Quality and Performance Improvement Program Evaluation 2024

CONTRA COSTA HEALTH

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2 INTRODUCTION

The 2024 Annual Evaluation assesses Contra Costa Health Plan's (CCHP) Quality Improvement Program. It examines the effectiveness of initiatives implemented across CCHP departments in 2024, identifying successes, areas for improvement, and potential program modifications for the following year. The evaluation reviews committee and subcommittee structures, resource adequacy, internal and external reporting, practitioner participation, leadership involvement, and quantitative and qualitative data to assess program outcomes.

The Quality and Health Equity Department leads the evaluation, gathering input from stakeholders, including committees, departments, content experts, data analysts, and work plans. The assessment involves analyzing qualitative and quantitative data, identifying barriers, evaluating interventions, and determining opportunities for improvement. Findings inform next steps for program development.

2.1 MAJOR ACCOMPLISHMENTS

In 2024, CCHP Quality and Health Equity Department led a number of initiatives with notable successes:

- In NCQA's Annual Health Plan Rating, CCHP ranked with 4.5 stars (out of 5). These ratings evaluate health plans on the quality-of-care patients receive, how satisfied patients are with their care, and health plans' efforts to keep improving.
- CCHP exceeded the 90th percentile nationally for 17 MCAS measures, including Well-Child Visits in the First 30 Months of Life (31d-15m), Prenatal and Postpartum Care, Breast and Cervical Cancer Screenings, Childhood Immunization Status- Combo 10, and Diabetes Hemoglobin Poor Control (>9.0%), demonstrating CCHP's commitment to high quality patient care.
- CCHP implemented a Value Based Payments (VBP) program to incentivize and reward providers for providing high quality, efficient care.
- CCHP developed reporting and automatic authorization for care management services from Admission, Discharge, and Transfer Feeds to allow for better real time identification of member discharges.
- Provider empanelment reports, gap in care lists, and members due for lead screening reports are now available on demand through the secure CCHP Provider Portal, ensuring that providers are able to access real time patient level data in a HIPAA compliant fashion.

- CCHP launched a maternal health redesign project to ensure comprehensive and equitable maternal health services. CCHP hosted kick off summit with representation from providers, doulas, public health, WIC, and other community partners that lead to a significant increase in the number of doula services provided.
- The Health Education team expanded to include one additional Senior Health Education Specialist and a Heath Education Specialist. The Health Education team began efforts to enhance relationships with network providers and other important community groups.
- CCHP enrolled 7,706 members in Enhanced Care Management, of which 1,916 were Adults at Risk for Avoidable Hospital or Emergency Department (ED) Utilization. CCHP is one of the highest amongst all health plans in the state in the provision of ECM according to overall membership size.
- CCHP provided Community Supports to 5,664 members, with 3,384 receiving medically tailored meals and 2,110 members receiving housing transition/navigation services.
- CCHP partnered with its largest provider group to implement an outreach project to reengage members into care. CCHP outreach staff were able to contact and directly schedule appointments for over 500 CCHP members who had been out of care for at least 12 months.
- CCHP engaged in a wide array of performance improvement projects, including activities aimed to address well care visits, colorectal cancer screening, lead screening in children, topical fluoride application, and improve follow-up care after emergency department visits for substance use.

3 Program Purpose, Goals, and Scope

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

Contra Costa County is located in the East Bay of the San Francisco Bay Area. In 2024, according to the American Community Survey 1-year estimate from the United States Census Bureau, the county population was 1.146 million residents. Contra Costa Health Plan serves more than 262,000 Medi-Cal members, providing health insurance to nearly one-quarter of the county population. CCHP also administers a commercial product for County employees and In-Home Support Services (IHSS) caregivers. It serves more than 6,000 commercial members.

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

The Quality Council, a physician committee consisting of plan and network physicians, and the Equity Council, a multidisciplinary group including providers, community organizations, and public health, oversee the development, implementation, and evaluation of the Quality Program. The Joint Conference Committee was delegated by the Board of Supervisors to oversee the quality and health equity programs for CCHP. CCHP's quality program is designed to support its purpose and goals to improve the quality, safety, and equity of care and services provided to members. CCHP is committed to continuous quality improvement for both the health plan and its care delivery system.

CCHP's quality and health equity program is designed to measure, monitor, evaluate, and improve the quality, safety, and equity of care and services provided to members. CCHP's overarching quality goals are to achieve better health outcomes, refine population health management, promote health equity, ensure patient safety, improve member experience, avoid unnecessary ED and hospital utilization, stabilize or reduce healthcare costs, and enhance provider experience. To achieve these goals, CCHP utilizes data analysis, solicits input from providers and members through committees, collaborates with community-based organizations, sets aims, measures, and improvement teams for Performance Improvement Projects (PIPs), leverages technology for early identification, and continuously monitors and sustains performance.

The Quality Program encompasses clinical care and services for all Medi-Cal and Commercial members, involving partnerships with various entities. The scope includes access to care, care coordination, population health strategy, utilization evaluation, patient safety standards compliance, health education, cultural and linguistic services, addressing health disparities, managing clinical services usage, member appeals, grievances, and accreditation compliance. CCHP ensures accessibility to all members, regardless of demographics or health status, complying with applicable civil rights laws.

In 2024, there was a substantial change made to the overarching purpose, goals, and scope of the quality program to ensure the inclusion of health equity in all program aspects. The current framework now effectively addresses the outlined goals, demonstrating the program's stability and effectiveness. Looking ahead to 2025, CCHP is working to achieve National Committee on Quality Assurance (NCQA) accreditation in Health Equity and Health Plan reaccreditation.

4 Program Structure and Governance

4.1 Overview

The Quality Council is the principal committee for directing and overseeing quality and patient safety operations and activities for CCHP. It plays a crucial role in directing clinical and service-related performance improvement projects, access to care studies, member grievances, potential quality issues, utilization management, and other programs requiring quality oversight. The Equity Council is the committee responsible for addressing health equity, including reviewing discrimination grievances, identifying health inequities, and promoting interventions to reduce disparities in care and outcomes. The Quality and Equity Councils' recommendations to the Joint Conference Committee contribute to the approval process for the Quality Program by the Contra Costa County Board of Supervisors.

4.2 Quality Department Structure

Quality staff at CCHP play a vital role in implementing and monitoring quality projects and improvement activities, supporting CCHP leadership in strategic priorities, and collaborating with CCHP providers to ensure quality care for members. Led by the Chief Medical Officer, staff include directors, managers, analysts, health educators, and administrative support.

The Quality and Health Equity Department continues to lead ongoing initiatives, including quality measurement, access and availability monitoring, member and provider experience, PIPs, population health management, provider engagement, and NCQA accreditation oversight. With an increased focus on equity in 2024, the department was renamed to the Quality and Health Equity Department and assumed responsibility for ensuring health equity is prioritized through marketing strategy, policies, member and provider outreach, quality improvement activities, grievance and appeals, and utilization management. In recognition of the importance of primary and secondary prevention in improving member outcomes and reducing long-term healthcare costs, CCHP hired a Senior Health Education Specialist and a Health Education Specialist. These roles will focus on promoting preventive services, chronic disease management, wellness initiatives, and member outreach. Their expertise will enhance member engagement, support health literacy, and ensure our members have access to critical health education resources.

4.3 Governing Body – Joint Conference Committee

The Joint Conference Committee (JCC) is one of the mechanisms by which the Contra Costa County Board of Supervisors provides oversight of CCHP, including quality operations and

activities. With two Board of Supervisors members assigned to the JCC, it operates transparently under the Brown Act, ensuring accessibility to the public. The JCC meets quarterly, and its responsibilities include promoting communication between the Board of Supervisors, Quality and Equity Councils, and CCHP administration; assessing and monitoring the overall performance of CCHP and its contracted providers, including, but not limited to, the quality of care and services provided to members; reviewing, evaluating, and making recommendations regarding modifications to the Annual Quality Program Description, Annual Quality Program Evaluation, and Quality Work Plan; and reviewing, evaluating, and acting on quarterly reports on quality and health equity from CCHP's Quality Director and Chief Medical Officer.

Throughout 2024, the JCC actively engaged in activities aimed at overseeing and improving the quality of CCHP's operations. At each meeting, a comprehensive quality report was presented, facilitating a continuous assessment of the health plan's performance. The JCC approved essential program documents, including the Annual Quality Program Description, Quality Evaluation, and Quality Work Plan. The committee also conducted a detailed review and discussion of access and availability, evaluating the effectiveness of CCHP's strategies in ensuring timely access to care. Another focal point was the assessment of population health management, evaluating the overall effectiveness of CCHP's strategies in addressing broader health trends and enhancing the well-being of the population. The JCC reviewed CCHP's Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results, involving a thorough examination of CCHP's performance against key quality measures in accordance with national standards.

4.4 Quality Improvement and Health Equity Committee (QIHEC)

The Quality Improvement and Health Equity Committee (QIHEC) is a requirement outlined by the California Department of Health Care Services (DHCS) for all Medi-Cal managed care plans. DHCS mandates that health plans establish a QIHEC to oversee the integration of quality improvement and health equity initiatives. At CCHP, this requirement is met through the collaboration of two distinct but complementary committees: the Quality Council and the Equity Council. These councils work together to ensure the ongoing development, implementation, and evaluation of quality and health equity programs. The Quality Council, clinically focused, includes providers across various specialties and monitors clinical care, performance improvement projects, and member outcomes. The Equity Council, which includes community organizations, addresses issues of health disparities, discrimination grievances, and the promotion of equitable care across the plan's member population. While the councils have distinct memberships, there is overlapping representation between the two, ensuring alignment and coordination of

efforts to improve both quality and equity in care delivery. In 2024, two Quality Councils and one Equity Council meeting were held each quarter.

4.4.1 Quality Council

The Quality Council is responsible for reviewing and acting on subcommittee reports, approving program documents, and providing recommendations to governing bodies. Chaired by the Chief Medical Officer and co-chaired by the Quality and Health Equity Director, the Council is comprised of a multi-specialty group of clinicians who meet eight times per year. Voting members, including the Chief Medical Officer and network clinicians, represent specialties essential to the Medi-Cal population.

Subcommittees that report to the Quality Council, such as the Pharmacy and Therapeutics (P&T) Advisory Committee, Peer Review and Credentialing Committee (PRCC), Utilization Management (UM) Committee, and Potential Quality Issues (PQIs) Committee play key roles in pharmaceutical management, credentialing, overseeing outpatient and inpatient utilization management, and patient safety. These committees report regularly to the Quality Council for oversight.

Throughout 2024, the Quality Council's effectiveness and member participation were evaluated through feedback from members and a review of past meeting agendas and minutes. The assessment indicated consistent attendance from providers. Updates from the Quality Council focused on CCHP's transition to a Single Plan Model, expanded provider networks, and improvements in access to care, including behavioral health and specialty services. Key initiatives in 2024 emphasized clinical quality, equity, and care coordination, with notable progress in HEDIS, performance improvement projects, and policy updates aimed at supporting maternal health and value-based payments. Surveys on member and provider experience identified strengths in access but highlighted areas for improvement in communication and follow-up. Additional updates covered long-term care quality monitoring, behavioral health utilization changes, and preparations for the D-SNP launch in 2026, reinforcing CCHP's commitment to continuous quality improvement.

4.4.2 Equity Council

In 2024, one meeting per quarter was dedicated to overseeing equity-focused initiatives, engaging a broader group of stakeholders, including community-based organizations, homeless services, public health, and other community health advocacy groups. These meetings centered on advancing health equity within the system, including efforts to achieve NCQA Health Equity Accreditation. Key initiatives included the launch of Diversity, Equity, and Inclusion (DEI) and Transgender, Gender Diverse, and Intersex (TGI) training

programs, the development of performance measures, and outreach and education for non-specialty mental health services.

4.5 The Community Advisory Committee

CCHP established the Community Advisory Committee (CAC) to ensure meaningful member input into CCHP's policies and decision-making processes and to promote member engagement as partners in the delivery of Medi-Cal Covered Services. The CAC focuses on cultural and linguistic services, health education, and health equity, fostering community participation and advocacy. With a commitment to addressing health disparities, CAC members contribute to discussions on preventive care practices, while CCHP's integration strategy enhances services with cultural and linguistic appropriateness.

In 2024, CCHP successfully relaunched the Community Advisory Committee, holding four meetings that addressed health equity, Performance Improvement Projects (PIPs), health education priorities, member satisfaction survey results, culturally appropriate services, and plan marketing materials and campaigns.

4.6 Quality Program Planning

CCHP employs a systematic documentation cycle for quality program planning, including the Quality Program Description, Quality Work Plan, and Quality Program Evaluation. These documents, along with the Quality Council charter, are reviewed annually by the Quality Council and Equity Council.

No major changes were made to the process in 2024. The process involved collaboration across departments to capture a comprehensive view of quality across CCHP. Additionally, the refined quality framework was shared with provider groups to encourage collaborative engagement in quality initiatives. Periodic reviews of the quality plan ensured that activities remained on track and met established deliverables. The evaluation provided a framework for developing the subsequent year's quality plan and overall program description. A new addition in 2024 was the creation of quarterly activity reports, which were presented to the Quality Council and also posted on CCHP's website to increase transparency and engagement.

5 NCQA Accreditation

The Quality and Health Equity Department plays a central role in interpreting standards, identifying gaps, collaborating with other department functions to address deficiencies,

ensuring the submission of appropriate and timely documentation, and maintaining oversight of the NCQA health plan accreditation status.

In 2024, CCHP undertook efforts to ensure survey readiness for the Health Plan and Health Equity Accreditations, both to take place in 2025. The HEDIS and Accreditation manager established a structure to ensure annual deliverables are met and a framework has been set for ongoing meetings with relevant stakeholders. By the end of the year, all expected deliverables had been requested and received.

6 Measurement, Analytics, Reporting, and Data Sharing

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

6.1 Healthcare Effectiveness Data and Information Set (HEDIS)

The Quality and Health Equity Department collaborates with the CCH Business Intelligence team to annually collect HEDIS data. Medi-Cal Managed Care plans are mandated by both the DHCS, the Department of Managed Health Care (DMHC) and NCQA to report annually on three distinct sets of measures. DHCS requires Medi-Cal Managed Care plans to report annually on a set of quality measures, known as the Medi-Cal Managed Care Accountability Set (MCAS). DMHC requires health plan reported on a set of stratified measures called the Health Equity Quality Measure Set (HEQMS), while NCQA requires health plans report on a set of Health Plan Accreditation measures. In sum, this encompasses over 70 measures spanning clinical effectiveness, clinical resource utilization, access and availability, and member experience with care. CCHP utilizes a certified HEDIS benefits engine for reporting and undergoes compliance audits to ensure the certification of all measures by June 15 each year. In June 2024, CCHP reported 2023 measurement year data.

The MCAS measures are comprised of various health-related outcomes, HEDIS measures, and Center for Medicaid and Medicare (CMS) Core Measures. DHCS establishes the targets, or Minimum Performance Level (MPL), on qualifying measures based on the NCQA national

Medicaid 50th percentile benchmark. CCHP's performance on Measurement Year (MY) 2023 MCAS measures and their trends over time are illustrated in Table 1.

Table 1. Summary Performance in MCAS Measures Overall MY 2019-2023

Measures	MY 2019	MY 2020	MY 2021	MY 2022	MY 2023	Trend	National Percentile
Adults' Access to Preventive/Ambulatory Health Services	-	-	-	69.75	71.99		25th ☆
Ambulatory Care - Emergency Dept Visits/1000 MM	634.80	437.40	483.24	563.04	563.33		90th ★
Antidepressant Medication Management - Effective Acute Phase Treatment	62.59	63.07	65.97	66.25	85.80		90th ★
Antidepressant Medication Management - Effective Continuation Phase Treatment	41.17	41.01	44.16	45.23	73.82		90th ★
Asthma Medication Ratio	60.48	63.93	64.48	75.23	83.22		90th ★
Breast Cancer Screening	68.86	58.33	58.66	63.95	63.81		90th ★
Cervical Cancer Screening	68.37	68.06	68.33	68.33	68.61		90th ★
Child and Adolescent Well-Care Visits	-	42.09	55.05	53.09	56.63		75th ★
Childhood Immunization Status - Combination 10	51.09	51.34	47.93	44.04	45.61		90th ★
Chlamydia Screening in Women	68.36	62.81	62.22	66.65	68.37		90th ★
Colorectal Cancer Screening	-	-	-	39.69	48.98		-
Contraceptive Care – All Women - Ages 15-20	19.78	18.34	17.59	19.01	19.33		25th ☆
Contraceptive Care – All Women - Ages 21-44	27.85	25.52	25.38	25.43	24.52		50th ☆
Contraceptive Care – Postpartum - Ages 15-20: 60 Days	57.89	57.78	47.32	46.43	66.67		75th ★
Contraceptive Care – Postpartum - Ages 21-44: 60 Days	46.44	46.19	45.03	46.73	52.03		75th ★
Controlling Blood Pressure	73.73	64.96	62.37	67.27	67.21		50th ☆
Depression Remission or Response- Follow-up	-	-	-	29.14	26.04		-
Depression Remission or Response- Remission	-	-	-	8.26	3.29		-
Depression Remission or Response- Response	-	-	-	11.48	7.37		-
Depression Screening and Follow-Up for Adolescents and Adults - Screening	-	-	-	29.73	30.06		-
Depression Screening and Follow-Up for Adolescents and Adults - Follow-up	-	-	-	81.66	75.21		-
Developmental Screening in the First Three Years of Life	24.38	21.68	37.45	52.57	56.90		75th ★
Diabetes - HbA1c Poor Control (>9.0%)*	37.71	38.93	34.55	33.99	29.11		90th ★
Diabetes Screening for People Who Are Using Antipsychotic Medications	87.78	79.41	84.32	85.31	85.14		75th ★
Follow-up after ED for AOD - 7 Day	2.94	8.94	4.46	16.53	19.64		25th ☆
Follow-up after ED for AOD - 30 Day	6.42	8.94	10.00	26.61	32.31		25th ☆
Follow-up after ED for Mental Illness - 7 Day	10.39	11.74	15.21	27.02	41.59		50th ☆
Follow-up after ED for Mental Illness - 30 Day	20.25	21.81	23.15	45.97	58.78		50th ☆
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	53.03	51.63	44.92	50.60	53.61		75th ★
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	47.23	62.50	48.65	62.50	59.42		50th ☆
Immunizations for Adolescents (IMA) - Combo2	50.85	43.80	44.28	53.36	55.56		90th ★
Lead Screening in Children	-	-	44.23	51.51	52.81		25th ☆
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing	61.11	42.22	54.00	46.08	49.48		75th ★
Number of Outpatient ED Visits per 1000 Long-Stay Resident Days	-	-	-	-	0.40		-
Pharmacotherapy for Opioid Use Disorder	-	-	37.04	27.32	21.72		25th ☆
Plan All-Cause Readmissions*	1.00	0.83	0.88	0.87	0.82		90th ★
Postpartum Care	88.08	90.97	91.19	90.48	89.94		90th ★
Postpartum Depression Screening and Follow Up- SCR	-	-	-	53.07	55.80		90th ★
Postpartum Depression Screening and Follow Up- FU	-	-	-	79.63	74.84		75th ★
Potentially Preventable 30-Day Post-Discharge Readmission Measure	-	-	-	-	0.77		-
Prenatal Care	93.43	93.40	94.34	93.88	93.08		90th ★
Prenatal Depression Screening and Follow Up- SCR	-	-	-	76.95	78.40		90th ★
Prenatal Depression Screening and Follow Up- FU	-	-	-	66.67	56.71		50th ☆
Prenatal Immunization Status	-	-	46.11	46.05	42.99		90th ★
SNF Healthcare-Associated Infections Requiring Hospitalization	-	-	-	-	5.45		-
Topical Fluoride for Children	-	-	-	12.73	15.21		<25th ☆
Well-Child Visits in the First 30 Months of Life (31d-15m)	70.32	56.69	54.35	65.88	73.17		90th ★
Well-Child Visits in the First 30 Months of Life (15m-30m)	-	69.85	64.58	73.05	75.59		75th ★

CCHP improved performance in several key MCAS measures in MY 2023. CCHP accomplished this through data improvements, performance improvement initiatives, and increased collaboration with contracted providers. CCHP has nearly doubled the number of MCAS measures at the High-Performance Level (HPL) from nine in MY 2022 to 17 in MY 2023. Additionally, CCHP achieved the 75th percentile for 9 measures and the 50th

percentile for another 6 measures. CCHP was under the 50th percentile for 7 measures, 3 of which were target measures (Follow-Up After Emergency Department Visit for Substance Use, Lead Screening in Children, and Topical Fluoride for Children).

