



QUALITY AND PERFORMANCE IMPROVEMENT PROGRAM EVALUATION 2025



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2 INTRODUCTION

The 2025 Annual Evaluation assesses Contra Costa Health Plan's (CCHP) Quality Improvement Program. It examines the effectiveness of initiatives implemented across CCHP departments in 2025, 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 2025, CCHP 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 20 MCAS measures, including both Well-Child Visits in the First 30 Months of Life measures, Prenatal and Postpartum Care, Breast and Cervical Cancer Screenings, Childhood Immunization Status-Combo 10, and Glycemic Status Assessment - Poor Control (>9.0%), demonstrating CCHP's commitment to high quality patient care.
- CCHP expanded a Value Based Payments (VBP) program to incentivize and reward providers for providing high quality, efficient care to provider groups with at least 5,000 assigned patients.
- CCHP expanded reporting and automatic authorization for care management services from Admission, Discharge, and Transfer Feeds to allow for better real time identification of member discharges.
- Members due for Medi-Cal Redetermination, due for IHA, and recently hospitalized patient 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 successfully produced a comprehensive perinatal services brochure that was distributed to over 2,500 members.
- The Quality Team expanded to include a Health Services Planner/Evaluator to implement the DSNP Stars program to ensure high quality care for our Medicare/Medi-Cal enrollees.
- CCHP enrolled 7,959 members in Enhanced Care Management, of which 1,672 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 7,469 members, with 5,421 receiving medically tailored meals and 1,787 members receiving housing transition/navigation services.
- CCHP engaged in a wide array of performance improvement projects, including activities aimed at addressing well care visits, colorectal cancer screening, lead screening in children, topical fluoride application, and improve follow-up care after emergency department visits for mental health and substance use.
- CCHP received Health Equity/Health Outcome Accreditation from NCQA.

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 2025, there were no 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 effectively addresses the outlined goals, demonstrating the program's stability and effectiveness. Looking ahead to 2026, CCHP is working to ensure high performance on CMS Stars measures and ensure a comprehensive quality program that incorporates DSNP.

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. In 2025, CCHP hired a Health Services Planner/Evaluator to oversee the CMS Stars program for dually enrolled members and ensure quality performance across all measures. Their expertise will enhance member experience and improve member outcomes for this vulnerable population.

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 2025, 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 2025, 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 2025, 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 the launch of a new Dual Eligible Special Needs Plan, expanded provider networks, and improvements in access to care, including behavioral health and specialty services. Key initiatives in 2025 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 2025, one meeting per quarter was dedicated to overseeing equity-focused initiatives, engaging a broader group of stakeholders, including providers, community-based organizations, homeless services, public health, and other community health advocacy groups. These meetings prioritized achieving NCQA Health Equity/Health Outcome Accreditation and implementing mandatory DEI and TGI trainings for staff and providers. Discussions focused on resolving health disparities identified through stratified HEDIS data, specifically targeting improved outcomes for African American and Pacific Islander members. Additionally, the Council monitored language access grievances and oversaw the Community Advisory Committee to ensure member feedback directly informed health plan operations.

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 2025, CCHP held 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 with the Community Advisory Committee. We continue to recruit new members annually to ensure CAC reflects the membership we serve.

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 2025. 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.

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 2025, CCHP achieved Health Outcomes Accreditation and submitted documentation for the Health Plan Accreditation. The Health Plan Accreditation is on track to be awarded in early 2026. The HEDIS and Accreditation manager established a structure to ensure annual deliverables were met and a framework was set for ongoing meetings with relevant stakeholders.

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 2025, CCHP reported 2024 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) 2024 MCAS measures and their trends over time are illustrated in Table 1.

