CONTRA COSTA COUNTY

AGENDA - PUBLISHED

Contra Costa Health Plan Joint Conference Committee

Friday, April 4, 2025 **9:30 AM** **Conservation & Development, 30 Muir Road, Martinez | https://cchealth.zoom.us/j/7415624178?omn=98639834127 | Call in:1 (646) 518-9805 access code: 741 562 4178**

Agenda Items: Items may be taken out of order based on the business of the day and preference of the Committee

1.1 Roll Call and Introductions

1.2 Agenda **25-1220**

Attachments: JCC Agenda - 04.04.2025 FINAL

1.3 Approve December 13, 2024, Minutes **25-1221**

Attachments: JCC Meeting Minutes 12.13.24 - Executed

1.4 Public comment on any item under the jurisdiction of the Committee and not on this agenda (speakers may be limited to two minutes).

1.5 JCC Comments

2.0 Responding to Federal Threats to California's Public Health Care Systems **25-1239**

Attachments: Responding to Federal Threats to California's Public Health Care Systems

3.0 Presentation - Healthcare Literacy Council **25-1240**

Attachments: Presentation - Healthcare Literacy Council

4.0 Interim Chief Executive Officer/Chief Medical Officer Report

4.1 CCHP Staffing Update **25-1241**

Attachments: CCHP Staffing Update

4.2 Summary of Regulatory Audits **25-1242**

Attachments: Summary of Regulatory Audits

4.3 DHCS 2024 Medical Audit Findings **25-1243**

Attachments: DHCS 2024 Medical Audit Findings

4.4 Public Health ECM Focused Audit **25-1244**

Attachments: Public Health ECM Focused Audit

4.5 D-SNP Status - High Level Overview of Project Plan/Strategy **25-1245**

Attachments: D-SNP Status - High Level Overview of Project Plan/Strategy

5.0 Quality Program Report **25-1246**

Attachments: Quality Program Report

5.1 Quality & Health Equity Evaluation, Program Description, and Work Plan Approval **25-1222**

Attachments: 2024 Quality Program Evaluation
2025 QIHETP Program Description
2025 QIHETP Work Plan

6.0 Focus Topics

6.1 Behavioral Health Focus Audit Update **25-1247**

Attachments: Behavioral Health Focus Audit Update

6.2 Member Appeals & Grievances **25-1248**

Attachments: Member Appeals & Grievances

6.3 Compliance Report **25-1249**

Attachments: Compliance Report

7.0 Progress Report

7.1 Executive Dashboard **25-1250**

Attachments: Executive Dashboard

7.2 Finance Report **25-1251**

Attachments: Finance Report

7.3 Next Meeting Reminders - 2025 **25-1252**

Attachments: Next Meeting Reminders - 2025

8.0 Adjournment

The Committee will provide reasonable accommodations for persons with disabilities planning to attend the Committee meetings. Contact the staff person listed below at least 72 hours before the meeting. Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the County to a majority of members of the Committee less than 96 hours prior to that meeting are available for public inspection at 595 Center Ave., Martinez, during normal business hours. Staff reports related to items on the agenda are also accessible online at www.contracosta.ca.gov. If the Zoom connection malfunctions for any reason, the meeting may be paused while a fix is attempted. If the connection is not reestablished, the committee will continue the meeting in person without remote access. Public comment may be submitted via electronic mail on agenda items at least one full work day prior to the published meeting time.

For Additional Information Contact: Norman Hicks at norman.hicks@cchealth.org

File #: 25-1220 **Agenda Date:** 4/4/2025 **Agenda #:** 1.2

Contra Costa Health Plan/Board of Supervisors
Joint Conference Committee

Friday, April 4, 2025
9:30 AM – 11:30 AM Pacific Time
Join us in Person:
Conservation & Development, ZA Conference Room, 30 Muir Road, Martinez, CA

The public may also attend this meeting remotely – information provided below
Join Zoom Meeting: https://cchealth.zoom.us/j/7415624178?omn=98639834127
If the link does not work, please type it into your browser
Join Via Call-In: +1 (646) 518-9805 Meeting ID: 741 562 4178

AGENDA

Tab	Item	Presenter
1.0	**Call to Order**	Supervisor Diane Burgis
	1.1. Roll Call	Dr. Irene Lo, Interim CEO
	1.2. Agenda	JCC Members
	1.3. Approve December 13, 2024, Minutes	JCC Members
	1.4. Public Comments	Public
	1.5. JCC Comments	JCC Members
2.0	**Responding to Federal Threats to California's Public Health Care Systems**	Erica Murray, President and CEO, CAPH
3.0	**Presentation – Health Care Literacy Council**	Supervisor Diane Burgis Michael Miller, Brown-Miller Communications Deneen Wohlford, Kaiser Permanente
4.0	**Interim Chief Executive Officer/Chief Medical Officer Report**	Dr. Irene Lo, Interim CEO
	4.1 CCHP Staffing Update	
	4.2 Summary of Regulatory Audits	
	4.3 DHCS 2024 Medical Audit Findings	
	4.4 Public Health ECM Focused Audit	
	4.5 D-SNP Status – High Level Overview of Project Plan/Strategy	
5.0	**Quality Program Report**	Elizabeth Hernandez, Quality Director
	5.1 Quality & Health Equity Evaluation, Program Description, and Work Plan Approval	
6.0	**Focus Topics**	
	6.1 Behavioral Health Focus Audit Update	Dr. Nicolás Barceló, Medical Director
	6.2 Member Appeals & Grievances	Dr. Nicolás Barceló, Medical Director
	6.3 Compliance Report	Chanda Gonzales, Compliance Officer
	6.3.1 Fraud, Waste, & Abuse	
	6.3.2 Compliance Workplan	
7.0	**Progress Report**	
	7.1 Executive Dashboard	Bhumil Shah, Chief Digital Officer
	7.2 Finance Report	Brian Buchanan, Interim CFO
	7.3 Next Meeting Reminders – 2025	
8.0	**Adjournment**	Supervisor Diane Burgis

Next Meeting is Friday, June 6, 2025
Meetings are customarily scheduled on the 1st Friday of the last month of the quarter
Materials distributed for the meeting are available for viewing at the Contra Costa Health Plan, 595 Center Ave, Suite 100, Martinez, CA

HOW TO PROVIDE PUBLIC COMMENT:

Persons who wish to address the Contra Costa Health Plan/Board of Supervisors Joint Conference Committee (JCC) during public comment on matters within the jurisdiction of the JCC that are not on the agenda, or who wish to comment with respect to an item on the agenda, may comment in person, via Zoom, or via call-in. Those participating in person should come to the podium when called upon. Those participating via Zoom should indicate they wish to speak by using the "raise your hand" feature in the Zoom app.

All public comments will be limited to two minutes per speaker.

For assistance with remote access contact: email cynthia.choi@cchealth.org or direct message Cynthia Choi during the Zoom meeting.

Public comments may also be submitted before the meeting by email to compliance@cchealth.org. Comments submitted by email or voicemail will be included in the record of the meeting but will not be read or played aloud during the meeting.

CONTRA COSTA
HEALTH

File #: 25-1221 **Agenda Date:** 4/4/2025 **Agenda #:** 1.3

Contra Costa Health Plan / Board of Supervisors
Joint Conference Committee Meeting Minutes
December 13, 2024 | 9:30 AM – 11:30 AM

Present:

Supervisor Candace Andersen, District II*
Supervisor Diane Burgis, District III*
*JCC Voting Member

Dr. Kimberly Ceci, Lifelong*
Dr. Gabriela Sullivan, CCRMC*

Sharron Mackey, CEO
Dr. Irene Lo, CMO
Brandon Azevedo
Melissa Bailey
Dr. Nicolás Barceló
Brian Buchanan
Sonia Bustamante
Dr. Nusrat Chaudhry
Dr. Michael Clery
Aaron Graessley
Cynthia Choi
David Culberson
Ian Greer
Sonia Escobar
Norman Hicks
Karl Fisher
Phil Froilan
Chanda Gonzales
Bruce Gorman
Joanna Gudino
Will Harper
Nikita Hughes
Elizabeth Hernandez
Matt Kauffman
Sarah Kennard
Clifton Louie
Hua Hsuan "Allison" Lui
Wendy Mascitto
Alicia Nuchols
Jill Ray
Paul Reyes
Heather Roberts
Rhonda Rochon Smith
Anna Roth
Darwin Seegmiller
Bhumil Shah
Dr. Samir Shah
Sylvia Taqi-Eddin
William Walker

SUBJECT	DISCUSSION	ACTION / WHO
1.0 Call to Order	**1.1 Roll Call** Supervisor Diane Burgis called the meeting to order on December 13, 2024, at 9:31 AM.	Supervisor Diane Burgis
	1.2 Agenda Agenda for December 13, 2024, reviewed and approved by Supervisor Diane Burgis.	JCC Committee
	1.3 Approve September 19, 2024, Minutes The minutes from September 19, 2024, were approved unanimously.	JCC Committee
	1.4 Public Comment None.	Public
	1.5 JCC Comment None.	JCC Members

2.0 **CEO Updates**	**<u>2.1 Operational Effectiveness</u>** Quick Wins: Starting with quick wins will deliver demonstrable value and build organizational momentum for further performance improvement. Organizational Effectiveness: CCHP is launching a governance process including decision rights, key metric dashboards, review meetings, management expectations, and escalation. We are aligning on organizational priorities and developing results-oriented key performance indicators (KPIs). Core Operational Functions: CCHP has enabled key member self-service functionality (e.g., primary care provider selection/change), enhancing provider education (e.g., claim submission process), and we have automated delegated provider rosters to ensure network accuracy. Shared Services/Health System Enablers: CCHP is resolving operion corrective action plans (CAPs). We are also publishing and socializing regulatory based compliance calendars. Post Assessment Next Steps: In early December, assessment meetings occurred with the leads from each department. KPIs were identified and departmental RACI (Responsible, Accountable, Consult, Inform) charters were designed. A project manager (consultant) was hired, and we continue to work with HR to recruit key positions such as the COO, Director of Compliance, and Utilization Management Nurse Managers. This will be an 18-month journey, 12/1/2024 through 6/1/2026 ***Question / Dr. Gabriela Sullivan:*** *What do you mean by Automated Provider rosters?* ***Answer / Sharron Mackey and Sonia Escobar:*** *Large providers such a Sutter and Stanford were sending updates to us in paper. IT has configured a way to take the provider rosters and upload them to PMIS and then PMIS sends the rosters out to be published.* **<u>2.2 Dual Eligible Special Needs Plan (D-SNP)</u>** We are addressing two major priorities related to D-SNP: • Modification to the Knox Keene license as required by the Department of Managed Healthcare (DMHC) • Updating and refiling the PerformRx contract CCHP is adding dental and vision benefits to the D-SNP for the first year to stay competitive, utilizing existing county contracts. Renegotiations with key providers, John Muir Health and Sutter Health, are expected to be completed by mid-January. ***Question / Supervisor Candace Andersen:*** *Is there a chance that we won't make the February deadline for these negotiations?* ***Answer / Sharron Mackey:*** *We are 150% committed to making the February deadline. The Model of Care, which is a very challenging component, has been drafted. We will have consultants score it internally. Also, CCHP added a certified project manager to the team.* **<u>2.3 CalAIM Centers Status</u>** To ensure the community was fully vested and informed of the CalAIM benefits, we developed the CalAIM Centers. The Supervisors nominated Community Based Organizations (CBOs) in their districts. Each CalAIM Center will be awarded $80,000 grant for a two-year period, 2025 – 2026.	Sharron Mackey, CEO Sharron will send a monthly status report to the Board.

	Outreach Specialists and Health Educators will establish weekly operating hours at the Centers. The following CBOs were chosen as the initial five CalAIM Centers: • Discovery Counseling Center – (Danville) • Opportunity Junction – (Antioch) • Monumental Impact – (Concord) • RYSE Center – (Richmond) • Brentwood Senior Activity Center – (Brentwood) **2.4 Legislative Update** The Medicaid program is entering a time of uncertainty under the new administration. Analysis from the health care trade affiliations project cuts to Medicaid and Obamacare. The proposed tariffs could increase the cost of medical care, and we expect reversals on some of the Biden health care policies. Looking at new Assembly and Senate bills for 2024-2025 implementation, there were 39 new bills signed by the Governor, 27 bills sponsored by the Assembly, and 12 bills sponsored by the Senate. Every department in the health plan is impacted by the legislated activity. There are many bills on emergency medicine, behavioral health, and women's health.	

3.0
Chief Medical Officer's Report
	3.1 Challenges with the D-SNP Model of Care
	The Model of Care (MOC) is the foundational framework guiding CCHP's delivery of D-SNP services and ensuring that all providers are aligned in delivering high-quality, patient-center care. This is a Centers for Medicare and Medicaid Services (CMS) requirement for all Medicare Advantage Special Needs Plans.
	
	Through the patient centered approach, there is an emphasis on prevention with routine visits, individualized goals of care, and medication management. We focus on outcomes by reducing avoidable hospitalization, reducing complications, and creating positive patient outcomes. Lastly, we focus on quality and embrace a "Care Team" approach by providing clear quality indicators and reporting progress to CMS.
	
	Currently the MOC is a robust and collaborative effort among multiple departments at CCHP, but we face challenges from:
	• Integration of Care Across Providers for Medicaid and Medicare
	• Care Coordination and Case Management
	  ○ Training care coordinators/managers
	  ○ Developing effective workflows
	  ○ Timely access to services
	  ○ Addressing the Social Determinants of Health
	• Quality Measurement and Reporting as required by CMS
	
	Question / Supervisor Diane Burgis: *Approximately how many people are with D-SNP?*
	
	Answer / Dr. Irene Lo: *We are conservatively estimating under 8,000 in our first year.*
	
	3.2 Long Term Care Issues
	Long Term Care (LTC) was carved in as a benefit to managed Medi-Cal in 2023. Issues have been encountered with care coordination between providers, integration of services, and provider network adequacy.
		Irene Lo, MD, CMO

	Currently, the care team collaborates interdepartmentally, holds regular meetings with the LTC providers, and closely monitors the grievances to look for potential quality issues. We have implemented several processes to increase operational effectiveness and increase continuing education for our members and providers. **3.3 Closed-Loop Referrals** DHCS defines a closed-loop referral (CLR) as a referral initiated on behalf of a Medi-Cal managed care member that is tracked, supported, monitored, and results in a known closure (i.e., member receiving services). CLRs are a key component of the DHCS Population Health Management Program under CalAIM. Though the initiative has a launch date of July 1, 2025, CCHP is proactively integrating it into the health plan. The priority services will be Enhanced Care Management and Community Supports. The goal is to increase the share of Medi-Cal members successfully connected to the services they need by identifying and addressing gaps in referral practices and service availability. The key requirements per DHCS are tracking member referrals, supporting referrals, and monitoring member referrals. **3.4 Transitions of Care** This program was initiated by the DCHS in 2023 and is part of the Population Health Management Program. It ensures that the health plan plays a role in care coordination, the members receive the care that they need, and the prevention of readmissions. The care team consists of the Chief Medical Officer, a Medical Director, CalAIM, Case Management, Behavioral Health, and Utilization Management. Collaboration is inter-departmental. There are regular meetings with hospitals and facilities to discuss discharging patients. Joint Operation Meetings (JOMs) are held at set times throughout the year with larger hospital and health care networks. Educational meetings are held to train providers on the program.	
4.0 Quality Program Report	**4.1 Health Equity / Cultural & Linguistics** Health Equity It is CCHP's goal that equity is incorporated into every program and initiative throughout the health plan, that we collaborate with communities to address barriers to care, and that we re-think current initiatives to improve outcomes. The framework for equity comprises the needs and feedback of members, community-based collaborations, national Culturally and Linguistically Appropriate Services (CLAS), NCQA health equity standards, and DHCS/DMHC equity initiatives. To understand where some of our disparities and areas of improvement exist, we look at gaps in quality measures. Asthma medication, prenatal care and postpartum care have the smallest gaps in White and Asian communities. Childhood immunizations and lead screening in children have the largest gaps in Black/African American and Asian communities. Equity is focused on improvement projects. Some inflight projects are: • Well care visits for children and adolescents • Pre-diabetic/diabetes outreach for disease management programs • Colorectal cancer FIT kit returns.	Elizabeth Hernandez, Quality Director

	Projects in the planning phase are: • Maternal health programming • Barriers to immunizations • Cervical cancer screening ***Question / Supervisor Diane Burgis:*** *Related to immunizations, is the disparity number consistent with pre-Covid numbers?* ***Answer / Elizabeth Hernandez:*** *Across the board nationally we have seen a decrease in immunizations.* ***Question / Supervisor Diane Burgis:*** *Related to childhood immunizations, are the parents not pursing it or are they rejecting it?* ***Answer / Elizabeth Hernandez:*** *That is a hard question to answer. What we can see is that children are getting into the doctor's office, but when they are there, they aren't taking the flu immunization shot.* <u>Cultural & Linguistics</u> About one third of our members prefer to be spoken to in a language other than English. Every month, about 20,000 members use the interpreter services. Over 500 people responded to the annual survey in 2024 and 72% of them used the service in the last six months. 77% of them responded positively to being able to have an interpreter, while 19% indicated they always or usually have friends/family interpret for them. Notably, 95% of the respondents felt their doctor showed respect for what they had to say. We are working to increase member awareness of the right to interpretation services, improve our Community Provider Network education on interpreter services usage, and follow-up on complaints and grievances related to language access. ***Question / Dr. Gabriela Sullivan:*** *There are many new technologies and vendors coming out. I'm wondering how CCHP might be looking at all the new services becoming available.* ***Answer / Elizabeth Hernandez:*** *CCHP tends to use whatever the wider delivery system uses, and I think that will continue to be the case.* ***Question / Dr. Gabriela Sullivan****: When patients are referred out to specialty care, we have heard that many of those vendors will not see patients that speak other languages.* ***Answer / Dr. Irene Lo:*** *We are very aware of this. One of our key priorities in our provider outreach is to let people know what access is available for interpreter services.*	
5.0 **Focus Topics**	**<u>5.1 Behavioral Health Update</u>** Improvements are underway in the Behavioral Health (BH) Department. We have a Memorandum of Understand (MOU) with county Behavioral Health Services (BHS) and Regional Center of East Bay (RCEB). We continue to partner with local emergency rooms to increase the quality of post-discharge care for members presenting with MH/SUD concerns, and we have revised referral processes to decrease the burden on primary care providers (PCPs) to access Neuropsychology consultations.	Nicolás Barceló, MD Medical Director

	Also, in response to SB-1019, we began new outreach initiatives related to the National Standards for Mental Health Services, and we are always looking for ways to refine and improve our authorization processes for mental health services for CCHP commercial members. ***Question / Supervisor Candace Andersen:*** How are we integrating our incarcerated population with behavioral health? ***Answer / Nicolas Barcelo:*** I can get back to you with more up-to-date information. The linkage to the justice involved population is a new benefit. BHS has been taking the lead in terms of ensuring that initial linkage. ***Question / Supervisor Diane Burgis:*** *With the Care Court coming, what kind of impact is that going to have on BHS?* ***Answer / Nicolas Barcelo:*** *Regarding A3 services, I would defer to our colleagues in BHS who are operationally leading the initiative. Regarding Care Court, we have not yet received petitions, but those petitions would go first to BHS for evaluation and consultation with the courts about treatment plans. For Medi-Cal members, there will be synergy with Community Supports and other resources available through the managed care plan.* ***Question / Supervisor Diane Burgis:*** *We probably can anticipate psychiatric inpatient and some of the more intense types of treatment. Will there be more of a burden on our systems, creating some challenges for us to get care for our members?* ***Answer / Nicolas Barcelo:*** *Absolutely, there have been revisions to the involuntary hold criteria and grave disability that would increase the eligible population for continued inpatient treatment. Together with the Care Court, that is a concern related to more inpatient hospitalizations or hospitalizations of longer duration.* CCHP's BH Department will be conducting active outreach to ensure that members are making their appointments with BHS and completing their assessments. One of the biggest challenges in collaborating with health care partners is navigating federal regulations related to the sharing of sensitive information.	
	<u>5.2 Member Appeals & Grievances</u> In October 2024, CCHP had 37 appeals which is relative to the greater number of 12,000 authorization requests received. The denials are less than a whole percent of cases that were appealed. A rise in grievances in March 2024 was due to an audit finding on how member concerns were classified. These issues had already been resolved. The increase in service complaints are mostly billing issues. Another concern is delays in care and not getting the desired appointment. We are working to create a more robust network of multiple provider types to address that concern.	Nicolás Barceló, MD Medical Director
	5.3 <u>Operational Key Performance Indicators (KPIs)</u> Annually, the DMHC requires changes to the health plan's operations through the Timely Filing process. As part of our best practices, we use regulatory KPIs while focusing on the Knox Keene license and DHCS contractual obligations. The DMHC audit is on a three-year cycle (as is the NCQA accreditation). Starting in 2027, CMS will be added to these audits. CCHP has had minimum sanctions over the past 10 years from either regulatory body (DHCS and DMHC). Our KPIs revolve around our	Sharron Mackey, Chief Executive Officer

	contractual and regulatory requirements verses our operational efficiency. Adding operational metrics based on those findings/recommendations will improve our procedures and processes. New operational KPIs will help us monitor performance and enhance staff accountability. The A&M assessment confirmed the need for a performance management system. Based on their recommendations, CCHP will create a Performance Management Unit consisting of a Project Management Office, an internal academy for staff, improved personnel policies, and we will update our three-year strategic plan with operational KPIs. **<u>5.4 Compliance Update</u>** Closed Corrective Action Plans (CAPs): • Long-Term Care (LTC) Intermediate Care Facility (ICF) for the Developmentally Disabled (DD) network readiness requirements; CAP imposed July 2024. ✓ 10/01/24 – DHCS confirmed requirements successfully fulfilled by CCHP • PCP Facility Site and Medical Record Review held in April 2024; CAP imposed May 2024. ✓ 9/24/24 – DHCS confirmed all requested items have been addressed and corrected There is one open CAP currently that is related to the focused audit in BH and Transportation. There are five findings in BH: • Case Management and Care Coordination • Coordination of Care for Transitioning Members • Care Coordination and Information Exchange with the Mental Health Plan • Good Faith Efforts to Confirm Treatments • Follow up to Understand Barriers and Adjust Referrals There are four findings in Transportation: • Provision of Door-to-Door Assistance • Plan Monitoring and Oversight of Door-to-Door Assistance • NEMT – Monitoring and Oversight of Providers' No-Show Rates • NMT – Monitoring and Oversight of NMT Providers' No-Show Rates In all these areas, CCHP is on track. Many of the local health plans have had the exact same findings as these are areas that DCHS has asked for new requirements.	Chanda Gonzales, Compliance Officer
6.0 Review and Approval of Progress Report	**<u>6.1 Executive Dashboard</u>** Sonia Escobar reviewed the executive dashboard in the areas of total membership, Utilization Management, Advice Nurse calls, Member Services calls, Case Management, and Claims. **<u>6.2 Finance Report</u>** Going forward, the finance report will be expanded to include more data. Based on the third quarter results, CCHP is on track relative to the budget for the year. In Finance, there is significant work being done internally on some of the financial processes related to the health plan. There have been issues with timely filing in the past, and we are completing a CAP.	Sonia Escobar, Analysis & Reporting Director Brian Buchanan, Interim Chief Financial Officer

	6.3 Next Meeting Reminders 2025 Friday, March 14, 2025 Friday, June 13, 2025 Friday, September 12, 2025 Friday, December 12, 2025	
7.0 Adjournment	Meeting adjourned at 11:30AM.	

Approved: **Date:**

1-31-25

Supervisor Diane Burgis, District III

Contra Costa Health Plan / Board of Supervisors
Joint Conference Committee

Friday, December 13, 2024
9:30AM – 11:30AM

In-Person Location:

Agriculture, 2380 Bisson Lane, Sequoia Conference Room, Concord, CA or
District II Supervisor's office, 309 Diablo Road, Danville, CA or
District III Supervisor's office, 3361 Walnut Blvd., Suite 140, Brentwood, CA

Virtual:

Virtual Meeting option via Zoom
https://cchealth.zoom.us/j/7415624178?omn=99122533244

Unless otherwise indicated below, Contra Costa Health Plan – Community Plan, hereby adopts all issues, findings, or resolutions discussed in the Agenda for Contra Costa Health Plan's Joint Conference Committee, dated December 13, 2024, and attached herein.

Excepted Matters: None

CONTRA COSTA HEALTH

File #: 25-1239 **Agenda Date:** 4/9/2025 **Agenda #:** 2.0

CALIFORNIA'S PUBLIC HEALTH CARE SYSTEMS: 17 Systems, 40 Hospitals & 150+ Clinics

Alameda Health System
- Alameda Hospital
- San Leandro Hospital
- Wilma Chan Highland Hospital
- St. Rose Hospital

Arrowhead Regional Medical Center

Contra Costa Health Services
- Contra Costa Regional Medical Center

Kern Medical
- Kern Medical Hospital

LA County Department of Health Services
- Harbor/UCLA Medical Center
- Los Angeles General Medical Center
- Olive View/UCLA Medical Center
- Rancho Los Amigos National Rehabilitation Center

Natividad Medical Center

Riverside University Health System

San Francisco Department of Public Health
- Zuckerberg San Francisco General
- Laguna Honda Hospital and Rehabilitation Center

San Joaquin General Hospital

San Mateo Medical Center

County of Santa Clara Health System
- O'Connor Hospital
- Santa Clara Valley Medical Center
- St. Louise Regional Hospital

Ventura County Health Care Agency
- Santa Paula Hospital
- Ventura County Medical Center

UC Health
- **UC Davis Health**
  - UC Davis Sacramento Medical Center
- **UC Irvine Health**
  - UC Irvine Medical Center
  - UC Irvine Health, Fountain Valley
  - UC Irvine Health, Lakewood
  - UC Irvine Health, Los Alamitos
  - UC Irvine Health, Placentia
- **UC San Diego Health**
  - UC San Diego Medical Center
    - UC San Diego Health, Hillcrest Medical Center
    - UC San Diego Health, Jacobs Medical Center
- **UC San Francisco Health**
  - UCSF Medical Center
  - UCSF Mission Bay Medical Center
  - UCSF Parnassus Medical Center
  - UCSF Mount Zion Medical Center
  - UCSF Benioff Children's Hospital, Oakland
  - UCSF Health Saint Francis Hospital
  - USCF Health Saint Mary's Hospital
- **UCLA Health**
  - Ronald Reagan UCLA Medical Center
  - UCLA Santa Monica Medical Center and Orthopedic Hospital
  - UCLA West Valley Medical Center

CAPH

Objectives

1. Contextualize Individual/Local Concerns with Federal, State Perspectives
2. Provide Updates on Budget Reconciliation
3. Answer Questions

CAPH

Four Major Arenas of Activity

1. Appropriations – Continuing Resolution passed through Sept. 30. 2025
2. ***Budget Reconciliation***
3. Executive Actions
4. State-Level Potential Threats

CAPH

2. Budget Reconciliation, cont'd

How Big Will the Medicaid Cuts Be?

- House-passed budget resolution instructs the Energy & Commerce Committee to find $880B in savings – impossible to do without cutting Medicaid if protecting Medicare and Social Security
- Senate now has two options:
    1. Take the House-passed budget resolution & amend it, or
    2. Start from scratch

1. Then goes back to the House, then Committees can get to work drafting actual language

- Narrow tightrope for the Senate to walk, given the two-vote margin in the House:
    - Moderates – protect Medicaid
    - Freedom Caucus: Medicaid expansions (federal $) must be rolled back

CAPH

2. Budget Reconciliation, cont'd

That's If They Follow the Rules…

- Latest rumor is that each chamber passes their own resolution & then there's a "conference" committee that makes the hard choices
  - Reflection of how challenging this is
  - Would be a major betrayal for the moderate Republicans
  - Committee composition likely Reps

CAPH

2. Budget Reconciliation, cont'd

Timing

- Goal is for the House and Senate to have both adopted a consensus budget resolution by the end of the second week of April.
- Speaker Johnson saying that he wants to have a finished reconciliation bill on the President's desk by Memorial Day.
- A lot of skepticism about that timing. Could go to August recess or into the fall
- Debt ceiling could also impact timing (and ultimate result)

CAPH

2. Budget Reconciliation, cont'd

The Spaghetti Strategy – What Might Stick?

Their goal is to label proposals as either "waste, fraud and abuse" or "reforms" – not cuts

What's On the Table/"Wall" This Week:

- **State Directed Payments (SDPs)**
  - Limiting them from the Average Commercial Rate to Medicare
  - California's SDPs include the Enhanced Payment Program & the Quality Incentive Pool
- **Provider Taxes**
  - Lowering the hold harmless threshold from 6 percent to 5.5 percent
  - CBO scored this to 5% = $48B
  - Every state except Alaska has a provider fee. California's is ~$5B (and is already at 5.05%)

CAPH

2. Budget Reconciliation, cont'd

- **Lowering the FMAP for States that cover the undocumented**
- **Per Capita Cap on Expansion Population**
- **Work requirements**
  - Would save roughly $100B due to declining enrollment… but potentially a greater "budget number"
- **Repealing Biden-era regulations**
  - Minimum staffing for nursing homes ($22B)
  - Others (e.g., Medicaid eligibility rule, access rule, managed care rule) – savings would on which provisions would be repealed and when the repeal would take effect.
- **Prevention and Public Health Fund**
  - Not a Medicaid cut but has been floated before
  - Savings < $20B

CAPH

2. Budget Reconciliation, cont'd

The Strategy:

1. **Educate & Explain** How each proposal is a CUT: if it wasn't, it wouldn't generate savings
2. **Target Republicans in districts with high Medicaid populations** to emphasize local impact
   - Rep. David Valadao (CA-22), Kern Medical in district
   - Rep. Ken Calvert (CA-41), Riverside University Health System in district
   - Rep. Jay Obernolte (CA-23), Arrowhead Regional Medical Center & Los Angeles Department of Health System facilities in district
   - Rep. Vince Fong (CA-20), Kern Medical facilities in district
   - Rep. Young Kim (CA-40), UC Irvine Health in district
3. **Strengthen partnerships with other (red) state Medicaid partners**

CAPH

2. Budget Reconciliation, cont'd

What's going to happen?!?!

Very fluid and hard to predict, but three broad possible scenarios:

1. **Worst case:** Moderates get rolled and we experience severe cuts.
   - Could happen even if they use the "current baseline policy"
   - Potentially more likely if debt ceiling rolled into the discussion; hawks could demand additional savings
2. **Middle:** Medicaid cuts included, but either
   - Don't take effect for 4-5 years, allowing us to live to fight another day – but the slower the phase-in, the lower the savings; or
   - Aren't a direct hit to PHS
3. **Best:** The whole things falls apart: too hard to thread the needle between the moderates and the hawks – due to complexity or voter response, affecting electeds

But that's just in the Congressional realm.

CAPH

3. Executive Actions

Immediate:

- Immigration, Gender-Affirming Care, NIH grants, DEI grants, HRSNs (aka SDoH, aka CalAIM)
- DOGE & Potential Impact on CMS Workforce/Capacity, which could slow impact reviews/approvals of SPAs, pre-prints

December 2026:

- 1115 waiver that includes the GPP expires
    - Full loss of Safety Net Care Pool ($236M/year and likely at least half of the Medicaid DSH ($1.2B, so half = $600M)
    - For CCHS, SNCP = $8.8M/yr, DSH = $44.5M/year, so likely a reduction of at least $30M

At Any Time:

- Rescind managed care rule, impose other limits on Medicaid supplemental funding
- Have already announced elimination of public comments to regulations

CAPH

At the State Level…

- **Newsom Administration seeking to borrow $6.2B to cover Medi-Cal costs**
- **Signal: Medi-Cal cuts in the May Revise**
  - Rollback of undocumented coverage?
  - Other eligibility, services?
- **More to learn; advocacy**
  - Potential impact to county indigent programs
  - Exploration of narrower coverage options

CAPH

Four Pieces of Advice

1. **Respond to what we know** (vs what we fear/anticipate)
   - Try to avoid modeling out the latest rumor
2. **Avoid rose-colored glasses**

CAPH

Our Advice, Cont'd

3. **Stay current** (without spinning…)
   - Things moving quickly!

4. **Engage in relentless advocacy!**
   - Patient stories
   - In targeted districts, as many touch points as possible

CAPH

File #: 25-1240 **Agenda Date:** 4/9/2025 **Agenda #:** 3.0

HEALTHCARE LITERACY COUNCIL

Contra Costa County

COUNTY SUPERVISOR DIANE BURGIS | KAISER PERMANENTE® | CONTRA COSTA HEALTH

HEALTHCARE LITERACY

Helping Contra Costans successfully access and use their healthcare in an informed and efficient way

A NEED FOR LITERACY

- Silver Tsunami places largest population ever on Medicare roles
- CalAIM increases Medi-Cal eligibility for low-income
- Peaked enrollment in East County
- Limited knowledge of healthcare system

CONSEQUENCES

- Seniors and low-income struggling to maximize benefits
- Elevated anxiety, anger and frustration
- Chronic misuse of EDs
- Significant cost to healthcare providers

COMMON CAUSE

Behooves stakeholders to combine resources:

- Improved efficiencies
- More appropriate use of existing facilities
- Better client outcomes
- Promotion of prevention models
- Healthier communities
- Resident empowerment

A HEALTHCARE LITERACY CAMPAIGN

PILOT CAMPAIGN

An integrated outreach and education campaign to help impacted communities properly access their healthcare

- Utilize key influencers and existing resources
- Culturally appropriate
- Community-based

CORE CAMPAIGN PARTNERS

East County leaders dedicated to healthcare literacy:

COUNTY SUPERVISOR DIANE BURGIS

KAISER PERMANENTE®

CONTRA COSTA HEALTH

KEY STRATEGIES

1. Council
2. Curriculum
3. Ambassadors
4. Outreach & Partners

COUNTY SUPERVISOR DIANE BURGIS | KAISER PERMANENTE | CONTRA COSTA HEALTH

HEALTHCARE LITERACY COUNCIL

Outreach and Education Campaign

- Direction, oversight and support
- Informational website, educational materials, social and traditional media
- Curriculum development
- Recruitment of college educators

HEALTH LITERACY CURRICULUM

Supportive Healthcare Education

- Comprehensive healthcare navigation assistance
- Medicare and Medi-Cal benefits optimization
- Specialized support for vulnerable populations(language, cultural, economic, transportation, etc.)