CCHP has seen notable improvement in pediatric well care visit metrics. For Well-Child Visits in the First 30 Months of Life (31d-15m), CCHP performed in the 90th percentile and surpassed pre-pandemic visit completion rates. In the Well-Child Visits in the First 30 Months of Life (15m-30m) measure, CCHP performed in the 75th percentile and has increased rates by 10 percentage points since MY 2021. CCHP also performed in the 75th percentile for Child and Adolescent Well Care Visits in MY2023.

For Lead Screening in Children (LSC), Follow-Up after ED for SUD – 30 Days (FUA-30), and Topical Fluoride Varnish (TFL), which were below the MPL, rates in MY 2023 increased compared to MY 2022. To ensure that CCHP exceeds the MPL for FUA-30, CCHP had instigated a Performance Improvement Project (PIP) for the 2023-2026 improvement cycle. This project focuses on connecting CCHP members who present to the ED with a SUD or mental health concern to care management. CCHP also continued improvement activities to address Lead Screening in Children. These efforts include targeted provider education and gap in care lists and are more detailed in 7.2.

6.2 Member Experience

Each year, CCHP surveys our members to help measure member satisfaction, access to services, and member experience with cultural and linguistic services. We also conduct a thorough analysis of member grievances to obtain a comprehensive understanding of the member experience and identify any opportunity for improvement.

The survey process encompasses three distinct instruments tailored to capture various aspects of the member experience. The CAHPS survey offers a comprehensive evaluation of overall experience and access to care. Additionally, the Experiences of Care and Health Outcomes (ECHO) survey specifically targets individuals receiving behavioral health services, aiming to delve deeper into their unique needs and experiences. Lastly, a specialized survey is administered to non-English speaking members, focusing on assessing the adequacy of language access services provided by CCHP.

By systematically gathering feedback through these surveys, CCHP gains valuable insights into members' perspectives, identifies areas for improvement, and aims to tailor services to better meet the diverse needs of its enrollees. This commitment to continuous assessment and enhancement underscores CCHP's dedication to providing accessible, culturally competent, and high-quality care to all members of the community.

The CAHPS survey is administered yearly and the data from the Adult Medi-Cal population in RY 2024 are presented in Table 2.

Table 2 CAHPS Results RY 2023-2024

Measure	RY 2023	RY 2024	Percent Change	Percentile
Overall Ratings				
Rating of all health care	78.2%	83.4%	6.6%	95th ▲
Rating of personal doctor	80.8%	84.3%	4.3%	66th ▲
Rating of specialist talked to most often	79.2%	88.1%	11.2%	95th ▲
Rating of health plan	79.6%	79.1%	-0.6%	50th ▲
Composite Scores				
Getting Needed Care	79.1%	80.8%	2.1%	33rd ▲
Getting Care Quickly	79.4%	75.2%	-5.3%	10th ▼
Communication	92.8%	91.4%	-1.5%	25th ▼
Customer Service	85.2%	87.9%	3.2%	10th ▼
Effectiveness of Care				
Advising Smokers to Quit	80.4%	88.5%	8.1%	95th ▬
Discussing Cessation Medications	63.0%	61.5%	-1.5%	90th ▼
Discussing Cessation Strategies	70.5%	52.0%	-18.5%	75th ▼

In RY 2024, CCHP improved in national percentile rankings in all four of the Overall Ratings and performed at the 95th percentile for Rating of All Health Care and for the Specialist Talked to Most Often. While CCHP saw improvement in the overall Composite Scores for Customer Service compared to the prior year, performance in the national percentile ranking decreased. CCHP also saw decreases in the overall Composite Scores for Getting Care Quickly and Communication, as well as decreases in national percentile rankings. Under the Effectiveness of Care domain, CCHP improved overall performance in Advising Smokers to Quit, but saw some decreases in both overall scores and national percentile rankings for Discussing Cessation Medications and Discussing Cessation Strategies.

In 2024, CCHP administered the ECHO survey to members who had utilized behavioral health services; this time through a vendor to allow for more robust and generalizable results. Overall results demonstrated high satisfaction with communication from behavioral health providers and ratings of counseling and treatment. Members' perceived improvement increased in 2024 compared to the 2023 administration, demonstrating the importance of connecting members to care. While more members responded positively to being able to see a provider as soon as they wanted in 2024 compared to 2023, the Getting Treatment Quickly domain is an opportunity for improvement.

The 2024 Language Access Survey results offer critical insights into member experiences with interpreter services, health promotion and communication efforts. This year's survey highlights significant opportunities for improvement, as seen by the decreases in member's

ability to get an interpreter and increase in members' reliance on their family for interpreter services.

In 2024, to assess additional improvement opportunities, CCHP created a new member survey to gather information on the clarity of materials and members' understanding of the health plan's policies and procedures, particularly those centered around navigating the health system to get desired care and services. This survey demonstrated that while redesigned new member materials were easy to understand, there were opportunities for improvement with regards to educating members on how to access their benefits, support services, and membership information. CCHP utilized this feedback to redesign the new member orientation and will report on the impact of this intervention in 2025.

More information about the ways in which CCHP evaluates the member experience can be found in the forthcoming 2024 Member Experience Report.

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

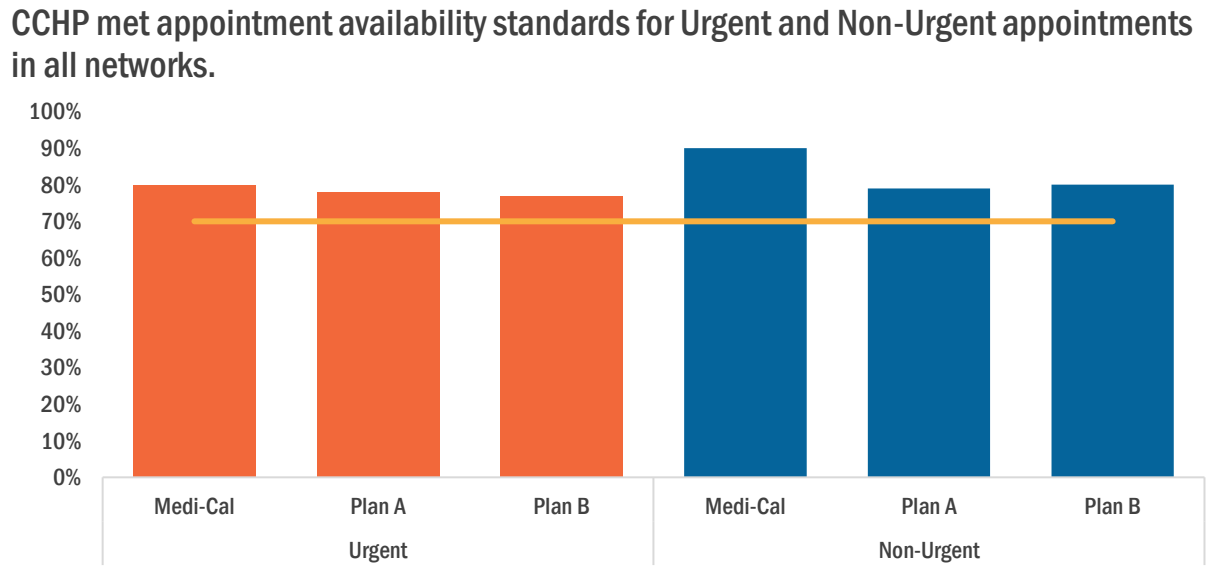
6.3 Network Adequacy

Effective healthcare delivery relies on the accessibility and availability of services when needed. CCHP adheres to access and availability standards as required by DMHC, DHCS, and NCQA. Through analysis of provider appointment availability, enrollee experience, provider satisfaction, and other key metrics, such as initial prenatal appointment availability, Initial Health Appointment (IHA) rates, in-office wait times, and others, CCHP assesses its performance in meeting regulatory standards while ensuring quality and timely service for its members.

The Provider Appointment Availability Survey (PAAS) assesses the readiness of network providers to deliver timely appointments to enrollees. The standard is that 70% of providers within the CCHP network must meet the standards for urgent and non-urgent appointments, and 80% meet standards for non-physician mental health follow-up appointments.

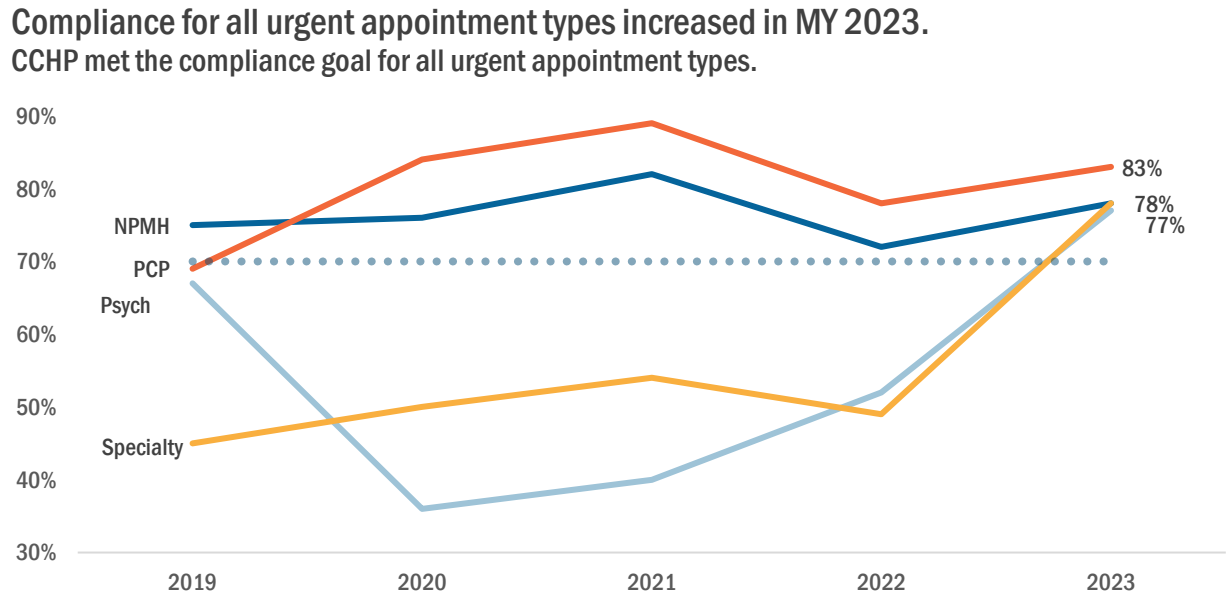
In 2024, CCHP met the standards for both urgent and non-urgent appointments.

Figure 1. PAAS Compliance Rates for Urgent and Non-Urgent Appointments by Line of Business



When stratifying urgent appointments by provider type, CCHP saw a universal increase across all provider types, with primary care, specialty, non-physician mental health, and psychiatry all exceeding the threshold. Notably, the rate for urgent psychiatry appointments meeting the standards increased from 52% to 77% between 2022 and 2023, and the rate for specialty urgent appointments increased from 49% to 78% between 2022 and 2023.

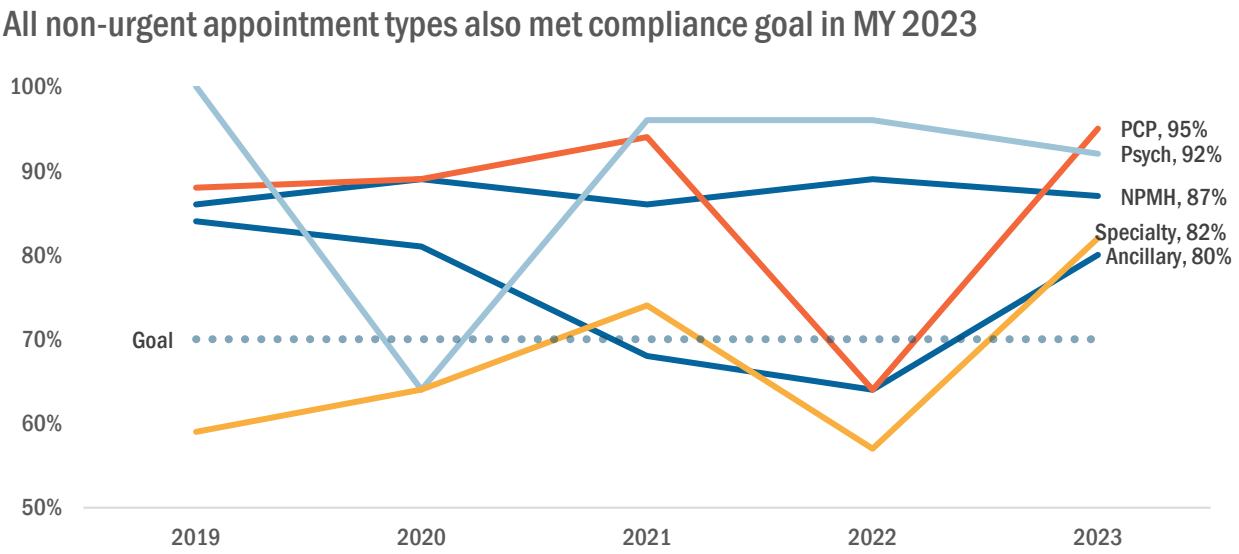
Figure 2. PAAS Urgent Appointment Compliance Over Time



Similarly, non-urgent appointments saw an increase across several provider types in 2023 compared to 2022. Notably, routine primary care appointments increased from 64% to

95%, specialty appointments increased from 57% to 82%, and ancillary care increased from 64% to 80%. Psychiatry appointments increased from 52% to 77%

Figure 3. PAAS Non-Urgent Appointment Compliance Over Time



CCHP implemented several targeted interventions based on the opportunities for improvement identified in the MY 2022 Access and Availability Report. The three main priorities were expanding the psychiatry network, improving provider education on appointment standards, and increasing the specialty network. More comprehensive information about how CCHP assesses its network adequacy can be found in the 2023 Annual Report on Access and Availability.

6.4 Long Term Care and Long-Term Support Services

Following state guidelines, CCHP developed a comprehensive Quality Assurance Performance Improvement Program (QAPI) to ensure members receiving care in Skilled Nursing Facilities (SNF) Long Term Care (LTC) receive high quality services. This report, developed in 2024, analyzes quality data from 2023, reviewing primary and secondary sources to present a comprehensive picture of SNF quality. In 2023, CCHP had 1,882 members placed during the reporting period, for a total of 2,139 facility placements. Of these, 1,750 members were placed into an in-network SNF, and 168 members were placed out-of-network.

In 2023, amongst the 26 SNP facilities with more than 20 CCHP members placed, CCHP identified that 13.8% of our facilities had survey deficiencies above the state average and approximately 5.2% were significantly above average (more than 50% above the state average). Three of our highest volume SNF had higher than average survey deficiencies.

For complaints and facility reported incidents, 20.7% of CCHP facilities were above average and approximately 5.2% were significantly above average. Five of our highest volume SNF had complaints and facility reported incidents above the state average. CCHP reviewed each SNF's data on the CMS Care compare website and recorded the ratings for each facility in the overall, health inspections, staffing, and quality measures categories. The average overall SNF rating was 3.94 which is higher than the state average of 3.2. There was a total of eight facilities (13.8%) with an overall 1- and 2-star rating and two of CCHP's high volume SNF had a 2-star rating. When looking at the individual quality measures, CCHP was above the state average in 8 of the 11 measures but fell below in two measures related to emergency department visits, and one related to antipsychotics.

CCHP also reported on three MCAS measures specific to long term care facilities:

- Healthcare-Associated Infections Requiring Hospitalization (HAI)
- Number of Out-patient ED Visits per 1,000 Long Stay Resident Days (OED)
- Potentially Preventable 30-day Post-Discharge Readmission (PPR)

Table 3. Comparison of LTC MCAS Measures to State and National Average.