Table 1. Summary Performance in MCAS Measures Overall MY 2020-2024

Measures	MY 2020	MY 2021	MY 2022	MY 2023	MY 2024	Trend	National Percentile
Adults' Access to Preventive/Ambulatory Health Services	-	-	69.75	71.99	67.27		25th ☆
Antidepressant Medication Management - Effective Acute Phase Treatment	63.07	65.97	66.25	85.80	90.07		90th ★
Antidepressant Medication Management - Effective Continuation Phase Treatment	41.01	44.16	45.23	73.82	80.99		90th ★
Asthma Medication Ratio	63.93	64.48	75.23	83.22	79.48		90th ★
Breast Cancer Screening	58.33	58.66	63.95	63.81	61.72		75th ★
Cervical Cancer Screening	68.06	68.33	68.33	68.61	67.88		90th ★
Child and Adolescent Well-Care Visits	42.09	55.05	53.09	56.63	59.11		75th ★
Childhood Immunization Status - Combination 10	51.34	47.93	44.04	45.61	42.34		90th ★
Chlamydia Screening in Women	62.81	62.22	66.65	68.37	69.22		90th ★
Colorectal Cancer Screening	-	-	39.69	48.98	50.66		90th ★
Contraceptive Care - All Women - Ages 15-20	18.34	17.59	19.01	19.33	17.74		25th ☆
Contraceptive Care - All Women - Ages 21-44	25.52	25.38	25.43	24.52	23.82		75th ★
Contraceptive Care - Postpartum - Ages 15-20: 60 Days	57.78	47.32	46.43	66.67	60.87		75th ★
Contraceptive Care - Postpartum - Ages 21-44: 60 Days	46.19	45.03	46.73	52.03	57.93		75th ★
Controlling Blood Pressure	64.96	62.37	67.27	67.21	72.75		90th ★
Depression Remission or Response- Follow-up	-	-	29.14	26.04	25.52		25th ☆
Depression Remission or Response- Remission	-	-	8.26	3.29	3.06		25th ☆
Depression Remission or Response- Response	-	-	11.48	7.37	6.64		25th ☆
Depression Screening and Follow-Up for Adolescents and Adults - Screening	-	-	29.73	30.06	32.47		90th ★
Depression Screening and Follow-Up for Adolescents and Adults - Follow-up	-	-	81.66	75.21	77.44		50th ☆
Developmental Screening in the First Three Years of Life	21.68	37.45	52.57	56.90	69.24		75th ★
Diabetes Screening for People Who Are Using Antipsychotic Medications	79.41	84.32	85.31	85.14	87.90		90th ★
Follow-up after ED for AOD - 7 Day	8.94	4.46	16.53	19.64	29.15		75th ★
Follow-up after ED for AOD - 30 Day	8.94	10.00	26.61	32.31	45.80		75th ★
Follow-up after ED for Mental Illness - 7 Day	11.74	15.21	27.02	41.59	41.52		50th ☆
Follow-up after ED for Mental Illness - 30 Day	21.81	23.15	45.97	58.78	61.71		50th ☆
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	62.50	48.65	62.50	59.42	55.68		50th ☆
Glycemic Status Assessment for Diabetic Patients - Poor Control*	38.93	34.55	33.99	29.11	24.44		90th ★
Immunizations for Adolescents (IMA) - Combo2	43.80	44.28	53.36	55.56	52.89		90th ★
Lead Screening in Children	-	44.23	51.51	52.81	66.10		50th ☆
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing	42.22	54.00	46.08	49.48	51.97		75th ★
Number of Outpatient ED Visits per 1000 Long-Stay Resident Days	-	-	-	0.40	0.43		-
Pharmacotherapy for Opioid Use Disorder	-	37.04	27.32	21.72	39.16		90th ★
Plan All-Cause Readmissions*	0.83	0.88	0.87	0.82	1.04		25th ☆
Postpartum Care	90.97	91.19	90.48	89.94	93.02		90th ★
Postpartum Depression Screening and Follow Up- SCR	-	-	53.07	55.80	46.43		90th ★
Postpartum Depression Screening and Follow Up- FU	-	-	79.63	74.84	72.30		75th ★
Potentially Preventable 30-Day Post-Discharge Readmission Measure	-	-	-	0.77	2.84		-
Prenatal Care	93.40	94.34	93.88	93.08	93.60		90th ★
Prenatal Depression Screening and Follow Up- SCR	-	-	76.95	78.40	69.38		90th ★
Prenatal Depression Screening and Follow Up- FU	-	-	66.67	56.71	63.58		75th ★
Prenatal Immunization Status	-	46.11	46.05	42.99	45.07		90th ★
SNF Healthcare-Associated Infections Requiring Hospitalization	-	-	-	5.45	5.43		-
Topical Fluoride for Children	-	-	12.73	15.21	22.31		50th ☆
Well-Child Visits in the First 30 Months of Life (31d-15m)	56.69	54.35	65.88	73.17	79.03		90th ★
Well-Child Visits in the First 30 Months of Life (15m-30m)	69.85	64.58	73.05	75.59	80.09		90th ★