HEALTH LITERACY AMBASSADORS

Community Ownership and Engagement

- Los Medanos College Students
- Recruited and trained as Ambassadors
- Present curriculum to High School and Adult Seniors
- Serve as informational conduit to Council
- True community empowerment and ownership

COMMUNITY OUTREACH & PARTNERS

Countywide Outreach Campaign

- Health Literacy Ambassadors expand across county
- Share information via social media, website, videos, mailers, apps, swag and partner-supported special events
- Recruit additional partners (CBOs, local leaders, media) to amplify messaging

ANTICIPATED OUTCOMES OF HEALTHCARE LITERACY CAMPAIGN

- Empowered residents who can better navigate their healthcare
- Trickle-down of information to family members
- Proper utilization of existing healthcare resources
- Ambassadors emboldened with knowledge, experience

TIMELINE

YEAR ONE

Lay groundwork

YEAR TWO

Execute campaign

YEAR THREE

Evaluate & expand

YEAR ONE

Estimated Costs: $95,650

- Research and exploration
- Council development and management
- Curriculum development
- Education and outreach materials
- Initial ambassador recruitment and training

YEAR TWO

Estimated Costs: $224,200

- Trainings with schools and seniors
- Education and outreach marketing
- Recruitment of partners and funders
- Evaluation benchmarks for educators
- Full public outreach materials and tools

YEAR THREE

Estimated Costs: $100,000

- Trainings across full region
- Active community outreach and education marketing campaign
- Evaluation of successes and publishing of outcome report
- Recruitment of additional funders
- Expansion to remainder of county

PILOT EVALUATION

Measurements based on:

- Partnerships developed
- Class evaluations
- Ambassador feedback
- ED usage
- Website analytics
- Media impressions
- Pre and Post surveys

HEALTHCARE LITERACY COUNCIL

Contra Costa County

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APPENDIX

Year One Estimated Cost Breakdown

ACTIVITY	Time	Rate	Cost	OOP	Total
Research and Exploration					
Literature Review and Internet Exploration	12	$ 225	$ 2,700		$ 2,700
Interviews with similar literacy programs	12	$ 225	$ 2,700		$ 2,700
Compilation of findings report	4	$ 225	$ 900		$ 900
Council Development and Management					
Planning and Organization	12	$ 225	$ 2,700		$ 2,700
Meetings organization (scheduling, agenda, etc.)	18	$ 225	$ 4,050	$ 300	$ 4,350
Member Recruitment and Outreach	6	$ 225	$ 1,350		$ 1,350
Curriculum Development					
Research and investigation	12	$ 225	$ 2,700		$ 2,700
Key Informant Interviews & Report	20	$ 225	$ 4,500		$ 4,500
Development of curriculum	28	$ 225	$ 6,300		$ 6,300
Testing of curriculum	10	$ 225	$ 2,250	$ 1,400	$ 3,650
Adaption and translation for different audiences (3)	12	$ 225	$ 2,700	$ 600	$ 3,300
Produce Tools (teacher's guide, PowerPoint, etc.)	20	$ 225	$ 4,500	$ 1,200	$ 5,700
Education and Outreach Materials					
Write and design outreach/marketing materials	18	$ 225	$ 4,050		$ 4,050
Website: write, design, produce, manage	48	$ 225	$ 10,800	$ 2,600	$ 13,400
Develop series of social media posts	42	$ 225	$ 9,450		$ 9,450
Modify tools for different audiences and languages	6	$ 225	$ 1,350	$ 500	$ 1,850
Printing and production of final pieces	4	$ 225	$ 900	$ 1,600	$ 2,500
Distribution of materials (posting, advertising, etc.)	28	$ 225	$ 6,300	$ 5,600	$ 11,900
Initial Ambassador Recruitment & Training					
Engagement/Partnerships with Community College	10	$ 225	$ 2,250		$ 2,250
Establish expectations and compensation package	8	$ 225	$ 1,800		$ 1,800
Outreach (meetings) to facilitate recruitment	16	$ 225	$ 3,600	$ 200	$ 3,800
Training of student-ambassadors	14	$ 225	$ 3,600	$ 200	$ 3,800
ESTIMATED TOTAL YEAR ONE COSTS					**$ 95,650**

APPENDIX

Year Two Estimated Cost Breakdown

ACTIVITY	Time	Rate	Cost	OOP	Total
Research and Exploration					
Focus Groups (2) to test curriculum	48	$ 225	$ 10,800	$ 2,000	$ 12,800
Focus Group Report Findings	6	$ 225	$ 1,350		$ 1,350
Council Development and Management					
Meetings organization (scheduling, agenda, etc.)	8	$ 225	$ 1,800	$ 500	$ 2,300
Council Support and Management	24	$ 225	$ 5,400	$ 1,100	$ 6,500
Member Recruitment and Outreach	16	$ 225	$ 3,600		$ 3,600
Curriculum Development					
Produce Tools (teacher's guide, PowerPoint, etc.)	24	$ 225	$ 5,400	$ 2,600	$ 8,000
Training instructors on curriculum	12	$ 225	$ 2,700		$ 2,700
Modifications and Enhancements	18	$ 225	$ 4,050	$ 1,200	$ 5,250
Ambassador Recruitment & Training					
Engagement/Partnerships with Community College	10	$ 225	$ 2,250		$ 2,250
Hire and on-board Ambassadors (4)	28	$ 225	$ 6,300	$ 20,000	$ 26,300
Training of student-ambassadors	12	$ 225	$ 2,700	$ 200	$ 2,900
Supervision, booking and directions	36	$ 225	$ 8,100	$ 200	$ 8,300
Education and Outreach					
Develop marketing plan	12	$ 225	$ 2,700		$ 2,700
Website updates and maintenance	24	$ 225	$ 5,400	$ 1,200	$ 6,600
Video (2) filming and production	48	$ 225	$ 10,800	$ 6,400	$ 17,200
Promotional material production (Swag)	12	$ 225	$ 2,700	$ 5,600	$ 8,300
Direct Mail Campaign (produce, lists and mail)	20	$ 225	$ 4,500	$ 18,000	$ 22,500
Media buy (TV, Radio, Print, Social)	24	$ 225	$ 5,400	$ 22,000	$ 27,400
Clalendared placement of social media posts	20	$ 225	$ 4,500		$ 4,500
Media outreach and pitches	18	$ 225	$ 4,050		$ 4,050
Special community events with partners (3)	60	$ 225	$ 13,500	$ 28,000	$ 41,500
Evaluation					
Conduct mid-term evaluation report	8	$ 225	$ 1,800		$ 1,800
Collect & collate evaluations from ambassadors	6	$ 225	$ 1,350		$ 1,350
Website analytics	2	$ 225	$ 450		$ 450
Collect and collate evaluation from students	6	$ 225	$ 1,350		$ 1,350
Collect media impressions	8	$ 225	$ 1,800		$ 1,800
Collect ED usage reports	2	$ 225	$ 450		$ 450
ESTIMATED TOTAL YEAR TWO COSTS					**$ 224,200**

APPENDIX

Year Three Estimated Cost Breakdown

ACTIVITY	Time	Rate	Cost	OOP	Total
Council Management					
Meetings organization (scheduling, agenda, etc.)	8	$ 225	$ 1,800	$ 500	$ 2,300
Council Support and Management	24	$ 225	$ 5,400	$ 1,100	$ 6,500
Member Recruitment and Outreach	8	$ 225	$ 1,800		$ 1,800
Curriculum Development					
Modifications and Enhancements	18	$ 225	$ 4,050	$ 1,200	$ 5,250
Ambassador Recruitment & Training					
Hire and on-board Ambassadors (2)	12	$ 225	$ 2,700	$ 6,000	$ 8,700
Supervision, booking and directions	30	$ 225	$ 6,750		$ 6,750
Education and Outreach Materials					
Media buy (TV, Radio, Print, Social)	24	$ 225	$ 5,400	$ 14,000	$ 19,400
Clalendared placement of social media posts	20	$ 225	$ 4,500		$ 4,500
Modify tools for different audiences and languages	12	$ 225	$ 2,700	$ 1,400	$ 4,100
Media outreach and pitches	18	$ 225	$ 4,050		$ 4,050
Special community events with partners (2)	42	$ 225	$ 9,450	$ 20,000	$ 29,450
Evaluation					
Conduct final evaluation report	8	$ 225	$ 1,800		$ 1,800
Collect & collate evaluations from ambassadors	6	$ 225	$ 1,350		$ 1,350
Website analytics	2	$ 225	$ 450		$ 450
Collect and collate evaluation from students	6	$ 225	$ 1,350		$ 1,350
Collect media impressions	8	$ 225	$ 1,800		$ 1,800
Collect ED usage reports	2	$ 225	$ 450		$ 450
ESTIMATED TOTAL YEAR THREE COSTS					**$ 100,000**

File #: 25-1241 **Agenda Date:** 4/9/2025 **Agenda #:** 4.1

CONTRA COSTA HEALTH

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CCHP Staffing Update

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New Staff Leadership

Irene Lo, MD
Interim
Chief Executive Officer

Bhumil Shah
Chief Digital Officer

Elena White
Interim
Director of Operations

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New Staff Leadership (continued)

Sara Levin, MD
Senior
Medical Director

Brandon Engelbert
Member Services
and Outreach
Director

Matt Verdier
Director of Compliance
and Government
Relations

File #: 25-1242 **Agenda Date:** 4/9/2025 **Agenda #:** 4.2

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Summary of Regulatory Audits

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Regulatory Audits and CCHP

- CCHP welcomes audits as a positive, constructive process.
- Audits are viewed as an opportunity for continuous improvement
  - Audit results are a tool for growth; they highlight areas for improvement and drive ongoing enhancements
  - They help CCHP ensure that its processes are aligned with best practices and regulatory requirements.
  - The audit process supports CCHP in providing high-quality, comprehensive health care to members.
- No audit is without findings—such results are common across health plans and help identify actionable areas for process improvement.
  - The findings are used to strengthen internal practices and enhance the member experience.
  - Audit findings are not seen as setbacks but as part of a broader strategy for success—they ensure that CCHP can evolve and remain compliant with regulations while adapting to member needs.
- The audit process aligns with CCHP's commitment to transparency, quality, and continuous innovation in health care delivery.

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Regulatory Audits

REGULATORY BODY	AUDIT FREQUENCY	AREAS OF AUDIT	LAST AUDIT	# OF FINDINGS	STATUS OF CORRECTIVE ACTION PLAN
Department of Health Care Services (DHCS)	Annual	• Six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, Administrative and Organizational Capacity • Evaluation of Plan's compliance with its DHCS Contract • Evaluation of Plan's adherence to previous audit findings and Corrective Action Plan	August 2024	19 No repeat findings	In Progress; On Track

Department of Managed Health Care (DMHC)	Every 3 years	• Assessed Plan operations in the following areas:
		  • Quality Assurance
		  • Grievances and Appeals
		  • Access and Availability of Services
		  • Utilization Management
		  • Continuity of Care
		  • Emergency Services and Care
		  • Prescription Drug Coverage
		  • Behavioral Health – SB855
			November 2022	16	4 corrected; Remaining In Progress; On Track

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CCHP Audit Approach

Year-Round:	Pre-Audit:	During the Audit:	Audit Exit Conference & Afterward:	Upon Receiving the Audit Report & Afterward:
• Regularly review and monitor audit findings from other health plans to ensure CCHP policies and procedures address these issues. • Continuously monitor corrective action plans to ensure compliance and resolution of findings. • Provide regular audit training and preparation for CCHP staff.	• Proactively identify potential concerns during audit preparation. • Implement immediate process improvements to address concerns.	• Identify areas of concern raised by auditors. • Make real-time process improvements to address issues as they arise.	• Review initial auditor concerns. • Develop corrective action plans and internal audit procedures for quick and thorough resolution.	• Review findings to ensure all recommendations are incorporated into corrective action plans. • Continuously monitor internal auditing processes. • Review timelines and confirm milestones are met to ensure timely and effective resolution of findings.

File #: 25-1243 **Agenda Date:** 4/9/2025 **Agenda #:** 4.3

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DHCS 2024 Medical Audit Findings

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Audit Details

- Audit period: August 1, 2023 – July 31, 2024
- Dates of Audit Interviews: August 19, 2024 – August 30, 2024
- Process:
  - Included documentation review, verification studies, and interviews with the Plan's representatives
  - Evaluated six categories of performance:
    - Utilization Management (UM)
    - Case Management and Coordination of Care
    - Access and Availability of Care
    - Member's Rights
    - Quality Management
    - Administrative and Organizational Capacity
  - Evaluated Plan's compliance with its DHCS Contract
  - Assessed implementation of the 2023 Corrective Action Plan from the prior 2023 DHCS Medical Audit

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Utilization Management

- **Finding 1.2.1: The Plan did not explicitly state in Notice of Action (NOA) letters how the member's condition did not meet the applicable clinical criteria or guidelines**
- **Recommendation: Revise and implement policies and procedures to ensure NOA letters explicitly state how the member's condition did not meet the clinical criteria or guidelines**
- Corrective Action Plan:
  - Policies/procedures revised to ensure NOA letters explicitly state how the member's condition did not meet the clinical criteria or guidelines
  - Detailed Training developed and provided to staff on writing NOA letters that comply with regulatory requirements.
  - Monthly auditing of NOA letters

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Utilization Management (continued)

- **Finding 1.5.1: The Plan did not ensure that Contra Costa Behavioral Health (CCBH), Plan delegate sent Notice of Action letters (NOAs) and accompanying "Your Rights" information, along with Nondiscrimination Notices (NDN) and Language Assistance Timeline (LAT) notices for prior authorization denial decisions, as required**
- Recommendation: Revise and implement policies and procedures to ensure delegates send required member information with prior authorization denials, including NOAs, “Your Rights” attachments, and NDN and LAT for all prior authorization denials as required.
- Corrective Action Plan:
  - CCHP Behavioral Health Department has insourced all these activities. CCBH is no longer being delegated these duties.
  - Internally, CCHP has robust mechanisms to ensure that NOA letters are sent with appropriate documents.

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Appeals

- **Finding 1.3.1: The Plan did not ensure that the person making the final decision for appeal resolutions did not participate in any prior decisions related to the appeals**
- Recommendation: Implement policies and procedures to ensure the final decision-maker for appeal resolutions has not participated in any prior decisions related to the appeals.
- Corrective Action Plan:
  - Revision of policies and desktop procedure for the Appeals Process
  - Monthly audit

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Initial Health Appointment

- **Finding 2.1.1: The Plan did not ensure that providers documented all required components of an Initial Health Appointment (IHA)**
- Recommendation: Implement policies and procedures to ensure the completion and documentation of all required components of an IHA.
- Corrective Action Plan:
  - CCHP Clinical Quality Auditing (CQA) is conducting bi-annual audit on IHA components
  - Training will be provided to providers on IHA components at Provider Network Trainings (PNT)
  - Through the Medical Record Review (MRR) process regularly performed by CQA, all IHA components will be reviewed. Corrective action plans (CAPs) will be given to providers who are out of compliance.

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Blood Lead

- **Finding 2.1.2: The Plan did not ensure that providers documented the completion of blood lead screening tests**
- **Recommendation: Revise and implement policies and procedures to ensure documentation and completion of all blood lead screening tests as required.**
- Corrective Action Plan:
  - CCHP Health education team is conducting phone call outreach to parents of children overdue for training.
  - Lists of overdue children are being shared on provider portal, which updates daily.
  - CCHP team actively working with providers to implement Point-of-Care Glucose Training (POCT) for lead screening in office.
  - Lead screening toolkit posted on health plan website.

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Blood Lead (continued)

- **Finding 2.1.3: The Plan did not ensure the provision of oral or written blood lead anticipatory guidance to the parent(s) or guardian(s) of members starting at six months to six years of age.**
- Recommendation: : Develop and implement policies and procedures to ensure oral and written blood lead anticipatory guidance is provided to the members parent(s) or guardian(s) starting at six months to six years of age.
- Corrective Action Plan:
  - CCHP Facility Site Review (FSR) team is conducting audits of whether participatory guidance is collected. If appropriate, Corrective Active Plans (CAPs) are issued to providers
  - Audits being conducted to identify providers that are not providing anticipatory guidance during well care visits.
  - Education has been made available on anticipatory guidance via the CCHP website
  - Personalized provider education was included in the Q1-2025 CCHP provider newsletter.

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Enhanced Care Management (ECM) Program

- **Finding 2.6.1: The Plan did not ensure the provision of comprehensive care management and coordination of care for the clinical needs relevant to members enrolled in the ECM program**
- Recommendation: Revise policies and procedures to ensure implementation of a comprehensive ECM program that effectively assesses and addresses the clinical needs of the Plan's ECM population.

- **Finding 2.6.2: The Plan did not ensure that all members received all seven ECM core service components**
- Recommendation: Revise and implement policies and procedures to ensure all ECM core service components are completed.

- **Finding 2.6.3: The Plan did not ensure that ECM members and their authorized support persons received a copy of the members' Care Management plan, along with information about how to request updates**
- Recommendation: Develop and implement policies and procedures to ensure that members and their authorized support persons receive a copy of the Care Management Plan, along with and information about how to request updates.

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ECM Program (continued)

- Corrective Action Plan:
  - CCHP policy regarding ECM Engagement, Operations, and Evaluation was updated to emphasize oversight process to ensure that ECM providers implemented a comprehensive ECM program to address a member's clinical needs and addresses core service components.
  - ECM providers will conduct regular internal audits, no less than quarterly, to ensure their ECM Program provides a comprehensive and whole-person, interdisciplinary approach to offering ECM, ensuring it addresses the clinical and non-clinical needs of high-need and high-cost members
  - CCHP will audit ECM Providers after they have been providing service for one year.
  - Monthly complex case rounds with all ECM providers to discuss non-clinical and clinical needs of members
  - ECM cases will be regularly audited to track trends and improvements

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Grievances

- **Finding 4.1.1: The Plan did not have policies and procedures to ensure medical Quality of Care (QOC) grievances were immediately submitted to the Medical Director for action**
- Recommendation: Develop and implement policies and procedures to ensure that medical QOC grievances are immediately submitted to the Medical Director for action.
- Corrective Action Plan:
  - Revised desktop procedure for QOC grievances to ensure that all QOC grievances are sent to the Medical Director immediately for review.
  - Monthly audit is performed to review samples of Grievance cases to ensure that this process is occurring.

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Grievances (continued)

- **Finding 4.1.2: The Plan did not submit grievances alleging discrimination, along with detailed information regarding the grievances to the DHCS as required**
- Recommendation: Implement policies and procedures to ensure grievances alleging discrimination, along with detailed information regarding the grievances are submitted to the DHCS.
- Corrective Action Plan:
  - Revised Discrimination desktop procedure to ensure that all key steps in discrimination complaints are followed
  - The CCHP Health Equity Department conducts regular audits to ensure submission

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Grievances (continued)

- **Finding 4.1.3: The Plan did not ensure all grievances, including exempt grievances, were reviewed and analyzed on at least a quarterly basis**
- Recommendation: Implement policies and procedures to include review and analysis of all grievances in the grievance quarterly track and trend monitoring report.
- Corrective Action Plan:
  - Grievance policy has been updated to ensure that all grievances, including exempt grievances, are incorporated into quarterly reports for review and analysis

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Provider Preventable Conditions

- **Finding 5.1.1: The Plan did not report all Provider Preventable Conditions (PPCs) to the DHCS as required**
- Recommendation: : Revise and implement policies and procedures to ensure all PPCs are reported to the DHCS.
- Corrective Action Plan:
  - The Clinical Quality Auditing Department has conducted a detailed training for the team on the submission of PPCs to the DHCS as required.
  - Since August 2024, all PPCs have been reported to DHCS.

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Provider Terminations

- **Finding 5.3.1: The Plan did not provide written notices to all impacted members for terminations of network providers, subcontractors, or downstream subcontractors**
- Recommendation: Develop and implement policies and procedures to ensure that all impacted members are provided written notice when the Plan, network providers, subcontractors, or downstream subcontractors terminate contracts.
- Corrective Action Plan:
  - Policies and procedures regarding written notification of members were enhanced to clearly delineate the process for CCHP Contracts and CCHP Member Services

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Compliance

- **Finding 6.2.1: The Plan did not ensure the designated Compliance Officer did not also serve in an operational role or capacity.**
- Recommendation: Revise and implement policies and procedures to ensure the Compliance Officer is independent and does not serve in both compliance and operational roles.

- **Finding 6.2.2: The Plan did not have policies and procedures that included criteria for selecting a Compliance Officer or job description outlining the responsibilities and authority of the position**
- Recommendation: Revise and implement policies and procedures to include criteria for selecting a Compliance Officer and a job description outlining the responsibilities and the authority of the position.

- **Finding 6.2.3: Finding: The Plan did not maintain a compliance program which included all required elements of a compliance plan.**
- Recommendation: Revise and implement a compliance program that includes all required compliance plan elements.

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Compliance (continued)

- Corrective Action Plan:
  - Compliance Plan and related Compliance policies and procedures have been revised to include an enhanced description of the Compliance Officer role and to ensure that the Compliance Officer is independent and does not serve in both compliance and operational roles
  - Compliance Program has been revised and implemented to ensure that all of the required Compliance Plan elements are included. This is detailed in revised Compliance Plan

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Fraud, Waste, & Abuse Reporting

- **Finding 6.2.4: The Plan did not report all suspected fraud cases to the DHCS within ten working days**
- Recommendation: Implement policies and procedures to ensure all suspected cases of fraud are reported to the DHCS within ten working days
- Corrective Action Plan:
  - Relevant policies have been revised to ensure that all suspected cases of fraud are reported to the DHCS within ten working days.

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Notification of Changes in Member's Circumstances

- **Finding 6.2.5: The Plan did not have policies and procedures to promptly notify the DHCS upon receipt of information about changes in a member's circumstances for income and death.**
- Recommendation: Develop and implement policies and procedures to ensure changes in a member's circumstances, including income and death, are promptly reported to the DHCS
- Corrective Action Plan:
  - Relevant policies/procedures and Member Services workflow have been revised to ensure that the DHCS is promptly notified regarding changes in a member's circumstances for income and death

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Audit Findings – Progress Report

Overall Corrective Action Plan Status: Excellent

AUDIT FINDING	STATUS	POLICIES AND PROCEDURES UPDATED	STAFF TRAINING COMPLETED	NEXT STEPS
1.2.1 Clinical Reasons for Prior Authorization Denials		+	+	• Internal audits ongoing • Ongoing training
1.3.1. Appeal Resolution Decision-Maker		+	+	• Internal audits ongoing
1.5.1 Notice of Action letters, Nondiscrimination Notice and Language Assistance Taglines		+	+	• CCHP continues to perform all responsibilities related to BH UM, including letters
2.1.1 Required Components of the Initial Health Appointment		+	+	• Ongoing provider training • Ongoing provider audits
2.1.2 Blood Lead Screening		+	+	• Ongoing member outreach • Ongoing provider training • Ongoing provider audits
2.1.3 Blood Lead Anticipatory Guidance		+	+	• Ongoing provider training • Ongoing provider audits

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Audit Findings – Progress Report (continued)

Overall Corrective Action Plan Status: Excellent

AUDIT FINDING	STATUS	POLICIES AND PROCEDURES UPDATED	STAFF TRAINING COMPLETED	NEXT STEPS
2.6.1 Comprehensive Enhanced Care Management Program		+	+	• Ongoing provider training • Ongoing provider audits • Ongoing chart review • Ongoing complex case rounds
2.6.2 ECM Core Service Components		+	+	• Ongoing provider training • Ongoing provider audits • Ongoing chart review • Ongoing complex case rounds
2.6.3 Care Plans for Member and Family Supports		+	+	• Ongoing provider training • Ongoing provider audits • Ongoing chart review • Ongoing complex case rounds • Ongoing member/family supports education and outreach

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Audit Findings – Progress Report (continued)

Overall Corrective Action Plan Status: Excellent

AUDIT FINDING	STATUS	POLICIES AND PROCEDURES UPDATED	STAFF TRAINING COMPLETED	NEXT STEPS
4.1.1 Quality of Care Grievances		+	+	• Ongoing internal audits
4.1.2 Grievances Alleging Discrimination		+	+	• Ongoing internal audits
4.1.3. Grievance Tracking and Trending		+	+	• Ongoing reporting
5.1.1 Reporting of Provider Preventable Conditions to Department of Health Care Services		+	+	• Ongoing reporting
5.3.1 Provider Terminations		+	+	• Ongoing notifications
6.2.1 Compliance Officer Independence		+	+	
6.2.2 Compliance Officer Criteria		+	+	
6.2.3 Compliance Plan		+	+	
6.2.4. Fraud, Waste, or Abuse Reporting		+	+	• Ongoing reporting
6.2.5 Notification of Changes in Member's Circmumstances		+	+	• Ongoing notifications

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Next Steps

- Corrective Action Plan responses submitted to DHCS 3/28/2025.
  - Corrective Action Plans include:
    - Root cause analyses
    - Update of relevant policies and procedures
    - Submission of relevant documents to demonstrate implementation, continuous self-monitoring, and effective oversight structure

- CCHP will continue proactive approach towards DHCS audits
  - Ongoing monitoring and oversight of 2024 DHCS Medical Audit Corrective Action Plan
  - Regular review of policies and procedures
  - Ongoing internal audits
  - Ongoing collaboration with amongst internal CCHP departments
  - Regular review of audit findings, best practices, and lessons learned from other Managed Care Plans
  - Preparation for future audits

File #: 25-1244 **Agenda Date:** 4/9/2025 **Agenda #:** 4.4

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PH ECM Focused Audit

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Background

- In their 2024 Medical Audit of CCHP, DHCS found three findings pertaining to CCHP's ECM program.
- CCHP recognizes its important role in the provision of the ECM benefit to its Medi-Cal members and is intent on ensuring that appropriate monitoring and oversight mechanisms are in place to ensure that its ECM providers are meeting regulatory requirements
  - Given the significance of these findings, CCHP pro-actively performed a Focused Audit of the Contra Costa Public Health Department to ensure that the Contra Costa Public Health Department had made mandatory improvements in its provision of ECM services to ensure compliance with regulatory requirements of ECM programs.

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Scope/Audit Procedures

- Audit Period: December 1, 2024 – January 31, 2025
- Audit Performed: February 7, 2025 - February 14, 2025
- Audit Procedures:
  - Public Health, the JCC, and the DHCS were notified that CCHP would perform an audit
  - The ECM Policy Guide and the 2024 contract were used as guidelines
  - Audit Team: Contra Costa Health Plan staff which included a Medical Director, two Assistant Medical Directors, one Nurse Practitioners, one Registered Nurse, and Compliance staff.
  - Case sample: Random sample of 65 cases for which CCHP provided ECM authorization to PH.
  - Chart review included a special focus on the three ECM related findings.
- Audit Goal:
  - To ensure that our members' lives are improving and that we are consistently meeting the objectives of CalAIM and the ECM benefit.
  - To confirm that effective monitoring and oversight mechanisms are in place, ensuring ECM providers comply with regulatory requirements.
  - To assess that PH ECM continues to implement improvements aligned with ECM provider expectations and the previously issued Corrective Action Plan.

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Audit Findings

Audit Element	7/1/24 Comprehensive Audit element compliance findings (%)	2/14/25 Focused Audit element compliance findings (%)
Connection/Introduction to Primary Care Provider (PCP) and other clinical providers	37%	84%
Medication Reconciliation	37%	95%
Long Term Supports Services (LTSS) assessment/Durable Medical Equipment (DME) Assessments	35%	95%
Review of Systems (clinical assessment)	N/A	92%
Vital Signs (clinical assessment)	N/A	70%

CONCLUSION

- CCHP determined that, compared to the previous audit period (January 1, 2022 – May 20, 2024), which led to the initial Corrective Action Plan (CAP), there have been significant and commendable improvements in the implementation of key elements of the ECM program and services reviewed in this focused audit.
  - Improved assessment of non-clinical needs and clinical needs
  - Improved care coordination
  - Improved connection to PCP and other clinical team members
  - Improved provision of care plans

File #: 25-1245 **Agenda Date:** 4/9/2025 **Agenda #:** 4.5

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D-SNP Status – High Level Overview of Project Plan/Strategy

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Dual Eligible Special Needs Plan (D-SNP)

- A SNP is a Medicare Advantage coordinated care plan, called a "Special Needs Plan"
- SNPs were established by the Medicare Modernization Act (MMA) of 2003 and first offered in 2006
- SNPs are specifically designed to provide targeted care to individuals with special needs
- "Special needs individuals" are:
  - Institutionalized individuals
  - Dual eligible individuals
  - Individuals with severe or disabling chronic conditions
  - Individuals living in the community and requiring institutional level of care
- In 2026, CCHP will be offering a Dual Special Needs Plan (D-SNP)

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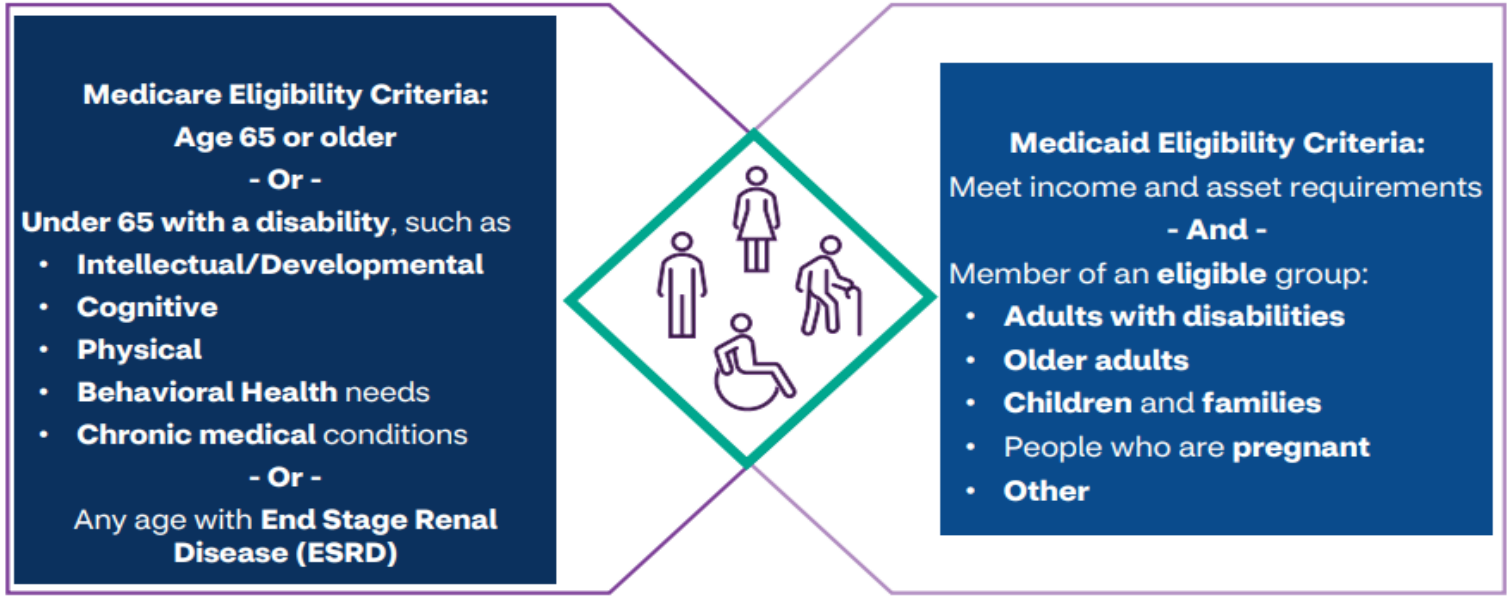
D-SNP Eligibility

- To be eligible for a D-SNP, an individual must meet the dual eligibility requirements for both Medicare and Medi-Cal:
  - Exclusions for enrollment in CCHP D-SNP include:
    - Partial Duals (those without full scope Medi-Cal or Medicare Part A or B)
    - Children under the age of 21



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D-SNP Benefits

Benefits to Members

Members receive expanded benefits under a D-SNP.

These expanded benefits include:

- Care coordination services provided to all members – including a designated care manager.
- Coordinated Medicare and Med-Cal benefits.
- Prescription drug coverage (Medicare Part D).
- Single health plan point of contact and ID card.
- Supplemental benefits like expanded vision.

Benefits to Providers

Providers will experience the following benefits under a D-SNP.

These expanded benefits include:

- Additional services for members like care management.
- Coordination of authorizations and services.
- Single payment and claims processing.
- Patient-centered approach to care.
- Enhanced collaboration with health care providers on care planning.
- Focus on prevention, quality, and outcomes.