	LTC-HAI	LTC-OED*	LTC-PPR
CCHP Rate	5.45%	1.86	0.77%
CA	NA	1.38	NA
National Average	6.9%	1.65	10.5%

*Lower is better

The report presents strengths and areas for improvement within the SNFs that serve CCHP members. The data shows CCHP has a strong in-network placements, ensuring continuity of care, improved health outcomes, and closer alignment with quality oversight activities. However, the evaluation also revealed a subset of facilities deviate from state and national averages in survey deficiencies, complaints, and CMS Care Compare ratings. More detailed information is presented in the 2023 Long Term Care Quality Assurance and Performance Improvement Report.

6.5 Other Quality Measurement Activities

In 2023, CCHP successfully completed a number of other quality reporting activities including DHCS encounter data validation, a provider satisfaction survey, and comprehensive reporting on CalAIM requirements, including Enhanced Care Management and Community Supports monitoring reports, and Incentive Payment Program reports.

A noteworthy achievement in 2024 was the improvement of sharing quality information with network providers. CCHP moved from sharing provider empanelment reports, lead

screening reports, and gap in care reports via SharePoint and encrypted emails to a more secure pathway through the CCHP Provider Portal. Primary Care Providers are now able to access these reports on-demand, in a more secure fashion. This demonstrates CCHP's commitment to patient privacy while maintaining real-time feedback loops with network providers.

7 Performance Improvement Projects

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

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

7.1 DHCS Performance Improvement Projects

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

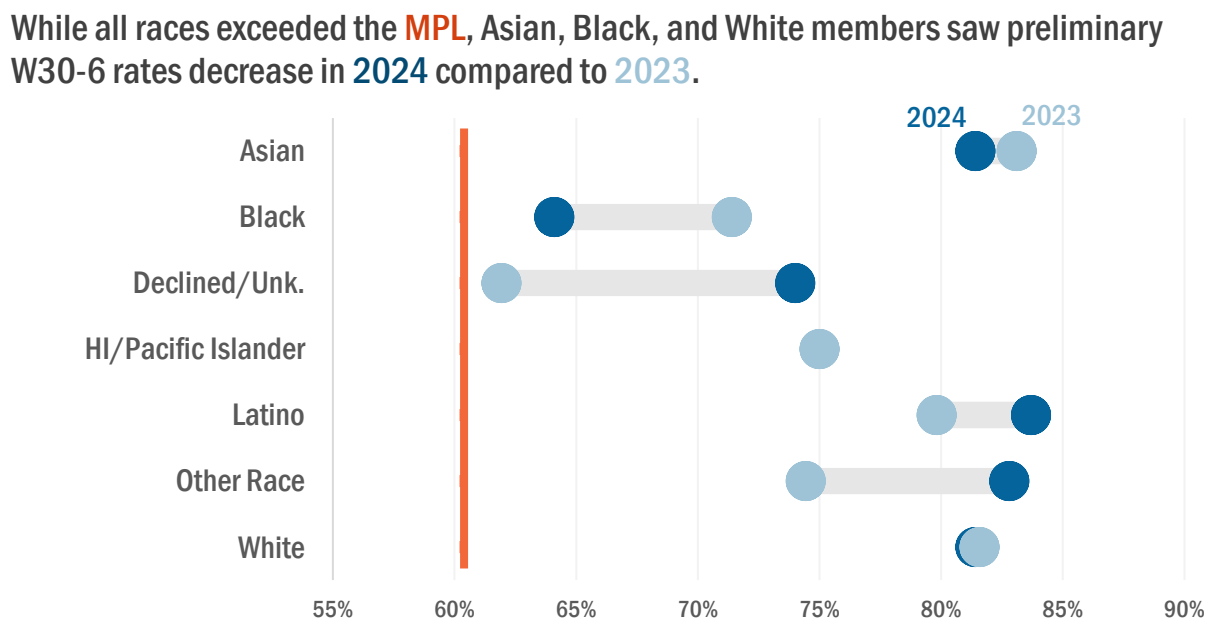
In 2024, CCHP submitted baseline MY2023 data and a summary of implemented interventions for the 2023-2026 DHCS PIPs. Both PIPs met 100% of evaluation elements and received high confidence ratings. The clinical PIP, Improving W30-6 Measure Rate Among Black Members, focuses on reducing disparities in well care visit rates between Black/African American children and children of other races. CCHP's non-clinical PIP, Improving the Percentage of Members Enrolled in Care Management Within 14 Days of SMH/SUD Diagnosis, focuses on connecting members with Case Management (CM) services after an ED visit for mental health or substance use diagnoses.

7.1.1 Improving W30-6 Measure Rate Among Black Members

In 2023, CCHP achieved the 90th percentile for the W30-6 measure, with 73.2% of continuously enrolled patients completing at least 6 well care visits with a PCP by 15 months of age. CCHP has demonstrated marked improvement in this measure since 2021, with 2023 rates exceeding the rates achieved prior to the COVID-19 pandemic.

However, despite CCHPs performance, disparities in WCV completion rates exist between racial categories. In MY 2023, Asian members had a W30-6 completion rate of 83.1%, compared to only 71.6% of Black/African American members. If the completion rate for Black members was the same as for Asian, 10 additional Black members would have been compliant with the measure. This equates to lost opportunities for vaccinations and important screenings, like lead and anemia, which has further downstream effects. Despite the 11.5%-point gap in the W30-6 rate, the rate for Black/African American members achieved 90th percentile of all Medicaid HMOs.

Figure 4. W30-6 Rates by Race, 2023-2024.



To achieve the DHCS' Bold Goal of reducing the disparities seen amongst well child visits between races, CCHP conducted outreach to members ages 0-15 months who were overdue for a well care visit, with a particular focus on Black/African American members, members with a declined/unknown race, and Hawaiian/Pacific Islander members. For patients within the Regional Medical Center (RMC) network, CCHP staff offered to directly book appointments for patients and offered caregivers an incentive to complete the appointment. For patients in the Community Provider Network (CPN), CCHP staff informed caregivers about the child's overdue well care visit and offered them the phone number of

the appointment scheduling unit for their child's PCP. If a caregiver was not reached, they were eligible for an additional phone call seven days after the first.

CCHP health education staff placed 117 calls to 101 members, including 70 (69.3%) within the RMC network and 31 (30.7%) in CPN. A total of 59 calls were made to 45 Black/African American members (1.3 calls/member) and 18 members with declined/unknown race and one Hawaiian/Pacific Islander member received 1 phone call each. Contact information was missing or invalid for 13.9% of members but was much higher at 20.0% for Black/African American members. Only 11.1% of members with declined/unknown race had missing or invalid contact information. Contact was made with a caregiver for 41 (40.6%) members, but only for 6 (33.3%) members with declined/unknown race. Despite the higher percentage of missing/invalid contact information, CCHP successfully contacted caregivers for 18 (40.0%) Black members. Of the 70 RMC patients who were outreached, 7 (10.0%) completed appointments, including 3 (7.9%) Black/African American children. For members who had a successful contact upon outreach, 17.1% of members, including 16.7% of Black/African American members, completed an appointment. Of the 31 CPN patients, 13 (41.9%) had a claim for a well care visit within 2-90 days of the outreach attempt. The average age at outreach was 8.3 months, so this intervention is predicted to have more of an impact in 2025 as these members turn 15 months old. Health education staff reported that about 10% of patients had moved out of the service area and that approximately another 10% had health insurance other than CCHP.

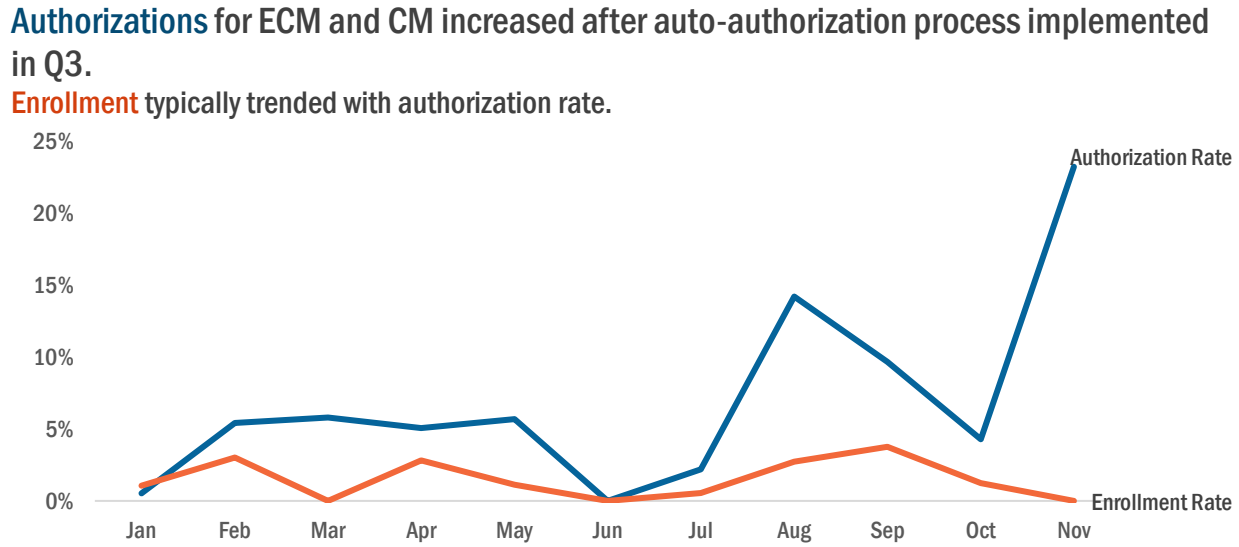
7.1.2 Improving the Percentage of Members Enrolled in Care Management within 14 Days of SMH/SUD Diagnosis

CCHP's non-clinical PIP is focused on improving enrollment in case management following an emergency department visit for mental health or substance use. Previous data analysis demonstrated that members who were previously enrolled in Enhanced Care Management (ECM) or Complex Case Management (CCM) were more likely than members not enrolled in care management (CM) to receive a clinical follow up visit after their ED visit for mental health or substance use.

According to baseline data, between 0-10% of members are authorized for case management within 14 days of an emergency department visit for behavioral health. One reason for this is claims lag, which prevents CCHP from identifying individuals for case management in a timely fashion and establishing workflows to trigger authorizations for needed services. In Q3 2024, CCHP implemented an automated process to authorize and triage potentially eligible members from Admit, Discharge, and Transfer (ADT) feeds. After implementation, the authorization rate ranged as high as 23.2%, with an average authorization rate of 6.7% in 2024, +3.1%-points (+86.1%) over 2023. Enrollment in ECM

and CM within 14 days of the ED visit increased from 0.9% in 2023 to a preliminary rate of 1.5% in 2024, an increase of 0.6%-points (+66.7%). This initiative, launched at the end of the year, was initially implemented at a gradual pace to ensure a measured approach. As the process matures and gains traction, enrollment rates are anticipated to increase progressively throughout 2025. Ongoing efforts will be directed toward optimizing the initiative's reach and impact.

Figure 5. The Authorization and Enrollment Rates for ECM and CM Servies in 2024.



7.2 PIPs for Low Performing MCAS Measurement

CCHP regularly monitors HEDIS and MCAS measures and develops improvement plans based on low performing measures. In MY 2023 (reported in 2024) CCHP identified lead screening, follow-up for ED visits for substance use, and topical fluoride application as low performing measures.

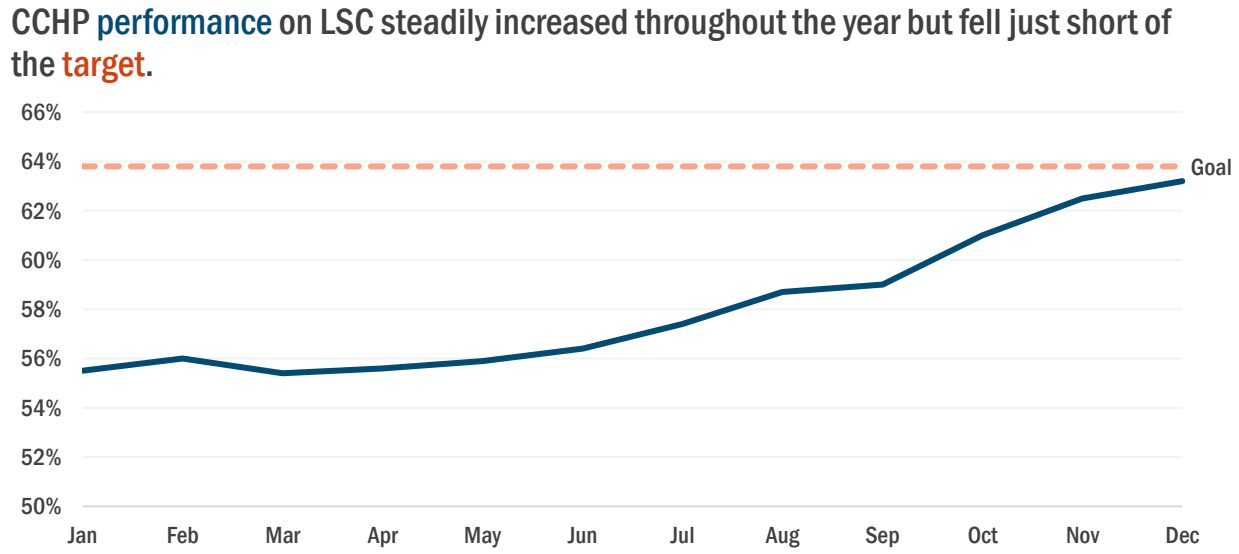
7.2.1 Lead Screening in Children

Lead Screening in Children (LSC) is a measure that CCHP must perform at the 50th percentile or better when compared to other HMO Medicaid plans. While LSC rates increased from 51.51% in MY 2022 to 52.81% in MY 2023, CCHP was at the 25th percentile nationally and therefore, did not meet the MPL. As part of CCHP's efforts to increase LSC in 2024, CCHP implemented an outreach campaign. Health education staff outreached caregivers of non-compliant members approaching their second birthday to inform them of the importance of lead screening and where to get screened. A total of 1,149 calls were made to 547 members' caregivers (avg. 2.1 calls/person) and a caregiver was reached for 397 (72.6%) of members. Ultimately, 109 (19.9%) of members who were outreached had a

lead test that was collected within two weeks of outreach. In total, 211 (38.6%) members in this population had a lead screening by the end of 2024, with 136 of these screenings occurring before the member's second birthday. In addition to the outreach calls, CCHP conducted a mailing campaign to 330 members in September 2024. Members were eligible for a mailer if they were overdue for a lead screen and their second birthday was in Q4 2024. Of the 330 members mailed a letter, 26 (7.9%) had a lead screen by the end of 2024, with 16 of those screenings occurring before the member's second birthday. The mailing was repeated in November for birthdays in the first quarter of 2025. To fulfill the DHCS requirement for MCPs to collaborate with a Local Health Jurisdiction (LHJ), CCHP, Contra Costa Health Public Health, and Kaiser Permanente jointly developed an informational flyer to educate members about the harms of lead on young children, where lead is found, and testing recommendations. These flyers were distributed to PCPs and were included in the mailers to members overdue for lead screening. CCHP also continued the partnership with the Contra Costa Lead Poisoning Prevention Program and posted social media messages during Lead Poisoning Prevention Week.

Preliminary MY 2024 HEDIS results for CCHP demonstrate increased improvement in LSC to 63.2%, which corresponds to 33rd percentile nationally. This is still below the MPL; however, claims lag and/or hybrid chart review may result in this rate reaching the target.

Figure 6. Lead Screening Rate by Month in 2024.



7.2.2 Follow-Up After Emergency Department Visit for Substance Use (FUA)

While CCHP has improved performance on the FUA measure, from 26.61% in MY 2022 to 32.31% in MY 2023, and exceeded the MPL in MY2022, the target increased in 2023 and CCHP was in the 25th percentile nationally. To further increase performance on this

measure, CCHP partnered with Contra Costa Behavioral Health Services to conduct a Performance Improvement Project. In coordination with the Access Line, the coordinated entry point for Specialty and Non-Specialty Mental Health Services and Substance Use Treatment services, a workflow was developed to connect patients that had presented to the ED with a substance use diagnosis to mental health services. During Access Line business hours, ED social workers, discharge planners, or navigators call the Access Line on behalf of the patient to conduct a warm handoff. If a patient leaves the ED during non-business hours, the Access Line will outreach patients directly during normal business hours. In 2024, there were 1,316 calls made for mental health and substance use linkages, 81 (6.2% of calls) were inbound calls and 1,237 were outbound calls after the patient was discharged. Of these calls, 189 (14.4%) members were reached and connected to specialty mental health, non-specialty mental health, or substance use treatment. Additionally, 121 (9.2%) of patients on the list to receive calls were already connected to services. The current estimate for MY 2024 FUA-30 is 41.4%, which would put CCHP above the MPL. Additionally, CCHP conducted in-service education events for local emergency departments to inform providers about the Access Line and how to connect their patients to mental health and substance use services, so people can leave the Emergency Department with a follow-up behavioral health appointment. CCHP and Behavioral Health staff conducted in-services at Sutter Delta Medical Center, Kaiser Richmond, Kaiser Walnut Creek, and John Muir Health Walnut Creek and Concord Emergency Department. In sum over 70 ED staff from 5 hospitals attended. These in-services had positive feedback from attendees and increased awareness of the Access Line referral process while people are still in the Emergency Department.

7.2.3 Topical Fluoride Varnish

While CCHP increased performance on TFL from 12.73% in MY 2022 to 15.21% in MY 2023, CCHP was in the 10th percentile nationally for this measure and anticipates marginal improvements in MY 2024 rates. In order to improve TFL rates and meet the MPL, CCHP implemented an outreach campaign to members ages 0-20, with a specific focus on members ages 6-20 who are only eligible for fluoride varnish at a dental visit. CCHP placed 55 calls to 52 caregivers and members to educate them about their dental benefits, as well as to inform them of dental providers in their area who are accepting Smile, California dental insurance. Contact was made to 38 members (73.1%) and all contacted members were receptive to receiving the dental information. Dental services are a carved-out benefit and CCHP does not control the dental network, so education and outreach is one of the few activities CCHP can engage in to address this rate.