CCHP improved performance in several key MCAS measures in MY 2024. CCHP accomplished this through data improvements, performance improvement initiatives, and increased collaboration with contracted providers. CCHP has more than doubled the number of MCAS measures at the High-Performance Level (HPL) from nine in MY 2022 to 20 in MY 2024. Additionally, CCHP achieved 75th percentile for 12 measures and the 50th percentile for another 6 measures. CCHP was under the 50th percentile for six measures, none of which were target measures.

CCHP has seen notable improvements in pediatric well care metrics between MY 2021 and MY 2024. For Well-Child Visits in the First 30 Months of Life (31d-15m), CCHP performed in the 90th percentile with a rate of 79.0%, leading to a 5.9 percentage point increase when compared to MY 2023 and a 24.7-point increase when compared to MY 2021. In the Well-Child Visits in the First 30 Months of Life (15m-30m) measure, CCHP performed in the 90th percentile and has increased rates by 4.5 percentage points since MY 2023 and 15.5 percentage points since MY 2021. CCHP also performed in the 75th percentile for Child and Adolescent Well Care Visits in MY 2024.

Follow-Up after ED for SUD – 7 Days (FUA-7), Follow-Up after ED for SUD – 30 Days (FUA-30), and Topical Fluoride for Children (TFL-CH), were below the MPL in MY 2023, but exceeded the MPL in MY 2024. All 21 measures subject to a minimum performance level exceeded the MPL, showcasing CCHP's strong and consistent commitment to quality healthcare.

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 Consumer Assessment of Healthcare Providers and System (CAHPS) Health Plan 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 sampled members who were continuously enrolled with CCHP for the last six months of 2024, with no more than one enrollment gap of 45 days or less. For the Adult Medicaid population, 1,650 members were mailed surveys and received 193 valid

responses, for a response rate of 11.7%. The data from the Adult Medi-Cal population in RY 2025 are presented in Table 2.

Table 2 CAHPS Results RY 2023-2025

Measure	RY 2023	RY 2024	RY 2025	Trend	Percent Change 24-25	Percentile	Goal	Goal Met
Overall Ratings								
Rating of all health care	78.2%	83.4%	81.6%		-2.2%	75th ▼	70.0%	Y
Rating of personal doctor	80.8%	84.3%	83.6%		-0.8%	50th ▼	70.0%	Y
Rating of specialist talked to most often	79.2%	88.1%	84.8%		-3.7%	50th ▼	70.0%	Y
Rating of health plan	79.6%	79.1%	77.4%		-2.1%	33rd ▼	70.0%	Y
Composite Scores								
Getting Needed Care	79.1%	80.8%	77.6%		-4.0%	10th ▼	70.0%	Y
Getting Care Quickly	79.4%	75.2%	71.9%		-4.4%	5th ▼	70.0%	Y
Communication	92.8%	91.4%	92.0%		0.7%	25th ▬	70.0%	Y
Customer Service	85.2%	87.9%	86.7%		-1.4%	10th ▬	70.0%	Y

In RY 2025, CCHP saw declines in both overall scores and national percentile ranking across all Overall Rating measures and most of the Composite CAHPS measures compared to the prior year. Despite this, the established performance goal of 70% was achieved for all measures. The observed decline is largely attributed to a lower survey response rate, which decreased by 0.8 percentage points from 12.5% in 2023 to 11.7% in 2024, along with a shift from oversampling membership to standard sampling.