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CONTRA COSTA HEALTH CARE PLUS (HMO-DSNP)

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CCHP D-SNP Approach

Creation of a member-centered D-SNP Plan

- Membership Analysis
- Benefit Plan Design
- Formulary Design
- Supplemental Benefits Design
- Model of Care Creation
- Provider Network Development
- Enrollment Strategy and Outreach
- Member Support and Services

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CCHP D-SNP Approach

Cultivate a Multidisciplinary/Team Approach

- Staff Training and Development
  - Case Management Enhancement
  - Establishment of a Marketing and Sales team
  - Redesign the Provider Relations Department
  - Education/Training
- Collaboration with CCHP Provider Network
  - Education/Training
  - Enhance/maintain relationships: Providers, Community Partners
  - Leverage Contra Costa Health Services Integrated Delivery System
- Technology and Data Integration
- Quality Monitoring and Continuous Improvement

D-SNP Implementation Milestones

MILESTONE	DEADLINE	STATUS	DETAILS
Notice of Intent to Apply	November 11, 2024	Completed	
Medicare Advantage (MA), Part D, and SNP Application Submission, including Model of Care and Provider Network	February 12, 2025	Completed	• Awaiting Application Review/Feedback by CMS • Awaiting NCQA Review of MOC
Model of Care Submission to DHCS	February 12, 2025	Completed	• DHCS found zero deficiencies with State-related MOC
MA Bid and Formulary Submission	June 2, 2025	In Progress	
D-SNP State Medicaid Agency Contracts (SMAC) Submission	July 2025	In Progress	
Medicare Advantage Contract Execution with CMS	August 31, 2025	In Progress	
Annual Enrollment Period	October 2025 – December 2025	In Progress	
D-SNP Launch	January 1, 2026	In Progress	

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Monitoring and Oversight

- D-SNP Steering Committee
  - Interim Chief Executive Officer
  - Chief Financial Officer
  - Chief Medical Officer
  - Chief Information Officer
  - Chief Operations Officer
  - Pharmacy Director
  - Quality Director
  - Compliance Officer

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EPIC Implementation Workgroups

- Standing
  - Medical Management
  - Case Management and Population Health
  - Call Management (CRM, Appeals and Grievances, Membership CRMs)
  - Membership and Enrollment
  - Claims
- Ad-Hoc
  - Provider Relations
  - Integrated Referrals
  - Finance

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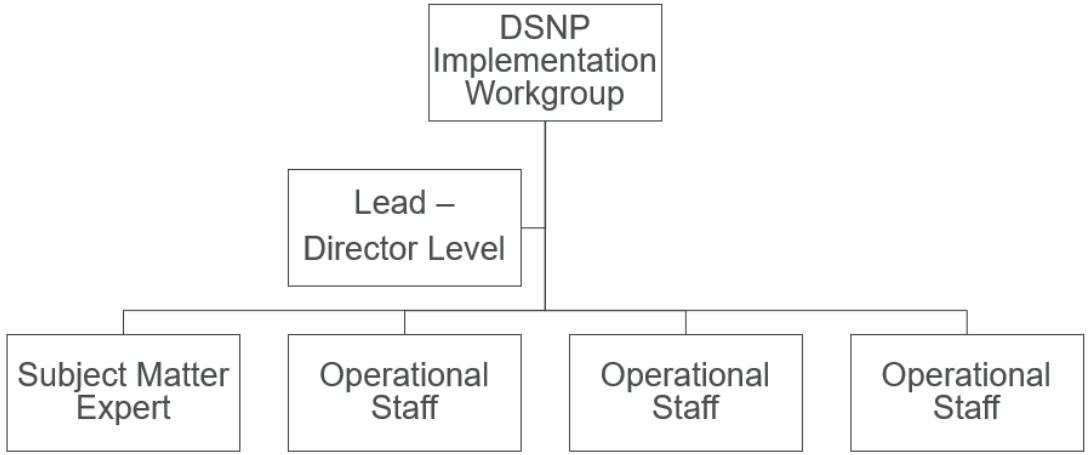
Operational Implementation Workgroups

- Appeals and Grievances
- Bid/Finance
- Sales
- Enrollment
- Marketing
- Customer Service
- Quality
- Claims
- Utilization Management
- Case Management
- Pharmacy
- Information Technology/Reporting
- Provider Network
- Compliance



File #: 25-1246 **Agenda Date:** 4/9/2025 **Agenda #:** 5.0

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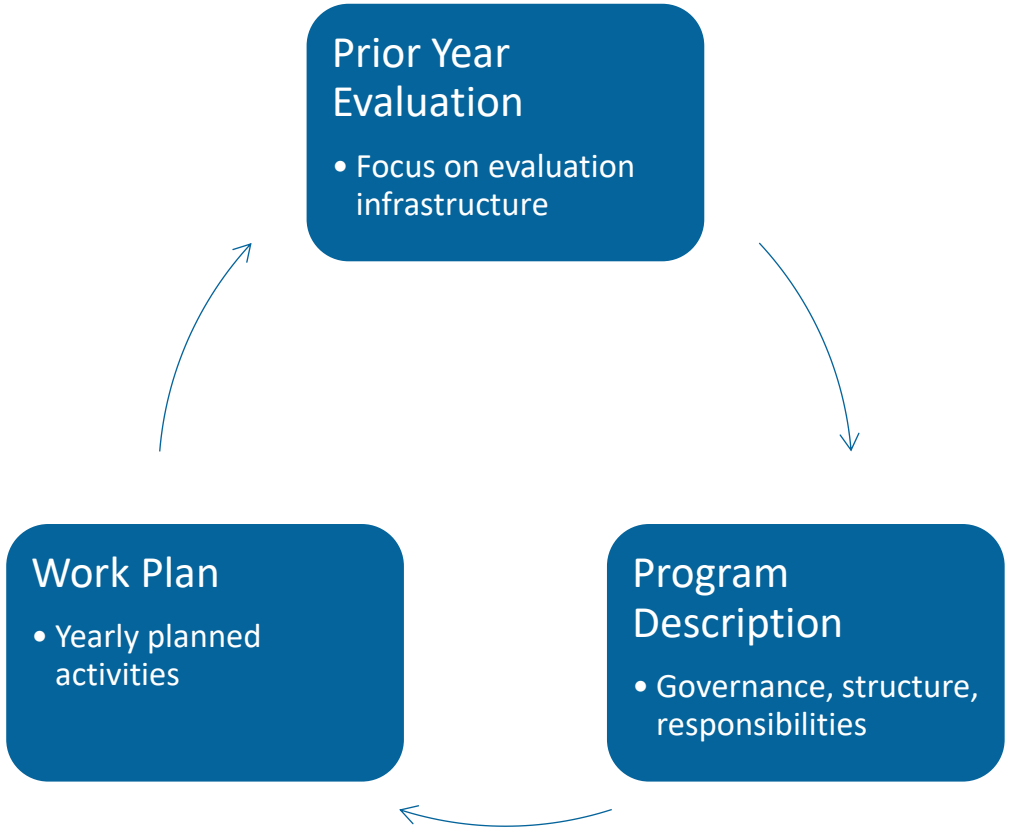
Quality Program Description, Work Plan, and Evaluation



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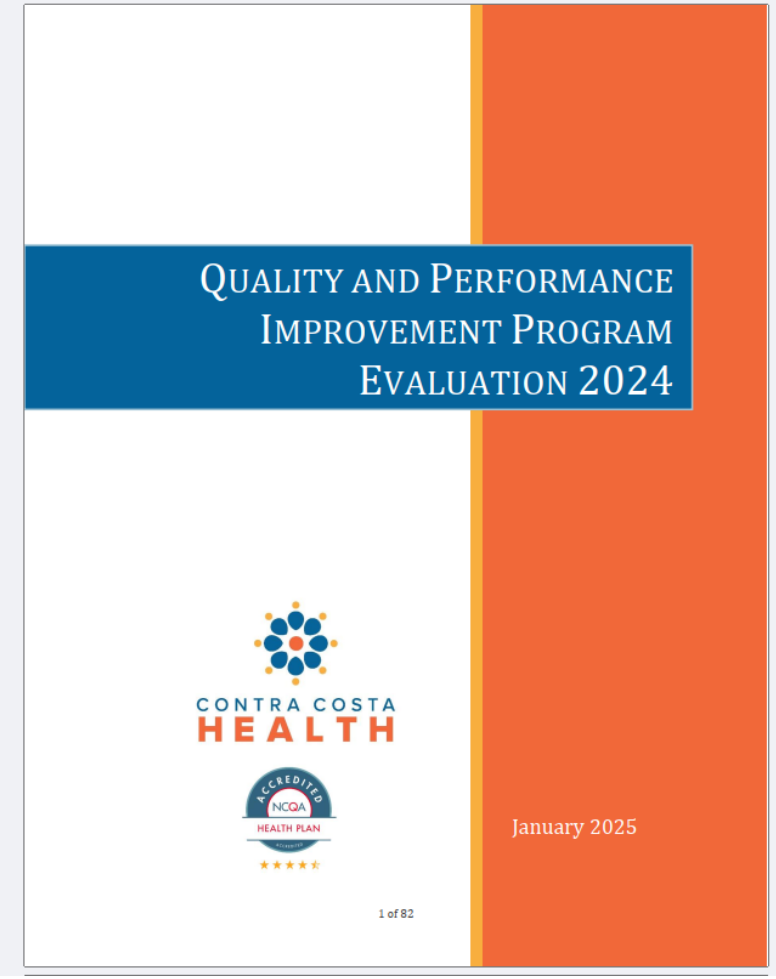
2024 Annual Evaluation



- Annual Health Plan Rating ranked with 4.5 Stars out of 5
- Exceeded 90th percentile nationally in 17 measures (up from 9 measures in 2023)
- Expansion of CalAIM services
- Improved internal infrastructure – Pay for Performance Program & Data Sharing with Providers with Provider Portal Reports

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CCHP Providers Rank High in Quality According to National Standards

ACCREDITED NCQA HEALTH PLAN ★★★★½

Measures	MY 2019	MY 2020	MY 2021	MY 2022	MY 2023	Trend	National Percentile
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 ★
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 ★
Diabetes - HbA1c Poor Control (>9.0%)*	37.71	38.93	34.55	33.99	29.11		90th ★
Immunizations for Adolescents (IMA) - Combo2	50.85	43.80	44.28	53.36	55.56		90th ★
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 ★
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 Immunization Status	-	-	46.11	46.05	42.99		90th ★
Well-Child Visits in the First 30 Months of Life (31d-15m)	70.32	56.69	54.35	65.88	73.17		90th ★

- Ranked in 90th percentile nationally in 17 measures, across a variety of domains
- One of 14 plans in nation to achieve 4.5 Stars

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2025 Quality Plan

QUALITY PROGRAM STRUCTURE

MEASUREMENT, ANALYTICS, REPORTING, AND DATA SHARING

PERFORMANCE IMPROVEMENT PROJECTS

POPULATION HEALTH

PATIENT SAFETY

PROVIDER ENGAGEMENT

DELEGATION OVERSIGHT

NCQA ACCREDITATION

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2025 Workplan

Program Structure

- Creation and approval of program documents. Quality Council, Equity Council, Community Advisory Committee

NCQA Accreditation

- Preparing for **2025 Health Plan Accreditation** Survey
- **Health Equity Accreditation**

Quality measurement

- Inclusion of DMHC reporting
- Expansion of internal quality measurement ongoing measures, improving data sharing with providers on gap in cares
- Standard HEDIS, Access reporting, Member and Provider experience, REAL data collection

Performance Improvement Projects

- Previously identified issues: Lead Screening, Topical Fluoride Treatment
- EQR PIP: Well Child Visit in first 15 months; Linkage to case management post ED for Behavioral Health
- IHI: Well child visits & Follow-up for ED for Behavioral Health

Population Health

- **D-SNP Preparations** – Chronic Care Improvement Program & Stars Preparation
- **Maternal health projects –** DHCS Birthing Pathways
- Health Education
- CHA/CHIP with public health
- CalAIM – ECM, CS, Closed Loop, Pre-Release Services, Transitional Care Services

Patient Safety

- PQIs, PPCs, Medication Safety, Facility Site Reviews

Provider Engagement

- Quality meeting with providers, provider trainings, portal data sharing
- Launch of **Pay for Performance** program

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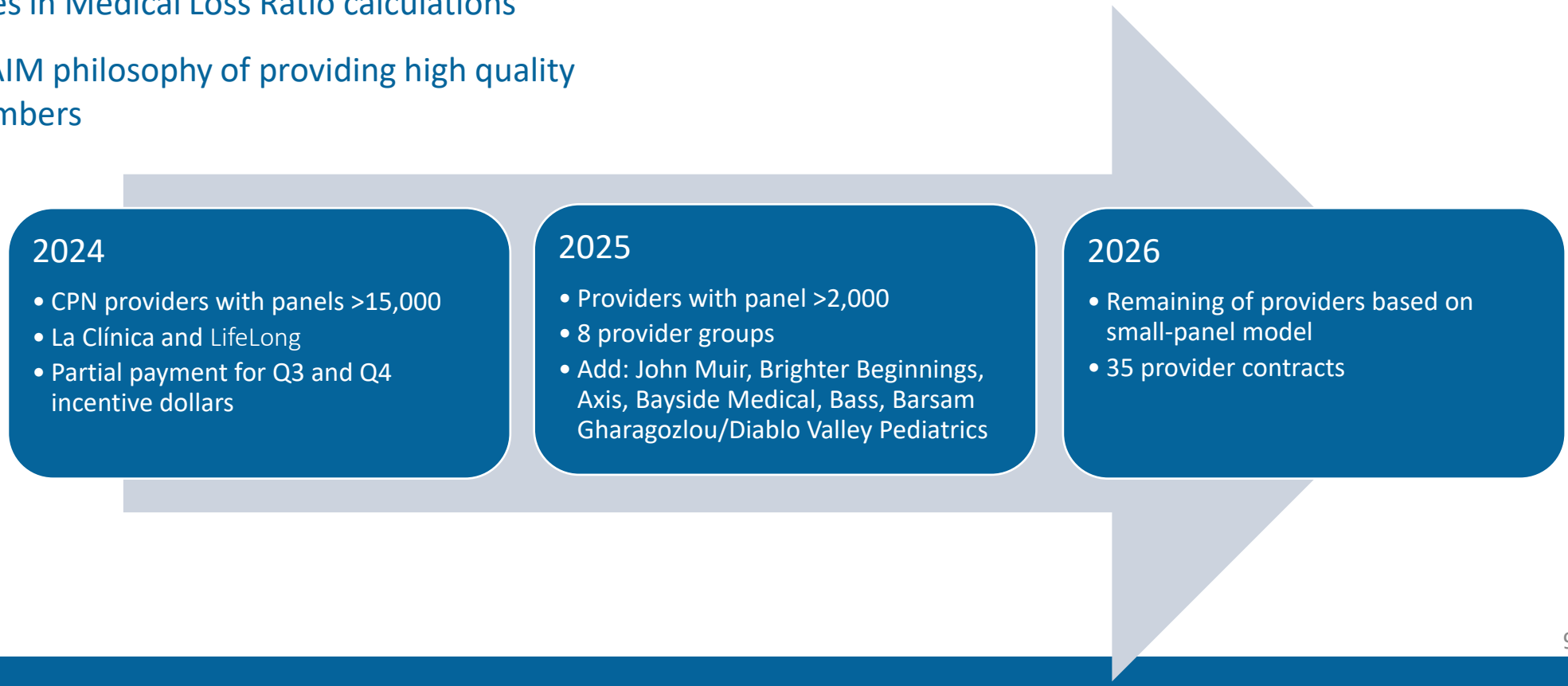
Transition to Value Based Contracts

- Historically, CCHP incentives have been quarterly-based capitation payments based on panel size and not linked to quality performance
- CMS and DHCS require a payment design linked to quality; changes in Medical Loss Ratio calculations
- Align with CalAIM philosophy of providing high quality of care for members



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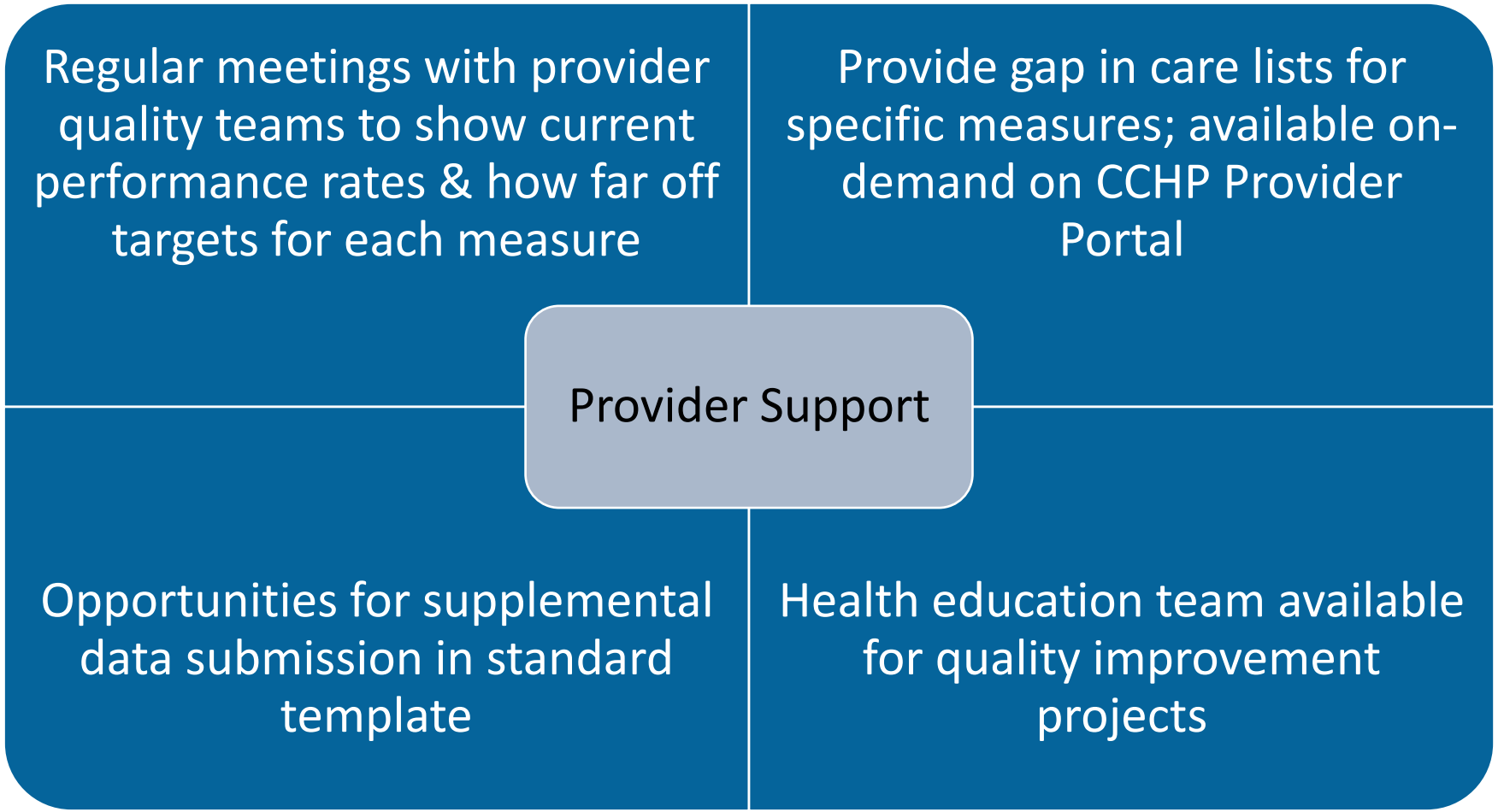
Provider Support



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Voting and approval of 2025 quality program documents

- **2024 Quality Evaluation**
- **2025 Quality Improvement and Health Equity Transformation Program Description**
- **2025 Quality Improvement and Health Equity Work Plan**

File #: 25-1222 **Agenda Date:** 4/4/2025 **Agenda #:** 5.1

Quality and Performance Improvement Program Evaluation 2024

January 2025

1 TABLE OF CONTENTS

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.

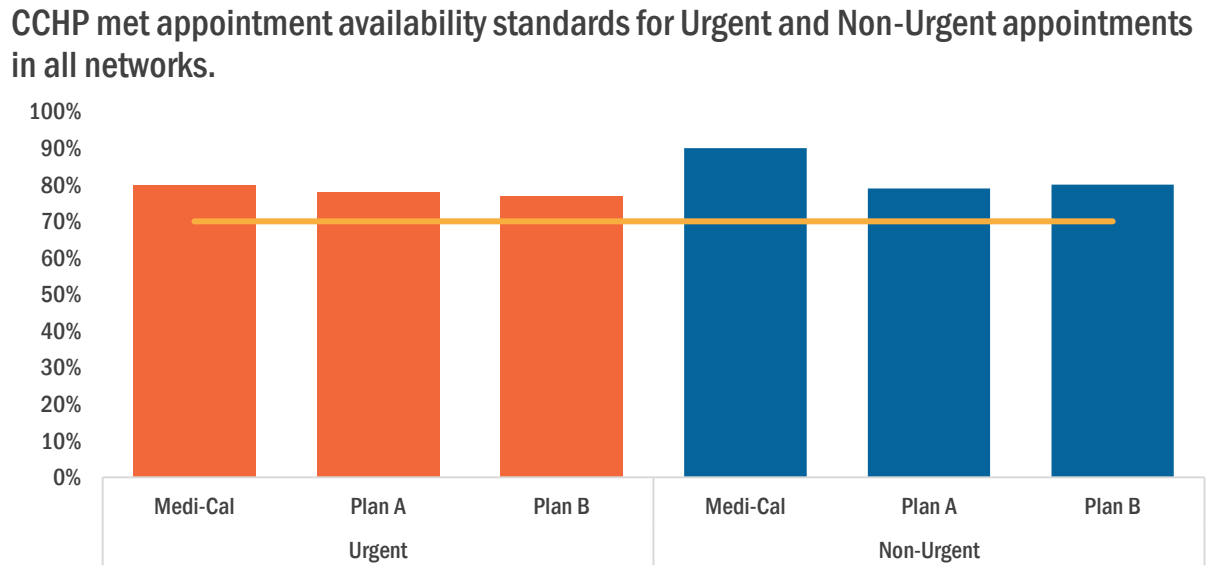
6.3 Network Adequacy

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.

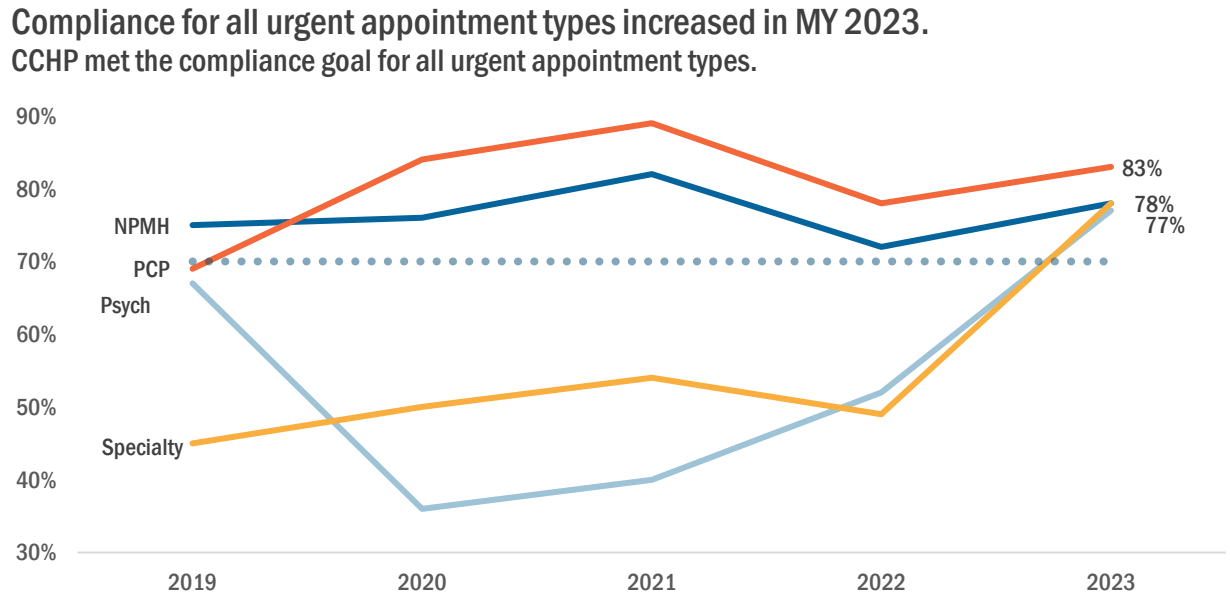
In 2024, CCHP met the standards for both urgent and non-urgent appointments.

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.

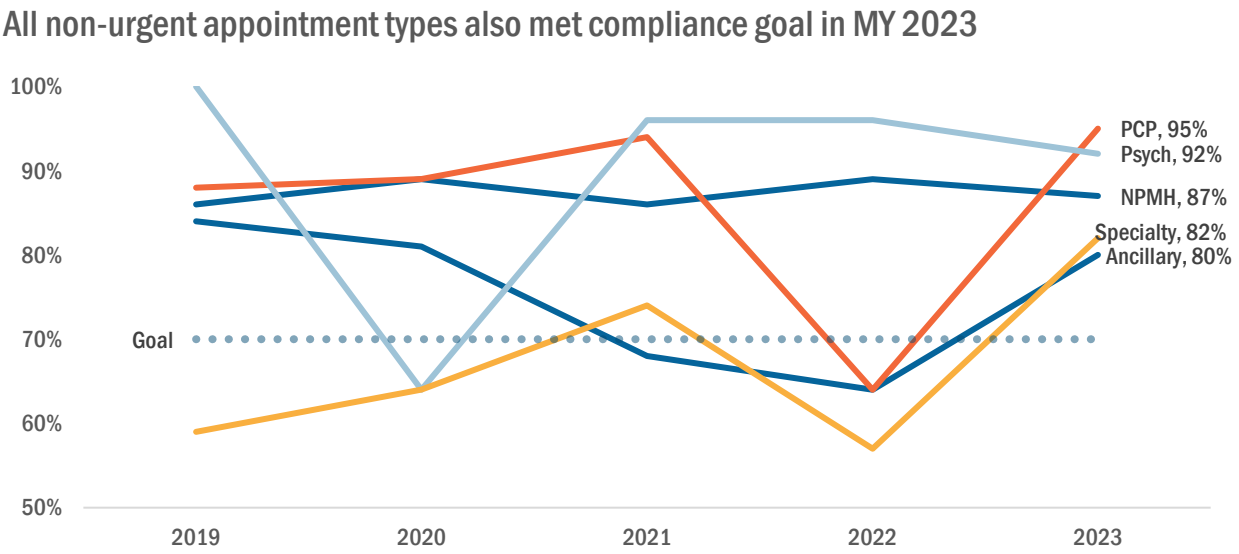
Figure 2. PAAS Urgent Appointment Compliance Over Time



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.

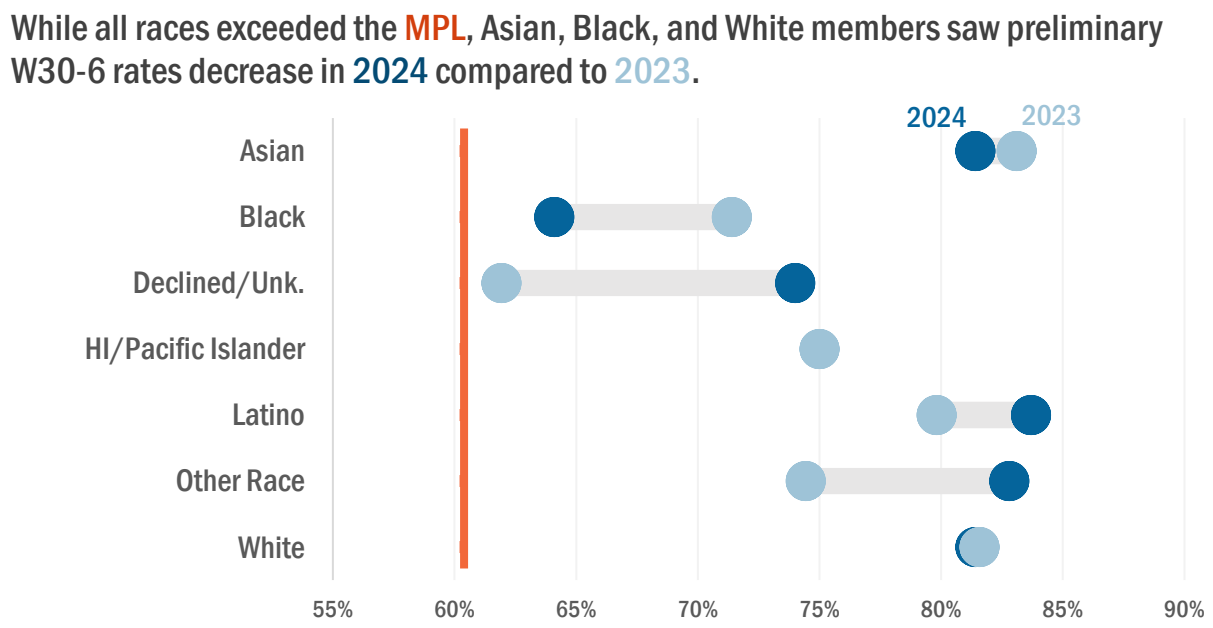
In 2024, CCHP submitted baseline MY2023 data and a summary of implemented interventions for the 2023-2026 DHCS PIPs. Both PIPs met 100% of evaluation elements and received high confidence ratings. The clinical PIP, Improving W30-6 Measure Rate Among Black Members, focuses on reducing disparities in well 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.

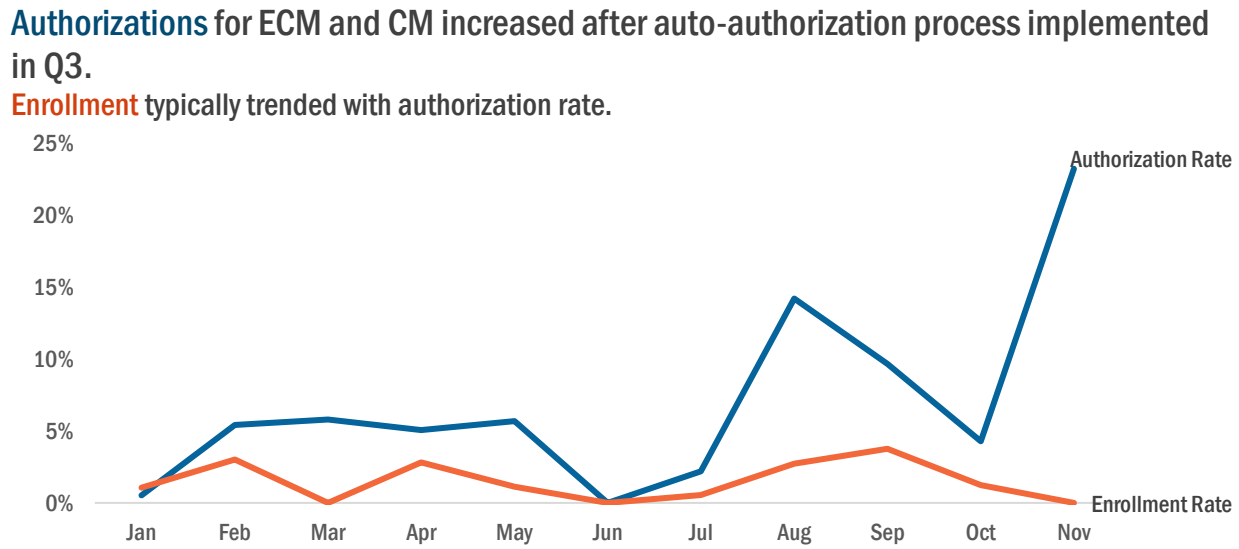
7.1.2 Improving the Percentage of Members Enrolled in Care Management within 14 Days of SMH/SUD Diagnosis

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.

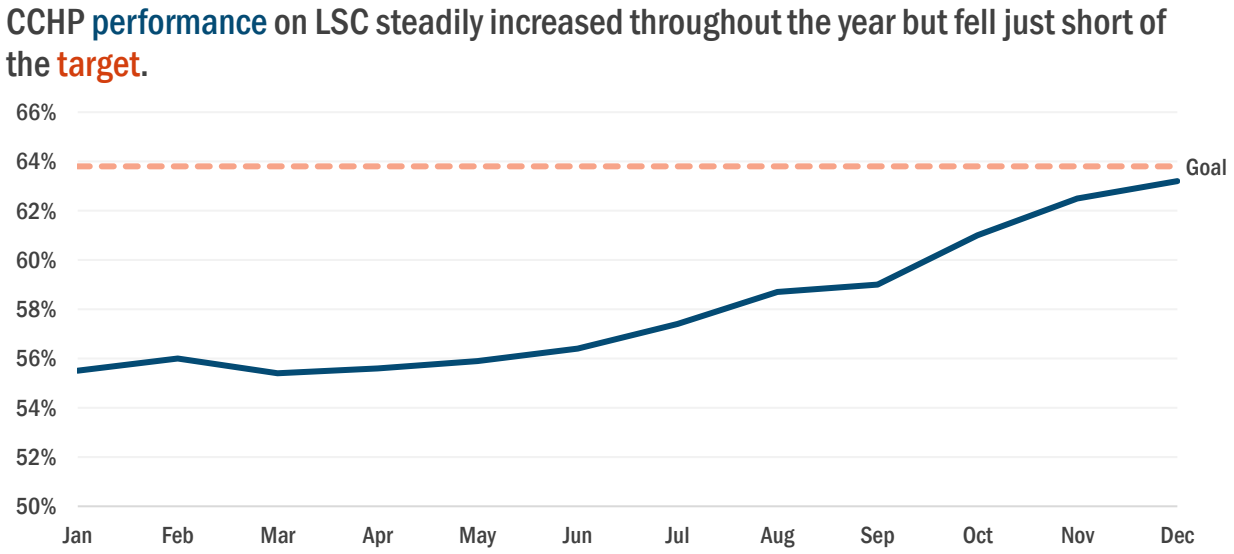
7.2.1 Lead Screening in Children

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.

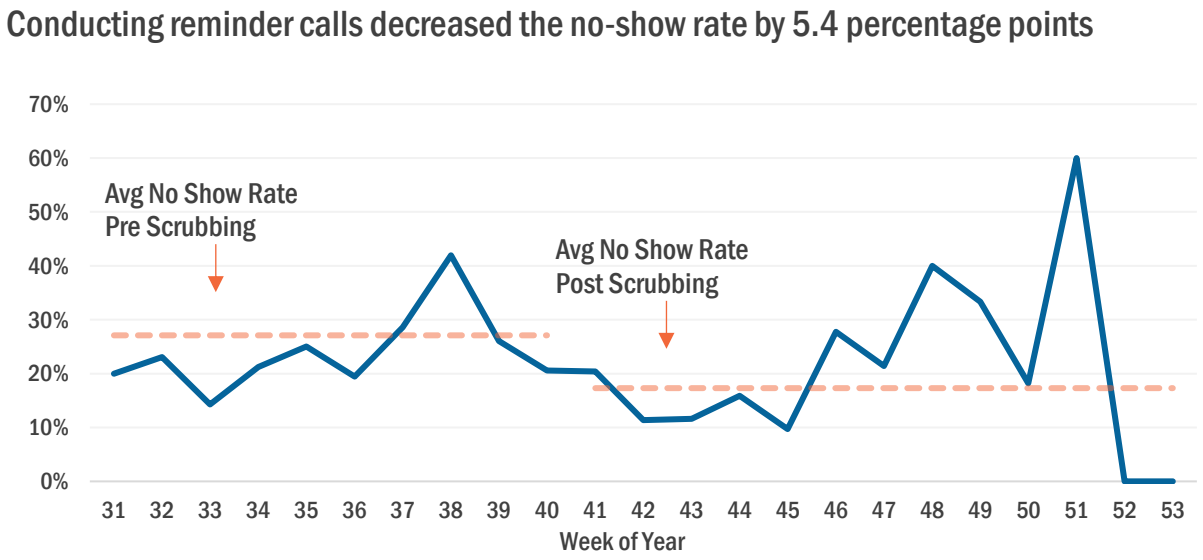
Table 4. Outreach Results by Population of Focus.

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

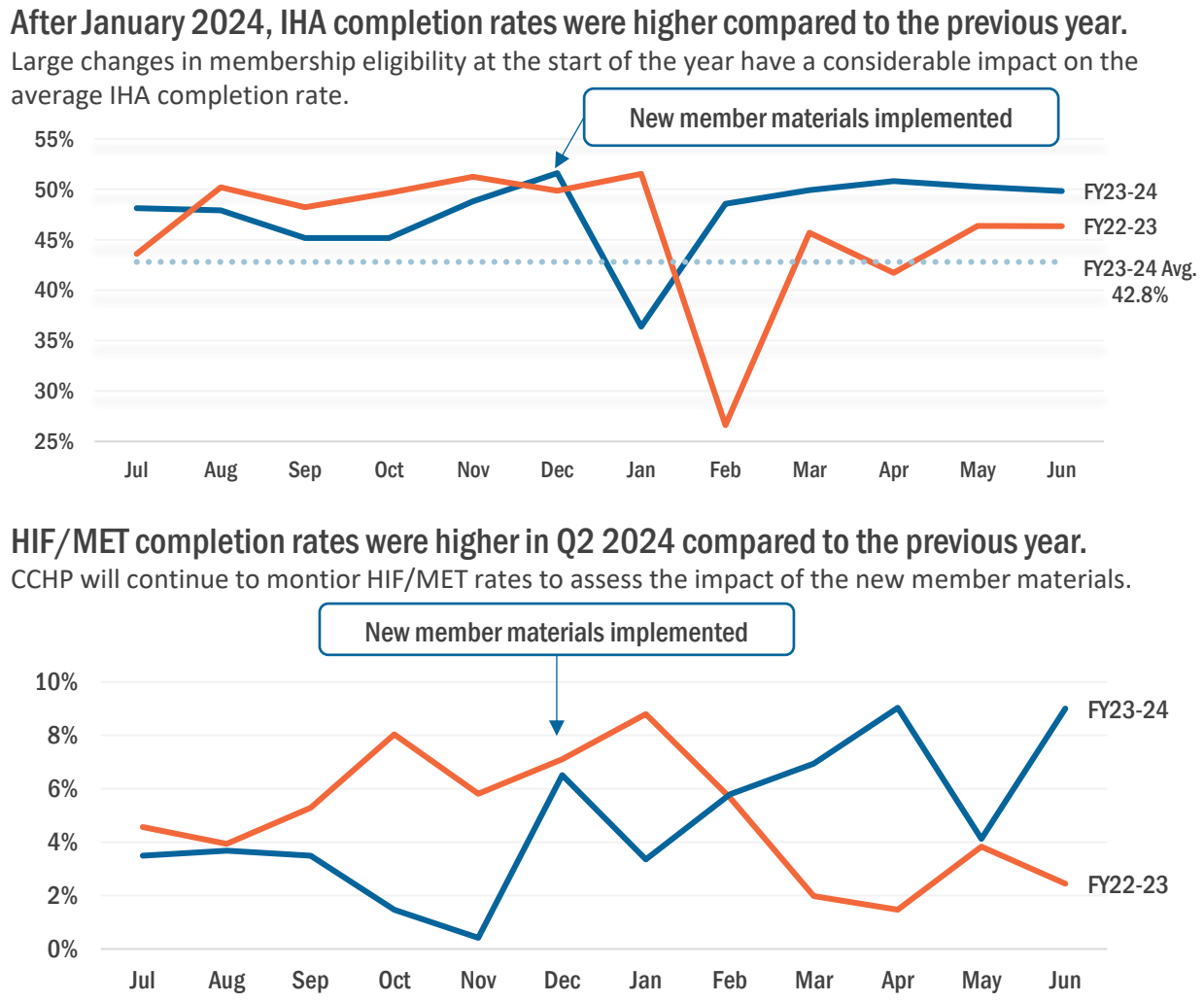
Leveraging its integration within the county delivery system, CCHP utilizes comprehensive data systems, centralizing data from claims, clinical data, detention health, EMS, social services, homeless systems, and public health into one unified member record. While CCHP's data infrastructure is robust, 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.