7.3 Institute for Healthcare Improvement Projects

In March 2024, DCHS announced a partnership with the Institute for Healthcare Improvement (IHI) to implement two improvement projects for all Medi-Cal Managed Care plans. Through a series of biweekly coaching calls, IHI committed to supporting Medi-Cal plans through the implementation evidence-based interventions to address pediatric well care visit completion rates and behavioral health follow-up visit rates. Critical elements to achieve this goal include effective team-based care, automation and effective use of technology, including Electronic Health Records, population health management, and addressing social drivers of health

7.3.1 Child Health Equity

To improve health equity in the pediatric domain, CCHP partnered with Brighter Beginnings, a provider group with 3 locations throughout the county. CCHP and Brighter Beginnings conducted a thorough data analysis and together decided to focus on improving the Well Care Visit rate for members ages 18-21. After selecting the measure, CCHP conducted patient interviews with Brighter Beginnings members in the target population, as well as Brighter Beginnings staff, to determine possible areas for intervention. After reviewing the journey map, Brighter Beginnings and CCHP then decided to implement a PDSA of conducting Saturday morning clinics for pediatric patients at two different clinic locations. CCHP conducted outreach to patients due for well care visits and offered health education, transportation support, and direct appointment scheduling. The clinics were held in early Q4 and while there was a high no-show rate, Brighter Beginnings learned that appointment times later in the morning worked better for teens and young adults, while the early morning appointments were best suited for young children. At the end of 2024, preliminary data showed that Brighter Beginnings increased their WCV rate for 18–21-year-olds by 63.8%, though there is still work to be done to ensure that this age group meets the WCV MPL. CCHP and Brighter Beginnings will continue to partner together through Q1 2025 to further work on this goal.

7.3.2 Behavioral Health

CCHP partnered with Contra Costa Health Behavioral Health Services (CCBHS), the specialty mental health and Drug Medi-Cal-Organized Delivery System plan in Contra Costa, to increase the follow-up visits for behavioral health by 5% from baseline for HEDIS FUM and FUA measures. The main intervention for this project was enhancing an existing dashboard to allow for more timely identification of patients who had been in the emergency department for behavioral health diagnoses. The previous dashboard had been a retrospective review of patients once the 30-days after the ED visit had elapsed, which

did not allow for the identification of members who still needed a follow-up visit. Additionally, the index ED visits were identified based on claims, but with claims lag this limited the plan's ability to do improvement work as we needed more timely notification of ED visits. CCHP decided to utilize ADT feeds, electronic messages that provide updates on patient movements within healthcare facilities. These ADT feeds are about the exchanges of data, and are not fundamentally about notifications, so CCHP underwent an extensive project to develop and validate notifications based on these feeds. CCHP then implemented a report based on these visits for outreach by the Access Line and auto referrals to ECM and CCM, detailed above in 7.2.2.

7.3.3 Assigned Not Seen Project

In Q2, CCHP partnered with the largest provider group within its network to engage CCHP patients who had been continuously enrolled and assigned to the provider group but had not completed a visit within the past 12 months. Pediatric members, especially Black/African American, Spanish speaking, Hawaiian/Pacific Islander, and non-English speaking members were prioritized for outreach. The goal was for 10% of outreached patients to complete a visit by the end of 2024. Over 12 weeks, 7 CCHP staff outreached to caregivers of members and offered direct appointment booking with the provider group. CCHP staff also informed caregivers that if the member completed the WCV, they would receive an incentive from the health center. The outreach results are summarized in the table below. CCHP exceeded the goal of engaging 10% of this population into care.

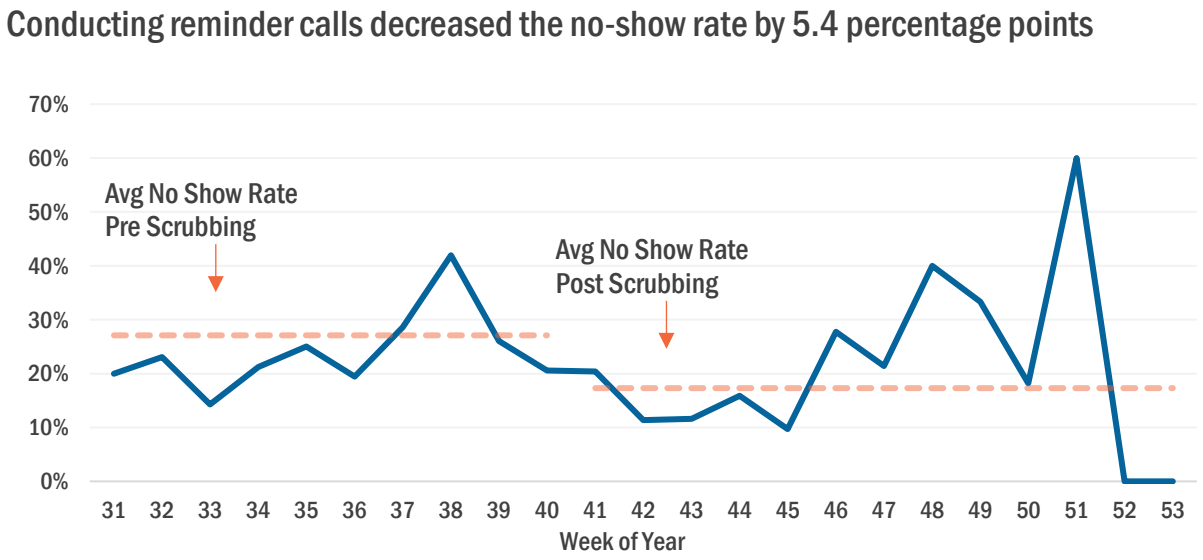
Table 4. Outreach Results by Population of Focus.

Population	Black/ African American	Spanish Speaking	Other Lang.	Hawaiian/ Pacific Islander	All
Number of People	1,007	1,764	306	120	3,380
Number of Calls	1,690	2,570	458	180	5,098
Calls/Person	1.7	1.5	1.5	1.5	1.5
Ever Reached %	34.4%	41.2%	30.7%	34.2%	37.7%
Percentage w/ Appt Scheduled	16.7%	23.7%	15.4%	25.0%	20.5%
Number of Completed Appts	106	341	38	20	532
Successful Engagment	10.5%	19.3%	12.4%	16.7%	15.7%
Overall No Show Rate	36.9%	18.4%	19.1%	33.3%	23.3%
No Show Rate w/o Scrubbing	39.5%	18.8%	26.3%	30.8%	25.3%
No Show Rate w/ Scrubbing	29.5%	17.7%	14.3%	35.3%	19.9%

After appointment no-show rates started increasing, CCHP outreach staff implemented reminder calls (also called scrubbing calls) to the caregivers two days before the scheduled

appointment. The overall no-show rate was 25.3% before the reminder calls were implemented, which decreased to 19.9% after. A total of 318 patients received reminder calls, and of those patients, 73.3% completed the appointment and 9.4% of patients canceled the appointment, allowing other members to access that appointment slot.

Figure 7. The Effects of Reminder Calls on the No-Show Rate.



8 Population Health Management

Population Health Management (PHM) at CCHP is dedicated to maximizing health by collaboratively designing services with members and providers. This involves delivering primary and secondary evidence-based interventions for illness prevention and management within our assigned population.

In 2024, CCHP continued our work to enhance the PHM program. This involved a comprehensive series of meetings engaging key CCHP leadership and collaborating with provider, county, and community partners. The ongoing collaboration with stakeholders demonstrates CCHP's dedication to advancing population health initiatives and adapting to the evolving landscape of healthcare services.

8.1 Population Needs Assessment, Strategy, and Impact Report

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

CCHP conducts an annual Population Health Impact report to evaluate the effectiveness of the implemented programs.

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

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

In addition to CCHP efforts, collaborative efforts with the Public Health Department's epidemiologist and quality team were initiated to align with Contra Costa's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). CCHP is an active stakeholder in Contra Costa County's next CHA, scheduled to begin planning in 2025, and has been a key participant in the CHA steering committee. CCHP also collaborated with Kaiser Permanente and Contra Costa Public Health on the shared DHCS Population Health Strategy goal to create lead education collateral for Contra Costa residents.

8.2 Improved Member Information

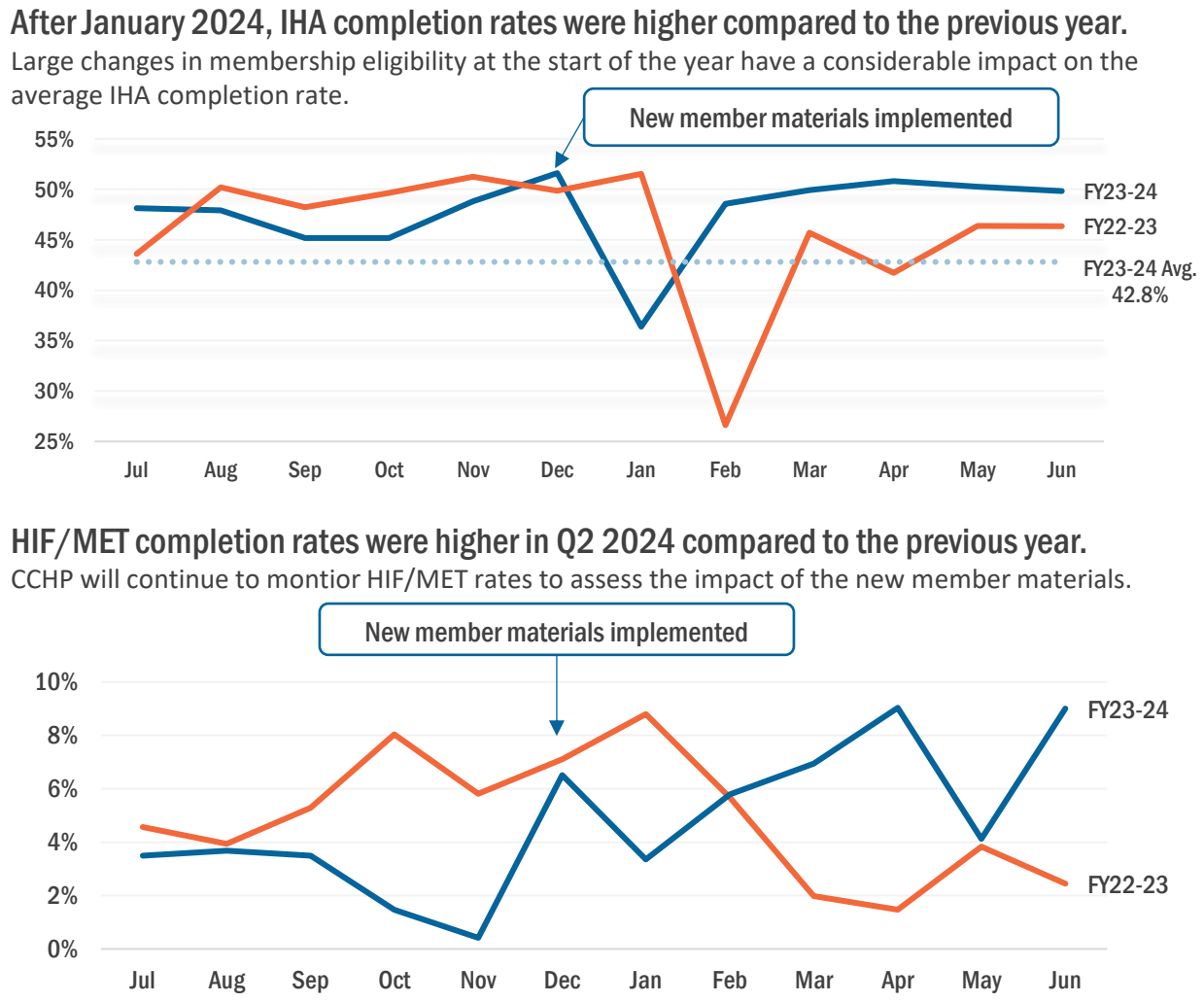
Leveraging its integration within the county delivery system, CCHP utilizes comprehensive data systems, centralizing data from claims, clinical data, detention health, EMS, social services, homeless systems, and public health into one unified member record. While CCHP's data infrastructure is robust,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

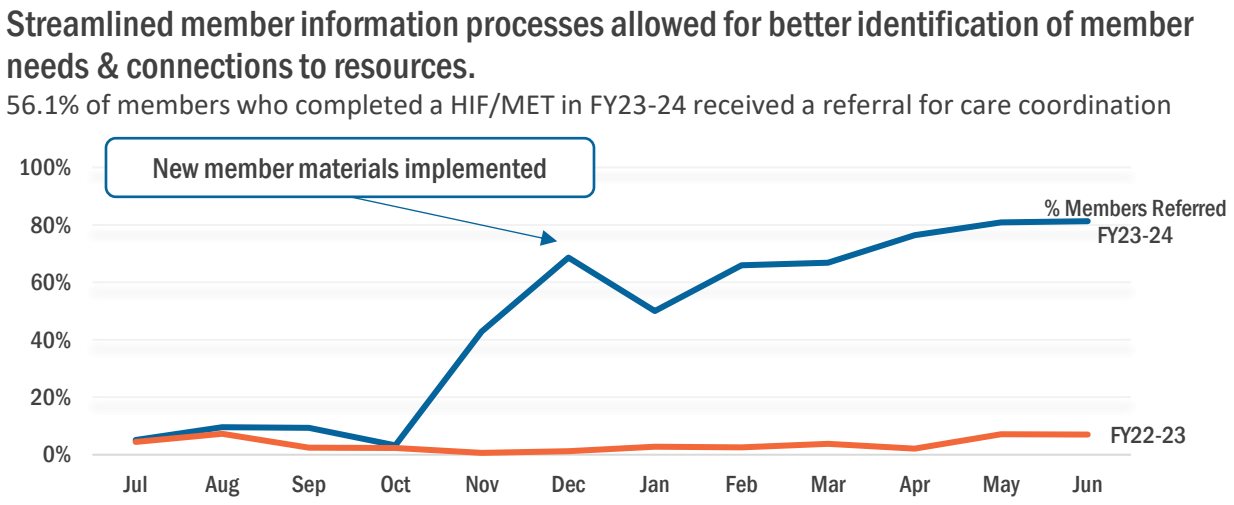
To address this opportunity, CCHP initiated a comprehensive overhaul of the new member workflow, streamlining activities for improved alignment. A revamped Health Insurance Form/Medical Evaluation Tool (HIF/MET) and Health Risk Assessment (HRA) were designed, featuring specific questions tailored for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

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

This refined process was implemented in December 2023, and its impact is demonstrated in the figures below. While the IHA rate in FY 23-24 was slightly lower compared to the previous year, CCHP saw an influx of nearly ten times the average amount of new members in January 2024 after the Single Plan Model was in effect. Excluding January 2024 from FY23-24 data increases the IHA completion rate to 48.6%, an increase of 12.8% compared to FY22-23.

Figure 8. The impact of new member materials on IHA, HIF/MET, and referral rates.





CCHP also noted that the percentage of the population with declined/unknown race decreased from 16.2% of the population to 10.4% (-5.8%-point [-35.8% change]) and unknown language decreased from 1.7% of members to 0.8% (-0.9%-point [-52.9% difference]) as of December 2024. In Q4 2024, CCHP updated the REAL forms to include Sexual Orientation and Gender Identity (SOGI) questions to further health equity.

8.3 Risk Stratification, Segmentation and Tiering

CCHP employs a comprehensive approach to risk stratification, segmentation, and tiering by harnessing data from diverse sources. Utilizing claims and encounter data, DHCS-provided data, screening and assessments, electronic health records, referral and authorization data, behavioral health data, pharmacy data, utilization data, and social services data including homelessness data, criminal justice data CCHP establishes the foundational data for its risk stratification and tiering methodologies.

This dataset enables CCHP to create individual member records based on risk, segmenting them into different risk categories and tiering based on acuity. Beyond classification, CCHP leverages this data to generate automatic referrals, proactively directing members to appropriate services and programs for which they may qualify. This ensures that individuals not only receive accurate risk assessment but are also seamlessly connected to the care and support they need. The incorporation of a broad range of data points facilitates the identification of interventions and eligibility criteria, allowing for the triaging of individuals to services.

In 2024, significant work was done to create an infrastructure to utilize ADT feeds for risk identification and program eligibility, combining both risk tiering with program eligibility and exclusion data. These data have then been leveraged to automatically identify and refer

people to services, without the need of a practitioner referrals. In Q3, CCHP was able to implement auto authorizations to ECM for serious mental illness or substance use, as well as identify and refer patients to CM who are high risk and had a recent hospital admission.

8.4 SERVICES

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

8.4.1 Basic Population Health Management Services

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

The evaluation of basic population health management primarily relies on HEDIS and MCAS measures, detailed in Table 1. These measures encompass critical aspects such as well care visits for children, immunizations, preventive screenings, and prenatal and postpartum visits.

8.4.1.1 Community Supports, Community Health Workers, Care Coordination, and Navigation with Social Services

In alignment with CalAIM, CCHP has expanded its service offerings aimed to address the comprehensive well-being of individuals. This broader spectrum of services includes doula services, community health worker assistance, care coordination services provided by CCHP's social workers and nurses, and community support services, covering a diverse array of needs for the homeless, individuals requiring long-term support, and those

managing chronic conditions that could benefit from specialized interventions such as medically tailored meals or asthma services.

Table 5 outlines the number of individuals who received these services in 2024. CCHP provided the following Community Support (CS) services for the first time in 2024: Personal Care and Homemaker Services, Nursing Facility Transition to Assisted Living Facility, Housing Deposits, Day Habilitation Programs, Environmental Accessibility Adaptations, and Nursing Facility Transition to Homes. In addition to the newly provided CS, CCHP significantly increased utilization of Medically Tailored Meals, Housing Transition/Navigation, Short-Term Post-Hospitalization Housing, and Housing Tenancy and Sustaining services in 2024 compared to 2023. CCHP Care Coordination Services and the number of unique members receiving CHW services also increased significantly in 2024 compared to 2023.