In 2025, CCHP administered the ECHO survey to members who had utilized behavioral health services. For adult members, CCHP sent 2,250 surveys and received 276 responses, for an overall response rate of 12.6%. The response rate in 2025 was higher than the 11.5% behavioral health survey response rate in 2024. Results for the survey are presented in Table 3.

Table 3 ECHO Survey Results, RY 2023-2025

Measure	RY 2023	RY2024	RY2025	Percent Change	Goal	Goal Met Y/N
Getting Treatment Quickly	-	61.4%	71.3%	16.1% ▲	70.0%	Y
Usually or always got help by telephone	64.8%	53.3%	58.6%	10.0% ▲		
Usually or always got urgent treatment as soon as needed	59.6%	61.1%	72.9%	19.4% ▲		
Usually or always got appointment as soon as wanted	69.6%	69.2%	79.9%	15.5% ▲		
Communication	-	91.5%	90.1%	-1.5% ▼	70.0%	Y
Clinicians usually or always listened carefully	81.9%	92.0%	90.7%	-1.4% ▼		
Clinicians usually or always explained things	84.8%	94.2%	92.6%	-1.7% ▼		
Clinicians usually or always showed respect	89.4%	92.8%	93.2%	0.4% ▲		
Clinicians usually or always spent enough time	80.8%	87.7%	88.8%	1.3% ▲		
Usually or always felt safe with clinicians	95.3%	94.9%	92.4%	-2.7% ▼		
Usually or always involved as much as you wanted in treatment	77.9%	87.7%	83.4%	-4.9% ▼		
Getting Information	-	45.2%	60.6%	34.1% ▲	70.0%	N
Delays in treatment while waiting for plan approval were not a problem	53.2%	44.2%	60.7%	37.3% ▲		
Getting help from customer service was not a problem	42.4%	35.3%	55.8%	58.1% ▲		
Perceived Improvement	-	66.7%	71.2%	6.7% ▲	70.0%	Y
Better able to deal with daily problems	66.1%	75.1%	76.4%	1.7% ▲		
Better able to deal with social situations	61.3%	64.4%	67.1%	4.2% ▲		
Better able to accomplish things	59.2%	62.0%	69.3%	11.8% ▲		
Better able to deal with symptoms or problems	59.2%	66.3%	71.9%	8.4% ▲		
Information About Treatment Options	-	46.0%	51.0%	10.9% ▲	70.0%	N
Told about self help or consumer run programs	31.4%	36.8%	40.6%	10.3% ▲		
Told about different treatment options	46.2%	54.1%	60.5%	11.8% ▲		
Rating of Counseling & Treatment	63.5%	71.4%	77.2%	8.1% ▲	70.0%	Y

Overall results demonstrated increased performance in the Getting Treatment Quickly domain, as well as the Getting Information domain. The rating for Getting Treatment Quickly went up by 9.9 percentage points between 2024 and 2025, showcasing increasing member satisfaction regarding timely access to behavioral health services. Members' perceived improvement increased in 2025 compared to the 2024 administration, exceeding the stated goal of 70%, demonstrating the importance of connecting members to care. While more members responded positively to getting information in 2025 compared to 2024, the Getting Information and Information About Treatment Options domains are opportunities for improvement as both remained below the 70% goal. The 2025 Language Access Survey results offer critical insights into member experiences with interpreter services, health promotion and communication efforts. The surveys were sent to members if they utilized services in the previous 6 months and their preferred language is Spanish, Chinese, Dari, Farsi, Vietnamese, Arabic, Punjabi, Tagalog, Russian, Hindi, Korean, Cambodian, Thai, Japanese, Armenian, or Hmong. The results of this year's survey are presented in Table 4.