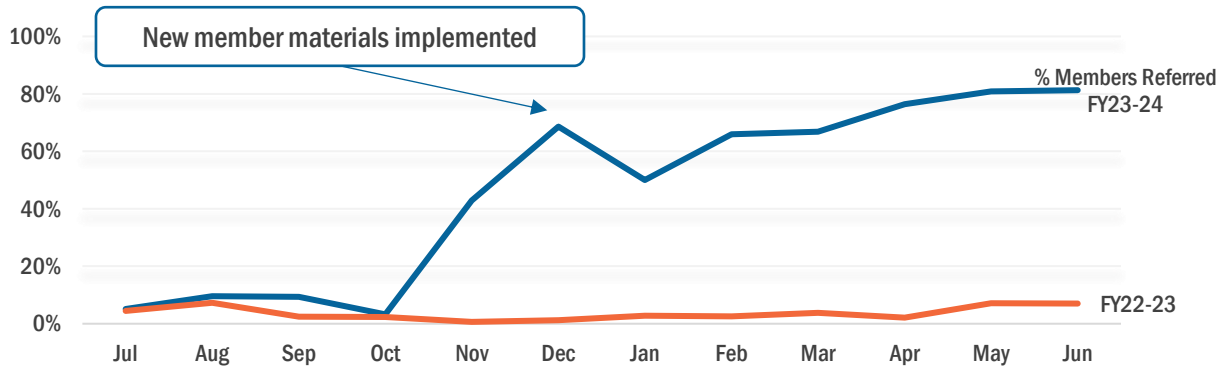
This refined process was implemented in December 2023, and its impact is demonstrated in the figures below. While the IHA rate in FY 23-24 was slightly lower compared to the previous year, CCHP saw an influx of nearly ten times the average amount of new members in January 2024 after the Single Plan Model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



Streamlined member information processes allowed for better identification of member needs & connections to resources.

56.1% of members who completed a HIF/MET in FY23-24 received a referral for care coordination



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

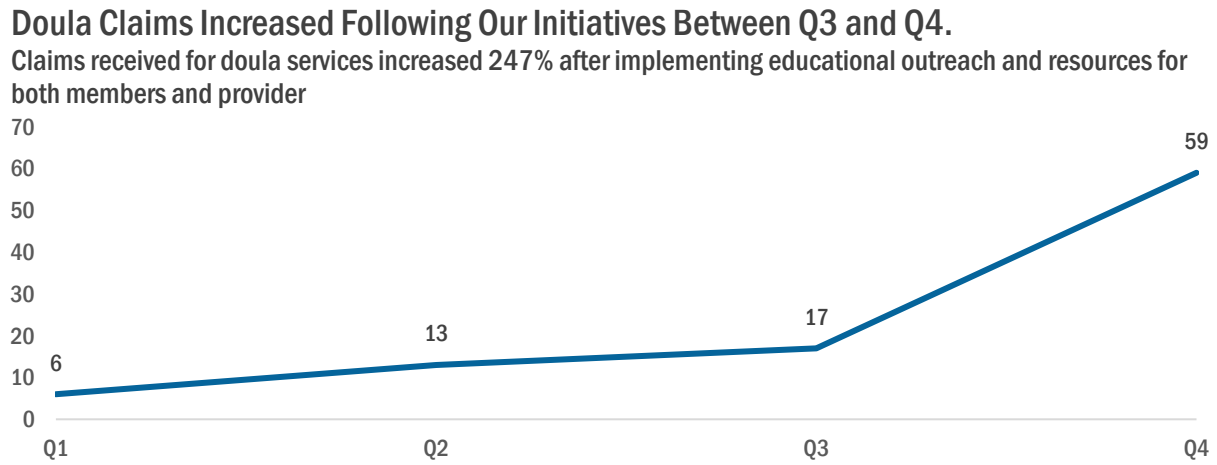
Through close collaboration with community partners and doula providers, CCHP has expanded its efforts to enhance maternal health education, member outreach, and provider support. While CCHP consistently performs well on maternal health quality measures, postpartum visit rates remain lower among African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

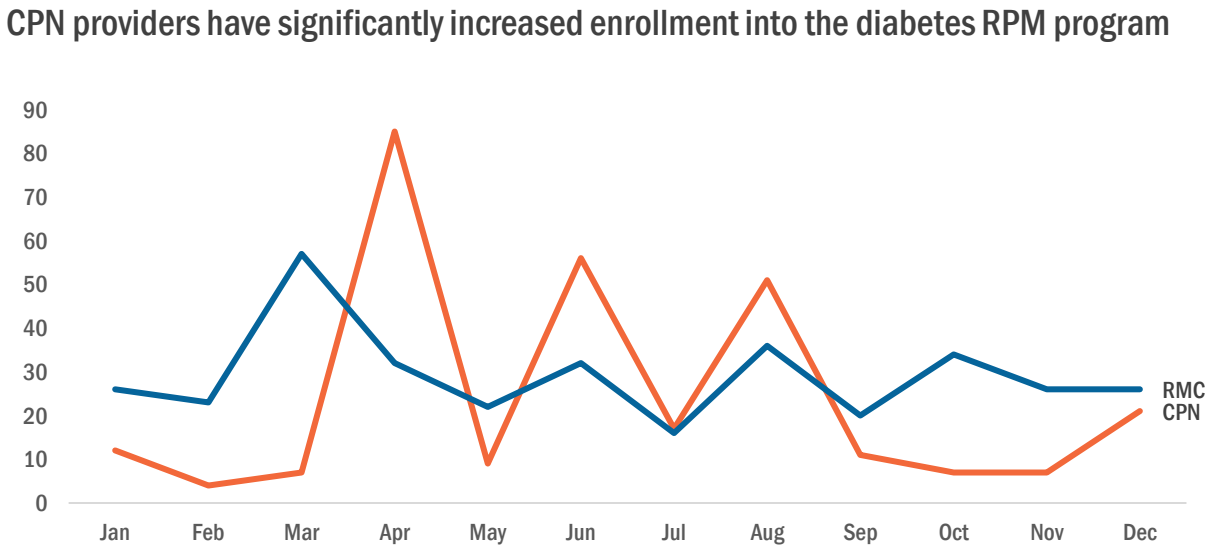
As part of the Community Supports, CCHP partners with 18 Reasons to provide the Food as Medicine (FAM) program, medically tailored foods for patients with diabetes, obesity or high-risk pregnancies. Members are sent weekly grocery deliveries and attend a cooking class with 18 Reasons and a medical provider. 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.

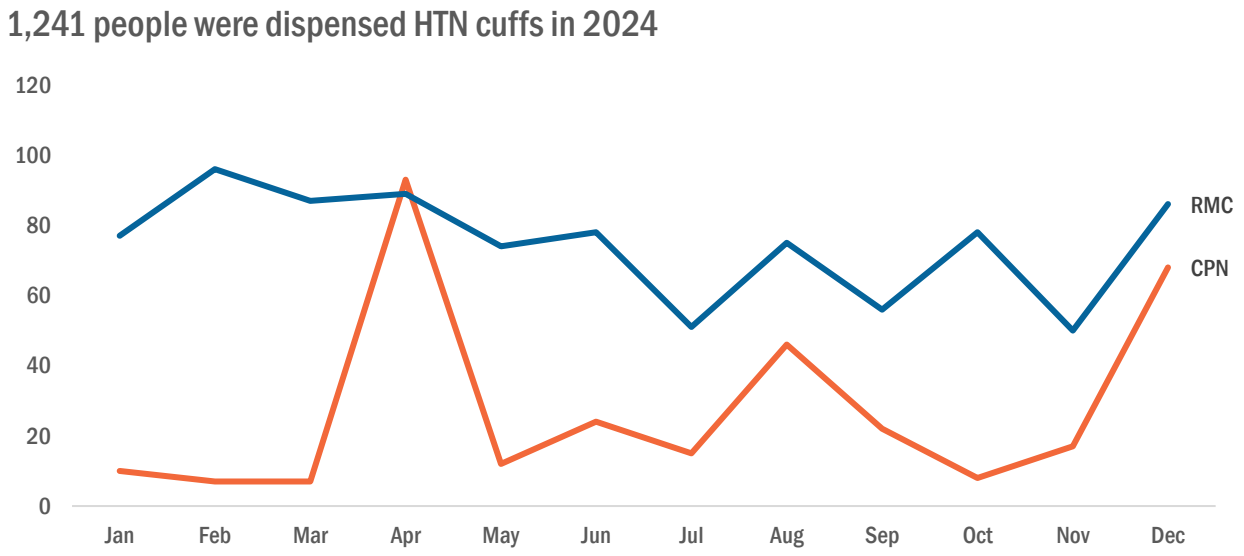
CCHP continued its partnership with Gojji Pharmacy to provide remote patient monitoring services for members with diabetes and/or hypertension. In 2024, CCHP contacted 2,030 members with uncontrolled diabetes and referred 493 (24.3%) RMC patients into the program, with 350 (71.0%) members ultimately 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.

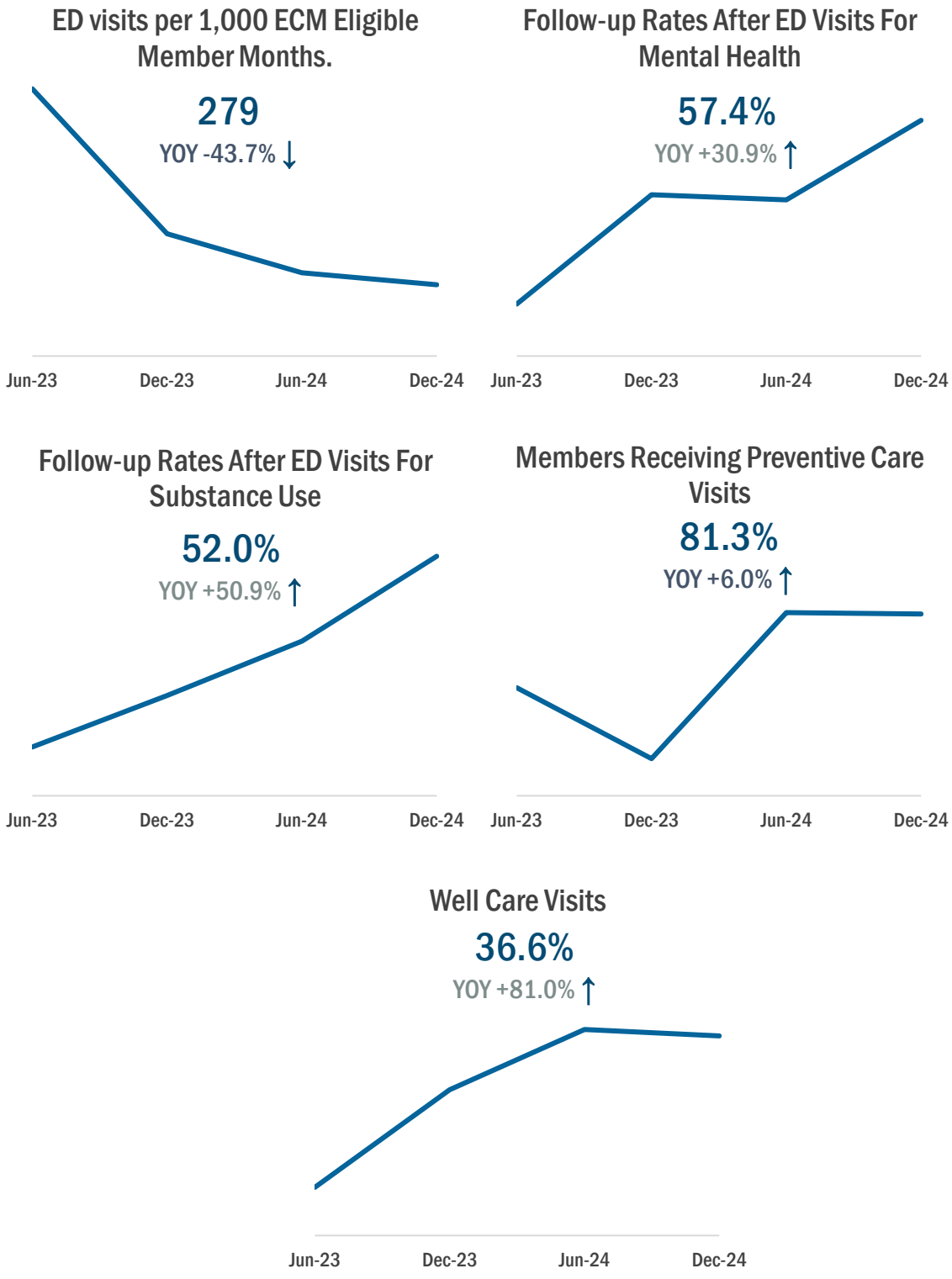
Table 7. Comparison of Enrollment in Care Management Programs

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.



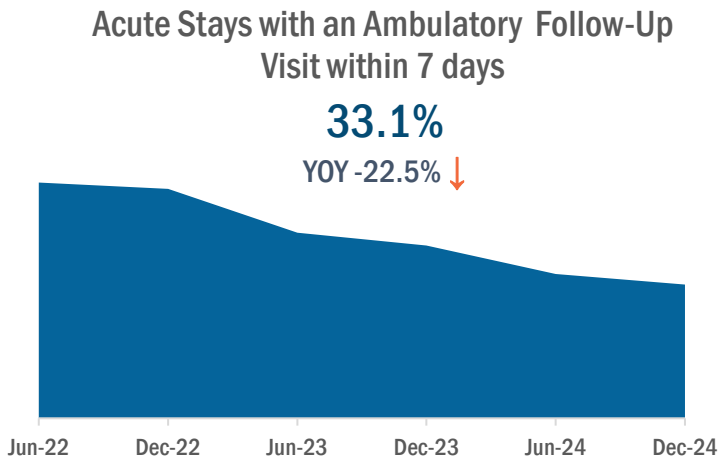
8.4.4 Transitional Care Services

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

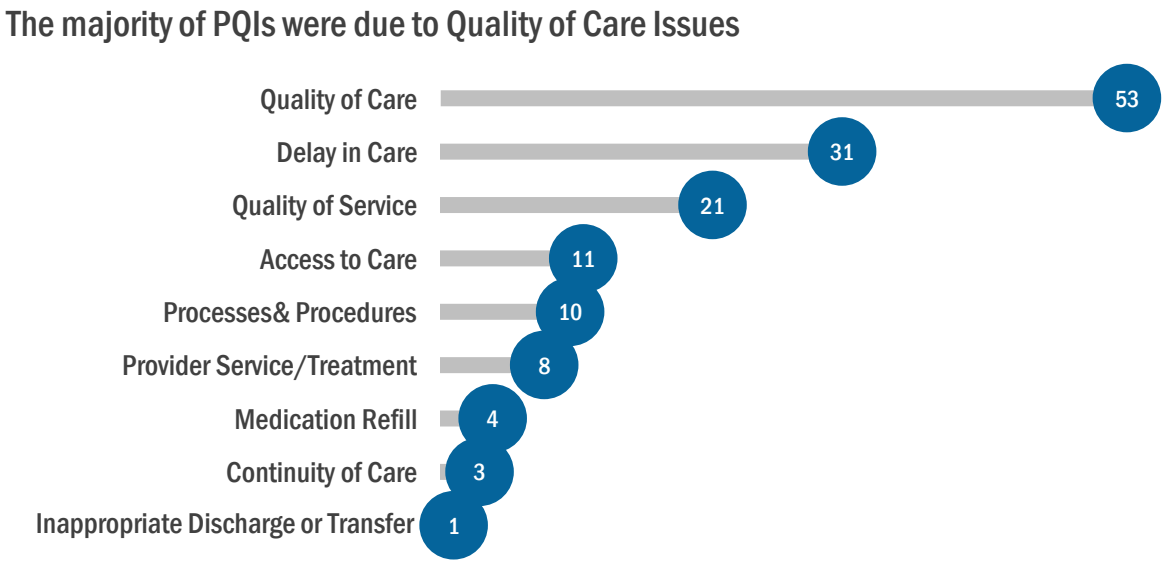
Patient safety is a top priority at CCHP, and various departments collaborate to address this critical aspect of healthcare. Routine reviews of data from sources such as grievances, appeals, access and availability metrics, claims, medical record review, HEDIS measures, satisfaction surveys, utilization 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.	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
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.

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
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.

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
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.

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
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	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
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	

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
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.

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
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.

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
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.

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
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.

Quality Improvement and Health Equity Transformation Program Description 2025

CONTRA COSTA HEALTH

ACCREDITED NCQA HEALTH PLAN ACCREDITED

January 2025

1 TABLE OF CONTENTS

2 INTRODUCTION

Contra Costa Health Plan (CCHP) is a federally qualified, state-licensed, and county-sponsored Health Maintenance Organization (HMO) serving Contra Costa County in the East Bay of the San Francisco Bay Area. Established in 1973, CCHP became the first county-sponsored HMO in the United States.

CCHP is a department within Contra Costa Health (CCH), the health services division of Contra Costa County's government. CCH integrates multiple departments that collectively support the health and well-being of the county's population. Other departments within CCH include:

- **Contra Costa Regional Medical Center (CCRMC),** a 166-bed public hospital, Level II trauma center that includes ten outpatient Federally Qualified Health Centers (FQHCs). CCRMC offers a comprehensive range of services, including a Cancer Care Program, and is home to a nationally recognized Family Medicine Residency Program.
- **County Behavioral Health Services**, which oversees specialty mental health and alcohol and other drug (AOD) services, carved out from Medi-Cal.
- **Community Health & Safety,** which houses a range of departments serving the entire county. The County Public Health Department operates a wide range of programs and services, including school health centers, health care for the homeless, case management programs, the Women, Infants, and Children (WIC) program, communicable disease control, HIV/AIDS Ryan White programs, family maternal and child health programs, and mobile clinics. Health, Housing, and Homelessness operates shelters, homeless street outreach, supportive housing, and other programs serving individuals experiencing homelessness. Environmental Health and HazMat focus on food safety, including restaurant licensing and inspections, as well as other public safety and environmental health initiatives such as hazardous materials (HazMat) management and response. Emergency Medical Services (EMS) provides oversight for prehospital care, ambulance services, and disaster preparedness.

All divisions of CCH, including CCHP, share centralized infrastructure for Human Resources, Finance, and Information Technology. This integrated structure enables collaboration and streamlines operations to support the mission of serving Contra Costa County residents.

According to the 2023 American Community Survey (1-year estimate) from the U.S. Census Bureau, Contra Costa County has a population of approximately 1.155 million residents. CCHP provides health insurance to roughly 270,000 members, covering over 20% of the county's population, including one-third of the county's children. Our membership is diverse and comprised of 42% Hispanic/Latino, 14.9% of White/Caucasian, 12% of Black/African American, 11.4% of Asian and 1.6% of more than one race. Language wise,

38% of CCHP members have preferred language other than English; besides English, Spanish is the most common preferred language at 28.6%, followed by Chinese (1.2%), Dari (0.9%) and Portuguese (0.75%).

Contra Costa Health Plan currently serves approximately 263,000 Medi-Cal members and is one of two Medi-Cal Health Plans serving the region.[1] CCHP serves over 85% of Medi-Cal members in Contra Costa County. Beginning in 2024, the Department of Managed Healthcare (DHCS) launched a new managed care contract and the managed care plan transition, in which members in various geographic regions were transitioned to new managed care plans. In 2024, Anthem Blue Cross left the Contra Costa service area and DHCS entered a direct contract with Kaiser Permanente. Previously, Kaiser Permanente was a delegate of CCHP.

CCHP also administers a commercial product for County employees, County retirees, and In-Home Support Services (IHSS) caregivers. CCHP covers approximately 6,500 commercial members with these product lines.

Starting in 2026, CCHP will be starting a new line of business for dually enrolled Medicare and Medicaid beneficiaries, a Dual-Special Needs Plan (D-SNP). CCHP has approximately 23,000 dual enrollees, and estimates that approximately 10% will enroll in the first year.

The CCHP provider network consists of Contra Costa Regional Medical Center and Health Centers and the Community Provider Network, which includes Federally Qualified Community Health Centers, contracted provider groups, and private practices.

The Quality Improvement and Health Equity Transformation Program (QIHETP) collaborates with Contra Costa Health divisions, CCHP internal departments, provider networks, and community-based organizations to facilitate safe, effective, cost efficient, equitable, and timely care to members. The Quality Council, a multi-disciplinary physician group, and the Equity Council, a group of community and provider stakeholders, guides the overall development, implementation, and evaluation of the quality and equity. The Joint Conference Committee was appointed by the Board of Supervisors to oversee the QIHETP for CCHP.

3 Program Purpose, Goals, and Scope

3.1 Program Purpose

CCHP is committed to the delivery of high-quality and equitable health care services to our culturally and linguistically diverse members. CCHP's Quality Improvement and Health Equity Transformation Program (QIHETP) is designed to measure, monitor, evaluate, and enhance the quality and safety of health care services, ensuring not only the equitable

[1] Kaiser Permanente is the other plan serving the Medi-Cal population, however, enrollment is limited to select populations according to Kaiser's direct contract with the California Department of Health Care Services (DHCS).

delivery of healthcare, but also promoting and achieving equitable health outcomes for all members.

3.2 GOALS

The overarching quality and equity goals at CCHP are to:

- Achieve better health outcomes for members by closing gaps in care that are informed by evidence-based practice guidelines.
- Provide a robust population health management strategy to address the needs of members across the continuum of care services.
- Promote health equity and reduce disparities in care through a coordinated strategy with members, providers, and the community.
- Ensure patient safety by ensuring adequate and timely identification and investigation of issues.
- Improve the member experience of care, including timely access to care that is convenient and culturally competent.
- Avoid unnecessary utilization in the ED and hospital by investing in preventive care and coordinating care across settings.
- Stabilize or reduce health care costs by targeting the right resources to the patients who need them most.
- Optimize the provider experience through meaningful collaboration and reducing administrative barriers.

To achieve these goals, CCHP:

- Uses data from a variety of sources to identify areas for improvement in clinical care, member experience, and provider experience measures.
- Solicits input from our providers and members through various committees and provider meetings. This includes the Community Advisory Committee, Equity Council, Quality Council, and Joint Conference Committee.
- Collaborates with community-based organizations and providers in developing outreach and health education strategies.
- Establishes aims, measures, interventions, and improvement teams for Performance Improvement Projects (PIPs).
- Leverages technology and automation to establish proactive identification and outreach systems for services.
- Continuously monitors performance, sustain performance where targets are met, and develop an improvement strategy to address where performance falls short.
- Provide training and education to staff and providers to ensure all services provided are culturally and linguistically appropriate.

3.3 PROGRAM SCOPE

The QIHETP scope includes the provision of clinical care (medical and behavioral health) and service for all Medi-Cal and Commercial members. In partnership with CCHP departments, provider networks and facilities, community-based organizations, and Contra Costa Health (CCH) departments, the QIHETP Program encompasses all aspects of care and service including, but not limited to:

- Access to care
- Continuity and care coordination between primary care and specialty care, as well as primary care and behavioral health
- Developing and implementing a population health strategy
- Evaluating utilization, cost, and clinical trends
- Facility Site Reviews and ongoing monitoring to assess compliance with patient safety standards
- Health education
- Cultural and linguistic services
- Identifying and addressing health disparities through targeted performance improvement projects
- Identifying and addressing overuse and underuse of clinical services
- Addressing member appeals and grievances
- Ensuring excellent member experience with care and service outcomes
- Achieving NCQA Accreditation standards for the Medi-Cal product line
- Potential quality issues identification and resolution
- Preventive, chronic care and acute health care guidelines compliance
- Developing and educating on clinical practice guidelines
- Ensuring high provider satisfaction with CCHP services
- Quality measurement and implementing Performance Improvement Projects (PIPs) in underperforming measures

Healthcare settings within the Scope of Services include:

- Acute hospital services
- Ambulatory care services including preventive health care, family planning, perinatal care, and chronic disease management
- Ancillary services including, but not limited to lab, pharmacy, radiology, medical supplies, durable medical equipment (DME), and home health
- Behavioral health (mild/moderate and substance use disorder)
- Emergency services and urgent care
- Long-term care including skilled nursing facilities and rehabilitation care
- Specialty care and tertiary care providers

CCHP complies with applicable Federal civil rights laws and is responsible for ensuring that all medically necessary covered services are available and accessible to all members

regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and that all covered services are provided in a culturally and linguistically appropriate manner.

4 Program Governance and Structure

4.1 Overview

Program governance and structure form the foundation of the program, ensuring effective oversight, accountability, and alignment with regulatory standards to meet the needs of members.

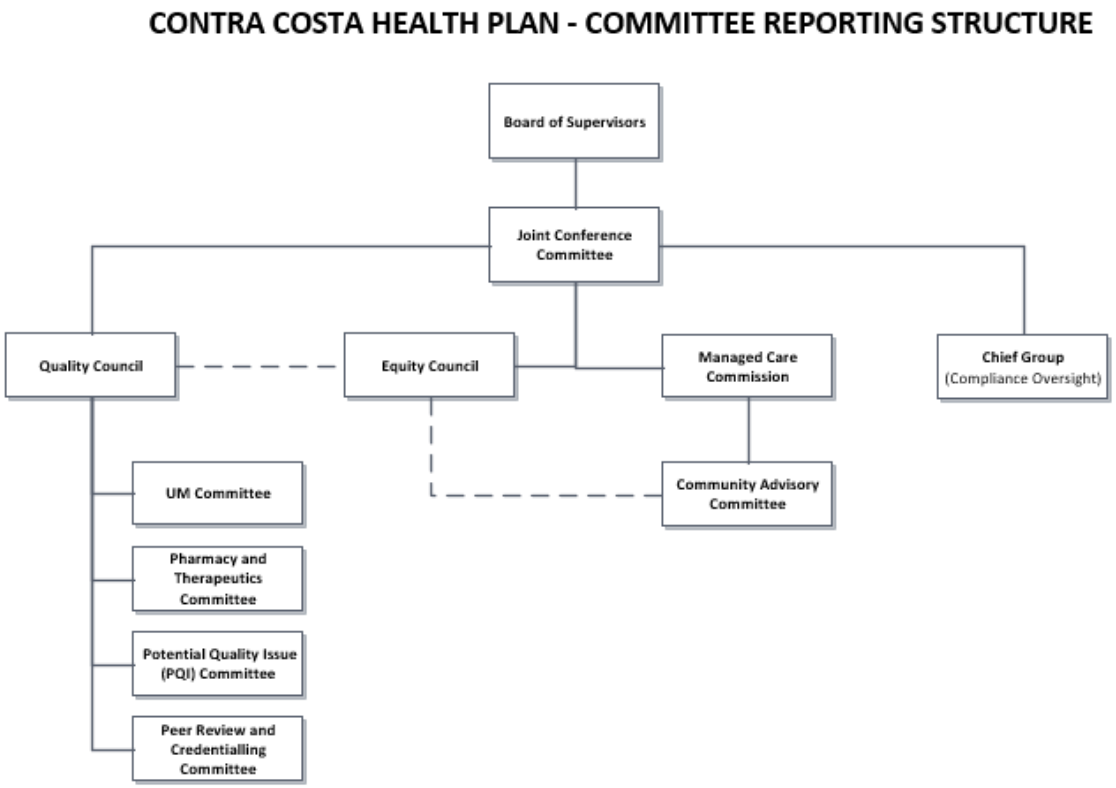
4.2 Program Governance

The Quality Council (QC) and the Equity Council (EC) are the principal committees for directing and overseeing quality, equity, and patient safety operations and activities for CCHP, including but not limited to, clinical and service-related performance improvement projects, access to care studies for medical and behavioral health, member grievances, potential quality issues, case management, utilization management, and oversight of delegated entities for utilization management and behavioral health. The Quality Council and Equity Council make recommendations to the Joint Conference Committee, which has been delegated the approval body for the Quality Program by the Contra Costa County Board of Supervisors.

As the governing body, the Joint Conference Committee gives authority to the Chief Medical Officer and the Chief Executive Officer of the Plan to ensure the QIHETP has the needed resources to meet its goals and to evaluate and monitor the program's progress toward reaching its goals. The CEO has authority over general administration of the Plan and reports to the JCC on the health plan's operations, including quality and equity.

4.2.1 Organizational Chart

Below is an organizational chart of the committee reporting structure.



4.2.2 Joint Conference Committee

The Joint Conference Committee (JCC) is one of the mechanisms by which the Contra Costa County Board of Supervisors exercises oversight of CCHP, including quality operations and activities. Two members of the Board of Supervisors are assigned to serve on the JCC. The other two JCC members are providers within the CCHP network, one representing CCRMC and one representing the CPN network. All meetings of the Joint Conference Committee are open to the public in accordance with the Brown Act. Responsibilities of the JCC include:

- Promote communication between the Board of Supervisors, the CCHP Quality Council, and CCHP administration.
- Assess and monitor the overall performance of CCHP and its contracted providers including, but not limited to, the quality of care and service provided to members.
- Review, evaluate, and make recommendations annually regarding modifications to the Annual QIHETP Program Description, Program Evaluation, and Work Plan.

- Receive, evaluate, and act on reports from the Quality Council and Equity Council on a quarterly basis or more frequently if needed. Any action taken by the JCC is subject to approval by the Board of Supervisors.

4.2.3 Quality Improvement and Health Equity Committee (QIHEC)

The California Department of Health Care Services (DHCS) requires all Medi-Cal managed care plans to establish a Quality Improvement and Health Equity Committee (QIHEC) to guide the integration of quality improvement and health equity efforts. Contra Costa Health Plan (CCHP) fulfills this requirement through the coordinated work of two complementary committees: the Quality Council and the Equity Council. Together, these councils support the continuous development, execution, and assessment of CCHP's quality and health equity initiatives.

The Quality Council, with a clinical focus, includes providers from various specialties and is responsible for overseeing clinical care, performance improvement projects, and member outcomes. The Equity Council expands membership to include community-based organizations, public health representatives, and other non-clinical stakeholders, alongside clinical participants, to address health disparities, review discrimination grievances, and promote equitable care across the member population. While each council maintains distinct membership to reflect their specific areas of focus, overlapping representation ensures alignment and coordination of efforts, fostering a comprehensive approach to improving both quality and equity in care delivery.

4.2.3.1 Quality Council

The Plan's Quality Council assists in oversight and assurance of the quality of clinical care, patient access, service excellence and patient safety of CCHP. The committee ensures that providers are involved in the planning, prioritization, and implementation of quality initiatives, as well as monitoring the care and service received by our members.

Responsibilities of the Quality Council include:

- Reviews, evaluates, and acts upon the reports of subcommittees.
- Reviews and approves the QIHETP Program Description, prior year's Annual Evaluation, and current Work Plan.
- Annually reviews, evaluates, and makes recommendations to the Board of Supervisors or the Joint Conference Committee on the status of contracted providers delegated for quality management, utilization management, credentialing, medical records, and member rights.
- Reviews reports concerning member grievances and potential quality and safety issues. The Quality Council investigates such occurrences and makes recommendations to the Credentialing Committee, Board of Supervisors and/or the Joint Conference Committee regarding resolution or implementation of any corrective action that may be required.
- Reviews reports regarding activities including, but not limited to: quality improvement projects, potential quality issues, population health management

programs, cultural and linguistic services, appeals and grievances, delegation audit scores and recommendations, access and availability reports, HEDIS quality measures, CalAIM updates, utilization review turn-around time and interrater reliability, and over/under utilization of clinical resources. The Quality Council evaluates these reports and makes recommendations to the Board of Supervisors and the Joint Conference Committee regarding implementation of any corrective action that may be required.

- Reviews and evaluates quality reports pertaining to medical, Pharmacy and Therapeutics, and benefit interpretation policy issues. The Quality Council makes recommendations to the Board of Supervisors and the Joint Conference Committee regarding trends and modifications to be implemented.
- Reviews and approves clinical practice guidelines at annually.

The Chair of the Quality Council is the Chief Medical Officer. The Co-Chair is the Director of Quality and Healthy Equity. The Quality Council meets eight times per year. A quorum is greater than 50% of voting member attendance. Voting members are the Chief Medical Officer and practicing clinicians in the provider network. The network clinicians participating in the Quality Council represent multiple specialties that align with the needs of our Medi-Cal population. Specialties that provide direct input into the Quality Program include a general surgeon, psychiatry, pediatrics, internal medicine, family medicine, OBGYN, and cardiology.

4.2.3.1.1 Subcommittees Reporting to Quality Council

The Pharmacy and Therapeutics (P&T) Advisory Committee report to Quality Council annually and meets at least quarterly to review pharmaceutical management activities. P&T keeps the Quality Council and provider networks abreast of pharmacy overuse/underuse, clinical projects, and pharmacy operations including authorization turnaround time (TAT), inter-rater reliability (IRR), activities related to fraud, waste and abuse, and other activities related to pharmacy management. P&T also reviews formulary changes, drug safety updates, recalls, pharmacy restriction and preference guidelines and generic substitution, therapeutic interchange and step therapy, and other pharmaceutical management policies.

The Director of Provider Relations presents updates from the Peer Review and Credentialing Committee (PRCC) to the Quality Council semi-annually. The Chief Medical Officer chairs the PRCC. Updates include summary data on the credentialing operations including number of providers credentialed and recredentialed, nonclinical provider complaints, and Facility Site Reviews performed including CAPS issued and completed. PRCC recommendations are submitted directly to the Board of Supervisors for approval.

The Chief Medical Officer or delegate chairs the UM Committee and minutes are reviewed at Quality Council. This committee oversees all outpatient and inpatient Utilization Management activities including the UM Program, UM Evaluation activities, UM Work Plan,

authorization TAT and IRR, and over/under utilization activities. Membership includes the Chief Medical Officer, Medical Directors, UM Director, UM Managers, UM Supervisors, and providers from the CCHP Provider Network. UM staff, Case Management Manager, and other department directors join on an ad-hoc basis. The committee meets at least every two months.

The potential quality issue (PQI) committee reviews all potential quality issues and levels cases. Voting members include the CCHP Medical Directors and Assistant Medical Directors. Nurses investigate cases and present to committee members who decide upon severity. The committee has oversight over PQI corrective actions.

4.2.3.2 The Equity Council

The purpose of the Equity Council is to provide oversight and collaboration with the CCHP Quality Improvement and Health Equity Transformation Program (QIHETP). The Equity Council reports to the Joint Conference Committee. CCHP's CMO is the committee chair, who works closely with the Director of Quality and Health Equity and the Cultural and Linguistics Manager on committee activities. The Equity Council meets four times a year and has representation from practicing network providers, community-based organizations, homeless services organizations, Contra Costa County Public Health, community health workers, and CalAIM providers.

Responsibilities of the Equity Council include oversight on the annual QIHETP annual plan, evaluation, and program description, overseeing activities surrounding National Committee on Quality Assurance (NCQA) Health Equity Accreditation, and ensuring all quality improvement projects and member surveys have a health equity lens, and reviewing appeals and grievances connected to health equity.

4.2.4 The Community Advisory Committee

Contra Costa Health Plan (CCHP) has a Community Advisory Committee (CAC) to ensure that its members have meaningful impact into CCHP's policies and decision making and are engaged as partners in the delivery of Medi-Cal Covered Services. CCHP utilizes the CAC to promote community participation within the areas of cultural and linguistic services, health education, and health inequities. CAC members identify and are advocates for health disparities that exist in the member population and discuss improvement opportunities for CCHP. CAC members work directly with the leadership of the operational departments within CCHP to receive oversight and direction. The CAC makes recommendations to the Board of Supervisors, County Health Services Director, and Chief Executive Office of CCHP.