Table 5. Basic Population Health Services

Program	2023	2024	% Change
Community Supports	1,743	5,664	225.0%
Medically-Supportive Food/Medically Tailored Meals	600	3,384	464.0%
Housing Transition/Navigation Services	719	2,110	193.5%
Personal Care and Homemaker Services	-	228	-
Short-Term Post-Hospitalization Housing	84	180	114.3%
Housing Tenancy and Sustaining Services	105	130	23.8%
Nursing Facility Transition to Assisted Living Facility	-	95	-
Asthma Remediation	86	83	-3.5%
Housing Deposits	-	72	-
Day Habilitation Programs	-	33	-
Recuperative Care	48	27	-43.8%
Respite Services	-	21	-
Environmental Accessibility Adaptations	-	20	-
Nursing Facility Transition to a Home	-	8	-
CCHP Care Coordination Services	1,537	2,170	41.2%
Members Receiving CHW Services	920	2,038	121.5%
Doula Services	5	48	860.0%

8.4.1.2 Cultural and Linguistic Services

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

language services and cultural humility, offer technical assistance to providers, collaborate with community agencies, and address health disparities.

In 2024, CCHP conducted a Language Access survey incorporating supplemental CAHPS questions, revealing critical insights into member experiences with interpreter services, health promotion and communication efforts. This year's survey highlights significant opportunities for improvement, as seen by the decreases in member's ability to get an interpreter and increase in members' reliance on their family for interpreter services. The table below highlights key survey measures and compares results from last year's findings.

Table 6. Language Access Survey Results

Measure	RY 2023	RY 2024	Percent Change
General			
How often did you get an interpreter when you needed one?	81.4%	77.3%	-5.0%
How often did your personal doctor show respect for what you had to say?	94.5%	95.5%	1.1%
How often were instructions for health conditions easy to understand?	90.8%	91.5%	0.8%
How often did you use a friend or family member as an interpreter?*	18.9%	19.4%	2.6%
Rating of Interpreter			
Members who rated their interpreter positively	83.9%	83.8%	-0.1%
Health Promotion & Education			
Attended a health-related class online	2.6%	2.6%	1.1%
Attended a health-related class in person	3.4%	3.1%	-9.8%
Used the health plan website	6.6%	5.1%	-22.6%
Watched an online video about health	6.8%	13.1%	93.2%
I didn't do anything	27.3%	18.8%	-31.0%
Spoke to a health professional	31.3%	26.4%	-15.6%
Searched the internet for health information	43.5%	30.2%	-30.5%
Communication			
Email	38.8%	38.1%	-1.9%
Text Messages	24.1%	24.3%	0.7%
Mail Sent to my House	17.3%	16.4%	-5.4%
CCHP Website	7.4%	6.1%	-17.4%
In Person (Face-to-Face)	6.6%	4.7%	-28.3%
Voicemail/Phone Messages	2.4%	4.7%	97.2%
Materials With Large Text/Font Size	1.8%	1.4%	-22.2%
Online Video	1.0%	2.8%	176.1%
Social Media (Facebook, Twitter, Instagram)	0.6%	1.0%	66.7%
In Braille	0.0%	0.2%	100.0%

*Lower is better

Looking ahead to 2025, CCHP plans to further the understanding of members' SOGI information by analyzing the impact of the new SOGI data collection forms.

8.4.1.3 Wellness, Prevention, and Health Education

CCHP works with providers on getting members into primary care and addressing care gaps. Two main initiatives in 2024 were the creation of pediatric wellness letters to inform RMC members of overdue health maintenance topics and improving Fecal Immunochemical Test (FIT) kit return rates. In Q4, CCHP developed pediatric wellness letter reminders to mirror the adult birthday letters that are already in place for RMC members. In addition to a personalized letter detailing a child's overdue health maintenance topics, members and their caregivers will a handout detailing age-specific health information and resources. These letters are anticipated to go out in late Q1 2025. In the second half of 2024, CCHP and RMC identified RMC patients who had previously returned a FIT kit but were non-compliant in 2024. These members were mailed a second FIT kit and were encouraged to mail them in. The second FIT kit mailing resulted in an overall return rate of 26.1%.

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

CCHP had previously identified the need for a more interactive, engaging, and mobile-friendly health education website and partnered with StayWell to implement the Krames Patient Education library. In Summer 2024, CCHP launched the overhauled healthed.cchealth.org website that includes a comprehensive library of interactive and dynamic health education resources, videos, interactive quizzes, animations, and personalized health content. The website launch was communicated to members and providers through the member newsletter, provider newsletter, provider network training, and was publicized at various provider meetings.

With the expansion of the Health Education team, CCHP was able to increase community engagement efforts. The Health Education team created health information flyers and developed CCHP branded materials for member outreach efforts. CCHP began to reinforce

existing relationships with FQHCs and in Q4 began resource tabling within partnering health centers. CCHP is looking to further strengthen our presence in the county by seeking out additional trusted community partners for outreach and education efforts, including the county library system.

8.4.1.4 Behavioral Health

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

To ensure compliance with SB1019, in 2024, CCHP developed the Non-Specialty Mental Health Services (NSMHS) Outreach and Education Plan. This plan was developed after a review of NSMHS utilization data and a comprehensive Population Needs Assessment (PNA) that elucidated where CCHP had the most opportunity for improvement. The NSMHS plan was presented to the CAC and the Equity Council to allow for members and providers to provide feedback on the plan. The final outreach and education plan includes outreach events at provider clinic locations, at county libraries, at local farmers' and open-air markets, and a new mental health specific e-newsletter.

In 2024, CCHP utilized the Agency for Healthcare Research and Quality (AHRQ) Experiences of Health Outcomes (ECHO) survey to gather feedback from members who had utilized behavioral health services. Overall, members' ratings of counseling and treatment were high, as well as clinician communication. Areas for improvement centered around educating members about different treatment options and members' abilities to obtain urgent treatment appointments.

8.4.1.5 Maternal Health

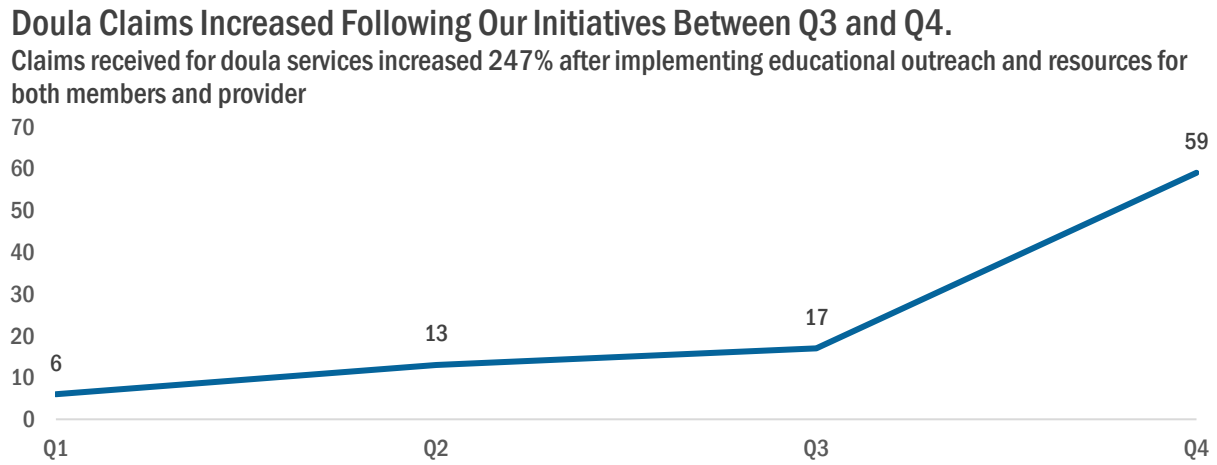
Through close collaboration with community partners and doula providers, CCHP has expanded its efforts to enhance maternal health education, member outreach, and provider support. While CCHP consistently performs well on maternal health quality measures, postpartum visit rates remain lower among African American members, highlighting a key area for improvement.

To address this, CCHP has implemented a range of health education and outreach initiatives aimed at increasing awareness of available benefits, their importance, and how to access them. These efforts include clinic flyers, educational brochures, a pilot maternal health e-newsletter, and a comprehensive guide to prenatal and postpartum services.

Recognizing the critical role doulas play in improving maternal health outcomes, CCHP has also strengthened provider support to expand and sustain its doula network. Initiatives such as doula office hours, joint operations meetings, and a dedicated doula provider manual have been introduced to foster collaboration and retention.

Since launching these initiatives in September 2024, doula claims have increased by 247% compared to previous quarters, reflecting significant progress in expanding access to doula care.

Figure 9. Doula Claims by Quarter, 2024.



8.4.2 Programs Addressing Chronic Disease

8.4.2.1.1 Food as Medicine

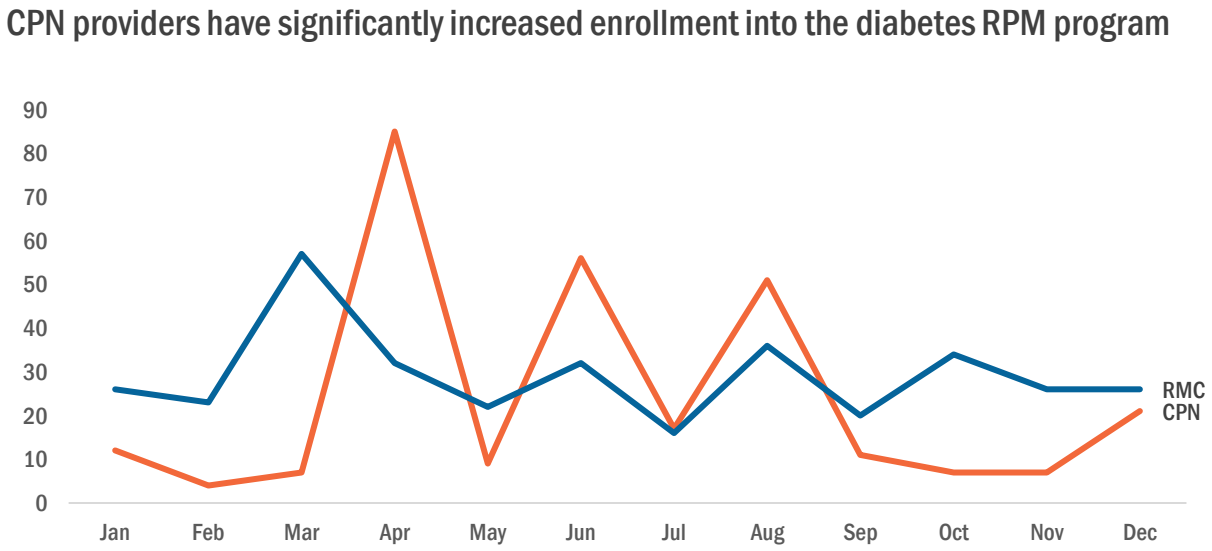
As part of the Community Supports, CCHP partners with 18 Reasons to provide the Food as Medicine (FAM) program, medically tailored foods for patients with diabetes, obesity or high-risk pregnancies. Members are sent weekly grocery deliveries and attend a cooking class with 18 Reasons and a medical provider. In 2024, 18 Reasons served 897 CCHP members and delivered over 15,000 boxes of groceries. CCHP supported outreach and enrollment into the FAM high risk pregnancy program by contacting 128 eligible patients, then referring 48 (37.5%) into the program and helping facilitate appointment scheduling for a subset of these patients. A propensity score analysis of FAM efficacy has demonstrated a 1.68-point drop in member A1c levels after participation, showing an effective intervention to improve members' health.

8.4.2.2 Remote Patient Monitoring for Diabetes and Hypertension

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

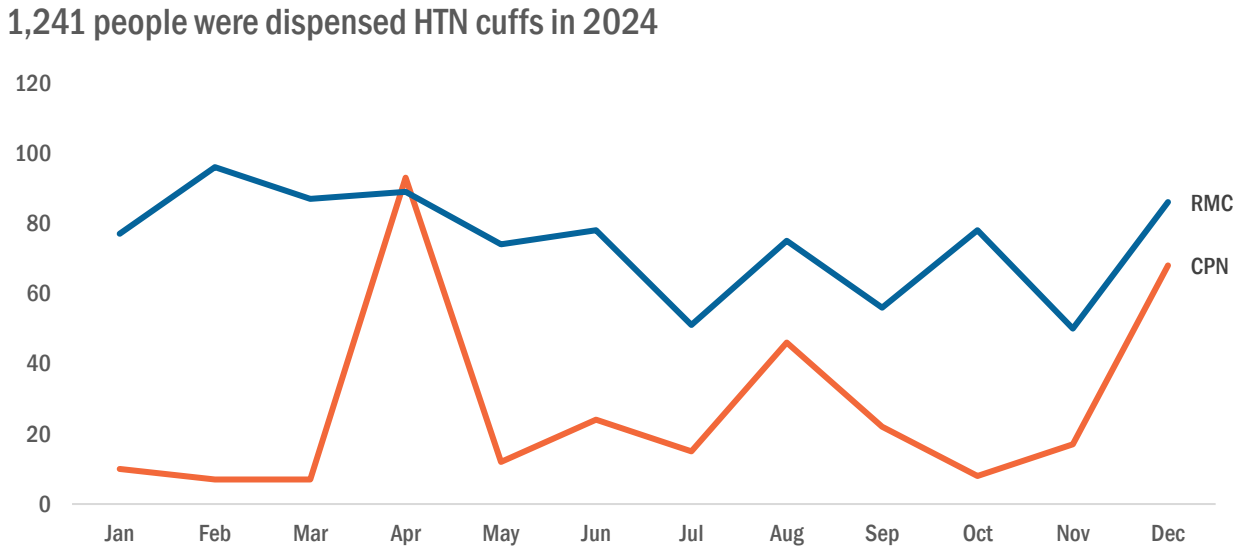
CCHP continued its partnership with Gojji Pharmacy to provide remote patient monitoring services for members with diabetes and/or hypertension. In 2024, CCHP contacted 2,030 members with uncontrolled diabetes and referred 493 (24.3%) RMC patients into the program, with 350 (71.0%) members ultimately enrolling. In addition to the 350 RMC member enrolled, CPN providers referred and ultimately enrolled 287 members, up significantly from the 38 enrolled in 2023. Since the program began in 2022, CCHP has enrolled 1,219 patients into the diabetes RPM program. A previous propensity score analysis on this program revealed that patients who participated in the program saw an average A1c decrease of nearly 16%. CCHP has also seen improvement in the HEDIS Diabetes HbA1c Poor Control (>9.0%) measure and performed at the 90th percentile in MY 2023.

Figure 10. Enrollment into the Diabetes RPM Program by Network.



In addition to the diabetes RPM, Gojji also offers a hypertension program. Currently, CCHP providers can enroll members by prescribing a blood pressure cuff and sending the prescription to be filled by Gojji pharmacy. In 2024, Gojji enrolled 1,241 members in the hypertension RPM program (Figure 11).

Figure 11. Enrollment into the Hypertension RPM Program by Network.



CCHP is undergoing contract negotiations to expand the data sharing agreement to allow for better tracking of patient outcomes.

8.4.2.3 Asthma Education and Remediation Services

Prior to 2024, CCHP utilized two grant-funded Community Health Workers (CHW) to provide Asthma Preventative Services (APS) and direct consumer remediation supplies. After the grant was successfully completed, CCHP contracted with a regional provider to offer these services to members via the APS benefit and CalAIM Asthma Remediation services. After the program transition, CCHP noticed a decline in the number of referrals for services, with only 18.5 members/month referred for services. The previous CCHP CHWs had access to the data structure to prospectively identify and recruit members with moderate to severe asthma, but after moving to the contracted provider recruitment into services relied on provider and case manager referrals. In order to increase the number of members served, CCHP conducted a PDSA in Q2 to increase referrals. The CCHP student intern conducted 52 outreach calls to 33 unique members who had a recent Emergency Department visit for asthma or who met the criteria for moderate to severe asthma. The student intern was able to make contact with 25 (75.8%) of the outreached members and 17 (51.5%) of all outreached patients received a referral. Overall, the number of referrals for CalAIM Asthma Services increased from an average of 18.5/month in the months preceding the PDSA to 35 referrals/month during the PDSA, an increase of 89.2%. CCHP expanded the contracted provider network in 2024 and now has two providers, demonstrating the continued commitment to ensuring capacity for these services.

In addition to the PDSA, CCHP has participated in the RMC Ambulatory Care Redesign project specifically focused on Alternative Care Models for patients with moderate to severe asthma. These patients will be contacted and invited to participate in a nurse-led asthma clinic to better address patient medication management and education. Recruitment for these clinics will be conducted by the CCHP Health Education Specialist and will begin in Q1 2025.

8.4.3 Care Management

CCHP prioritizes the needs of its most vulnerable members through two essential programs, Enhanced Care Management (ECM) and Complex Case Management (CCM). ECM, designed for the most complex patients offers community-based case management, offering personalized, in-person interactions. This program targets diverse populations with unique needs, including homeless individuals, those at risk for avoidable hospitalizations, individuals with severe mental illness and substance use, those with a history of incarceration, children with a welfare background, and adults transitioning from skilled nursing facilities. In 2024, the ECM expanded again to include pregnant and postpartum women who are subject to racial and ethnic disparities (Black, American Indian or Alaska Native, or Pacific Islander women). Recognizing the intricate needs of these members, ECM enrollment is for one year, with the option to extend based on individual requirements. In contrast, CCM supports higher and medium-risk members not served by ECM, providing chronic care disease management and episodic interventions. The fluid transition between ECM and CCM ensures comprehensive care management.

In 2024, CCHP made significant investments to direct qualified individuals to ECM, leveraging the robust data infrastructure discussed in the risk stratification section above. The implementation of automated authorizations streamlined service access. The capacity of ECM providers increased from eight to 23 by year-end, showcasing CCHP's commitment to expanding capacity. CCHP made a concerted effort to increase referrals to these new community ECM provider groups. CCHP stands out as one of the leading health plans in the state for ECM provision, surpassing others in overall ECM enrollment relative to assigned Medi-Cal lives.

