9/30/2023	

Public Comment

ALAMEDA Alliance FOR HEALTH

Thank You for Joining Us

Next Meeting: February 16, 2024

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