4.3 Quality Improvement and Health Equity Structure

The quality improvement and health equity structure at CCHP is organized to ensure that all departments and key personnel work collaboratively to deliver high-quality, equitable care to our members.

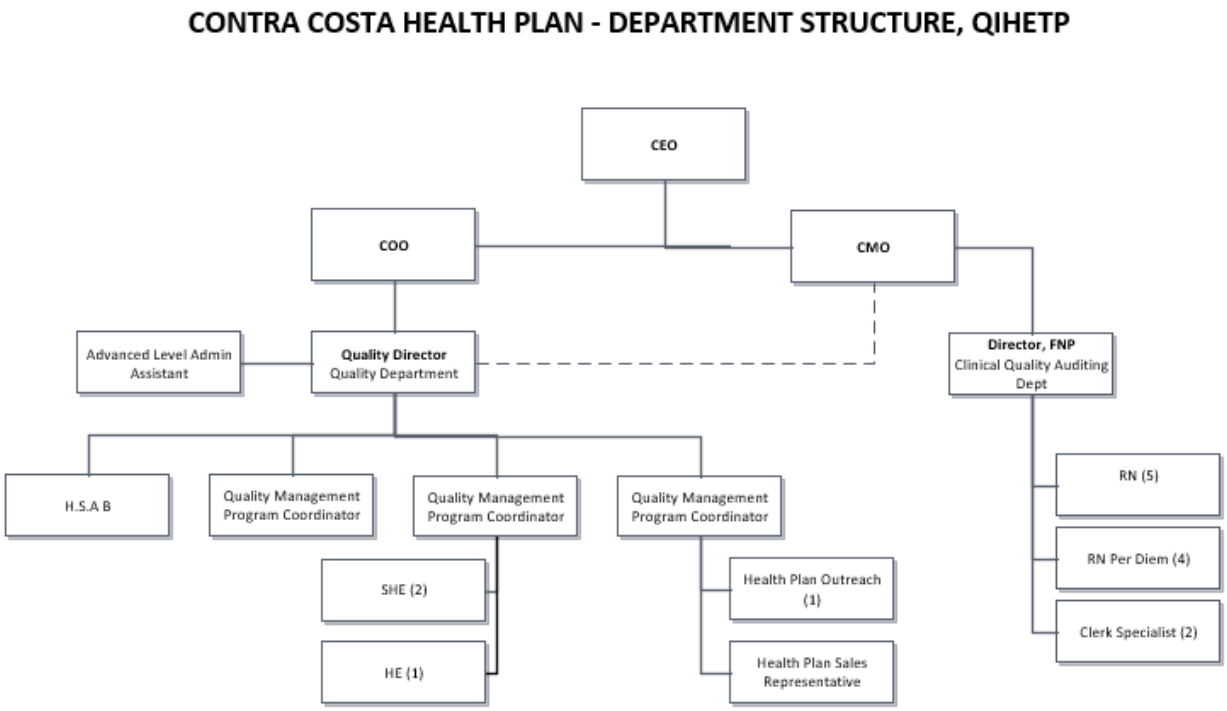
4.3.1 Key Departments Supporting Quality and Health Equity

The Quality and Health Equity Department and the Clinical Quality Auding (CQA) Department are the primary drivers of Contra Costa Health Plan's quality improvement initiatives. Together, these departments lead efforts to monitor, evaluate, and enhance the quality of care and services provided to our members. Their work encompasses quality measurement, patient safety, compliance, health equity, and strategic partnerships with other departments and providers to ensure continuous improvement.

The **Quality and Health Equity Department** is accountable for implementing quality measurement, quality improvement projects, health equity initiatives, cultural and linguistic services, health education, and population health management. Quality staff monitor quality indicators, implement, evaluate improvement activities, support CCHP leadership in strategic priorities, and collaborate with CCHP and CCH departments on the overall quality program. Additionally, the department ensures health equity is prioritized through the marketing strategy, policies, member and provider outreach, quality improvement activities, grievance and appeals, and utilization management. The Quality and Health Equity department collaborates with community-based organizations and develops targeted interventions designed to eliminate inequities. Population health management is a key aspect of the overall quality program, integrated into the Quality and Health Equity Department. Staff work together to achieve the shared goals of quality and population health initiatives. Both quality and population health report to the Director of Quality and Healthy Equity, with dotted line accountability to the Chief Medical Officer (CMO).

The **Clinical Quality Auditing Department** is responsible for patient safety initiatives at CCHP. This includes conducting all facility site reviews, medical record reviews, and physical accessibility reviews for primary care providers (PCP) and providers with specialties that are considered high-volume and/or high-impact. Responsibilities extend to investigating potential quality issues and provider preventable conditions and conducting ad hoc internal clinical audits. The team also conducts chart abstractions for HEDIS. This department reports to the Chief Medical Officer.

Below is an organizational chart of CCHP's quality and health equity department structure.



4.3.2 Supporting Departments in Quality

In addition to the Quality and CQA Departments, several other departments play vital roles in supporting Contra Costa Health Plan's quality improvement efforts. These departments, include both Clinical Operations departments and non-Clinical operations. Each contribute through their specialized expertise and programs to ensure comprehensive, coordinated, and member-focused care.

The **Utilization Management (UM) Department** is responsible for ensuring the appropriate use of healthcare services. This includes reviewing both medical necessity and appropriateness of care through pre-authorization, concurrent review, and retrospective analysis. The UM department also oversees the coordination of care across service areas and is involved in the monitoring over and under-utilization of health services. The department ensures that utilization practices align with the overall quality and health equity goals of the health plan, ensuring services are delivered efficiently, effectively, and equitably. This department reports to the Chief Medical Officer.

The **Behavioral Health Department** addresses the mental health and substance use needs of members. This department provides ensures behavioral health services are provided to members and staff facilitate transitions between carved-in and carved-out Medi-Cal services, collaborating closely with Contra Costa County Behavioral Health Services, which provided carved-out specialty mental health services and substance use services. Additionally, CCHP's Behavioral Health Department collaborates with primary care providers, school districts, and community organizations, and non-specialty mental health

providers, ensuring treatment is provided for members. By providing culturally sensitive and accessible care, CCHP works to reduce disparities in behavioral health access and outcomes, particularly for underserved communities.

The **Appeals and Grievance Department** is responsible for overseeing the formal process for handling member complaints, appeals, and grievances. The department ensures that all concerns are addressed promptly and thoroughly, and it plays an integral role in protecting member rights and improving member satisfaction. In addition to resolving individual issues, the department tracks trends in complaints and appeals, identifying opportunities for system improvements and enhancing the overall member experience and improving care quality.

The **Case Management Department** provides case management services and works closely with providers to ensure that high-risk and complex members receive the care and resources they need. This department helps to close gaps in care, manage chronic conditions, and provide a coordinated approach to treatment. It ensures members have access to the necessary healthcare services while also focusing on improving outcomes for vulnerable populations. The Care Management Department plays a crucial role in improving health equity by addressing disparities in access and outcomes for underserved groups and working on population health management with at-risk members and those needing care transitions.

The **CalAIM Department** at Contra Costa Health Plan plays a crucial role in connecting our most at-risk members to the services they need. This department works closely with Enhanced Care Management (ECM) and Community Supports (CS) providers to ensure that members facing complex health and social challenges are linked to appropriate, comprehensive care. By coordinating these services, the CalAIM Department helps to improve health outcomes and reduce disparities for vulnerable populations.

The **Member Services Department** is responsible for ensuring that members have a positive experience with the health plan. This includes providing support in accessing healthcare services, resolving complaints and grievances, and offering education on health plan benefits and services. Member Services plays a vital role in health equity by ensuring that all members, especially those from historically underserved communities, receive the appropriate support to navigate the healthcare system. They are also involved in outreach and engagement efforts to improve member satisfaction and involvement in their care.

The **Provider Relations Department** serves as the primary liaison between Contra Costa Health Plan and our network of healthcare providers. This department is dedicated to building strong partnerships with providers, addressing their needs, and ensuring seamless communication. Provider Relations supports contracting, onboarding, and training, as well as assisting providers with operational issues to ensure they have the tools and resources needed to deliver high-quality care to our members.

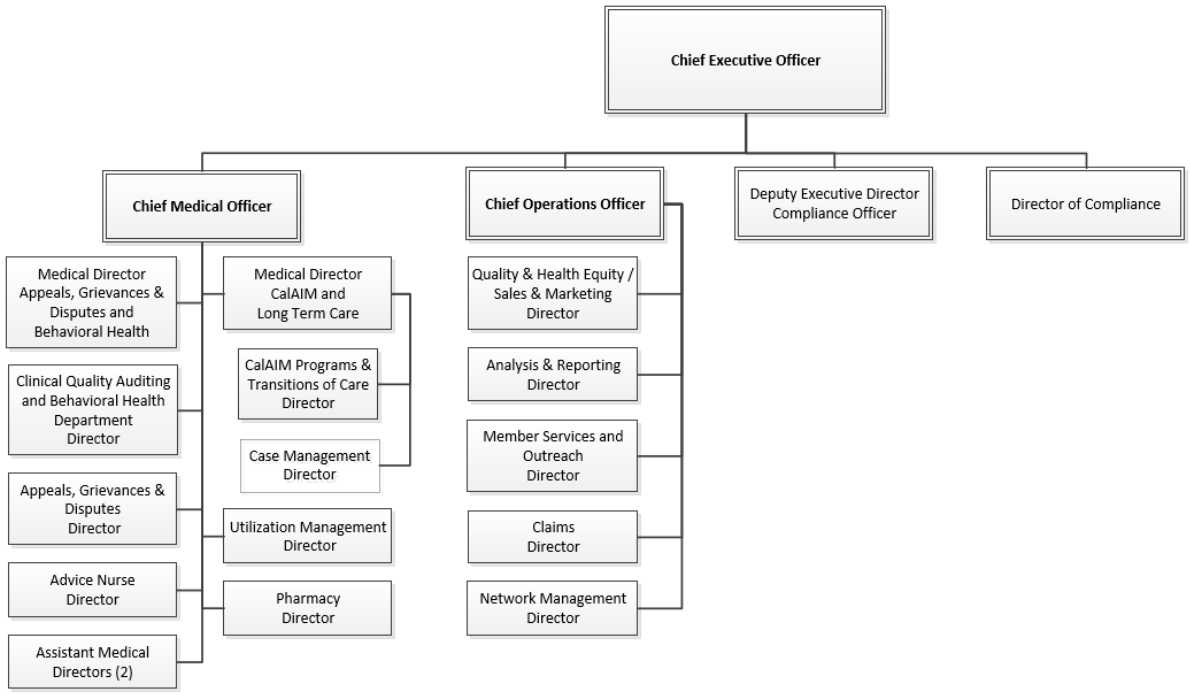
The **Business Intelligence Department**, centrally located in Contra Costa Health Information Technology Department, is responsible for the collection, aggregation, and

reporting of health data to measure and track performance against quality indicators. This department provides aggregates data for HEDIS quality measures, develops dashboards, reports, and drives analysis that allow for continuous improvement and ensure the success of quality improvement initiatives. The team works closely with both clinical and operational departments to identify trends, monitor progress, and make data-driven decisions that can improve care delivery and address health disparities.

Each department collaborates closely to ensure the quality of care and health outcomes for all members, with a particular focus on eliminating health disparities and improving care for historically marginalized groups. This collaborative approach supports the overall mission of CCHP to provide high-quality, equitable care to its diverse member population.

Below is an organization chart of CCHP.

CCHP Organizational Chart



4.3.3 Key Quality Personnel

The key quality personnel at Contra Costa Health Plan (CCHP) provide leadership and expertise to drive quality improvement, ensure patient safety, and promote health equity efforts. These individuals oversee critical functions, including clinical quality, behavioral health, pharmacy, and equity initiatives, ensuring that CCHP delivers high-quality, equitable care to its diverse member population.

4.3.3.1 Chief Medical Officer

The Chief Medical Officer is the Chair of the Quality Council, Equity Council, Pharmacy & Therapeutics, Peer Review and Credentialing Committee, and Utilization Management Committee. The Chief Medical Officer provides oversight and guidance to the development of clinical guidelines, improvement projects, and other initiatives. The Chief Medical Officer makes determinations in potential quality issues, grievances and appeals and has authority over peer review. The Chief Medical Officer oversees all medical staff at CCHP, including the Medical Directors, medical consultants, and nursing.

4.3.3.2 Medical Director, Behavioral Health

The CCHP Medical Director oversees behavioral health services at CCHP. The Medical Director provides oversight and guidance on the provision of behavioral health services, utilization management of behavioral health services, and oversight of the partnership and collaboration with County Behavioral Health, which provides Special Mental Health Services and Alcohol and Other Drug program. The Medical Director is a member of the Quality Council and Equity Council. This position is an MD is psychiatry and reports to the CMO.

4.3.3.3 Director of Behavioral Health Services

Contra Costa County's Behavioral Health Services Director oversees Contra Costa's Specialty Mental Health, network of non-specialty mental health, and Alcohol and Other Drug treatment services. The County Behavioral Health Services Director is a member of the Quality Council and provides guidance and insight on all behavioral health aspects of the quality program at CCHP. This position is a PhD.

4.3.3.4 Director of Pharmacy

CCHP's Director of Pharmacy oversees pharmaceutical safety services, the development of formularies, pharmacy utilization review, and the oversight of CCHP's pharmacy benefit manager for the commercial line of business. The Director of Pharmacy is the co-chair of the Pharmacy & Therapeutics Committee. This position is a PharmD and reports to the CMO.

4.3.3.5 Director of Quality and Health Equity

The Director of Quality and Healthy Equity works closely with the Chief Medical Officer, the Quality Council, and Equity Council on developing, implementing, and evaluating the QIHETP activities. The Director of Quality and Health Equity is responsible for the oversight of the QIHETP work plan, population health management portfolio, and overseeing department staff. The Director of Quality and Healthy Equity reports to the Chief Operations Officer with a dotted line to the Chief Medical Officer.

4.3.3.6 Clinical Quality Auditing Director

The Clinical Quality Auditing (CQA) Director works closely with the Chief Medical Officer (CMO), the Director of Quality and Healthy Equity, the Appeals and Grievances Department, and with the Quality Council, on adopting, assessing, and implementing clinical quality

activities. The CQA Director oversees the clinical quality nurses. The CQA Director reports to the CMO.

4.3.3.7 Quality Managers

The QIHETP has Quality Managers responsible for the day-to-day management of the quality improvement and equity activities. One is responsible for the NCQA health plan accreditation. The second is responsible for population health management activities, administering quality improvement projects, member experience surveys, disease management programs, and overseeing CCHP's team of health educators. This person serves as CCHP's Qualified Health Educator for DHCS. The third serves as the Cultural and Linguistic Services Manager who is responsible for implementing all aspects of the Cultural & Linguistics program and cultural competency trainings according to state and federal regulations and providing technical assistance to providers to ensure provision of culturally sensitive and appropriate care to CCHP members. This position reviews member grievances with a health equity lens to identify any potential acts of discrimination against members. In addition, this position is responsible for successful implementation of all Equity Committee priorities as well as leading equity-focused improvement projects. These positions report to the Director of Quality and Health Equity.

4.3.3.8 Quality Nurses

Nurses in the clinical quality auditing department oversee Facility Site Reviews, Medical Record Reviews, Physical Accessibility Review Survey, HEDIS chart abstractions, potential quality issues, and ad hoc audits and oversight. The Quality Nurses report to the Clinical Quality Auditing Director.

4.3.3.9 Health Education Specialists

CCHP has two Senior Health Education Specialists and one Health Education Specialist that ensure that the health education program is responsive to members' needs. The health educators develop, implement, and evaluates the Health Education Program, which includes a range of health education resources and delivery modalities, and the position works internally with other departments to assess literacy levels of health education and member informing materials, including the member newsletter. The Senior Health Educator reports to the Quality Management Program Coordinators.

4.3.3.10 Health Services Administrator

The Health Services Administrator is responsible for management HEDIS reporting and access and availability reporting. This person conducts analysis and develops reports for CCHP's quality measures. This position reports to a Director of Quality and Healthy Equity.

4.3.3.11 Secretary Advanced Level

The Secretary Advanced Level is responsible for providing administrative support to the Quality and Equity Team. The Secretary organizes and takes minutes at the Quality Council and Equity Council meetings, provides administrative support to access studies, and

coordinates encounter data validation chart abstractions. The Secretary reports to the Director of Quality and Healthy Equity.

5 Quality Improvement, Equity, and Population Health Programs

5.1 Quality Improvement and Health Equity Program Planning

CCHP incorporates ongoing documentation cycles that applies a systematic process of assessment, identification of opportunities, action implementation, and evaluation. This documentation cycles includes: Quality Program Description, Quality Work Plan, and Quality Program Evaluation. These documents, along with the quality council charter, are reviewed annually by the Quality Council.

5.1.1 QIHETP Program Description

The Quality Program Description is a document that outlines CCHP's structure and process to monitor and improve the quality and safety of care to members.

5.1.2 QIHETP Work Plan

The work plan identifies the scope of the quality programs and defines activities to be complete in the program year. The work plan is developed annually after completing the Quality Program Evaluation from the previous year. The work plan includes objectives, planned activities, timeframe, and staff members responsible.

5.1.3 QIHETP Program Evaluation

The quality program evaluation includes an annual summary of all quality activities, impact the program had on member care, and an analysis of the achievement of goals, and an assessment of revisions.

5.2 NCQA Accreditation

5.2.1 NCQA Health Plan Accreditation

The quality and health equity department takes the lead on interpreting standards, identifying gaps, consulting with other department functions on closing their gaps, ensuring submission of appropriate and timely documentation, and providing general oversight and maintenance of the NCQA accreditation status. CCHP was granted its fourth full three-year Accreditation early in 2023. The next review is March 2026.

5.2.2 NCQA Health Equity Accreditation

The quality and health equity department takes the lead on the NCQA Health Equity Accreditation which must be achieved no later than January 2026. In preparation for this initial accreditation, the cultural and linguistic manager with the other CCHP departments to ensure compliance on the health equity accreditation standards. Data will be stratified

to identify health disparities and work collaboratively with CCHP departments to implement targeted interventions and update policies and practices.

5.3 Measurement, Analytics, Reporting, and Data Sharing

CCHP in partnership with Contra Costa Health IT department has the technology infrastructure and data analytics capabilities to support goals for quality management and improvement actives. 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 support quality activities. This integrated data warehouse allows for the collection of all quality performance data across the health plan and delivery system.

The Quality and Health Equity Department partners with our Business Intelligence team to collect HEDIS data annually for Managed Care Accountability Sets (MCAS), NCQA HEDIS Accreditation measures, and DMHC Health Equity and Quality Measure Set (HEQMS). This includes over 70 measures that cover clinical effectiveness, clinical resource utilization, access and availability, and member experience with care. CCHP utilizes a certified HEDIS engine for reporting. CCHP also contracts with a vendor to conduct the CAHPS survey. HEDIS data is stratified by race, ethnicity, language, provider network, provider and other key demographic variables to identify variations and opportunities to improve care and service. The Quality and Health Equity Department works with the BI and IT teams to develop and utilize dashboard and reports to evaluate performance and identify opportunities for improvement.

In addition to HEDIS reporting, CCHP regularly produces the following mandated reports: DMHC Timely Access to Care, Member and Provider experience, DHCS Encounter Data validation, DHCS Performance Improvement projects, and External Quality Review (EQR) reporting. CCHP also tracks internal quality metrics aimed at improving care and services for members. CCHP reviews the EQR technical report and evaluation recommendations to make improvements annually.

5.4 Performance Improvement Projects

5.4.1 Quality Improvement Framework

The Quality Program utilizes the Model for Improvement and PDSA cycles to continuously evaluate and improve care and services for our members. Our broader aims focus on improving health, member experience, health equity, and cost efficiency. Work is prioritized by:

- Regulatory requirements from DHCS, DMHC, and NCQA
- Data-driven by performance in in HEDIS and other quality metrics
- Findings from the Population Needs Assessment
- Data on PQIs, member grievances, internal member surveys, and access studies
- Assessment on value and impact on members

- Synergies with the delivery system to identify areas where combined health plan and delivery system collaboration can best achieve results.

5.4.2 Active Performance Improvement Projects

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. Additionally, CCHP identifies additional performance improvements in the work plan based on an analysis of quality data. Annually, CCHP reviews quality metric data, assesses measurement areas that need improved, and develops improvement projects to be added to the work plan. On an at minimum of monthly basis, CCHP reviews quality metric data and may modify the work plan to add additional performance improvement projects. CCHP identifies areas where there is a decline in performance level or CCHP is under the desired quality target. Quality staff conduct a root cause analysis and develop a plan to implement a performance improvement project.

5.5 Population Health Management

The work of population health is to maximize health by co-creating services with members and providers which deliver primary and secondary evidence-based interventions for the prevention and management of illness in our assigned population. In 2023, the Department of Health Care Services (DHCS) launched Population Health Management, a key feature of CalAIM. Population Health Management will establish a cohesive, statewide approach that ensures Medi-Cal members have access to a comprehensive program that leads to longer, healthier and happier lives, improved health outcomes, and health equity. This will be accomplished through the following initiatives:

5.5.1 Population Needs Assessment, Strategy, and Impact Report

Annually, as part of NCQA accreditation, CCHP conducts a comprehensive Population Needs Assessment uses available data sources to identify disparities and trends. CCHP utilizes the Population Needs Assessment to develop its Population Health Management Strategy, an annual document approved by the Quality Council that outlines the programs CCHP will implement to address the needs of the population. CCHP assesses the population health impact of the programs implemented in the strategy to determine the efficacy of programming and inform future programming. Population Needs Assessment is also used to identify priorities for Cultural and Linguistic Program.

CCHP also participates on the steering committee for Contra Costa County's Public Health Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). By aligning our Population Health Management Strategy with the overall needs identified in the CHA and CHIP, we ensure that our initiatives are responsive to broader community health priorities and foster collaborative, community-wide health improvements.

5.5.2 Gathering Member Information

Member data is fragmented between provider clinical systems, claims, and other administrative data systems, including social services. Screening questions to members are

often duplicative across settings. Leveraging its integration within the county delivery system, CCHP utilizes comprehensive data systems, integrating data from claims, clinical data, detention health, EMS, social services, homeless systems, and public health into one unified member record to co-locate this information for population health management activities.

5.5.3 Risk Stratification, Segmentation, and Tiering

CCHP employs a comprehensive approach to risk stratification, segmentation, and tiering by leveraging 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 and criminal justice data, CCHP establishes the foundational data for its risk stratification and tiering methodologies.

This diverse dataset enables CCHP to create individual member records based on risk, segmenting them into different risk categories, and tiering based on acuity. The incorporation of a broad range of data points facilitates the identification of interventions and eligibility criteria, allowing for the triaging of individuals to services. CCHP regularly evaluates its risk stratification methods for potential biases to ensure equitable resource allocation across all populations.

5.5.4 Population Health Services

CCHP has established a comprehensive population health program aimed at promoting overall well-being and addressing the varying needs of our members. This program focuses on keeping healthy members well, offering self-management resources for individuals with well-controlled chronic conditions, and providing case management support to those with poorly controlled chronic diseases. For our highest-need members, we offer Enhanced Care Management services tailored to those with significant healthcare utilization. Case Management Services, including Complex Case Management and Transitional Case Management, are structured around risk stratification to ensure the most appropriate support for those with the greatest needs. Additionally, our basic population health services provide health education, wellness promotion, and preventive care for all members.

5.5.4.1 Cultural and Linguistic Services

CCHP prioritizes culturally and linguistically sensitive care for its diverse membership, and ensures all services provided are non-discriminatory and meet all state and federal requirements. CCHP Cultural and Linguistic Services (C&L) program aims to prevent discrimination, offering culturally appropriate care to all members, including those with limited English proficiency and diverse backgrounds. CCHP C&L program advocates and uses the application of national standards for Culturally and Linguistically Appropriate Services (CLAS) developed by the Office of Minority Health to health plan operations by providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health

literacy, and other communication needs. To ensure members have access to cultural and linguistic services for effective communication during healthcare services, CCHP actively collects Race, Ethnicity, and Language (REAL) and sexual orientation and gender identity (SOGI) data to identify health disparities.

CCHP C&L Program coordinates and oversees all linguistic services to members, this includes 24-hour access to interpreter services, document translation, alternative format of information and ensures all critical materials are available in threshold languages. C&L Program provides annual training for staff and providers on health equity, communication skills, linguistic services, cultural competency, awareness and sensitivity. C&L program also develops and updates Diversity, Equity & Inclusion (DEI) training and Transgender, Gender Diverse, Intersex (TGI) cultural competency training, and ensures these trainings are incorporated within QIHETP goals. C&L program provides technical assistance to providers, collaborates with county health services and community agencies to reduce health disparities, and promptly responds to the cultural and linguistic needs of both providers and members. C&L program monitors cultural and linguistic needs and trends of CCHP's membership and works closely with Health Educators to ensure health education services meet the cultural and linguistic needs of our members.

In addition, C&L Program seeks community and member feedback through Community Advisory Committee, Equity Council, Population Health Assessment, member surveys and grievance monitoring to identify and prioritize opportunities for improving cultural and linguistic services.

5.5.4.2 Basic Population Health Management

Access, Utilization, and Engagement with Primary Care: CCHP ensures ongoing primary care access, member engagement, and strategies for non-duplication of services. The focus is on health equity, meeting National Standards for Culturally and Linguistically Appropriate Services (CLAS), and reporting on primary care spending.

Care Coordination, Navigation, and Referrals Across all Health and Social Services, Including Community Supports: CCHP guarantees access to needed services, partnering with primary care and other systems for effective care coordination, navigation, and referrals. Closed Loop Referrals are emphasized, ensuring coordination with various community resources.

Information Sharing and Referral Support Infrastructure: CCHP implements information-sharing processes and referral support infrastructure, complying with privacy laws and professional standards.

Integration of Community Health Workers (CHWs): CHWs are integrated into PHM, addressing various health-related issues. The new CHW benefit facilitates reimbursement for basic population health management services.

Wellness and Prevention Programs: Contra Costa Health Plan provides health education resources that meet the needs of members as identified in the Population Needs

Assessment and other sources such as HEDIS, Community Advisory Committee feedback, and member surveys. CCHP ensures members have access to low-literacy health education and self-management resources in all threshold languages. Resources are available on the CCHP website and through providers. CCHP provides classes, articles, videos, interactive tools for self-management, and links to community resources. CCHP maintains a directory of resources online and publishes this at least annually in the member and provider newsletters. Topics covered include health weight maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, avoiding at-risk drinking, and identifying depressive symptoms.

Programs Addressing Chronic Disease: CCHP offers evidence-based disease management programs, focusing on improving member health and well-being. Key conditions, including diabetes, cardiovascular disease, asthma, and depression, are addressed through health education interventions, member engagement, and closing care gaps to enhance equity and reduce health disparities. Aligned with the Population Needs Assessment and Population Health Management Strategy, initiatives are tailored to the unique needs of diverse Medi-Cal populations, fostering collaboration with community programs and supporting overall health improvement.

Programs to Address Maternal Health Outcomes: CCHP works to improve maternal health outcomes, adhering to comprehensive perinatal service program standards.

PHM for Children: CCHP ensures ensure early and periodic screening, diagnostic, and treatment for children, meeting federal and state requirements, coordinating health and social services, and actively promoting preventive services. CCHP is developing MOUs with WIC providers, First 5 programs, and Local Education Agencies strengthen support for school-based services.

Behavioral Health: CCHP is responsible for mild to moderate behavioral health services for Medi-Cal and all behavioral health services for commercial members. For Medi-Cal, CCHP partners with the Contra Costa County Behavioral Health Services to triage patients to determine level of severity and to provide appropriate treatment. For members who are seen at FQHCs in the community, members are generally triaged and treated at those facilities. Some Community Health Centers are providing embedded behavioral health services, and CCHP contracts with telehealth providers to further expand access. Quality activities for behavioral health focus on HEDIS measures, continuity and coordination of care for outpatient behavioral health, measuring behavioral health practitioner access and availability, and conducting an annual satisfaction survey aimed at those receiving behavioral health services. Updates on the quality activities are provided to the Quality Council quarterly and a Behavioral Health clinician is a member of the Quality Council.

5.5.4.3 Care Management

Care management services are designed to meet the needs of the most vulnerable members. CCHP has two essential programs - Complex Care Management (CCM) and Enhanced Care Management (ECM), both integral to addressing the diverse needs of MCP

members. CCM, aligning with NCQA standards, provides extra support for higher- and medium-rising-risk members who are not covered by ECM. It offers chronic care coordination and interventions for episodic needs, emphasizing flexible eligibility criteria determined by CCHP. CCM includes a comprehensive assessment, care plan, various interventions, and basic population health management integration. Care managers, assigned to each member, ensure effective communication, and access to needed services, including Community Supports.

ECM, initiated in January 2022, is a community-based benefit addressing the clinical and nonclinical needs of Medi-Cal's highest-need members through intensive coordination. CCHP contracts with ECM providers, which include providers, county agencies and community-based organization. The ECM providers assign a lead care manager to each member for personalized in-person interactions. ECM eligibility is based on specific "Populations of Focus" criteria, rolled out in phases throughout 2022-2024. ECM and CCM operate on a continuum, with members transitioning from ECM to CCM as needed, ensuring comprehensive care management. DHCS monitors outcomes through quarterly reporting, evaluating and enhancing Populations of Focus definitions and policies over time to optimize the ECM benefit.

5.5.4.4 Transitional Care Services

The concept of care transitions encompasses the movement of members from one care setting to another, such as hospital discharges to home-based settings, community placements, or post-acute care facilities. Key responsibilities include services such as comprehensive medication reconciliation upon discharge and follow-up care by a provider. Individuals considered high risk are assigned a care manager upon discharge who coordinate transitional care services. Individuals considered low risk can access additional coordination services as needed by having a direct pathway to transitional care services.

5.6 Patient Safety Activities and Projects

Patient safety is addressed by multiple plan departments. Staff regularly review data from grievances and appeals, access and availability data, MCAS measures, satisfaction survey results, utilization and case management data, studies on adherence to clinical guidelines, and data from facility site reviews and chart reviews to identify areas of risk to members' safety. Data is presented regularly to the Quality Council.

5.6.1 Potential Quality Issues and Provider Preventable Conditions

Any department, provider or member can identify a potential quality issue (PQI) and forward it to the Clinical Quality Auditing Department for investigation and resolution. Additionally, a quality nurse reviews a report that identifies Provider Preventable Conditions (PPCs) and develops PQIs as necessary. The quality nurses investigate all cases and present these to the PQI committee, which consists of the Chief Medical Officer, Medical Director, and Director of Pharmacy. The committee reviews and assigns levels to all PQIs. PQIs with a level of 3 will receive a Corrective Action Plan (CAP) and may be forwarded to

the Peer Review and Credentialing Committee. Provider Relations further identifies any trends at the provider level where intervention is warranted. The PRCC uses data from facility site reviews, grievances, and PQIs. Trends, recommendations, and updates on PPCs and PQIs are provided to the Quality Council at least annually.

5.6.2 Pharmaceutical Safety

Pharmaceutical safety is also addressed through overuse/underuse use activities. These include: reviewing members with fifteen or more prescriptions and referring to case management if applicable, reviewing members with opioid prescriptions from multiple providers and/or pharmacies, reviewing members with potentially unsafe medication regimens, and reviewing prescription trends for potential fraud, waste, and abuse. Actions include notifying providers around medication safety and educating patients.

5.6.3 Facility Site Review and Medical Record Review

CCHP ensures that primary care provider sites operate in compliance with all applicable local, state, and federal regulations, and that sites can maintain patient safety standards. CCHP ensures that medical records follow legal protocols and provider have documented the provision of preventive care and coordination of primary care services. Facility Site Review nurses complete periodic full scope review of facilities and their medical records, and complete corrective action plans for cited deficiencies.

5.6.4 Clinical Practice Guidelines

CCHP reviews clinical practice guidelines annually through the Quality Council to ensure they reflect current, evidence-based standards of care. These guidelines are reviewed and approved by the Chief Medical Officer and the medical team, then distributed to all network providers to support consistent, high-quality clinical practices across the network.

5.7 Provider Collaboration

CCHP collaborates with provider stakeholders on improvement efforts. This includes 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 among diverse entities. CCHP actively participates in the Safety Net Council structure, engaging with FQHCs and regional clinical consortiums. The commitment to collaboration includes participation in various operational, quality, and provider-focused meetings, underscoring the shared goal of enhancing healthcare quality and delivery.

CCHP hosts quarterly provider trainings that cover updates on quality activities and provides an opportunity for providers to share their input on the Quality Program. Efforts to support quality also focus on building partnerships through committee and workgroup participation. CCHP regularly meets with internal departments and external agencies to collaborate on quality improvement initiatives.

Examples of these supports to our providers and partners are listed below:

- CCHP CEO and CMO attend regular Joint Operations Meetings with hospitals.
- CMO, Provider Relations, Case Management, and Quality staff conduct regular provider site visits.
- Community clinics meet quarterly as part of the Safety Net Council with attendance by the CCHP's Chief Executive Officer, CMO and Director of Quality and Healthy Equity. FQHC CMOs meet monthly with the CCHP CMO and Medical Directors. CCHP Director of Quality and Healthy Equity meets every other month with individual FQHCs sites quality teams, going over quality projects and areas of opportunity. Providers from the RMC and CPN networks are members of CCHPs Quality Council, chaired by CCHP's Chief Medical Officer and Quality Management Director (CMO).
- The Medical Director of Case Management and Long-Term Care hosts quarterly Joint Operations Meetings with CalAIM providers.
- CCHP Director of Quality and Healthy Equity attends the Ambulatory Redesign workgroup, Quality Incentive Pool (QIP) improvements meetings, Outreach Committee, and presents annually at the Patient Safety/Performance Improvement Committee at CCRMC.
- CCHP Medical Director of Behavioral Health meets regularly with County Behavioral Health Services and CCHP Director of Quality and Health Equity meet regularly with County Behavioral Health Services quality team to coordinate on quality initiatives.
- Senior leaders and practitioners from Behavioral Health Services attend CCHP's monthly Quality Council meetings.
- The Chiefs across all CCH divisions meet at least monthly to collaborate on CCH strategies including population management.
- Updates on CCHP's population management activities are communicated regularly to our Board, the Joint Conference Committee.

5.8 Delegation

Delegated activities are supported by a delegation agreement that define the specific functions and responsibilities for the delegated entities. CCHP does not delegate any quality and health equity or utilization management functions.