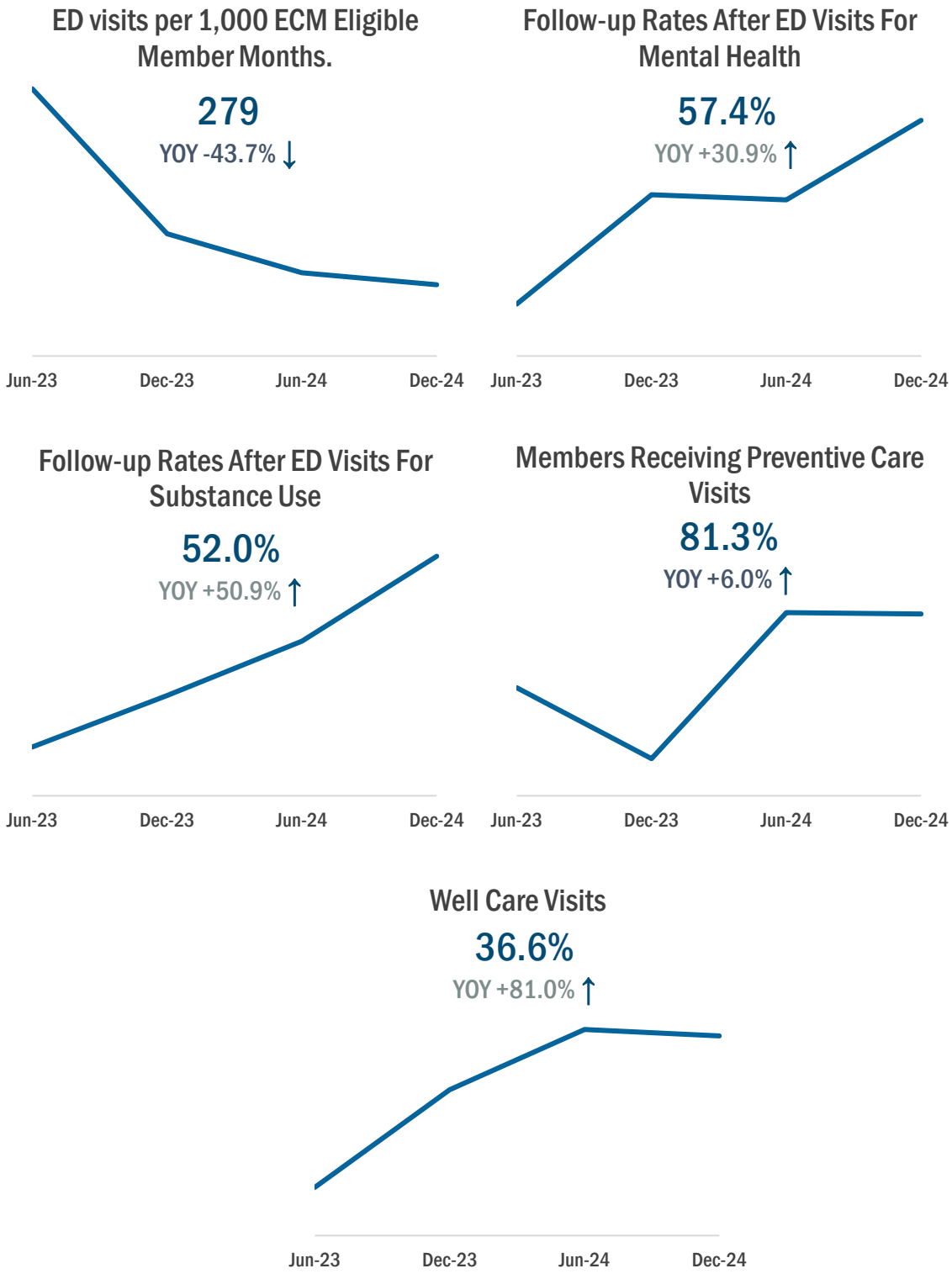
Table 7. Comparison of Enrollment in Care Management Programs

Care Management Program	2023	2024	% Change
ECM Population of Focus	6,488	7,706	18.8%
Adult High Utilizer	836	1,916	129.2%
Adult Homelessness Individual	1,081	1,707	57.9%
Adult SMI/SUD	806	1,595	97.9%
Child/Youth High Utilizer	453	1,278	182.1%
Child/Youth SED/CHR	138	510	269.6%
Adult Incarceration Transition	490	409	-16.5%
Adult LTC	30	321	970.0%
Child/Youth CCS/WCM	149	303	103.4%
Adult Homelessness Family	56	262	367.9%
Adult Nursing Facility Transition	30	215	616.7%
Child/Youth Homelessness Family	71	153	115.5%
Child/Youth Homelessness	30	138	360.0%
Child/Youth Welfare Hx	48	83	72.9%
Adult Birth Equity	-	41	-
Child/Youth Incarceration Transition	32	30	-6.3%
Child/Youth Birth Equity	-	18	-
Case Management	981	3,425	249.1%
Transitional Care Services	634	2,882	354.6%
Complex Case Management	200	400	100.0%
CCS Transitions	147	143	-2.7%

CCHP notably increased the number of members served in 2024 compared to 2023, especially for the Adult Long Term Care, Adult Nursing Facility Transition, Homeless Families with Adult CCHP members, and Unaccompanied Homeless Children populations of focus (POF). The RSS tiering discussed in 8.3 also lead to significant increases in Transitional Care Services and the number of members receiving Complex Case Management.

To assess impact of ECM, CCHP has begun trending several HEDIS measures for the ECM enrolled population: Emergency Department Visits/1000 Member Months, Follow-up for ED with Mental Health, Follow-up for ED with AOD, Adult Access to Preventive/Ambulatory Health Services, and Child and Adolescent Well Care Visits. Even with the Adult High Utilizer POF more than doubling in 2024, the number of ED visits per 1,000 ECM Eligible Member Months decreased over 43% at the end of 2024 compared to June 2023.The follow-up rates after ED visits for behavioral health reasons and the Adult Access to Preventive/Ambulatory Health Services increased as well. While there were notable improvements in the Child and Adolescent Well Care Visit rates, the rate for children receiving ECM is much lower than the overall CCHP average.

Figure 12. Select HEDIS Measures in the ECM Population.



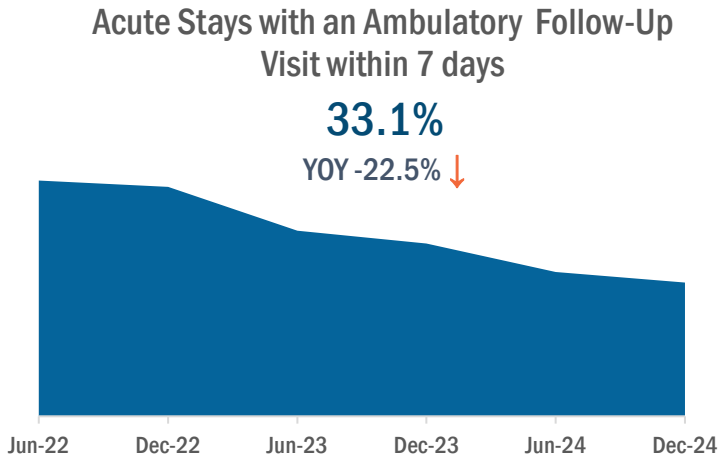
8.4.4 Transitional Care Services

Transitional Care Services (TCS) at CCHP focuses on facilitating the movement of members across different care settings, ensuring a smooth transition from hospitals to home-based or community settings. Essential services include comprehensive medication reconciliation upon discharge and post-discharge, linkage to a primary care appointment post discharge, review of discharge paperwork, and coordination of any post-discharge needs, which may include durable medical equipment, coordination of services, transportation, and other supports. High-risk individuals receive personalized care management, while low-risk individuals have direct access to coordination services.

In 2024, 2,882 members were successfully linked to a CCHP case manager for TCS, in addition to those members that had a pre-identified case manager through ECM or CCM at the time of discharge. This is an increase of over 355% compared to the number of members in TCS in 2023.

Throughout 2024, analyzed the DHCS Acute Stays with an Ambulatory Follow-Up Visit within 7-Days measure, which indicated 33.1% of individuals had an ambulatory visit within 7-days post-discharge. The identified barriers to achieving this target include timely identification of admissions, assigning a case manager promptly, and ensuring effective member engagement within a limited timeframe. To overcome these challenges and enhance efficiency, CCHP implemented auto referrals based on ADT feeds, as described in 8.3. After the implementation of these auto referrals in Q3, both the number of patients and the overall percentage of patients with a CM visit per quarter increased. CCHP will continue to trend these metrics over time and implement improvement activities as needed.

Figure 13. Acute Stays with a Timely Follow-Up Ambulatory Visit.



9 Patient Safety Activities and Projects

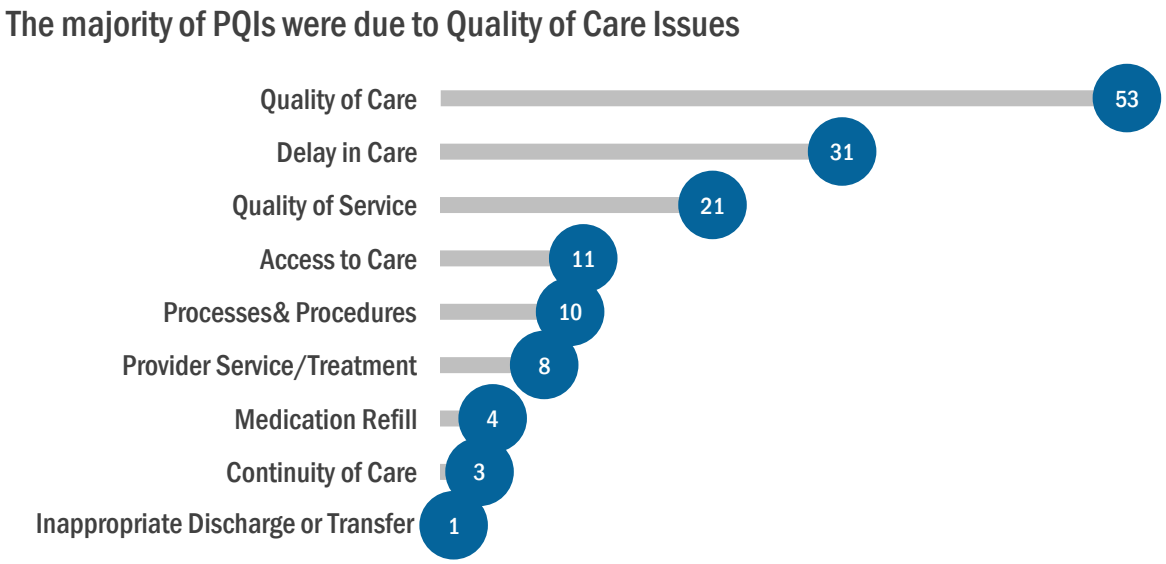
Patient safety is a top priority at CCHP, and various departments collaborate to address this critical aspect of healthcare. Routine reviews of data from sources such as grievances, appeals, access and availability metrics, claims, medical record review, HEDIS measures, satisfaction surveys, utilization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

9.1 Potential Quality Issues and Provider Preventable Conditions

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

During 2024, CCHP reviewed 264 cases, primarily referred through grievances, followed by utilization review. Of those cases 122 were determined to have no quality issue (level 0), 77 had minor issues (level 1), 48 moderate issues (level 2), and 17 presented significant quality issues (level 3). PQIs predominantly centered around Quality of Care. Through diligent follow-up, corrective action plans (CAPs) were initiated, empowering providers to enhance services and elevate overall care quality. All PQIs are protected under California Evidence Code 1157.

Figure 14. PQIs by Issue Type.



Compared to 2023, there was a slight decrease in PQI cases.

9.2 Pharmaceutical Safety

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

Throughout the reporting period, CCHP executed the outlined pharmaceutical safety activities to ensure the ongoing safety and appropriateness of medication regimens. For example, CCHP tracked, communicated with and provided education to 72 members being treated for Hepatitis C to ensure completion of therapy. Additionally, 74 letters were sent to providers alerting them of their patients who were currently taking the dangerous drug therapy combination of opioids and benzodiazepines. Continuous efforts in provider communication and patient education underscore CCHP's commitment to pharmaceutical safety, aligning with best practices in healthcare quality management.

9.3 Facility Site Review and Medical Record Review

CCHP prioritizes the adherence of primary care provider sites to local, state, and federal regulations to uphold patient safety standards. Stringent protocols ensure medical records comply with legal standards, documenting the provision of preventive care and effective

coordination of primary care services. Facility Site Review nurses conduct periodic full-scope reviews, addressing deficiencies through corrective action plans.

In 2024, CCHP completed 33 Facility Site Reviews, with 31 providers undergoing medical record reviews, totaling 381 records. This comprehensive assessment process identified areas for improvement, resulting in the formulation of 31 corrective action plans. Additionally, Physical Accessibility Review Surveys (PARS) were conducted for PCP sites, high volume specialists, ancillary providers, and community-based adult services providers, with 58 PARS completed during the year. The identified corrective actions and PARS contribute to an ongoing cycle of improvement, reinforcing CCHP's dedication to fostering a healthcare environment that prioritizes patient safety and regulatory compliance.

10 PROVIDER COLLABORATION

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

In 2024, CCHP completed Joint Operations Meetings with hospitals, SNFs, ECM, and CS providers and established a new framework for JOM meetings with doula providers. Four quarterly provider network trainings and 2 newsletters successfully provided updates and a forum for direct community with providers. Regular round meetings occurred between the Utilization Management (UM) and Case Management teams and hospitals to refine member transitions and discharge processes. The Quality and Health Equity Department continued bi-monthly quality meetings with individual FQHC quality teams, emphasizing focused discussions on quality improvement activities. Over 20 dedicated meetings transpired, focusing on reviewing quality measures and crafting active improvement initiatives. To ensure alignment on quality improvement efforts, the CCHP Quality Program Manager also participated in weekly meetings with RMC Quality Incentive Pool (QIP) teams focused on pediatric measures.

In 2024, CCHP launched its Pay-for-Performance (P4P) program to directly support and reward providers who deliver high-quality care and improve patient outcomes. The P4P

program focuses on key areas such as preventive care, chronic disease management, and maternal and child health. This program aims to align provider incentives with high-quality care by rewarding those who meet or exceed established performance benchmarks. By linking financial incentives to the achievement of quality measures, CCHP seeks to enhance patient outcomes, promote efficient care delivery, and foster a culture of continuous improvement. The program supports CCHP's commitment to delivering exceptional healthcare by rewarding provider groups that excel in their performance and achieve superior results for their patients. In the first year, provider groups with more than 15,000 assigned CCHP patients are eligible for incentives; in 2025 CCHP will expand the program to include provider groups with more than 2,000 CCHP members.

In 2024, leveraging enhanced provider engagement, CCHP has successfully strengthened its coordination and service delivery to members through effective partnerships. The year was marked by structured engagements, strategic meetings, and proactive communications, fostering collaborative initiatives, transparent communication channels with providers, and a steadfast commitment to continuous quality improvement.

11 DELEGATION

Delegated activities at CCHP are governed by a comprehensive delegation agreement, defining specific functions and responsibilities assigned to delegated entities. After the transition to the county Single Plan Model, Kaiser Permanente is no longer in the CCHP network and therefore, there are no delegated entities for Quality functions

As a sister organization, CCHP had previously extended its delegation to CCBHS for utilization management. In 2024, CCHP resumed oversight for UM functions and no longer delegates this activity to CCBHS.

12 CONCLUSION

12.1 BARRIERS

In 2024, CCHP successfully completed and met a large majority of the ambitious goals and objectives outlined in the 2024 Quality Work Plan. There were, however, some barriers to successfully meeting all objectives in the year.

One of the more challenging barriers stemmed from the complex regulatory landscape coupled with the rollout of simultaneous ambitious initiatives by DHCS. Navigating through the requirements associated with the implementation of the Single Plan Model and additional CalAIM initiatives, as well as efforts to launch a Dual-Special Needs Plan proved

to be demanding. These project rollouts required meticulous execution amidst competing priorities while ensuring ongoing compliance with existing statutes and organizational goals.

A significant barrier that CCHP encountered was the large membership increase in 2024 due to Blue Cross exiting the market in Contra Costa. CCHP saw an influx of 36,124 new members in January 2024, about ten times as many new members in an average month. This large influx of members will likely impact MY2024 HEDIS rates as they meet measure specific continuous enrollment criteria.

Addressing access and availability concerns, CCHP is actively engaged in expanding the provider network to improve appointment availability, particularly in specialties facing significant impact. At the end of 2024, CCHP made a significant expansion with bringing on the Sutter specialties in network.; however, challenges persist due to shortages of providers willing to accept Medi-Cal rates, especially in certain specialties. CCHP remains dedicated to the ongoing development of its population health services, with a focus on expanding transitional care services and refining processes to facilitate effective linkage and navigation for individuals at critical junctures.

12.2 Overall Effectiveness

CCHP achieved 4.5 stars in NCQA's Health Plan Report Card, the highest rating given to Medi-Cal plans in California. This endorsement is a recognition of CCHP's commitment to quality and patient care.

One of the primary indicators of CCHP's success is improved patient outcomes. CCHP's efforts in preventive care, chronic disease management, and care coordination have contributed to better health outcomes and enhanced overall patient well-being as demonstrated by the 17 MCAS measures that achieved the 90th percentile ranking of all Medicaid HMOs nationally.

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

Central to CCHP's quality program is the use of data-driven decision-making to inform our quality improvement efforts. CCHP has established robust data collection, analysis, and reporting mechanisms that provide actionable insights into our performance metrics, outcomes, and areas for improvement. By leveraging data analytics and performance

metrics, the quality department can identify trends, track progress, and make informed decisions to drive continuous quality improvement.

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

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

A critical aspect of our success is the continuous evaluation of our quality improvement program resources. The addition of health education staff has allowed for greater outreach and engagement with members. With these additions, we believe our current resources are adequate. Our current quality improvement committee and subcommittee structure are robust, ensuring a comprehensive approach to quality initiatives. The addition of the Equity Council in 2024 provided an additional layer of insight to our quality improvement and health equity efforts and has provided meaningful feedback to drive improvement. CCHP's CMO and other Medical Directors provide meaningful practitioner engagement and leadership in the quality improvement program, with fruitful meetings and valuable input from providers. The active participation and leadership in the quality program played a pivotal role in achieving strong quality results. Through strategic oversight, clinical expertise, and engagement with key stakeholders, the CMO and physician leadership helped drive data-driven decision-making and fostered a culture of continuous improvement. This leadership ensured the successful implementation of evidence-based interventions, ultimately enhancing health outcomes and performance metrics. This collaboration has further enriched our quality initiatives.