2025 Quality Improvement and Health Equity Transformation Program (QIHETP) Work Plan

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Dates	Responsible Team
1. QIHETP Structure					
1.1	**QIHETP Program Documents**	By March 2025, approve annual quality program documents at 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 2024 QIHETP Evaluation	January -February 2025	Beth Hernandez, Quality Director Jersey Neilson, Quality Manager
1.2			Develop annual 2025 QIHETP Program Description, incorporating structural changes identified in the evaluation	January -February 2025	Beth Hernandez, Quality Director Magda Souza, Clinical Quality Auditing Director
1.3			Develop annual 2025 QIHETP Work Plan, including monitoring of issues identified in prior years that require follow -up.	January -February 2025	Beth Hernandez, Quality Director Magda Souza, Clinical Quality Auditing Director
1.4	**Quality Council**	Ensure Quality Council oversight of CCHP's quality and health equity program through regular meeting schedule	Convene monthly Quality Council meetings. Convene a minimum of 8 Quality Council meetings annually	January -November 2025	Irene Lo, CMO Beth Hernandez, Quality Director Arnold DeHerrera, Administrative Asst
1.5		Ensure program governance of Quality Council meeting	Revise Quality Council charter; approval of program description, evaluation and work plan	January -February 2025	Beth Hernandez, Quality Director
1.6		Ensure there are policies and procedures to meet regulatory and operational needs	Review CCHP policies annually and upon any new APL changes	January 2025 - December 2025	Beth Hernandez, Quality Director
1.7	**Equity Council**	Ensure Equity Council oversight of CCHP's quality and health equity program through regular meeting schedule	Implement the QIHETP work Plan and convene quarterly scheduled meetings	March, June, September, December 2025	Irene Lo, CMO Hua Hsaun Liu, Quality Manager Beth Hernandez, Quality Director Arnold Deherrera. Administrative
1.8		Ensure program governance of Equity Council meeting	Create Equity Council Charter and ensure approval of program description, evaluation and work plan.	January 2025-December 2025	Irene Lo, CMO Beth Hernandez, Quality Director
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.	January 2025-December 2025	Beth Hernandez, Quality Director Hua Hsuan Liu, Quality Manager Irene Lo, CMO
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.	January 2025-December 2025	Belkys Teutle, Member Services Manager Cynthia Laird, Member Services Supervisor Hua Hsuan Liu, Quality Manager
2. NCQA Accreditation					
2.1	**NCQA Health Plan Accreditation**	By December 2025, complete NCQA survey submission for survey submission due date in December. Achieve re-accreditation by March 2026.	Complete submission materials on standards and guidelines according to project plan and timeline.	January 2025 - December 2025	Shari Jones, Quality Manager Beth Hernandez, Quality Director

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Dates	Responsible Team
2.2	**NCQA Health Equity Accreditation**	By August 2025, complete NCQA survey submission for survey submission due date in August. Achieve accreditation status by December 2025.	Complete submission materials on standards and guidelines according to project plan and timeline.	January 2025 - August 2025	Shari Jones, Quality Manager Hua Hsuan Liu, Quality Manager Beth Hernandez, Quality Director
3. Measurement, Analytics, Reporting, and Data Sharing					
3.1	**HEDIS Reporting and Quality of Clinical Care (DHCS, NCQA, DMHC)**	1. By June 15, 2025, report HEDIS MY2024 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 MPL measures and establish performance improvement plan for those near or at risk 3. Achieve 4.5 Stars on NCQA Health Plan Ratings. 4. Prepare for transition to ECDS by identifying efficiencies in data system measurement 5. Align HEDIS measurements to quality improvement projects and strategic goals for 2025	Complete all annual HEDIS, MCAS, and HEQMS activities, ensuring compliance with quality measurement regulatory agencies, including NCQA, DHCS, EQRO, and DMHC.	January 2025 - June 2025	Dustin Peasley, HEDIS Manager Shari Jones, Quality Manager Business Intelligence Analysts CQA Nurses
3.2			Complete annual HEDIS MY2024 report, analyzing yearly trends and identifying areas for improvement. Incorporate report into Population Health Needs Assessment.	July 2025 -September 2025	Dustin Peasley, HEDIS Manager Jersey Neilson, Quality Manager Beth Hernandez, Quality Director
3.3			Identify areas of opportunity for data systems and data sources for MY2025	July 2025 - August 2025	Beth Hernandez, Quality Director Dustin Peasley, HEDIS Manager Business Intelligence
3.4			Develop and implement improvement projects targeting at risk measures and those measures that align with other strategic goals of CCHP	March 2025 - August 2025	Jersey Neilson, Quality Manager Beth Hernandez, Quality Director
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	January 2025 - December 2025	Business Intelligence Beth Hernandez, Quality Director
3.6			Maintain quality feedback mechanism for providers, which shares performance rates by provider group on CCHP priority measures and identify unique areas of opportunities	July 2025 - September 2025	Beth Hernandez, Quality Director Jersey Neilson, Quality Manager
3.7			Maintain system of data sharing gap in care lists with CPN network to allow for ongoing quality improvement	January 2025 - December 2025	Beth Hernandez, Quality Director Jersey Neilson, Quality Manager

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Dates	Responsible Team
3.8	**Member Experience and Quality of Service (NCQA, DHCS)**	By June 30, 2025, gather, analyze, and highlight areas of opportunity utilizing member experience surveys and grievances 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.	August 2025 - September 2025	Jersey Neilson, Quality Manager
3.9			Host internal CAHPS think tank to gather insights into member experience from cross-functional teams	July 2025 - August 2025	Jersey Neilson, Quality Manager
3.10			Review and analyze the limited English enrollee survey	August 2025 - September 2025	Hua Hsuan Liu, Quality Manager
3.11			Review and analyze behavioral health specific member experience surveys	October - November 2025	Jersey Neilson, Quality Manager
3.12			Develop report on MY2024 member experience	February - March 2025	Jersey Neilson, Quality Manager
3.13			Review and analyze grievance and appeals data according to NCQA methodology and review quality of service and quality of care. Complete annual report	February - March 2025	Jill Perez, Director of UM/AGD Jersey Neilson, Quality Manager Nicolas Barcelo, Medical Director
3.14			Develop survey tool to assess member experience with Case Management, conduct survey, analyze results	October 2025 - November 2025	Beth Hernandez, Quality Director Leizl Avecilla, Case Management Director
3.15			Conduct new member survey to assess comprehension of new member materials	April 2025	Jersey Neilson, Quality Manager
3.16			Collect member experience on population health programs	March 2025 - August 2025	Health Educators Jersey Neilson, Quality Manager
3.17			Gather member input on member experience utilizing Community Advisory Committee. Incorporate into annual Population Health Needs Assessment, Impact Report, Strategy as well as Cultural & Linguistic Program.	April 2025 - September 2025	Hua Hsuan, Quality Manager Jersey Neilson, Quality Manager
3.18	**Provider Experience**	Implement standard process for collected provider experience and identify areas for opportunity	Implement Provider Experience Survey. Incorporate feedback into annual access report.	August 2025 - September 2025	Dustin Peasley, Quality Analyst Terri Leider, Director of Provider Relations
3.19	**Access to Care and Quality of Service (DMHC, DHCS)**	Achieve at least 70% compliance for urgent and non-urgent appointments during Provider Appointment Availability Survey Implement quality monitoring program on timely access standards	Complete all access monitoring through surveys and auditing 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	March 2025, June 2025, September 2025, December 2025	Dustin Peasley, Quality Analyst
3.20			Develop process for DHCS quarterly access monitoring	March 2025 - May 2025	Dustin Peasley, Quality Analyst
3.21			Create comprehensive annual access report that identifies trends and identifies areas for opportunities	March 2025 - May 2025	Dustin Peasley, Quality Analyst Beth Hernandez, Quality Director
3.22			Develop feedback loop to providers on their results from the annual PAAS/NCQA survey, providing education and timely access standards.	August - September 2025	Dustin Peasley, Quality Analyst

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Dates	Responsible Team
3.23	**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 Population Health Monitoring Reports, reviewing key KPIs on population health metrics	February, May, August, November	Beth Hernandez, Quality Director
3.24			Complete DHCS quarterly CalAIM ECM-CS Quarterly Monitoring Reports, reporting enrollment and utilization of CalAIM services	February, May, August, November	Pasia Gadson, CalAIM Director Sara Levin, Medical Director
3.25			Complete the monthly JSON CalAIM reporting	January - December 2025	Tyler Heslinger, Business Intelligence
3.26	**REAL and SOGI Data**	Achieve 90% of race/ethnicity reporting for membership Improve collection of sexual orientation and gender identify data.	Input new member REAL and SOGI surveys into ccLink	January 2025 - December 2025	Student Interns Arnold DeHerrera, Executive Assistant
3.27			Develop baseline measurement for SOGI data collection and establish targets.	February - March 2025	Hua Hsuan Liu, Quality Manager
3.28	**CLAS Reporting**	Ensure cultural and linguistic needs of population are being met by provider network	Conduct annual CLAS analysis of patient and provider population	January - February 2025	Hua Hsuan Liu, Quality Manager
3.29	**Encounter Data Validation (DHCS)**	Implement the encounter data validation study per the timelines and requirements from DHCS	Procure medical records and submit according to auditors deadlines	February 2025 - June 2025	Arnold DeHerrera Shari Jones, HEDIS Manager
3.30	**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	May - July 2025	Eloisa Lopez-Valencia, Quality Intern
4. Performance Improvement Projects					
4.1	**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	March 2025 - December 2025	Jersey Neilson, Quality Manager Nicolas Barcelo, Medical Director ECM providers
4.2	**Well Care Visits in the First 15-Months of Life**	Narrow the health disparities gap between Black/African American and Asian members to 5%	Identify regional and provider level disparities in WCV completion performance and develop targeted improvement project.	March 2025 - December 2025	Jersey Neilson, Quality Manager Hua Hsuan Liu, Quality Manager
4.3	**IHI Improvement Projects**	1. Increase WCV in 18-21 year olds at Brighter Beginnings to MPL. 2. Increase FUM and FUA rates by 5% over baseline.	Complete IHI Child Health Equity Collaborative.	April 2025	Jersey Neilson, Quality Manager Hua Hsuan Liu, Quality Manager Health Educators
4.4			Complete IHI Behavioral Health Collaborative with CCBHS.	April 2025	Beth Hernandez, Quality Director CCBHS
4.5	**Blood Lead Screening***	Increase pediatric blood lead screening rates to exceed the DHCS MPL. (Previously identified issue)	Collaborate with providers with low lead screening rates to identify opportunities for improvement	January 2025 - December 2025	Jersey Neilson, Quality Manager Health Educators
4.6	**Topical Fluoride Treatment in Children***	Increase the percentage of member under 21 who complete Topical Fluoride Treatment by 5%. (Previously identified issue)	Conduct outreach to member who did not have tropical fluoride treatment in the last 12 months, develop and distribute dental benefits material.	January 2025 - December 2025	Jersey Neilson, Quality Manager Hua Hsuan Liu, Quality Manager

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Dates	Responsible Team
4.7	**Disparities in Well Care Visits**	Reduce the disparity in well care visits for African American and Native Hawaiian/Pacific Islander children by reducing the gap to the 50th percentile benchmark by 50%.	Conduct regular outreach to African American and Native Hawaiian/Pacific Islander children who have not seen provider for over 12 months, and connect them to services they need.	January 2025 - December 2025	Jersey Neilson, Quality Manager Hua Hsuan Liu, Quality Manager
4.8	**D-SNP QIP Planning**	Identify QIP options for D-SNP based on eligible Medicare Population	Research quality measures for Medicare-only population and identify areas for opportunity upon D-SNP launch in 2026.	July 2025 - December 2025	Jersey Neilson, Quality Manager Beth Hernandez, Quality Director
4.9	**ED Workgroup**	Understand areas for improvement with regards to ED utilization	Convene workgroup to analyze ED utilization and identify areas for opportunity.	July 2025 - December 2025	Irene Lo, CMO Michael Cleary, Medical Director Beth Hernandez, Quality Director Jersey Neilson, Quality Manager
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.	January 2025 - December 2025	Jersey Neilson, Quality Manager Beth Hernandez, Quality Director
			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 2024 population needs assessment according to NCQA guidelines	July 2025 - October 2025	Jersey Neilson, Quality Manager
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	January 2025 - December 2025	Lisa Demoiz, CCH Epidemiologist Ashley Kokotaylo, Public Health Beth Hernandez, Quality Director Jersey Neilson, Quality Manager Business Intelligence
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, cultural and linguistic needs to identify and prioritize opportunities for improvement.	October - December 2025	Hua Hsuan Liu, Quality Manager
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	July 2025 - October 2025	Jersey Neilson, Quality Manager Beth Hernandez, Quality Director
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	July 2025 - October 2025	Jersey Neilson, Quality Manager
5.6	**Initial Screening Process**	Provide streamlined new member experience, with regards to HIF/MET, HRA/LTSS, and other assessments. Develop an new member outreach workflow to maximize Initial Health Appointments and New member survey completion Ensure system exists so members with positive screenings are identified for the appropriate services Develop data system so screening questions are results are shared across providers	Monitor ongoing HIF/MET and HRA completion rate and follow-up for positive screenings	September - December 2025	Beth Hernandez, Quality Director Leizl Avecilla, Case Management Director Pasia Gadson, CalAIM Director
5.7			Implement electronic HIF/MET and HRA screenings utilizing myChart questionnaires	March 2025 - June 2025	Beth Hernandez, Quality Director Leizl Avecilla, Case Management Director

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Dates	Responsible Team
5.8	**Initial Health Appointment***	Increase IHA completion rates. (Previously identified issue)	Conduct chart audits and give feedback and education to providers missing IHA elements	April 2025, October 2025	Magda Souza, FNP CQA Nurses
5.9			Implement text message and email reminder for patients to complete Initial Health Appointment	September - December 2025	Beth Hernandez, Quality Director
5.10	**DHCS Population Health Service/Risk Stratification, Segmentation, and Tiering**	Implement DHCS Population Health Service into existing workflow	Implement DHCS Population Health Service based on forthcoming guidance upon service launch.	July 2025 - December 2025	Beth Hernandez, Quality Director Bhumil Shah, Assoc Chief Information Officer
5.11	**Assessment and Reassessment**	Ensure annual assessment and reassessment of Members with LTSS needs and CSHCN	Utilize custom assessment for SPDs and CSHCN and triage according to needs	January 2025 - December 2025	Beth Hernandez, Quality Director
5.12	**Ongoing Engagement with PCP**	Increase regular engagement with PCPs Close Member gaps in preventative care	Utilized disengaged member reports and connect Members with PCPs & close care gaps	July - December 2025	Jersey Neilson, Quality Manager Health Educators
5.13	**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	June 2025 - December 2025	Pasia Gadson, CalAIM Director Business Intelligence
5.14	**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	March 2025 - July 2025	Pasia Gadson, CalAIM Director
5.15	**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	Educate providers and staff on available health education tools	January 2025 - December 2025	Jersey Neilson, Quality Manager Health Educators
5.16			Develop in person and telehealth classes to be facilitated by CCHP Health Educators	February - December 2025	Jersey Neilson, Quality Manager Sofia Rosales, Sr. Health Educator
5.17	**Colorectal Cancer Screening**	Increase colorectal cancer screening rates	Send out FIT kits monthly to Members due for colorectal cancer screening	January - December 2025	Regional Medical Center
5.18	**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	March 2025 June 2025 Sept 2025 Dec 2025	Jersey Neilson, Quality Manager Irene Lo, CMO Nicolas Barcelo, Medical Director Joseph Cardinalli, Pharmacy Director Beth Hernandez, Quality Director
5.19	**Chronic Conditions: Diabetes Management Program**	Reduce number of CCHP members with uncontrolled diabetes Increase the number of people enrolled in the Diabetes Prevention Program	Provide medically tailored meals to patients with uncontrolled diabetes. Evaluate efficacy of MTM.	January 2025 - December 2025	Sara Levin, Case Management Medical Director
5.20			Continue expansion of remote blood glucose monitoring partnership with Gojji	January 2025 - December 2025	Jersey Neilson, Quality Manager
5.21			Conduct PDSA with DPP provider to increase referrals & enrollment of prediabetic Members	January - March 2025	Jersey Neilson, Quality Manager Health Educators

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Dates	Responsible Team
5.22	**Maternal Health Outcomes**	Improve key maternal health outcomes across quality measures	Develop brochures for pregnant Members	January 2025 - March 2025	Jersey Neilson, Quality Manager Health Educators
5.23			Increase the number of pregnant Members receiving Transitional Care Services (TCS)	January 2025 - December 2025	Leizl Avecilla, Case Management Health Educators Outreach Team
5.24	**Keeping Members Healthy: Gaps in Care**	Notify members of gaps in care for needed preventive services	Continue mailing adult birthday letters	January 2025 - December 2025	Jersey Neilson, Quality Manager Sr. Health Educators
5.25			Develop specific pediatric birthday letter that provider more specific information to members in terms of gaps in care	July 2025 - October 2025	Jersey Neilson, Quality Manager Sr. Health Educators
5.26	**Health Education Materials and Resources**	Assure that members are provided health education materials and are informed on new community and medical services. Develop a strong community presence.	Publish member facing newsletter three times per year	February 2025, June 2025, November 2025	Jersey Neilson, Quality Manager Sr. Health Educators
5.27			Conduct outreach events at health clinics, CBOs, and other relevant locations.	January 2025 - December 2025	Jersey Neilson, Quality Manager Sr. Health Educators
5.28	**Culturally and Linguistically Competent Care**	Ensure systematic processes in place to promote cultural competent care and health equity by providing linguistics services, educational opportunities, current and up-to-date resources, and understanding of CLS needs. Less than 20% of respondent in member experience survey state they use friends/family for interpreter. More than 95% of respondent in member experience survey indicate they get interpreter services when request one.	Complete provider trainings and educate providers on interpretation requirements and resources, and reading level requirements	January 2025 - December 2025	Hua Hsuan Liu, Quality Manager
5.29			Facilitate translation and interpreter services request of educational materials, website, forms, and other documents.	January 2025 - December 2025	Hua Hsuan Liu, Quality Manager
5.30			Ensure all CCHP staff complete Transgender, Gender Diverse, or Intersex (TGI) by February 2025.	January - February 2025	Hua Hsuan Liu, Quality Manager Otilia Tuitin, Compliance Manager
5.31			Ensure all CCHP staff and providers complete Diversity, Equity, and Inclusion (DEI) training by December 2025.	January - December 2025	Hua Hsuan Liu, Quality Manager Otilia Tuitin, Compliance Manager
5.32			Educate and advocate interpreter services to CCHP members.	January - December 2025	Hua Hsuan Liu, Quality Manager
5.33			Review, monitor and track all grievances related to discrimination, language access and trans-inclusive care.	January 2025 - December 2025	Hua Hsuan Liu, Quality Manager

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Dates	Responsible Team
5.34	**EPSDT / Medi-Cal for Teens and Kids**	Ensure coverage of and timely access to all medically necessary EPSDT services to correct or ameliorate defects and physical and mental illnesses and conditions. Ensure Members <21 must receive all age-specific assessments and services required by MCP contract and AAP/Bright Futures periodicity schedule. Ensure provision of Medically Necessary Behavioral Health Treatment. Ensure compliance with all Case Management & Care Coordination requirements. 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. Ensure all network providers completed EPSDT-specific training no less than every 2 years using DHCS materials.	Monitor and trend denials for Members <21 years old	March 2025 June 2025 Sept 2025 Dec 2025	Jill Perez, Director of UM/AGD
5.35			Conduct outreach and education for identified Members who have fallen off of the pediatric well care visit periodicity.	January 2025 - December 2025	Jersey Neilson, Quality Manager Health Educators
5.36			Annual notification to Members <21 years old regarding EPSDT services	February 2025	Jersey Neilson, Quality Manager
5.37			Ensure and monitor bi-annual DHCS EPSDT training	February 2025	Heather Peang, Provider Relations Manager Jersey Neilson, Quality Manager
5.38	**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	January 2025 - December 2025	Leizl Avecilla, Case Management Director Pasia Gadson, CalAIM Director Sara Levin, Medical Director Beth Hernandez, Quality Director
5.39	**D-SNP CPIP Planning**	Develop comprehensive Chronic Care Improvement Program for D-SNP Population	Research regulatory requirements, conduct needs assessment of Medicare population, and develop comprehensive care improvement program.	March 2025 - December 2025	Irene Lo, CMO Beth Hernandez, Quality Director
5.40	**Transitional Care Services***	Ensure all high risk members receive transitional care services. (Previously identified issue)	Ensure high risk members receive referrals for transitional care services, utilizing automated referrals from ADT feeds as well as manual referral pathways.	March - May 2025	Leizl Avecilla, Case Management Director Sara Levin, Medical Director
5.41			Develop oversight process on discharge planning process	March 2025 - December 2025	Sara Levin, Medical Director Irene Lo, CMO
5.42		Ensure transitional care services support for low risk members	Provide phone number for low risk members to access transitional care services	January 2025	Belkys Teutle, Member Services Manager Cynthia Laird, Member Services Supervisor Hua Hsuan Liu, Quality Manager
5.43	**Non Specialty Mental Health Outreach and Education**	Conduct member outreach and education to inform of Non Specialty Mental Health Services	Streamline member information presented on cchealth.org website	January 2025 - June 2025	Jersey Neilson, Quality Manager Health Educators
5.44			Conduct outreach at Farmers' Markets, Open Air (Flea) Markets, and health clinic locations to inform members about NSMHS benefits.	January 2025 - December 2025	Health Educators
			6. Patient Safety		
6.1	**Potential Quality Issues (PQIs)**	Review and resolve potential quality issues within 120 days	Investigate and level all PQIs within timeframes. Issue CAPS according to leveling guidelines, report on trends.	January 2025 - December 2025	Maggie Souza, DNP - Clinical Quality Auditing Director

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Dates	Responsible Team
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	January 2025 - December 2025	Maggie Souza, DNP, Director Clinical Quality Auditing Department
6.3	**Over/Under Utilization**	Develop a standard over-under utilization report and develop standards with how reporting is used to improve care	Define measures to track and identify areas of opportunity for improvement initiatives	April - June 2025	Irene Lo, CMO
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	January 2025 - December 2025	Joseph Cardinalli, Director of Pharmacy
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	January 2025 - December 2025	Joseph Cardinalli, Director of Pharmacy
6.6		Antipsychotic, anti-depressant and mood stabilization prescriptions for children	Quarterly audit to determine if these medications that are being prescribed to children have a qualifying diagnosis	January 2025 - December 2025	Joseph Cardinalli, Director of Pharmacy
6.7		Improve Hepatitis C medication adherence	Review HepC medication to ensure that members are fully completing their course of treatment	January 2025 - December 2025	Joseph Cardinalli, Director of Pharmacy
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	January 2025 - December 2025	Joseph Cardinalli, Director of Pharmacy
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.	January 2025 - December 2025	Joseph Cardinalli, Director of Pharmacy
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	January 2025 - December 2025	Joseph Cardinalli, Director of Pharmacy
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.	January 2025 - December 2025	Maggie Souza, DNP - Clinical Quality Auditing Director Facility Site Review nursing team
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.	January 2025 - December 2025	Maggie Souza, DNP - Clinical Quality Auditing Director Facility Site Review nursing team
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	November 2025	Irene Lo, MD Quality Council
6.14			Distribute and educate providers on Clinical Practice Guidelines during quarterly provider trainings and in quarterly newsletter	January - March 2025	Irene Lo, CMO
			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	January 2025, April 2025, July 2025, October 2025	Irene Lo, CMO
7.2	**Provider Newsletters**	Provide regular communication to providers through provider newsletters	Provide quarterly provider newsletters covering a range of topics including regulatory changes/updates for providers	January 2025, April 2025, July 2025, October 2025	Provider Relations Compliance
7.3	**Quality Provider Meetings and Resources**	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	January 2025 - December 2025	Beth Hernandez, Quality Director
7.4	**Value Based Payment**	Implement newly created VBP program with provider groups to improve quality measurement activities	Implement newly created VBP program with large provider groups to increase quality measurement rates.	January 2025 - December 2026	Beth Hernandez, Quality Director Terri Leider, Director of Provider Relations

Item #	Program/Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Dates	Responsible Team
7.5	**Provider Portal and Panel Reports - Data Sharing**	Provider member level data on quality and gaps in cares to providers to assist in delivering needed services to members	Maintain daily update of provider portal with quality reports and gap in care reports. Implement new reports including well care periodicity schedules and admit, transfer, and discharge admittance data to providers on portal.	January 2025 - December 2025	Beth Hernandez, Quality Director
7.6	**Provider Site Visits**	Conduct site visits with provider to update on health plan operations	Conduct site visits with ten or more medical offices to open communication channel with providers.	January 2025 - December 2025	Irene Lo, Chief Medical Officer Beth Hernandez, Quality Director Fabiola Quintara, Network Management
7.7	**Training on Diversity Equity and Inclusion**	Ensure all providers are trained in DEI by December 31, 2025	Utilize newly developed DEI training and ensure providers receive training by December 31, 2025 and upon re-credentialing	January 2025 - December 2025	Hua Hsuan Liu, Quality Manager Heather Peang, Provider Relations
7.8	**Shared Decision-Making Aids**	Ensure all provider received evidence based shared decision making	Update website and provide evidence based decision aids to providers through regular communications	July 2025 - September 2025	Jersey Neilson, Quality Manager
			8. Delegation Oversight		
8.1	**Delegation oversight**	Assess whether delegation for quality and population health is necessary	Review activities to determine if delegation for quality or population is needed to enhance operations.	January 2025 - December 2025	Beth Hernandez, Quality Director Terri Leider, Director of Provider Relations

** Previously Identified Issue*

File #: 25-1247 **Agenda Date:** 4/9/2025 **Agenda #:** 6.1

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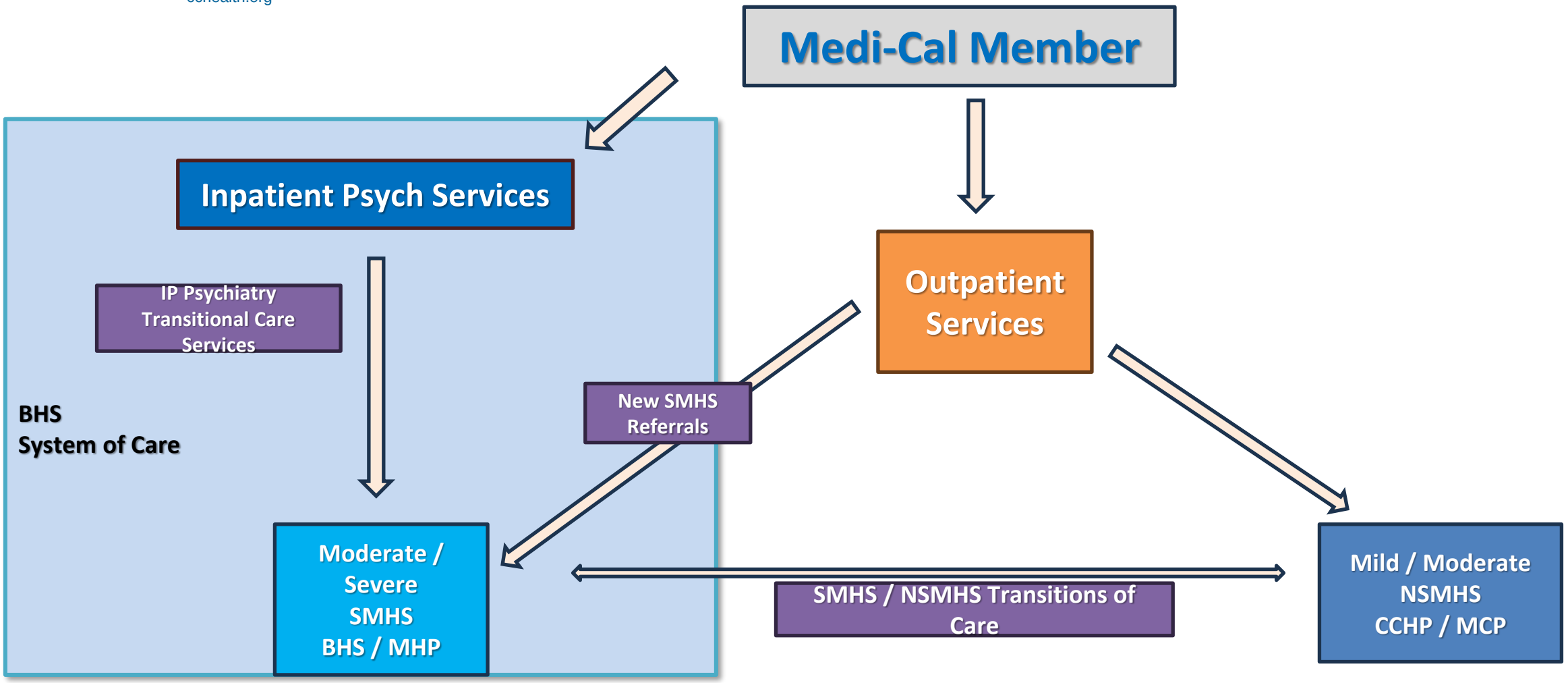
Mental Health Systems Navigation



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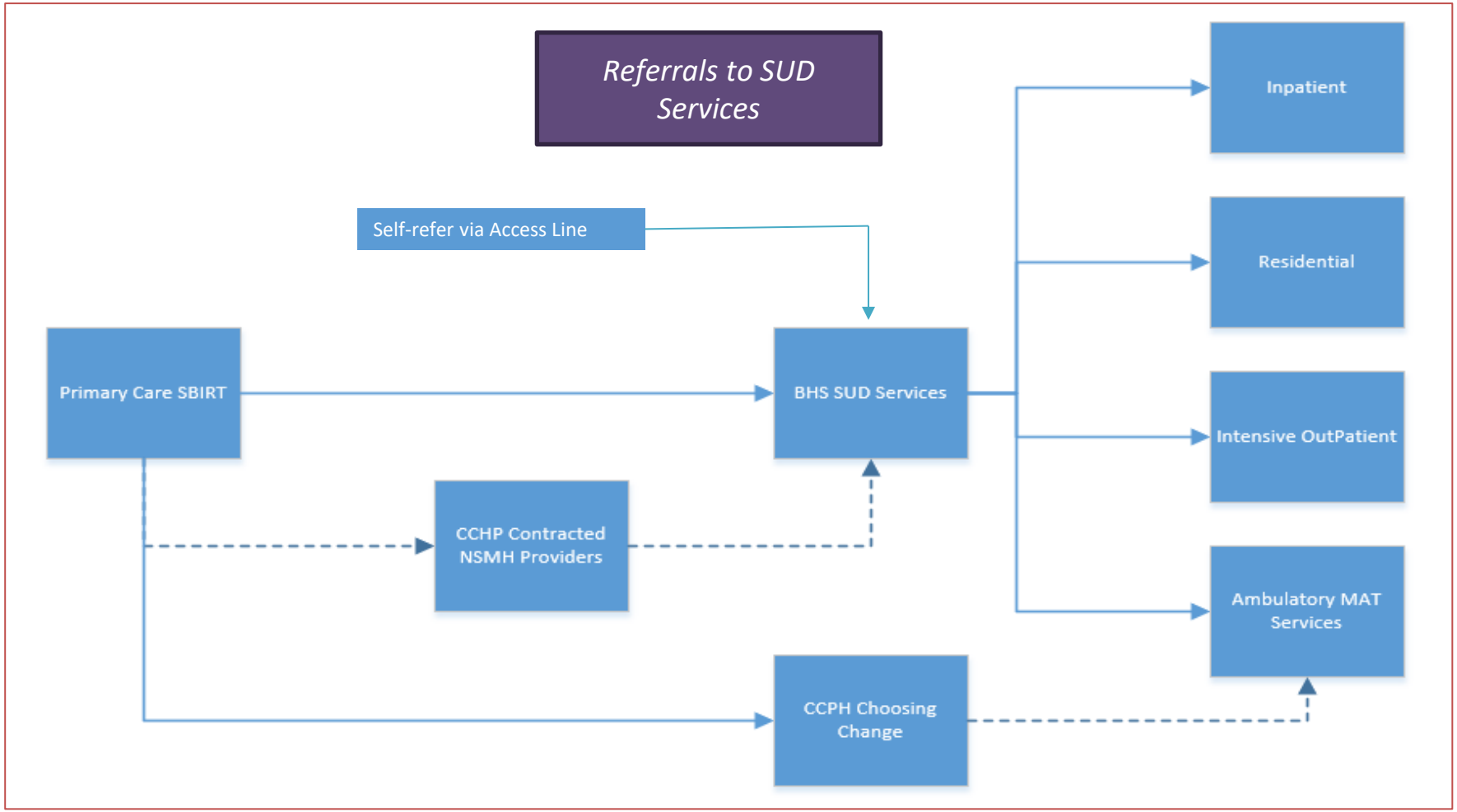
Access to Substance Use Disorder (SUD) Services via Drug Medi-Cal Organized Delivery System (DMC-ODS)



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Important Steps To Addressing Focused Audit Findings

Staffing

- New Per Diem Staff Hired to expand bandwidth of BHD to conduct coordination efforts
- Creation of 2 Charge Relief Nursing Positions within BHD to support operational expansion

Inter-Departmental collaboration

- Cross over of Case Management operations within BHD as related to member support (Transitional Care Services)

Inter-System collaboration

- New lines of communication and partnership between CCHP and BHS to identify and resolve barriers
  - Clinical collaboration between CCHP's BHD and BHS' ECM and Transitions Teams

Data Sharing

- CCHP having access to timely data regarding member referral and access to services (*within limitations of 42 CFR)

IT Support

- Automation of ccLink encounters based on Admissions data
- Expansion of Compass Rose Case Management interface specific to BHD activity – Trackable BHD Episodes with Finding-specific categories
- Enhanced Reporting from Compass Rose for management and audit purposes

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DHCS Mental Health Focused Audit Progress to Date

Five Audit Findings

2.1 *BH Case Management & Care Coordination* (for new referrals to SMHS)

2.2 *Coordination of Care for Transitioning Members* (moving from SMHS to NSMHS and vice-versa, closing the referral loop)

2.3 *Care Coordination/ Info Exchange with MHP* re: post-discharge care of In-patient Psych members

For each of these three:

- 4 of 5 dimensions completed/accepted
  - Policy & procedure updates
  - Design and implement data sharing
  - Care coordination plan
  - Increased Staffing and Training to do care coordination
- Pending: review and approval by DHCS of CCHP internal audit of process/results

2.4 *Good Faith Efforts to Confirm SUD Treatment*

- Initially hampered by terms of 42CFR Part 2, limiting exchange of identifying info
- DHCS has agreed to a plan to look at effectiveness (percent of referrals actually receiving treatment) in aggregate using claims data; new report developed by BI, pending DHCS approval of approach *(see next slide)*
- Future: in concert with BHS/DMC-ODS, devise a plan for outreach and care coordination for members not receiving care

2.5 *Follow Up to Understand Barriers to SUD Care*; Adjust Referral and Care Coordination System to Address Barriers

- Future – depends upon ability to share information; will require extensive collaboration with DMC-ODS

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DHCS Mental Health Focused Audit Next Steps

Focus on Continued Collaboration with BHS SMHS

- Increase show-rate for intake assessment
- Expand mental health services networks to allow for timely transitions
- Streamline member entry and navigation through Mental Health Services landscape

Expand collaboration opportunity with BHS (DMC-ODS) for coordination of Substance Use Services Care

- CCHP is not in possession of member-level information on patients who were referred and did *not* complete their intake.
- Ongoing conversations with BHS DMC-ODS regarding best next steps – for *trackable* outreach to members

Month	Referral Count	Completed Referral Count	% Completed Referrals
2024-03	334	267	79.9%
2024-04	347	277	79.8%
2024-05	368	269	73.1%
2024-06	286	225	78.7%
2024-07	377	300	79.6%
2024-08	367	292	79.6%
2024-09	301	238	79.1%
2024-10	339	267	78.8%
2024-11	258	188	72.9%
2024-12	308	233	75.6%
2025-01	414	297	71.7%
2025-02	320	202	63.1%
2025-03	111	55	49.5%

Draft of Report on SUD Referral Effectiveness

(not yet QA'd internally or approved by DHCS)

File #: 25-1248 **Agenda Date:** 4/9/2025 **Agenda #:** 6.2

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Member Grievances

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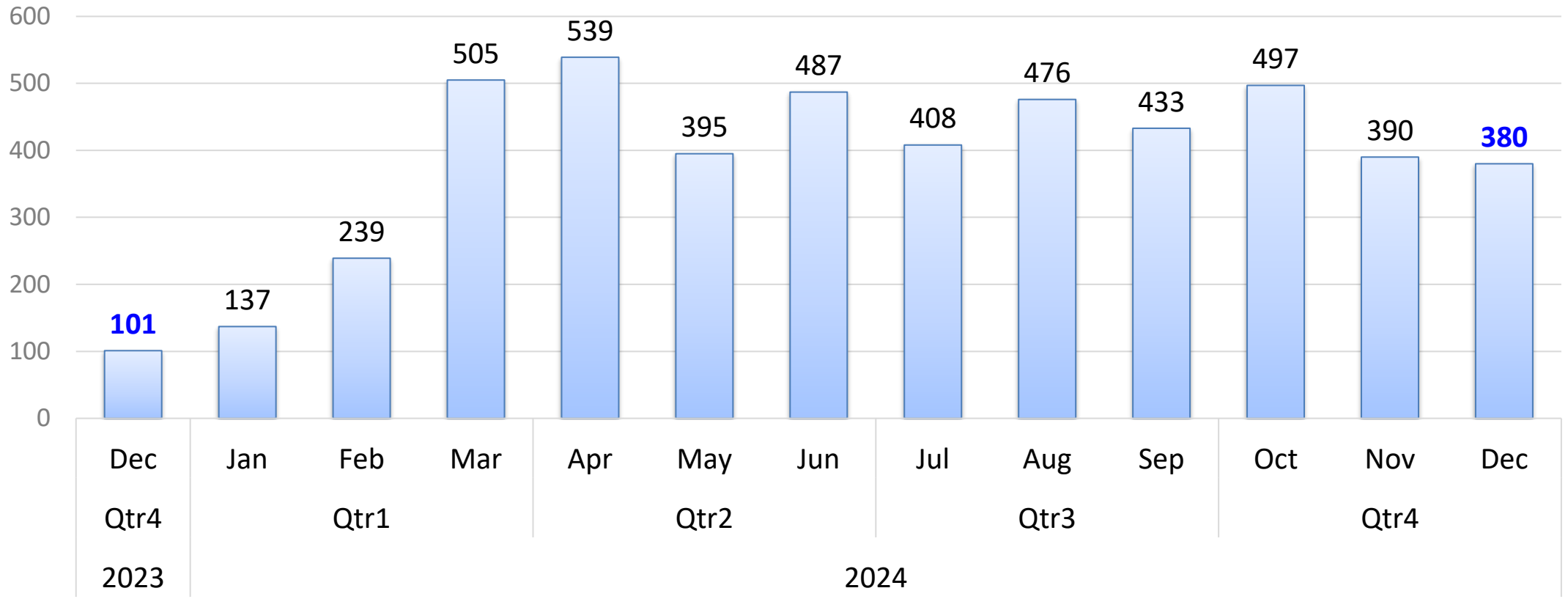
Total Grievances

12/2023 – 12/2024, by Month



Grievances in **December 2024 more than doubled by 276% compared** to last year same period.