As we reflect on the year, CCHP acknowledges the adequacy of our quality improvement program resources, the effectiveness of our committee structure, and the active practitioner participation and leadership. Looking ahead, the quality improvement program for the subsequent year will maintain its current structure, with no major changes planned for 2025. This decision is grounded in the success and positive outcomes witnessed in our current approach.

The effectiveness of CCHP's quality program is evident in improved patient outcomes, enhanced patient experiences, and the positive impact on key metrics. By fostering a

culture of excellence, innovation, and continuous improvement, we remain dedicated to delivering exceptional healthcare services and achieving meaningful improvements in patient well-being. Our commitment to patient-centered care, data-driven decision-making, and a culture of continuous improvement positions CCHP as a leader in enhancing the quality, safety, and efficiency of healthcare delivery.

13 2024 Quality Work Plan and Evaluation of Activities

2024 Quality Improvement and Health Equity Transformation Program (QIHETP) Work Plan

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
1. QIHETP Structure				
1.1	***QIHETP Program Documents***	By March 2024, approve annual quality program documents at the March JCC meeting. Evaluate quality program to ensure that resources and priorities reflect organizational missions and strategies.	Conduct annual evaluation of the QIHETP program and develop written 2022 QIHETP Evaluation	Met. CCHP reviewed and approved the annual quality documents at the February 2024 Quality Council Meeting and at the March Joint Conference Committee Meeting. The annual plan and priorities served as a focal point for meetings with providers throughout the year.
1.2			Develop annual 2023 QIHETP Program Description, incorporating structural changes identified in the evaluation	
1.3			Develop annual 2023 QIHETP Work Plan, including monitoring of issues identified in prior years that require follow -up.	
1.4	***Quality Council***	Ensure Quality Council oversight of CCHP's quality program through regular meeting schedule	Convene monthly Quality Council meetings. Convene a minimum of 8 Quality Council meetings annually	Met. CCHP convened 8 Quality Council meetings in 2024. Program documents and policies were reviewed and updated in a timely fashion. Attendance remained strong.
1.5		Ensure program governance of Quality Council meeting	Revise Quality Council charter; approval of program description, evaluation and work plan	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
1.6		Ensure there are policies and procedures to meet regulatory and operational needs	Review CCHP policies annually and upon any new APL changes	
1.7	***Equity Council***	Ensure Equity Council oversight of the Quality Improvement and Health Equity Transformation Program through regularly scheduled meetings.	Implement the QIHETP work Plan and convene quarterly scheduled meetings	Met. CCHP convened 4 Equity Council meetings in 2024. Program documents were completed and presented at the Q1 meeting and policies were reviewed and revised as required.
1.8		Ensure program governance of Equity Council meeting	Create Equity Council Charter and ensure approval of program description, evaluation and work plan.	
1.9		Ensure there are policies and procedures to meet regulatory and operational needs to ensure health equity is woven into the fabric of the organization	Review CCHP Policies with a specific view of health equity annually and update policies per APL changes.	

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1.10	***Community Advisory Committee***	Ensure community feedback and incorporate member input into CCHP Quality and Health Equity policies and procedures	Engage with community-based organizations and CCHP members through Quarterly CAC meetings.	Met. CAC meetings were revamped to be more interactive, with nine new members recruited in 2024. Four meetings covered the 14 required topics; additional topics such as benefits, transportation, and appointment scheduling were discussed based on member interest.
2. NCQA Accreditation				
2.1	***NCQA Health Plan Accreditation***	By January 2024, ensure CCHP staff are trained and survey ready for the 2025 Health Plan Accreditation survey.	Organize kick off meeting and identify department team members	Met. The CCHP Quality Department met and trained with all departments to ensure a successful 2025 Health Plan Accreditation survey. Regular meetings were held with various departments to collect survey deliverables, with a mock file review being completed. Policies were updated as needed.
2.2			Complete training on new standards, review standards and guidelines, develop project plan and timeline for submission of materials to be ready for the 2025 survey	
2.3		Ensure deficiencies identified during the 2020-2022 NCQA accreditation survey are corrected and update policies and procedures as they related to new 2024 and 2025 NCQA Standards	Modify internal processes and report formats for any "not met" or "partially met" areas	
2.4			Revise policies and procedures according to new NCQA standards and guidelines	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
2.5	***NCQA Health Equity Accreditation***	By February 2024, identify NCQA Health Equity Accreditation survey and timeline.	As part of the NCQA Health Plan Accreditation, identify, the Health Equity Standards to be implemented	Met. CCHP scheduled the NCQA Health Equity Accreditation survey for Fall 2025. Staff were trained on standards and guidelines; policies and workflows were updated as needed.
2.6		Review NCQA Health Equity Accreditation 2024 standards	Complete training on health equity standards, review guidelines and develop project plan and timeline	
2.7		Program development of NCQA Health Equity Accreditation for implementation in 2025.	Create policies and procedures and systems to implement accreditation guidelines.	
3. Measurement, Analytics, Reporting, and Data Sharing				
3.1	**HEDIS Reporting and Quality of Clinical Care (DHCS, NCQA, DMHC)**	1. By June 15, 2024, report HEDIS MY2023 scores for NCQA Health Plan Accreditation, the DHCS Managed Care Accountability Set (MCAS), and the DMHC Health Equity and Quality Measures Set (HEQMS) 2. Exceed the 50th percentile for all MCAS measures and establish	Complete all annual HEDIS, MCAS, and HEQMS activities, including incorporating new measures and completing medical record abstraction.	Partially Met. CCHP achieved 4.5 stars in Health Plan ratings and high performance (over the 90th percentile nationally) in 17 MCAS measures. However, three MCAS measures were under the minimum performance level, lead screening, follow-up after ED visits for AOD, and topical fluoride application in children. CCHP began improvement projects on all three measures
3.2			Complete annual HEDIS MY2023 report, analyzing yearly trends and identifying areas for improvement. Incorporate report into Population Health Needs Assessment.	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
3.3		performance improvement plan for those near or at risk 3. Prepare for transition to ECDS by identifying efficiencies in data system measurement 4. Align HEDIS measurements to quality improvement projects and strategic goals for 2024	Identify areas of opportunity for data systems and data sources for MY2024	in 2024 and will continue with these projects in 2025. Data system improvements included improving coverage tables, reviewing enrollment files, standardizing LabCorps and Quest data files, working on standard supplemental data templates for providers, and improving local mapping on the following measures: FUM, FUA, EED, PPC, BCS, CCS, TFL-CH.
3.4			Develop and implement improvement projects targeting at risk measures and those measures that align with other strategic goals of CCHP	
3.5	**CCHP Quality Measurement Infrastructure**	Create quality dashboard and quality monitoring program with feedback loop to providers to allow for ongoing tracking of all HEDIS MCAS measures, including measuring disparities, trends by year, and current rates	Maintain CCHP quality metric dashboard, updating to include rolling 12-month measurements for MCAS MPL measures	Met. CCHP updated the Quality Dashboard to include rolling 12-month measurements for MCAS MPL measures. CCHP can stratify measures by providers groups and rates are shared with providers during regularly held quality meetings. Panel reports, Gap in Care reports, and Children due for Lead Screening Reports that are updated daily are now available to providers on the provider portal, allowing
3.6			Create quality feedback mechanism for providers, which will share performance rates by provider group on CCHP priority measures and identify unique areas of opportunities	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
3.7			Develop system of data sharing gap in care lists with CPN network to allow for ongoing quality improvement	CCHP to exchange data with providers in a secure fashion.
3.8	**Member Experience**	1. By June 30, 2024, gather, analyze, and highlight areas of opportunity using the CAHPS survey 2. Process 95% percent of grievances within required timeframes. 3. Develop member feedback channel through the Community Advisory Committee	Review and analyze CAHPS survey results trending results by year. Incorporate into Population Health Needs Assessment.	Met. CCHP completed and analyzed the CAHPS survey, behavioral health survey, interpreter services survey, and member experience surveys for the diabetes remote patient monitoring and asthma home remediation programs. These experience surveys were administered and results analyzed, with trending and comparison to benchmarks when available. The CCHP Medical Director regularly reported grievance data during Quality Council meetings and communicated that CCHP exceeded goals for grievance processes. The CCHP Quality Director presented and gathered input from the Community Advisory Committee during meeting throughout 2024. The input from the CAC was
3.9			Review and analyze the limited English enrollee survey	
3.10			Review and analyze behavioral health specific member experience surveys	
3.11			Develop report on MY2023 member experience	
3.12			Review and analyze grievance and appeals data according to NCQA methodology and review quality of service and quality of care. Complete annual report	
3.13			Develop survey tool for collecting member experience on population health programs	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
3.14			Gather member input on member experience utilizing Community Advisory Committee. Incorporate into annual Population Health Needs Assessment, Impact Report, and Strategy	incorporated into the SB1019 workplan and other population health documents.
3.15	**Provider Experience**	Implement standard process for collected provider experience and identify areas for opportunity	Implement Provider Experience Survey	Met. CCHP sent out a provider experience survey at the end of 2024 utilizing a new vendor. Results have not yet been received at time of the evaluation report.

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3.16	**Access to Care and Quality of Service (DMHC, DHCS)**	1.Review results of Provider Appointment Availability Survey and NCQA High Volume/High Impact specialists monitoring and develop and act on at least one opportunity for improvement.2. Implement quality monitoring program on timely access standards	Complete all access monitoring through surveys and secret shopper calls:*DMHC Provider Appointment Availability Survey*NCQA High Impact/High Volume specialists *OB/GYN and midwife providers survey on first prenatal appointment*Initial Health Appointment*After hour triage and emergency access*In-office wait time*Telephone wait times and time to return call*Call Center wait times*Shortening or Expanding timeframes*Skilled Nursing Facility placement	Met. Completed annual PAAS survey and additional monitoring activities as part of Annual Access report. CCHP met all urgent and non-urgent appointment standards for all lines of business, demonstrating improved performance compared to 2023. The report was submitted to DMHC and presented at May Quality Council and results were communicated back to provider groups.
3.17			Create comprehensive annual access report that identifies trends and identifies areas for opportunities	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
3.18			Develop feedback loop to providers on their results from the annual PAAS/NCQA survey, providing education and timely access standards.	
3.19	**CalAIM Reporting (DHCS)**	Complete all DHCS CalAIM reporting deliverables and maximize incentive dollars available through continuous improvement in pay for performance measures	Complete the quarterly CalAIM Population Health Monitoring Reports, reviewing key KPIs on population health metrics	Met. CCHP completed all reporting in a timely manner and engaged in DHCS workgroup on PHM Monitoring KPI metrics to provide feedback on new methodology and specifications.
3.20			Complete the DHCS Incentive Payment Program reporting	
3.21			Complete DHCS quarterly CalAIM ECM-CS Quarterly Monitoring Reports, reporting enrollment and utilization of CalAIM services	
3.22			Develop measure specifications and compete the transition to JSON report for CalAIM enrollment reporting	
3.23	**REAL and SOGI Data**	Improve collection of race, ethnicity, preferred spoken and written language data collection	Input new member REAL surveys into ccLink	Met. CCHP developed a process for ingesting Race, Ethnicity, And Language (REAL) data from new member surveys and race/ethnicity 834 data into the
3.24			Develop process for ingesting race/ethnicity 834 data into ccLink	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
3.25		Improve collection of sexual orientation and gender identity data	Modify new member packets to incorporate SOGI collection	EHR, ccLink. CCHP also developed a new SOGI form that was sent out to new members beginning in Q4.
3.26	**CLAS Reporting**	Ensure cultural and linguistic needs of population are being met by provider network	Conduct annual CLAS analysis of patient and provider population	Met. The results were presented at March Equity Council meeting.
3.27	**Encounter Data Validation (DHCS)**	Implement the encounter data validation study per the timelines and requirements from DHCS	Procure medical records and submit according to auditor's deadlines	Met. CCHP successfully completed the encounter data validation study with a 97.1% submission rate, higher than the state average of 90.6%. Omission rates for encounter data were consistently well under the 10% benchmark with high accuracy rates.
3.28	**Long-Term Care and Long-Term Support Services**	Develop quality measurement measure set that supports long-term care quality improvement and a systematic monitoring system for members with long term support services	Complete annual report on long term care and long-term support services	Met. The report was completed and presented at October Quality Council.
4. Performance Improvement Projects				

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
4.1	**Follow-Up After Emergency Department Visit for Mental Illness (FUM)**	Increase the percentage of members who complete a follow-up appointment within 30-days of an ED visit for mental illness. (Previously identified issue)	Conduct comprehensive analysis on FUM data to identify areas of opportunity; collaborate with Contra Costa Behavioral Health on improvement project	Met. CCHP conducted weekly meetings and ongoing collaboration with CCBH and the 2024 FUM rate is 54.5% (preliminary data). This puts CCHP above the minimum performance level of 53.8%. In addition to weekly meetings, CCHP enrolled in the IHI Behavioral Health Collaborative with CCBH and engaged with CCRMC QIP FUM/FUA Committee
4.2	**Follow-up for Emergency Department Visits after ED Visit Substance Use (FUA)**	Increase the percentage of members who complete a follow-up appointment within 30-days of an ED visit for substance use. (Previously identified issue)	Conduct comprehensive analysis on FUA data to identify areas of opportunity; collaborate with Contra Costa Behavioral Health on improvement project	Met. CCHP conducted weekly meetings and ongoing collaboration with CCBH on FUA, the rate increased from 32.31% in 2023 to 41.2% in 2024 (preliminary data). This 8.89%-point increase puts CCHP over the minimum performance level of 36.2%. (Percent change: +27.5%). In addition to weekly meetings, CCHP enrolled in the IHI Behavioral Health Collaborative with CCBH and engaged with CCRMC QIP FUM/FUA Committee

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
4.3	**Enrollment in Case Management after Emergency Department visit for Mental Health and Substance Use**	Increase the percentage of members who enroll in case management within 14-days of an ED visits for mental health or substance use. (Previously identified issue)	Develop workflow for authorizing and enrolling eligible individuals into case management after ED visit for mental health and substance use	Met. The rate of enrollment in case management of naive patients who visited the ED for mental health or substance increased from 0.9% in 2023 to 1.5% in 2024 (preliminary data), an increase of 0.6% points. (Percent change: +66.7%). CCHP implemented auto-referrals for patients in this population in late Q3.
4.4	**Blood Lead Screening**	Increase pediatric blood lead screening rates to exceed the DHCS MPL. (Previously identified issue)	Distribute lead outreach toolkit and lead education materials to providers	Not met. The preliminary 2024 data for LSC shows that the rate increased from 52.81% in 2023 to 63.0% in 2024. This increase of 10.19% points leaves CCHP just shy of the 63.8% target. (Percent change: +19.3%) Efforts to address this measure included outreach calls and mailers to patients due for screening.
4.5			Collaborate with providers with low lead screening rates to identify opportunities for improvement	
4.6			Increase provider awareness of lead testing options, including POCT and microcontainers	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
4.7	**Well Child Visits in First 6 Months of Life**	Narrow the health disparities gap between Black/African American and Asian members	Identify regional and provider level disparities in WCV completion performance and develop targeted improvement project.	Partially met. The health disparities gap between Asian and Black members increased from a difference of 11.7% in 2023 to 17.3% in 2024 (preliminary data), a difference of 5.6% points (+47.9% increase). CCHP identified that the provider group with the most opportunity for impact on this metric was RMC and implemented an outreach campaign to target members who had not been seen by their PCP in over 12 months for outreach and direct appointment scheduling. CCHP also conducted outreach to members under 15 months of age who were out of compliance with the expected cadence of their WCV and connected the members' caregivers to the PCP appointment lines.

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4.8	**Continuity and Coordination of Medical Care (NCQA)**	Improve continuity and coordination of member care between medical providers through at least 3 projects that meet NCQA standards.	Establish baseline report for projects and implement interventions	Abandoned. The NCQA requirements for QI3 & QI4 were revised and the resources to meet these requirements were incorporated into various improvement projects.
4.9	**Continuity and Coordination Between Medical Care and Behavioral Healthcare**	Improve continuity and coordination of member care between medical providers and behavioral health providers through at least 2 projects that meet NCQA standards.	Establish baseline report for projects and implement interventions	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
4.10	**Monitoring and rapid improvement cycles**	Develop process for monitoring MCAS and HEDIS measures and conduct rapid improvement for measures that are dipping below expected rates.	Develop and monitor dashboard and deploy rapid improvement outreach efforts where needed for measures.	Met. CCHP continuously monitored the MCAS dashboards and began improvement efforts as needed for lead screening in children (LSC), topical fluoride for children (TFL), and well-care visits in the first 15 months of life (W30-015). Outreach efforts were also implemented for FIT kit completions to impact the COL measure. Outreach efforts were implemented at the Access Line for follow-up measures after ED visits for mental health and substance use (FUM & FUA).
5. Population Health				
5.1	**Population Needs Assessment and Community Health Needs Assessment**	Understand member needs and health to create a responsive population health program	Complete MY 2023 population needs assessment according to NCQA guidelines	Met. CCHP completed a population needs assessment and presented to the Quality Council. Additionally, CCHP

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
5.2			Develop cross functional team collaborating with Contra Costa County Public Health in preparation for the 2025 Community Health Needs Assessment and Community Health Implementation Plan	joined the cross divisional CHA and CHNA workgroup to participate in the CHA planning process. CCHP advised the CAC about the workgroup and encouraged them to participate in the planning process and to give the county input on its findings and activities.
5.3			Engage CAC as part of CHNA process by reporting involvement and findings, obtain input/advice from CAC on how to use findings from the CHNA to influence strategies and workflows related to the Bold Goals, wellness and prevention, health equity, health education, and cultural and linguistic needs.	
5.4	**Population Health Management Strategy**	Develop population health strategy in alignment NCQA and DHCS requirements, involving delivery system, county, and community partners	Complete PHM Strategy in alignment with DHCS and NCQA guidelines	Met. Completed PHM Strategy and submitted on time to DHCS.