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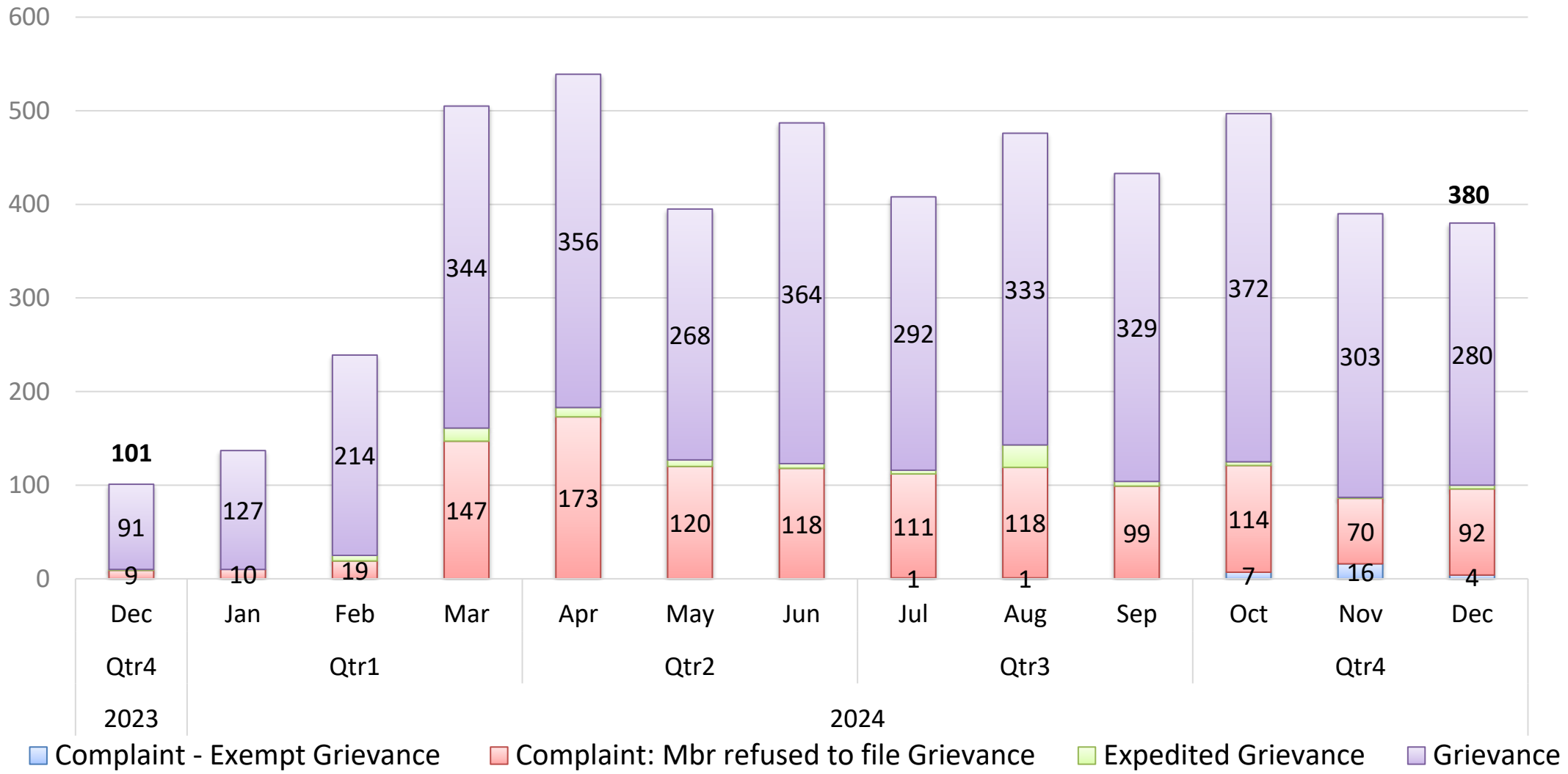
Grievance Topics
12/2023 – 12/2024, By Month



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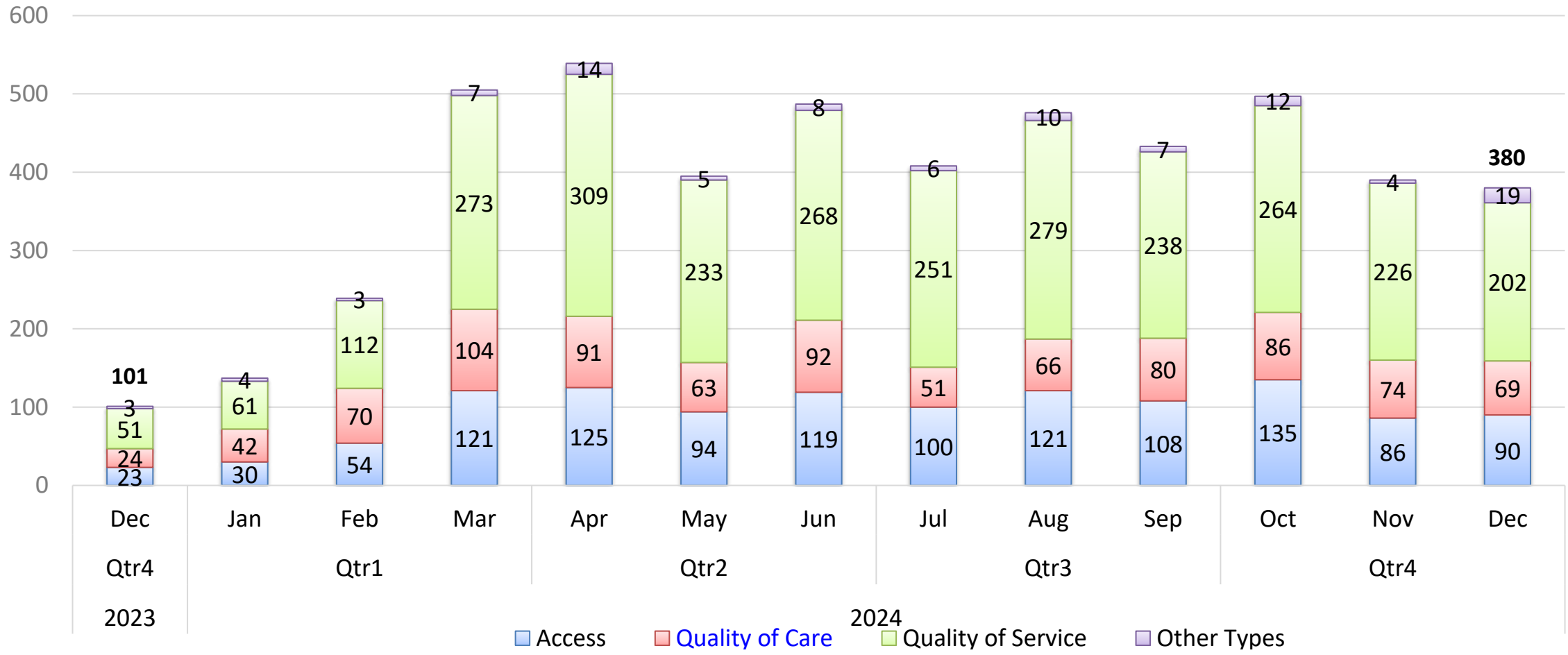
Grievance Issue Types
12/2023 – 12/2024, by Month



Top two drivers or **80% of grievances are Quality of Service & Access** grievance issue types, while **Quality of Care** makes up the difference at **~18% of total grievances.**

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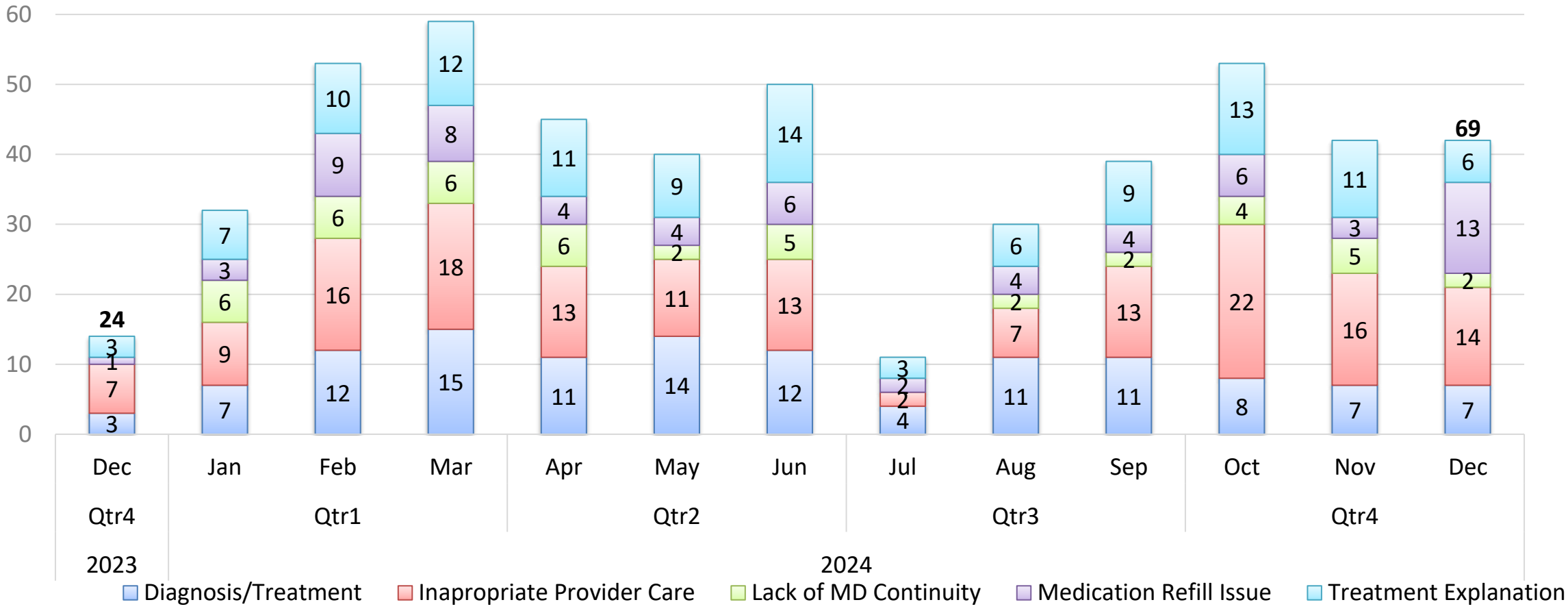
Top 5 Grievances – Quality of Care

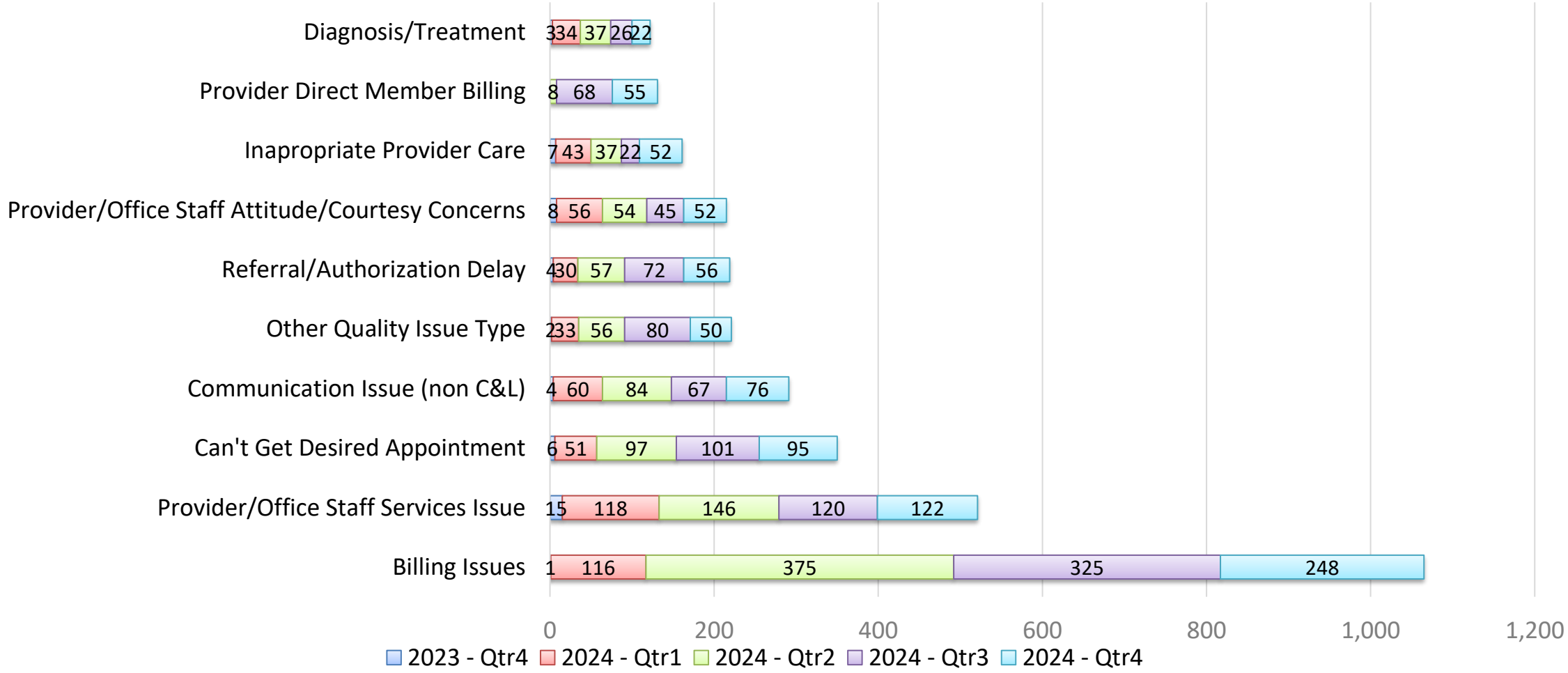
12/2023 – 12/2024, by Month



Inappropriate Provider Care & Medication Refill Issue make up **40%** of Quality of Care sub-topics.

Top 10 Grievance Sub-Topics

12/2023 – 12/2024, by Quarter



Billing Issues remain #1 grievance sub-topics in last few quarters of 2024 with **Q4 ’24** showing **34% improvement compared to Q2 ’24**.

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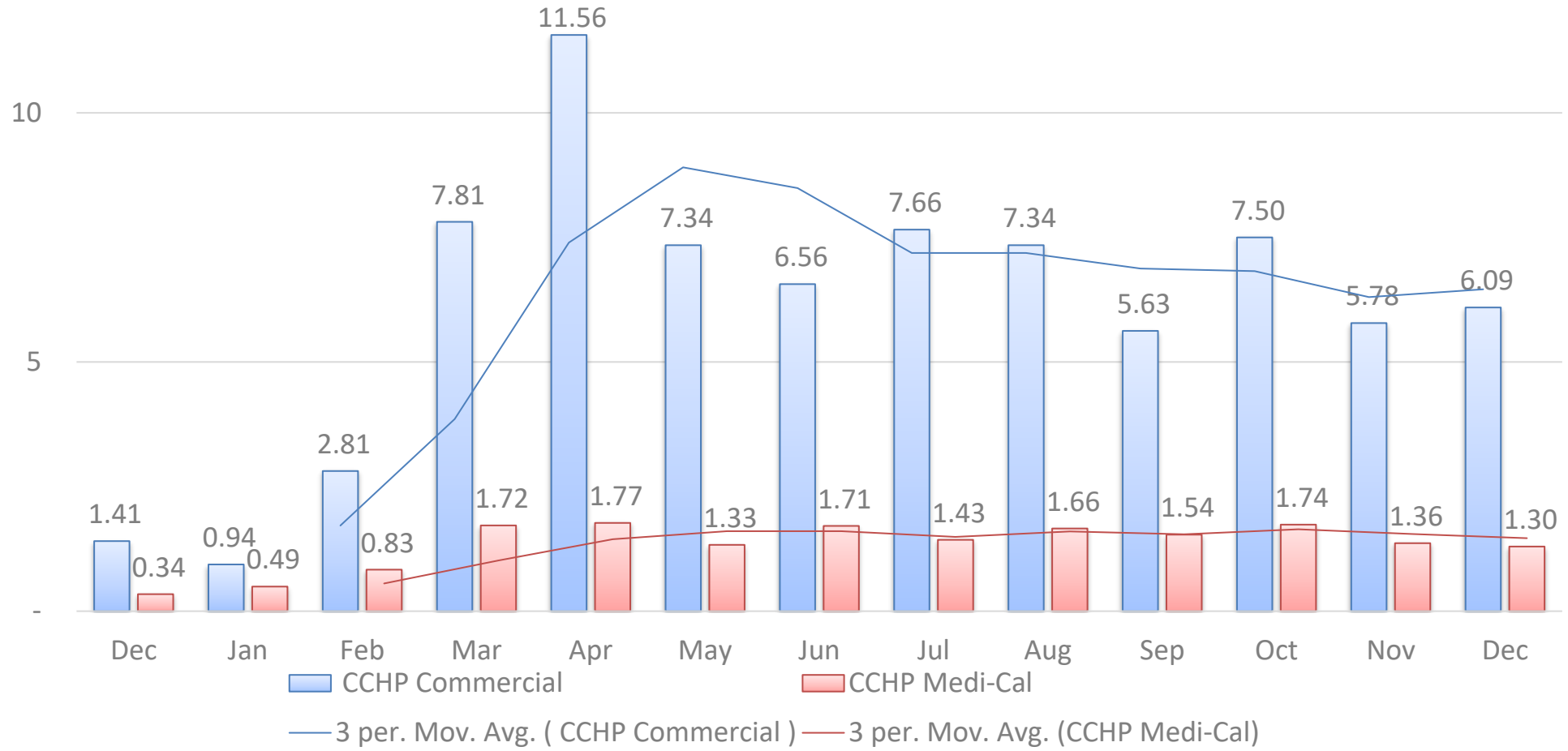
Total # of Grievances per 1K member by Line of Business
12/2023 – 12/2024, By Month



Moving average per quarter shows **spike in grievances in Q2' 24** for both **CCHP Commercial & Medi-Cal members**.

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Member Appeals

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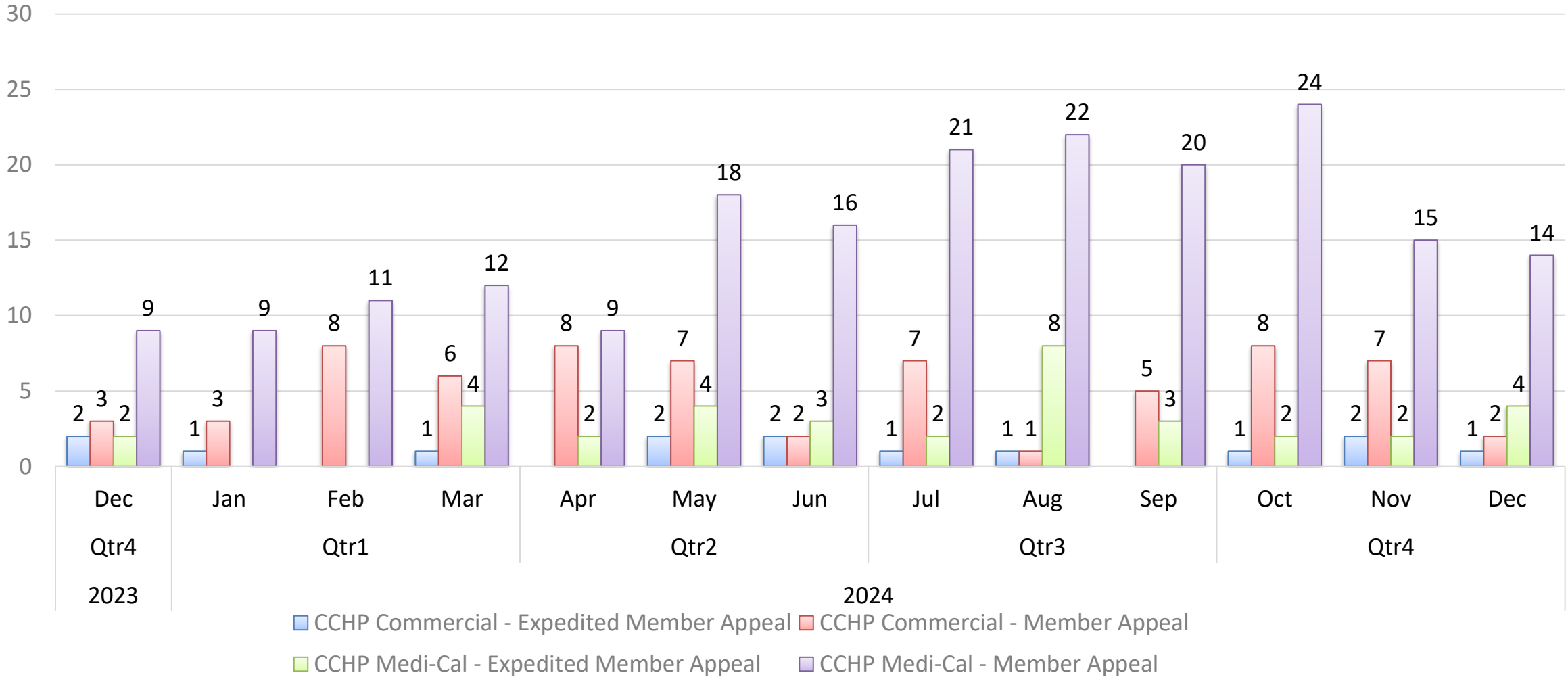
Total Appeals by Line of Business
12/2023 – 12/2024, by Month



74% of total appeals are **Medi-Cal member related, with 15%** of those appeals **expedited.**

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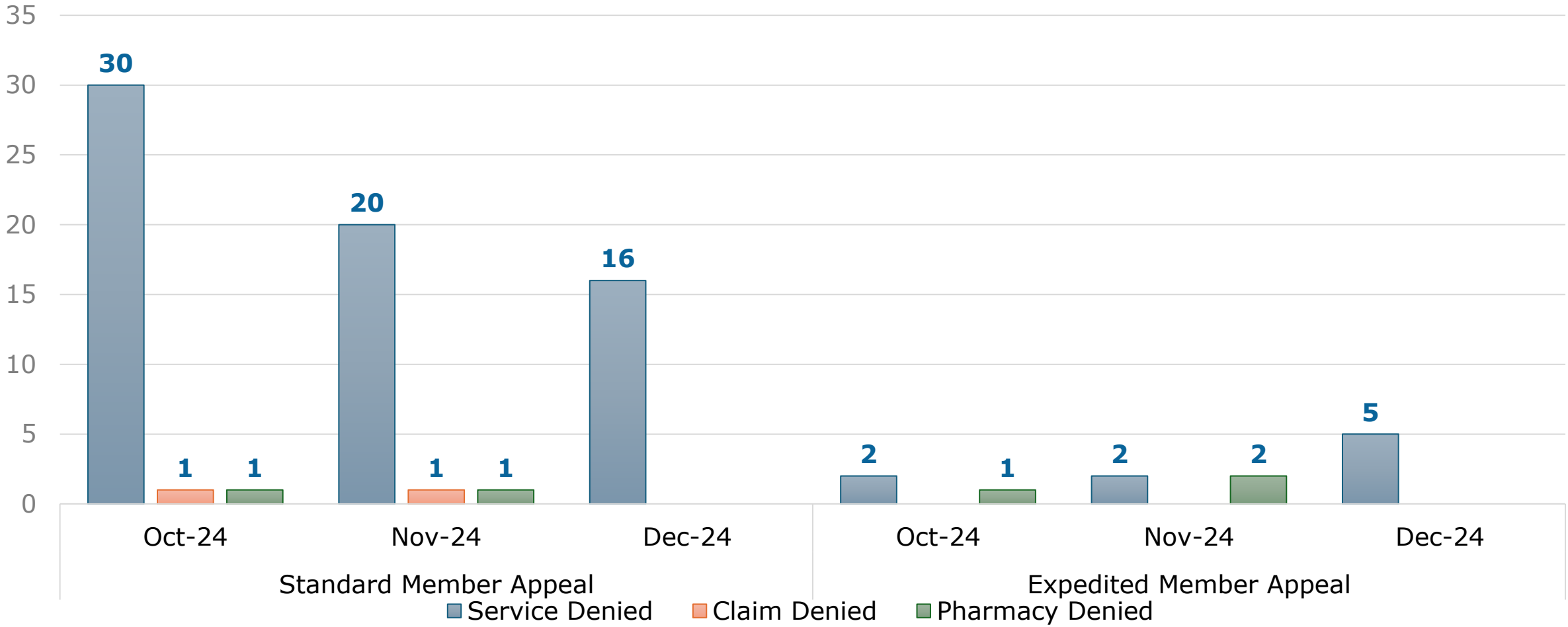
Appeal Reasons by Appeal Type
Quarter Four, 2024



88% decrease in Standard Member Appeal of Services Denied in December 2024 compared to start of that quarter.
In contrast, **Expedited Member Appeals doubled**.

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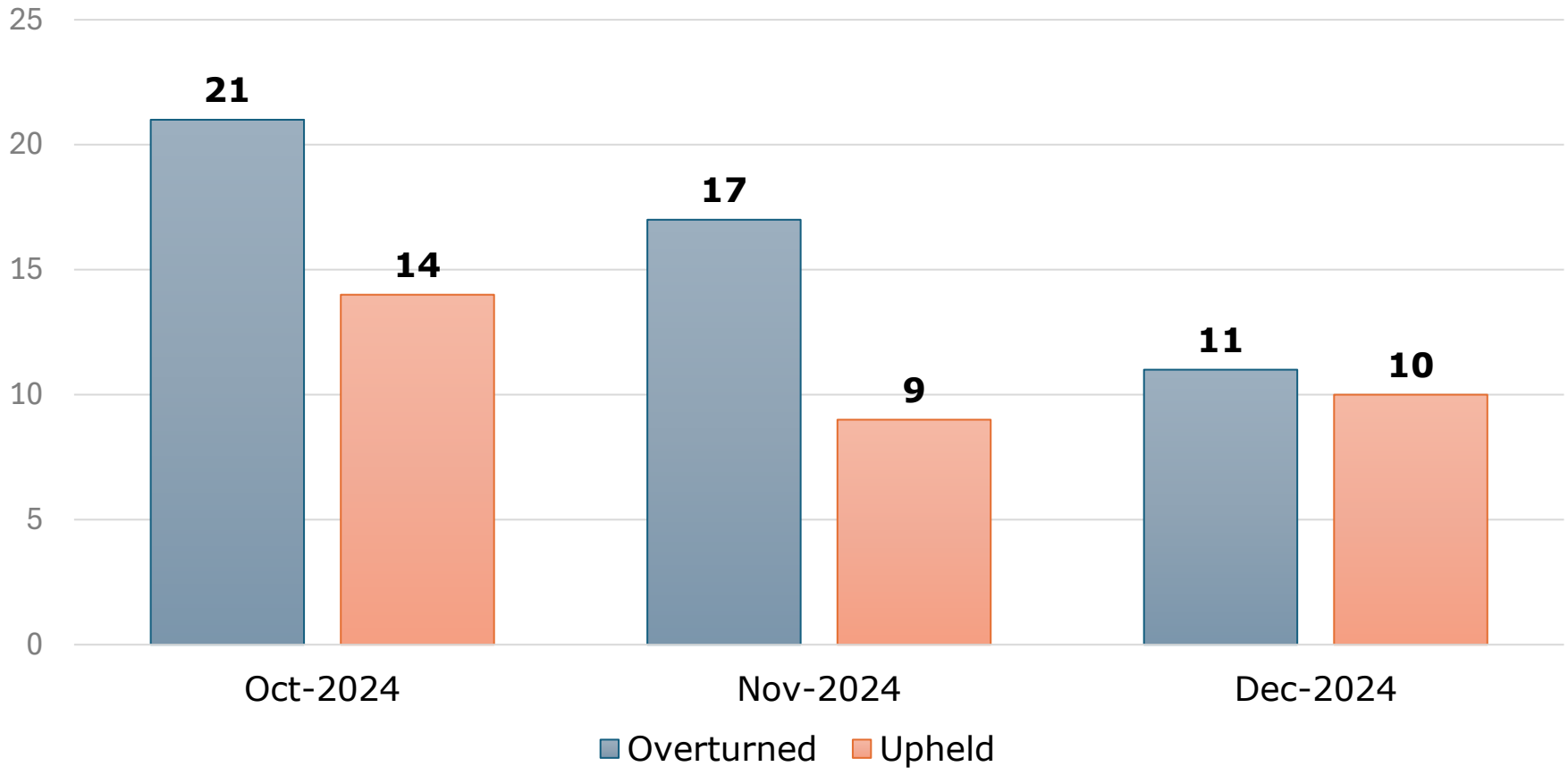
Appeals Outcome
Quarter Four, 2024



~60% of appeals are overturned.

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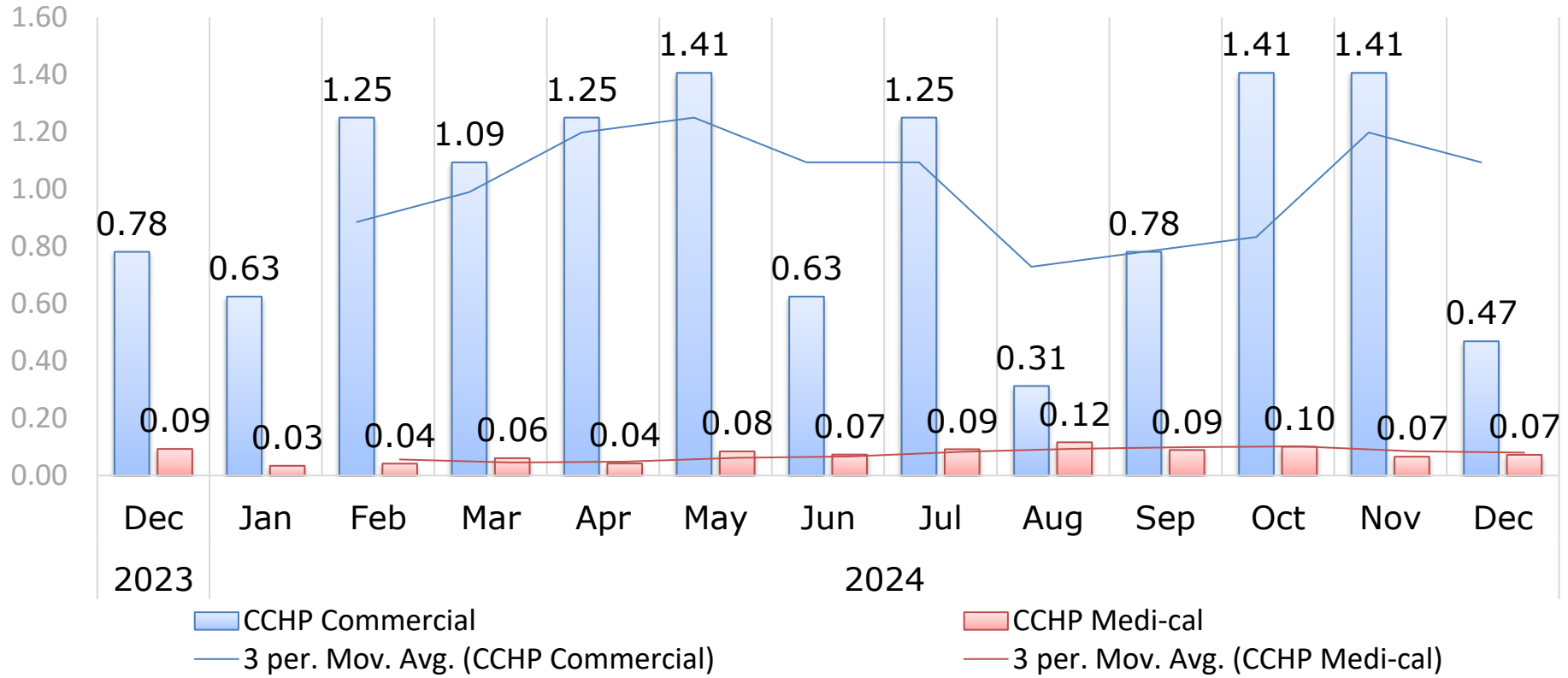
Total # of Appeals per 1K Member by Line of Business
12/2023 – 12/2024, By Month



Moving average per quarter shows **downward trend in Q4 ’24 for appeals per CCHP Medi-Cal member**.