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
5.5	**Population Impact Report and Evaluation**	Develop framework for evaluating CCHP's population health program and measuring impact to ensure programs are achieved desired outcomes	Complete PHM Impact and Evaluation report	Met. Completed PHM Impact and Evaluation report to assess the Population Health Program.
5.6	**Initial Screening Process**	1. Provide streamlined new member experience, with regards to HIF/MET, IHA, LTSS, and other assessments. 2. Develop a new member outreach workflow to maximize Initial Health Appointments and New member survey completion 3. Ensure system exists so members with positive screenings are identified for the appropriate services 4. Develop data system so screening questions are results are shared across providers	Implement electronic HIF/MET and LTSS screenings utilizing myChart questionnaires	Partially Met. 1. Met: All positive screenings are referred to CHW providers and the IHA report was updated to incorporate HIF/MET responses. 2. Not Met: Electronic HIF/MET and LTSS screenings utilizing MyChart has been deferred to when CCHP has an active DSNP.
5.7			Develop and implement workflows with community health workers for following up on positive screenings	
5.8			Develop reporting for on-going monitoring of HIF/MET	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
5.9	**Initial Health Appointment**	Increase IHA completion rates. (Previously identified issue)	Conduct chart audits and give feedback and education to providers missing IHA elements	Partially Met. 1. Met: CCHP completed IHA audits and presented the findings at the May Quality Council.2. Not Met: IHA rates decreased slightly from 43.1% in FY22/23 to 42.8% in FY23/24. Text message and email reminders to complete the IHA were deferred.
5.10			Implement text message and email reminder for patients to complete Initial Health Appointment	
5.11	**DHCS Population Health Service/Risk Stratification, Segmentation, and Tiering**	1. Implement DHCS Population Health Service into existing workflows 2. Refine CCHP's risk stratification, segmentation, and tiering processes utilizing all available data sources	Implement DHCS Population Health Service based on forthcoming guidance upon service launch.	Met. No updates from DHCS regarding PHM Service
5.12			Modify RSS and Tiering and supporting workflows to incorporate the DHCS Population Health Services	
5.13	**Assessment and Reassessment**	Ensure annual assessment of Members with LTSS needs and CSHCN	Utilize custom assessment for SPDs and CSHCN and triage according to needs	Met. CCHP is currently utilizing the new custom assessment for new members to triage members with positive LTSS questions.
5.14		Ensure annual reassessment of Members with LTSS needs and CSHCN	Develop workflows to ensure annual reassessment of Members with LTSS needs and CSHCN	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
5.15	**Ongoing Engagement with PCP**	1. Increase regular engagement with PCPs 2. Close Member gaps in preventative care	Develop disengaged member reports to identify population	Met. CCHP participated in and provided significant support for the Contra Costa Health Assigned Not Seen project. Outreach staff conducted over 5,000 calls to patients ages 0-17 who had fallen out of care for over 12 months; leading to over 600 appointments completed by patients at the end of 2024. Reports were developed to identify patients ages 0-3 who have fallen off of the Brighter Futures well visit periodicity schedule to easily identify members for outreach and engagement. Gap in Care reports at the provider level were also developed to allow providers to more proactively identify their panel and close care gaps.
5.16			Develop workflows to connect disengaged Members with PCPs & close care gaps	
5.17	**Closed Loop Referrals**	Understand closed loop referral guidelines and implement technical system to support regulations	Develop workplan for implementing closed loop referrals based on DHCS guidance	Met. CCHP is on track to implement closed loop referrals for ECM and CS on 7/1/2025 per DHCS guidance.

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
5.18	**Community Health Workers, Care Coordination, and Navigation with Social Services**	Implement social resources into health education workflows and support referrals to CHW services	Develop referral process for CHW services based on identified social needs	Met. CCHP implemented a referrals process to CHW providers based on identified social needs.
5.19	**Wellness and Prevention Programs**	Improve preventative health of members with regards to: healthy weight, smoking/tobacco, physical activity, healthy eating, managing stress, avoiding at-risk drinking, identifying depressive symptoms	Implement Health Education Krames to have dynamic website that offers self-management tools.	Met. CCHP launched the healthed.cchealth.org website in Q3. CCHP advertised the new website and the available tools to members in the Fall newsletter and to CCHP providers at the provider network training. Telehealth asthma classes were recorded and made available online. In person classes are in development.
5.20			Educate providers and staff on available new health education tools	
5.21			Develop in person and telehealth classes to be facilitated by CCHP Health Educators	
5.22	**Colorectal Cancer Screening**	Increase colorectal cancer screening rates	Send out FIT kits monthly to Members due for colorectal cancer screening	Met. CCHP increased COL rates from 47.97% in 2023 to 58.6% in 2024 (preliminary data), an increase of 10.6% points (percent change +22.2%). Outreach staff conducted over 2,600 calls to patients to encourage them to complete their FIT kit test.

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5.23	**Chronic Disease Management**	Monitor Chronic Disease Management Programs	Monitor programs for the following chronic conditions: Diabetes, Cardiovascular Disease, Asthma, and Depression and identify any areas for improvement	Met. CCHP monitored activities in these programs and conducted PDSAs related to diabetes prevention and asthma education & remediation.
5.24	**Chronic Conditions: Diabetes Management Program**	1. Reduce number of CCHP members with uncontrolled diabetes 2. Increase the number of people enrolled in the Diabetes Prevention Program	Provide medically tailored people to patients with uncontrolled diabetes. Evaluate efficacy of MTM.	Met. In MY2023 CCHP achieved the 90th percentile for the Hemoglobin A1c Control (updated to Glycemic Status Assessment for Patients with Diabetes in MY2024) and was exceeding the target for the measure for MY2024, with an estimated GSD >9.0% of 31.8% (preliminary data). In 2024,
5.25			Continue expansion of remote blood glucose monitoring partnership with Gojji	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
5.26			Conduct PDSA with DPP provider to increase referrals & enrollment of prediabetic Members	CCHP referred 493 RMC members to Gojji and 350 enrolled. CPN patients saw increased access to Gojji services, with 287 enrolling in Gojji's diabetes RPM program in 2024. CCHP increased referrals to the contracted DPP provider from 63 in 2023 to 169 in 2024, with 87 consenting to services and 29 completing at least one visit. CCHP conducted an outreach PDSA to help outreach to 21 referred members and complete the sign-up process.
5.27	**Chronic Conditions: Asthma Mitigation Program**	Reduce the number of CCHP members with acute asthma exacerbations that require emergency department visits and/or hospitalization	Complete Bay Area Healthy Homes Initiative (BAHHI) data collection and reporting	Partially Met. 1. Met: CCHP successfully completed BAHHI data collection and reporting in Q2. In 2024, 217 CCHP members were referred to the CalAIM Asthma Home Remediation Program, with 14 of those referrals coming direction from Quality outreach

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
			Expand referrals to Asthma Home Remediation CalAIM Programs	efforts. Inpatient hospitalizations for asthma decreased from 0.6 IP stays per 1,000 members in 2023 to 0.3 IP stays per 1,000 members in 2024 (difference: -0.3 visits, percent change: -50.0%). The average number of admissions per patient decreased from 1.4 per member to 1.2. 2. Not Met. ED visits for asthma increased from 5.6 visits per 1,000 members in 2023 to 7.7 visits per 1,000 members in 2024 (difference: +2.1 visits, percent change: +37.5%). The average number of ED visits per person remained unchanged at 1.3 visits per person.
5.28	**Maternal Health Outcomes**	Improve key maternal health outcomes across quality measures	Develop reporting metrics for Baby Steps	Met. CCHP continues to exceed the minimum performance level for the Prenatal and Postpartum Care measures and expects to continue performance in the highest percentiles. CCHP opened 118 members to the Baby Steps case management
5.29			Develop brochures for pregnant Members	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
5.30			Increase the number of pregnant Members receiving Transitional Care Services (TCS)	program (now rebranded as Baby Steps) in 2024, compared to 41 in 2023. CM workflows and data reporting were updated and CCHP has enrolled at least 39 postpartum members in TCS. Additionally, in 2024 after targeted efforts, 47 CCHP members received 145 doula services in 2024 compared to 4 members receiving 26 services in 2023.
5.31	**Keeping Members Healthy: Gaps in Care**	Notify members of gaps in care for needed preventive services	Continue mailing adult birthday letters	Met. Over 90,000 letters were mailed to adult CCHP patients, with over 12,500 patients (14.0%) completing a health maintenance topic within 60 days of outreach. Pediatric wellness letters and health education handouts were developed during Q4 2024, with the goal of mailing the first letters by the end of Q1 2025.
5.32			Develop specific pediatric birthday letter that provider more specific information to members in terms of gaps in care	
5.33	**Health Education Materials and Resources**	1. Assure that members are provided health education materials and are informed on new community and	Publish member facing newsletter three times per year	Met. The CCHP Member Newsletter, Healthy Sense, was published in Spring, Summer, and Fall 2024. Printed copies

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
5.34		medical services.2. Develop comprehensive health education program	Develop health education plan, including the following: classes, provider-based strategy, direct patient outreach strategy, including triggering event notifications, community presence at CBOs, churches and school, and referral and request process for members, digital strategy for health education which may include email campaigns, care pathways, social media calendar, and health education council.	were mailed to each member household and email newsletters were sent to members with a valid email address on file. The CCHP Health Education team expanded from 1 Senior Health Education Specialist (SHES) to 2 SHES and 1 Health Education Specialist (HES). The HE Team has worked to develop virtual asthma classes, increased community presence at local FQHCs, and is continuing to expand our reach.
5.35	**Cultural and Linguistic Access**	Ensure systematic processes in place to promote cultural competency/health equity by making accessible: educational opportunities, current and up-to-date resources, and understanding of CLS needs.	Complete provider trainings and educate providers on interpretation requirements and resources, and reading level requirements	Met. Cultural & Linguistic Manager attended Provider Network Training in August 2024 to provide information on interpretation requirement, resources and reading level requirement. Instruction and resources for linguistic services were also sent to providers as needed.

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
5.36			Facilitate translation request of educational materials, website, forms, and other documents.	Met. Cultural & Linguistic manager facilitates and coordinates translation request and ensure materials are available in threshold languages.
5.37			Review CLAS grievances	Met. Cultural & Linguistic manager collaborate with Appeals and Grievance department to review all grievances related to discrimination and linguistic access; also reports these grievances to Equity Council quarterly.
5.38	**EPSDT / Medi-Cal for Teens and Kids**	1. Ensure coverage of and timely access to all medically necessary EPSDT services to correct or ameliorate defects and physical and mental illnesses and conditions. 2. Ensure Members <21 must receive all age-specific assessments and services required by MCP contract and AAP/Bright Futures periodicity schedule.	Create quarterly reporting to track and trend denials for Members <21 years old	Met. CCHP created a report to easily identify members ages 0-3 who have fallen out of compliance with the AAP/Brighter Futures periodicity schedule. The report is available on a real time basis to network providers via the EHR provider portal. Additionally, notifies members about their EPSDT benefits and services through the Member Newsletter and online at the cchealth.org website. CCHP has developed a
5.39			Create report to identify Members who are out of compliance with AAP/Brighter Futures periodicity schedule. Create workflows for outreach and education for identified Members.	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
5.39		3. Ensure provision of Medically Necessary Behavioral Health Treatment. 4. Ensure compliance with all Case Management & Care Coordination requirements. 5. Inform Members <21 about EPSDT, including benefits of Preventive Care, services available under EPSDT, where & how to obtain these services, and that transportation & scheduling assistance is available. Must be provided annually or within 7 days of enrollment for new members. 6. Ensure all network providers completed EPSDT-specific training no less than every 2 years using DHCS materials.	Develop standardized process and procedures for annual notification to Members <21 years old	report to identify providers who are non-compliant with the DHCS EPSDT training, which is emailed monthly to relevant stakeholders for follow-up. CCHP conducted two email campaigns to non-compliant providers informing them of state requirements. Quarterly monitoring is in progress for all activities.
5.40			Develop report to identify providers who need to complete DHCS EPSDT training	

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5.41	**Case Management Services**	Utilize RSS to identify individuals eligible for CCM, ECM, and other services and ensure eligibility for these services	Monitor automatic authorization pathways and utilize new and expanded data sources to expedite enrollment into ECM and CCM	Met. CCHP implemented automated referrals for SMI/SUD ECM and finalized the process for CCM auto referrals beginning in Q1 2025.
5.42	**Transitional Care Services**	Ensure all high-risk members receive transitional care services. (Previously identified issue)	Develop ADT feeds and supporting workflows to utilize ADT feeds, including automating referrals and incorporating ADT feeds into care pathways and monitoring reporting	Met. CCHP developed ADT feed reporting and incorporated it into Follow-up for ED measures. CareEverywhere is available on the ccLink Provider Portal so CCHP providers can view recent admissions. CCHP developed a process for high risk TCS members to be identified through ADT feeds and get automatically assigned a TCS care manager. The health plan implemented a dedicated phone number for low-risk members to contact for discharge care coordination that is placed into local area hospital discharge instructions.
5.43			Develop workflow to re-share ADT feeds with PCPs and ECM providers	
5.44			Develop oversight process on discharge planning process	
5.45		Ensure transitional care services support for low-risk members	Create dedicated phone number for member contact and support for low-risk members	
6. Patient Safety				

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
6.1	**Potential Quality Issues (PQIs)**	Review and resolve potential quality issues within 120 days	Issues CAPS according to leveling guidelines, report on trends. Modify ccLink workflow for ease of reporting	Met. CCHP met timeframes on all PQIs.
6.2	**Provider Preventable Conditions (PPCs)**	Review and investigate PPC through the PQI process	Capture all PPCs through accurate reports, Investigate all identified PPCs. Report to DHCS and track all confirmed PPCs, Provide education on PPCs for contracted network	Met. CCHP investigated all PPC. Education on PPCs was provided during quarterly network training.
6.3	**Over/under utilization - ED Use**	Develop a standard over-underutilization report and develop standards with how reporting is used to improve care	Define measures to track and identify areas of opportunity for improvement initiatives	Met. CCHP completed UM identified measures for standard O/U report. Included for July QC.
6.4	**Medication Safety**	Reduce concurrent prescribing of opiate and benzodiazepine	Provide quarterly reports to providers on patients that are co-prescribed opioids and benzodiazepines	Met. 74 letters were sent to providers alerting them of their patients who were currently taking the dangerous drug therapy combination of opioids and benzodiazepines/anti-psychotics.
6.5		Reduce concurrent prescribing of opioids and anti-psychotic medications	Provide quarterly reports to providers on patients that are co-prescribed opioids and anti-psychotics	

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6.6		Antipsychotic, anti-depressant and mood stabilization prescriptions for children	Quarterly audits to determine if these medications that are being prescribed to children have a qualifying diagnosis	Met. CCHP completed quarterly audits.
6.7		Improve Hepatitis C medication adherence	Review HepC medication to ensure that members are fully completing their course of treatment	Met. CCHP tracked, communicated with and provided education to 72 members being treated for Hepatitis C to ensure completion of therapy.
6.8		Reduce number of members with 15 or more medications	Review CCHP members with 15+ prescriptions, develop personalized recommendations when appropriate and refer members to case management	Met. CCHP pharmacy reviewed medications and referred individuals to CCHP case management.

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6.9		Ensure members can get their prescriptions filled after ED discharge	Audit Emergency Department discharges with prescriptions and confirm that individuals were able to fill their prescriptions; educate pharmacies on prescription benefits. Additionally, this quarterly audit will look for members with 4 or more ED visits in a 6-month period and refer them to case management.	Met. Completed ED visit audit and educated pharmacies on benefits.
6.10		Reduce prescription opiate abuse	Review potential unsafe prescriptions where members have multiple opiate prescriptions from multiple prescribers and pharmacies—refer to case management for potential follow up with members and providers	Met. Reviewed unsafe combinations and referred individuals to case management for review.

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6.11	**Facility Site Reviews**	Ensure PCP sites operate in compliance with all applicable local, state, and federal regulations, and that sites can maintain patient safety standards and practices.	Complete an initial Facility Site and Medical Record Review and the Physical Accessibility review Survey for newly contracted PCPs. Conduct periodic full scope reviews for PCPs. Complete corrective action plans for cited deficiencies.	Met. Completed all scheduled FSR, MRR, and PARs. Developed and tracked corrective action plans with providers.
6.12	**Medical Record Reviews**	Ensure medical records follow legal protocols and providers have documented the provision of preventive care and coordination of primary care services.	Conduct MRR of provider office in accordance with DHCS standards.	Met. Completed all scheduled MRR according to DHCS standards. Developed and tracked corrective action plans as necessary
6.13	**Clinical Practice Guidelines**	Review clinical practice guidelines with Quality Council and train providers on practice guidelines	Annually Review and approve Clinical Practice Guidelines at Quality Council	Met. The Clinical Practice Guidelines were presented and unanimously approved at the November Quality Council. The previously approved Clinical Practice Guidelines were distributed in the Q1 2024 Provider Bulletin and during the Q1 Provider Network Training.
6.14			Distribute and educate providers on Clinical Practice Guidelines during quarterly provider trainings and in quarterly newsletter	
6.15	**Long Term Care Facility Reviews**	Ensure members that were recently carved into Medi-Cal are receiving optimal care while they are in skilled nursing facilities	Develop monitoring plan for long term care facilities	Met. CCHP completed a long-term care monitoring report and presented it for review at October Quality council.

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7. Provider Engagement				
7.1	**Provider training**	Conduct quarterly provider network trainings, increase attendance and satisfaction with trainings.	Develop and implement four Quarterly trainings covering a range of topics including regulatory changes/updates and topics that matter most to providers; solicit input from providers on agenda topics	Met. CCHP conducted 4 quarterly network trainings.
7.2	**Quality Provider Meetings**	Conduct quality meetings with provider groups to discuss quality measures and improvement plans	Meet with the largest provider groups on a regular basis to discuss quality topics	Met. CCHP met with all FQHC provider groups on a bimonthly basis throughout 2024.
8. Delegation Oversight				
8.1	**Delegation oversight**	Review credentialing and UM files to ensure Behavioral Health CMU is in compliance	Report out delegation oversight activities annually during Quality Council.	Met. CCHP completed the delegation oversight report and presented during February Quality Council meeting.