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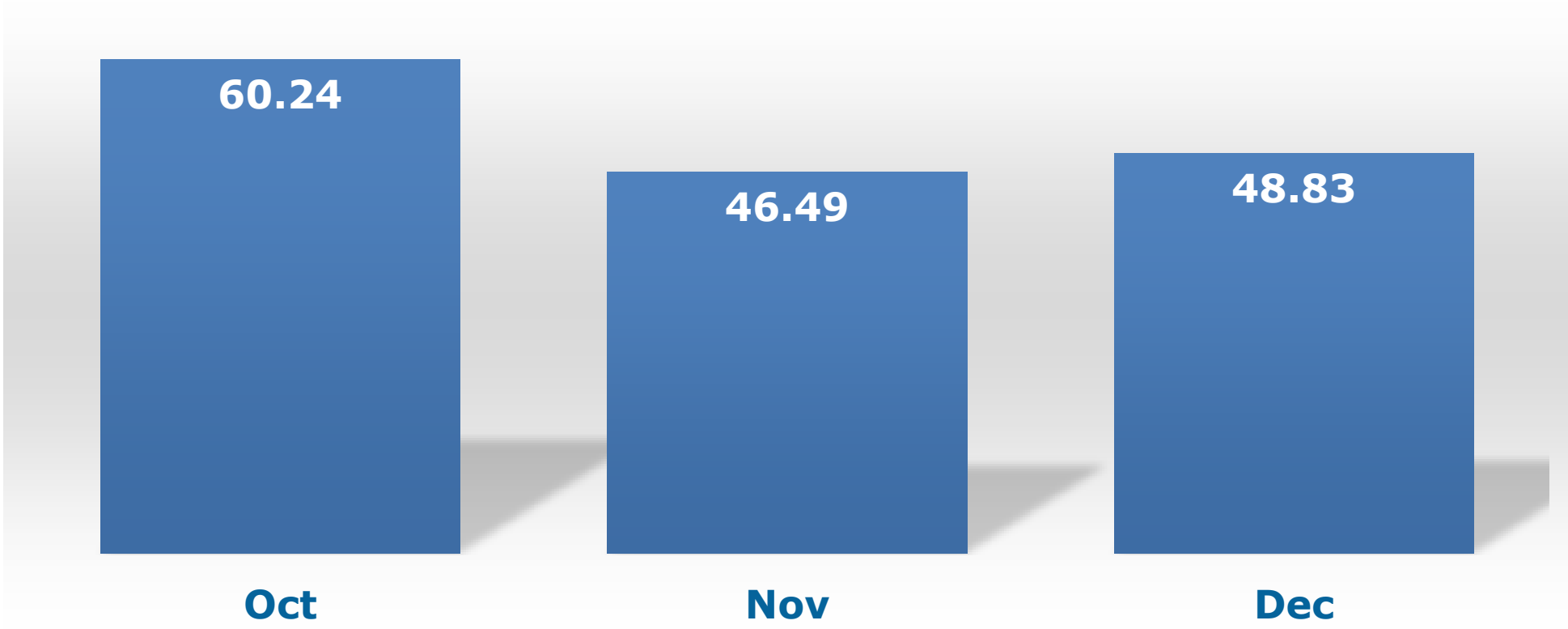
Total # of Referrals per 1K Member

Quarter Four, 2024



File #: 25-1249 **Agenda Date:** 4/9/2025 **Agenda #:** 6.3

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Fraud, Waste, and Abuse (FWA) - Update

Q1 2025 Case Update

- January: no potential cases
- February: 1 potential case; report submitted to DHCS within 10 days.
- March: no potential cases (as of 3/13)
- *Pending cases with DHCS*: 2 (one from Dec. and one from Feb.)

FWA Process Update - Cotiviti

- 3/2/25: CCHP has completed a work order with Cotiviti to add additional FWA services
- Upgraded platform: Cotiviti 360 Review Pattern
  - More comprehensive tool to identify billing patterns and prevent FWA
- Special Investigative Unit (SIU): 2 FTEs to support CCHP with in-depth investigations

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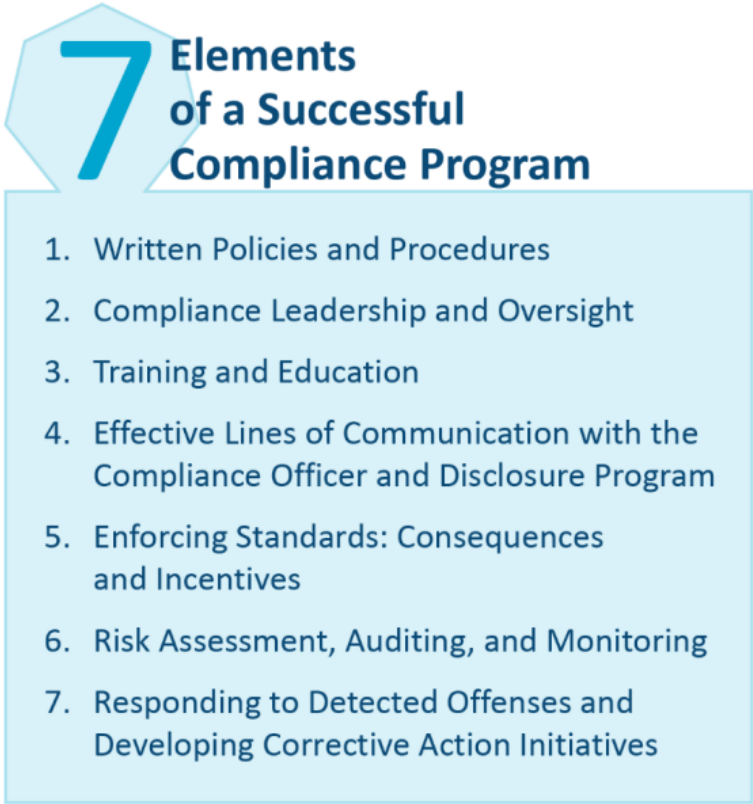
Compliance Workplan

- The Compliance Workplan has been updated and meets federal requirements
- Incorporates all seven core components as listed by the HHS Office of Inspector General (OIG)
- Includes requirements for ensuring:
  - Effective communication
  - Oversight and monitoring
  - Identifying risks
  - Preventing FWA



File #: 25-1250 **Agenda Date:** 4/9/2025 **Agenda #:** 7.1

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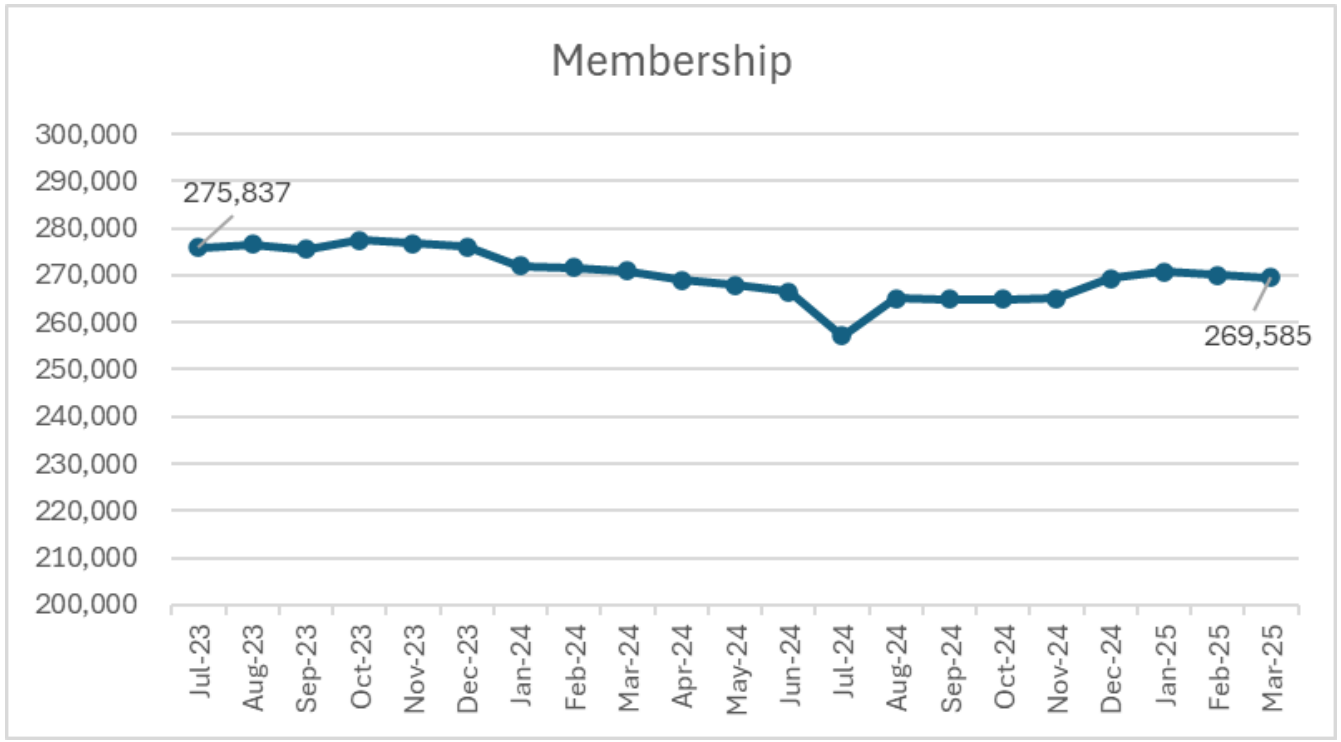
Membership



Source: CCHP Population Health Dashboard (Power BI) as of 3/19/2025

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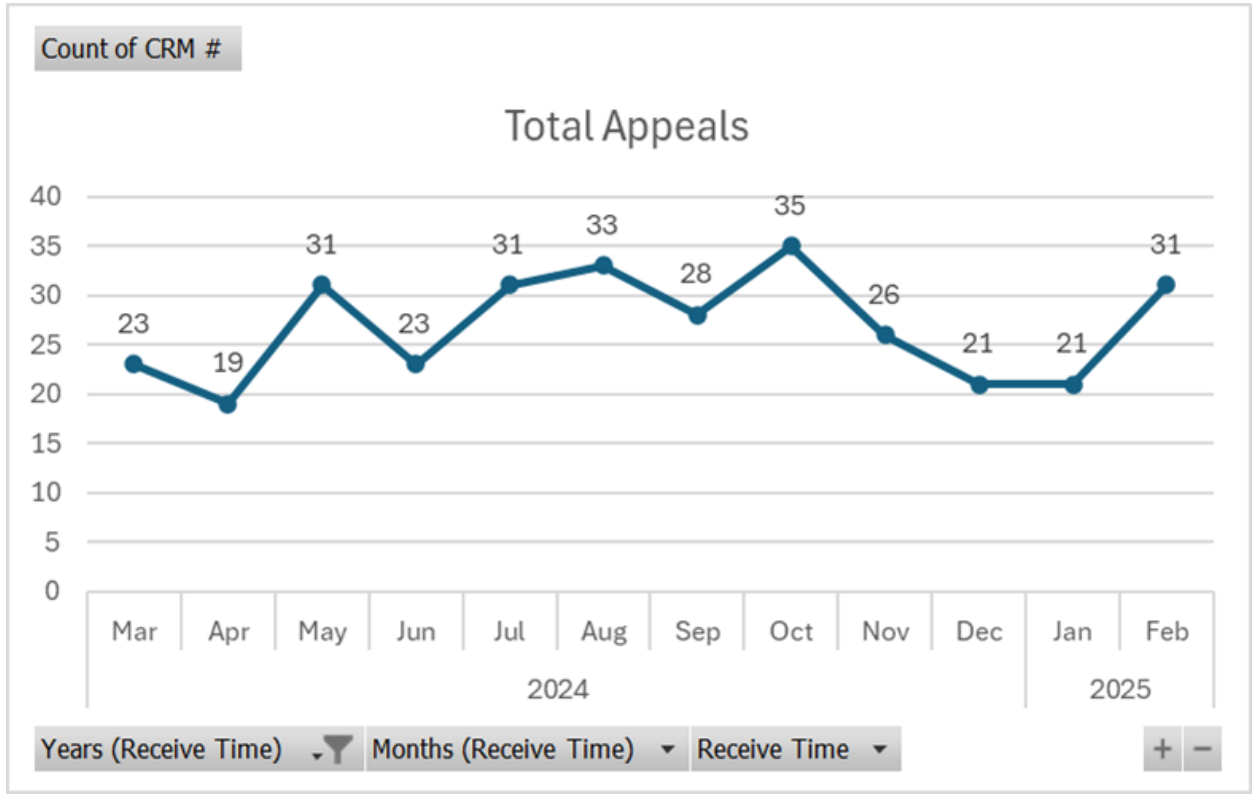
Appeals



Source: TAP2393 CRM Appeals Report
Date Range: 3/1/2024 – 2/28/2025

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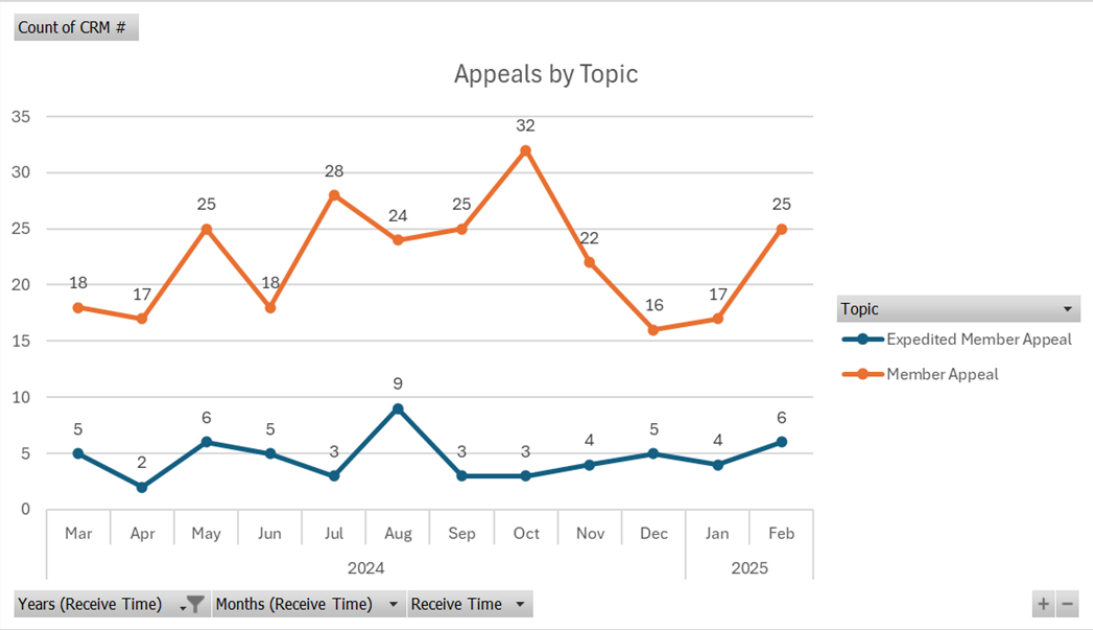
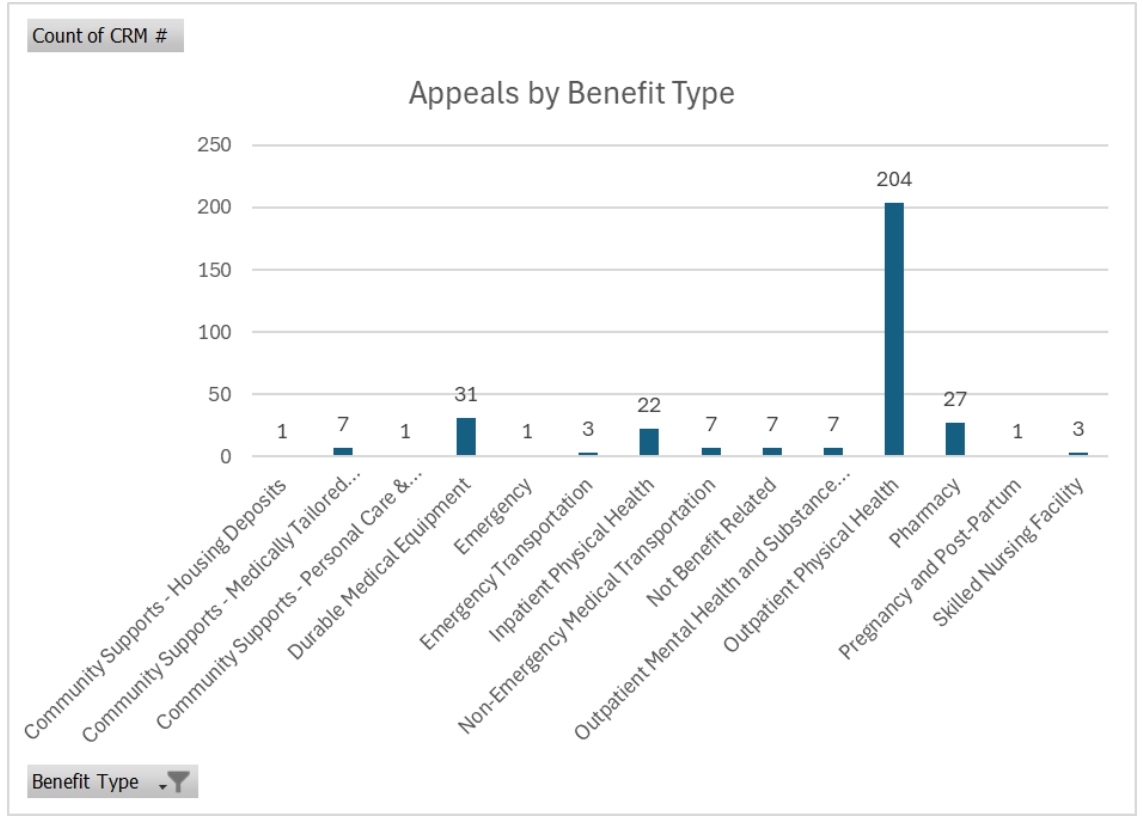
Appeals (continued)





Expedited appeals are defined as appeals where waiting for a standard decision may seriously put the health of the member at risk (like if they are currently in the hospital or urgently need medication)

Source: TAP2393 CRM Appeals Report
Date Range: 3/1/2024 – 2/28/2025

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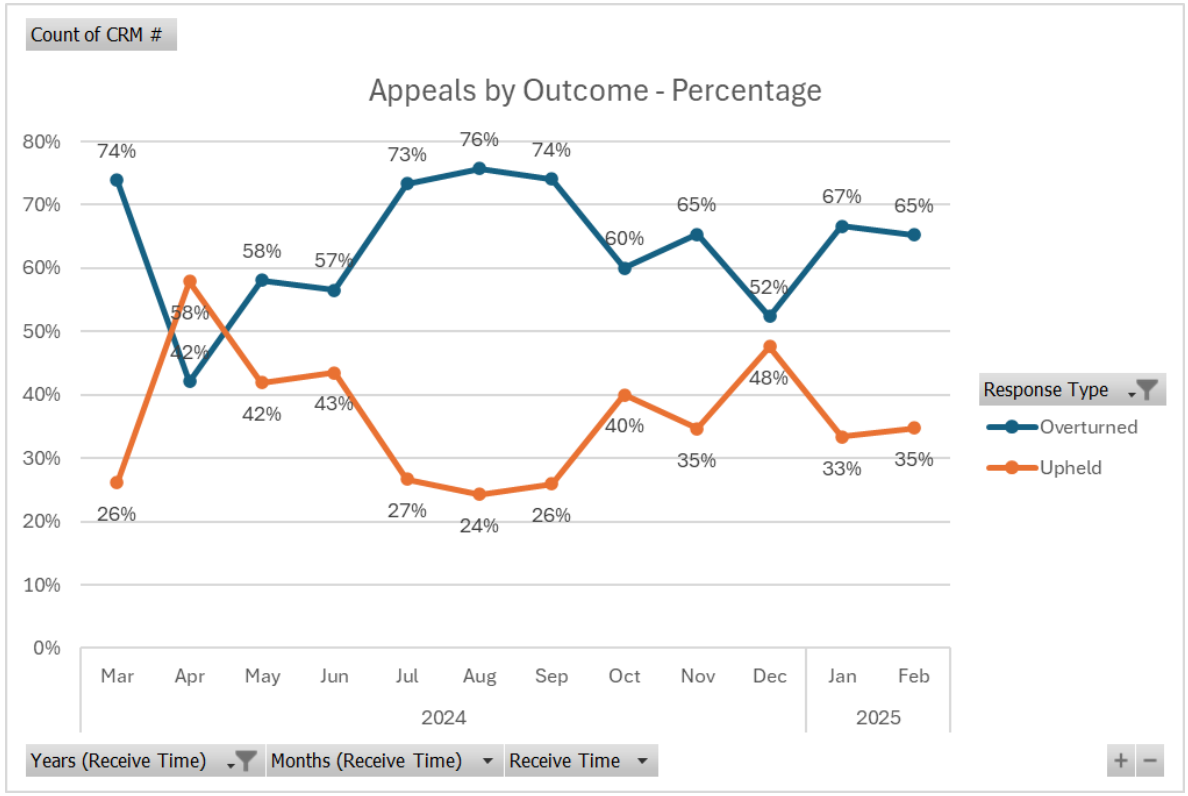
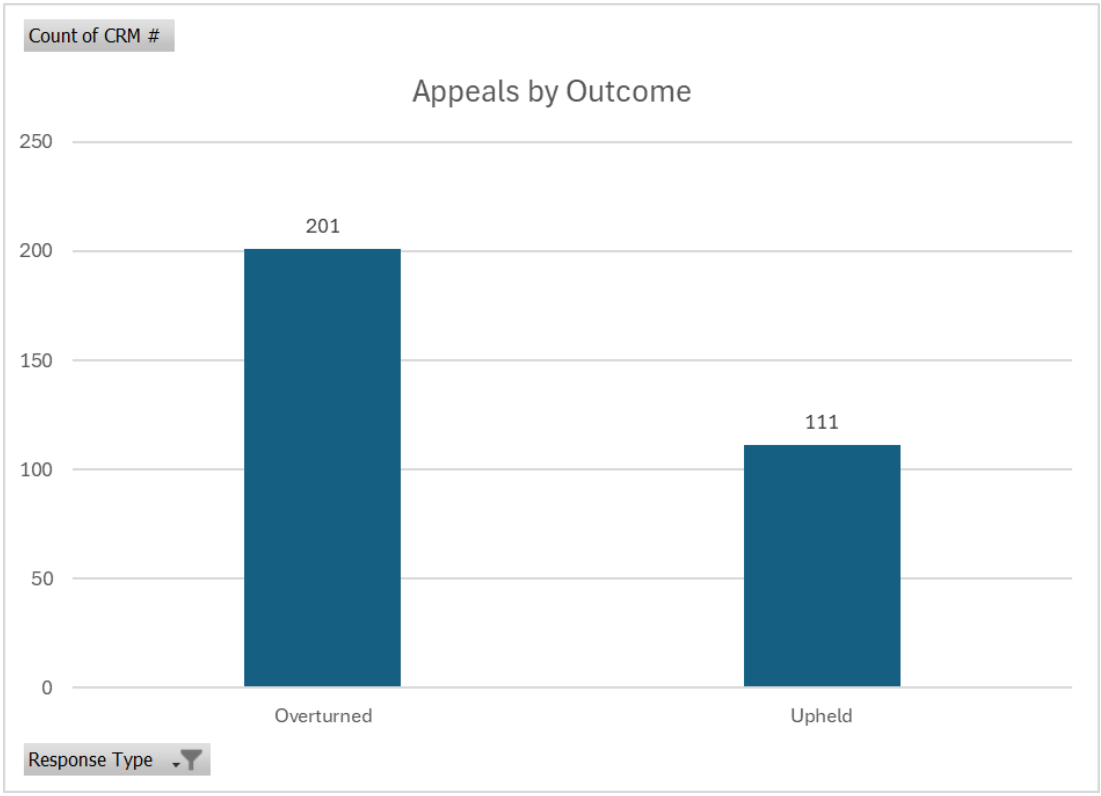
Appeals (continued)





Source: TAP2393 CRM Appeals Report
Date Range: 3/1/2024 – 2/28/2025
Filter: Removed “Other” outcomes (member cancelled or not yet resolved)

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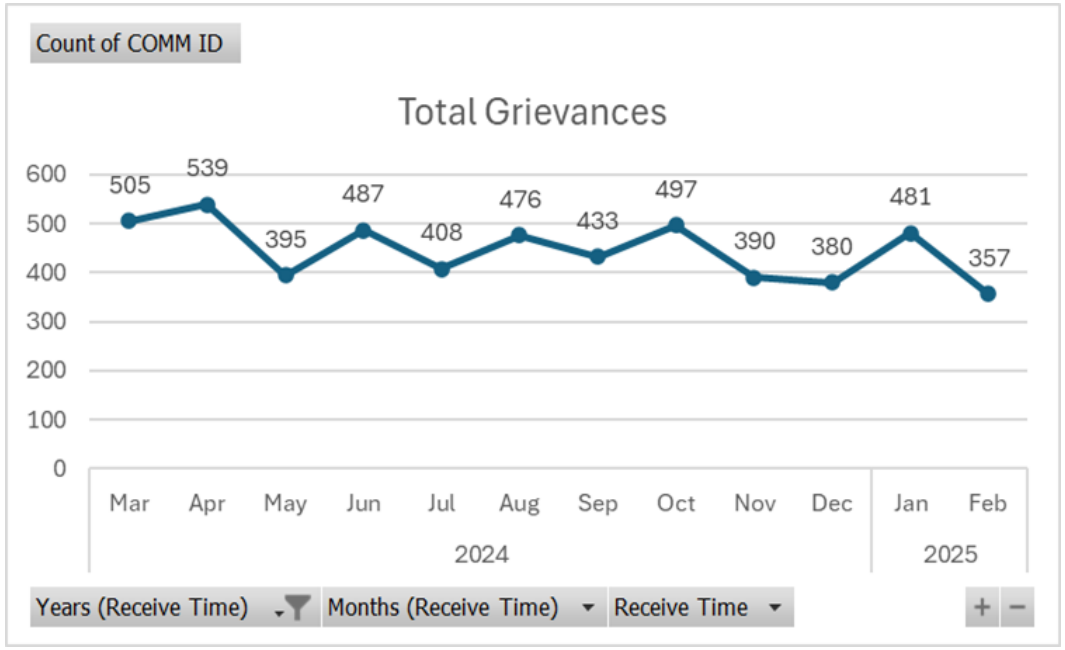
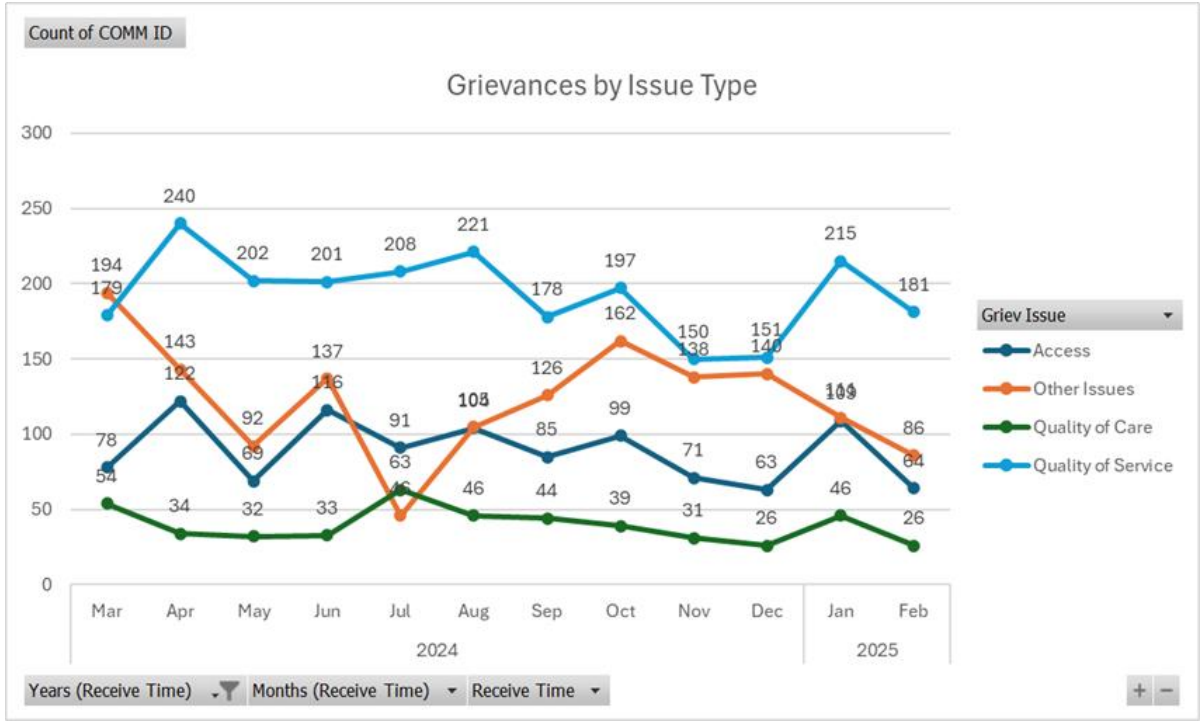
Grievances



1.7 grievances per 100K member
California Medi-Cal average is 3.1 grievances per 100K member

Source: TAP2392 CRM Grievance Summary
Date Range: 3/1/2024 – 2/28/2025



Access examples: physical access, provider availability, language access
Quality of Care examples: inappropriate care, provider grievances
Quality of Service examples: case management, provider/staff attitude, member materials
Other Issues examples: Referrals, billing, appeal timeliness

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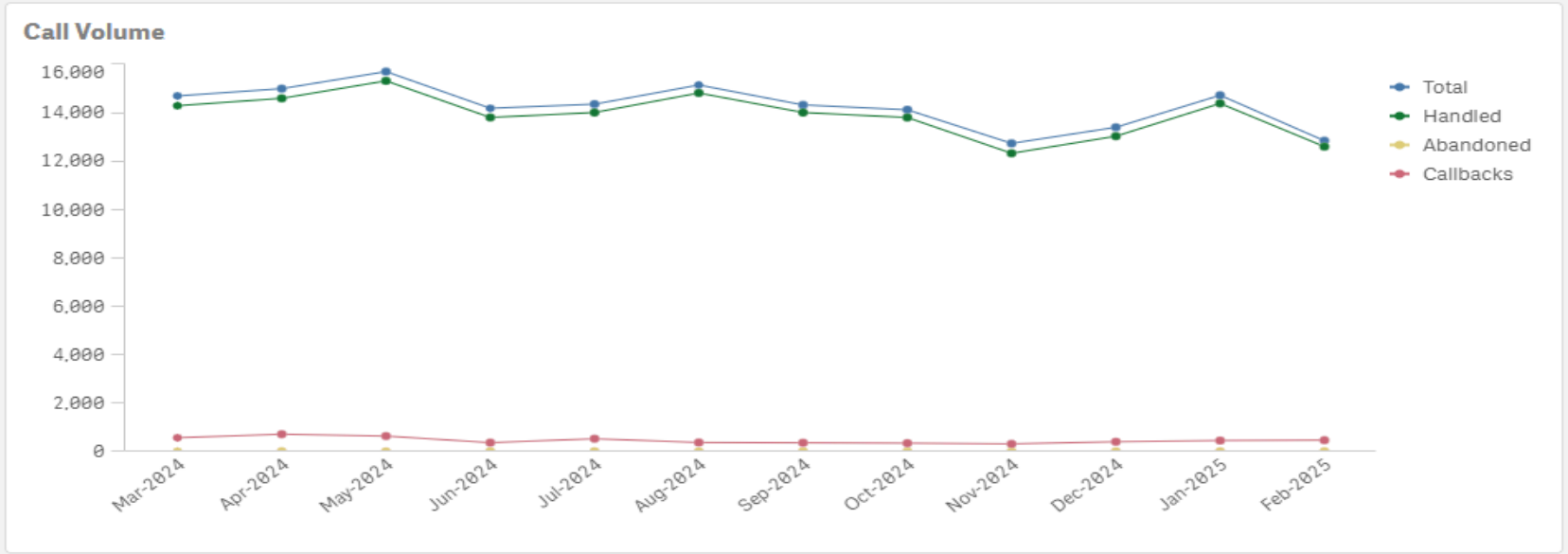
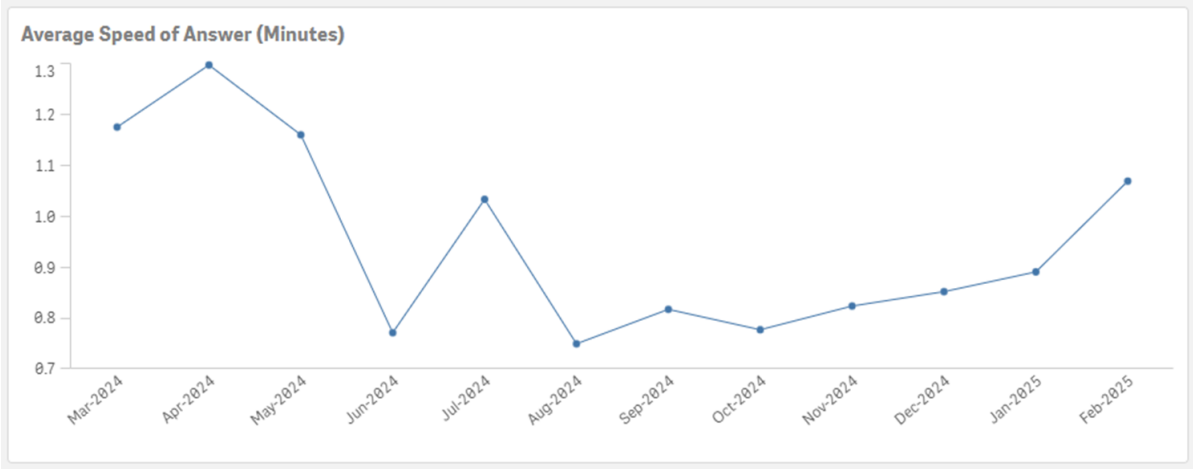
Advice Nurse





Source: Call Center Dashboard (Qlik)
Date Range: 3/1/2024 – 2/28/2025
Team Filter: AN – Advice Nurse

File #: 25-1251 **Agenda Date:** 4/9/2025 **Agenda #:** 7.2

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Finance Report

Contra Costa Health Plan Product Line Financial Summary
For the Year Ending June 30, 2025 (based on December 2024 YTD Actual) ($ in 000s)

Description	Commercial (1) Dec. 2024 YTD	Commercial (1) Projection	Medi-Cal (2) Dec. 2024 YTD	Medi-Cal (2) Projection	Totals (3) Dec. 2024 YTD	Totals (3) Projection	FY2024/25 Budget	Surplus (Deficit)
Total Revenues	$ 42,457	$ 87,501	$ 967,637	$ 2,227,614	$ 1,010,094	$ 2,315,114	$ 1,249,491	$ 1,065,624
Total Expenditures	44,920	91,257	986,913	2,212,224	1,031,833	2,303,480	1,249,491	(1,053,990)
Income/(Loss)	$ (2,463)	$ (3,756)	$ (19,276)	$ 15,390	$ (21,739)	$ 11,634	$ -	$ 11,634

Notes:
(1) Includes Commercial and In-Home Support Services.
(2) Includes Community Provider Network, Other Medi-Cal Non-Crossover, AFDC & Medi-Cal ACA Expansion
(3) General Fund contribution $3.7M for IHSS.
(4) M-Cal rates used for June 2025 projection include Add-on rates for Medi-Cal Enhanced Care Management.
(5) CCHP is self-insured for all medical claims (no stop loss insurance coverage).

File #: 25-1252 **Agenda Date:** 4/9/2025 **Agenda #:** 7.3

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7.3 Meeting Reminders for 2025

Joint Conference Committee

2025 Meeting Dates

Friday, June 6, 2025
Friday, September 5, 2025
Friday, December 5, 2025

Meetings are scheduled from 9:30 to 11:30 AM

Location: Conservation & Development, ZA Conference Room
30 Muir Road, Martinez, CA

District II Supervisor's office:
309 Diablo Road
Danville, CA

District III Supervisor's office:
3361 Walnut Boulevard
Brentwood, CA

Join in person or via Zoom

The Zoom link will be posted prior to each meeting