Table 4. Language Access Survey Results, 2024-2025

Measure	RY 2024	RY 2025	Percent Change
General			
How often did you get an interpreter when you needed one?	77.3%	80.0%	3.5% ▲
How often did your personal doctor show respect for what you had to say?	95.5%	93.5%	-2.1% ▼
How often were instructions for health conditions easy to understand?	91.5%	90.3%	-1.3% ▼
How often did you use a friend or family member as an interpreter?*	19.4%	25.8%	33.0% ▼
Rating of Interpreter			
Members who rated their interpreter positively	83.8%	72.0%	-14.1% ▼
Communication			
Email	38.1%	36.0%	-5.4% ▼
Text Messages	24.3%	32.7%	34.8% ▲
Mail Sent to my House	16.4%	13.1%	-20.0% ▼
CCHP Website	6.1%	5.6%	-8.4% ▼
In Person (Face-to-Face)	4.7%	5.1%	7.7% ▲
Voicemail/Phone Messages	4.7%	4.2%	-11.3% ▼
Materials With Large Text/Font Size	1.4%	2.3%	64.3% ▲
Online Video	2.8%	0.9%	-67.4% ▼
Social Media (Facebook, Twitter, Instagram)	1.0%	0.0%	-100.0% ▼
In Braille	0.2%	0.0%	-100.0% ▼

*Lower is better

This year's survey highlights improvements in some areas of language access services, such as increased access to interpreter services when compared to 2024. However, the rating of interpreters decreased by 11.8 percentage points when compared to 2024. Additionally, there was an increase of 6.4 percentage points in the rate of members that had to use friends or family for interpretation when compared to 2024. With these mixed results from the 2025 Language Access Survey, it is clear that there are still significant opportunities for improvement despite the increased access to interpreter services.

Understanding how well new members comprehend their benefits and how to navigate the health plan is essential for delivering accessible, equitable care. CCHP administered a member survey in 2024 and again in 2025 to assess new members' understanding of key topics such as how to access care, use support services, and get help when needed. Results are presented in Table 5.

Table 5. New Member Survey Results, 2024-2025

Question	% Responding Yes	
	2024	2025
<i>Accessing Care</i>		
Do you know the name of your Primary Care Provider	72.2%	82.4%
If you want to change your primary care provider, do you know how?	44.4%	41.2%
When your primary care provider is not available, do you know where to go for care?	53.3%	50.0%
Do you know how to find a pharmacy where you can get your prescriptions?	90.0%	88.2%
Do you know how to access mental health services?	53.3%	50.0%
Do you know how to find a Medi-Cal dentist?	51.1%	41.2%
Are you familiar with how to find a CCHP healthcare provider?	58.9%	64.7%
<i>Support Services</i>		
If you need help with rides or transportation to and from medical appointments or other Medi-Cal services, do you know what to do?	48.1%	30.4%
Do you know how to access interpreter services?	50.0%	77.8%
Do you know how to get help if you have questions or problems with CCHP or accessing health services?	58.6%	51.7%
<i>Membership Information</i>		
If you lose or don't have a CCHP member ID card, do you know how to get one?	53.3%	41.2%
Do you know how to file a complaint if you are not happy about CCHP, a CCHP decision, or the health care services you received?	46.7%	29.4%
Can you find your CCHP membership information online or on MyChart?	66.7%	79.4%
<i>Clarity of Materials</i>		
How easy or hard was it to understand the mail we sent you when you joined CCHP?	82.2%	70.6%

Areas that saw improvement included knowledge of PCP name (+10.2%), knowledge of how to find a network provider (+6.1%), knowledge of how to access interpreter services (+27.8%), and knowledge of MyChart (+12.7%).

While CCHP made important progress in several areas, significant gaps remain in helping members understand how to use foundational services. Patient knowledge of accessing dental services is low and CCHP has quality measures related to dental care.

More information about the ways in which CCHP evaluates the member experience can be found in the forthcoming [2025 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, NCQA. Through analysis of provider appointment availability, enrollee experience,

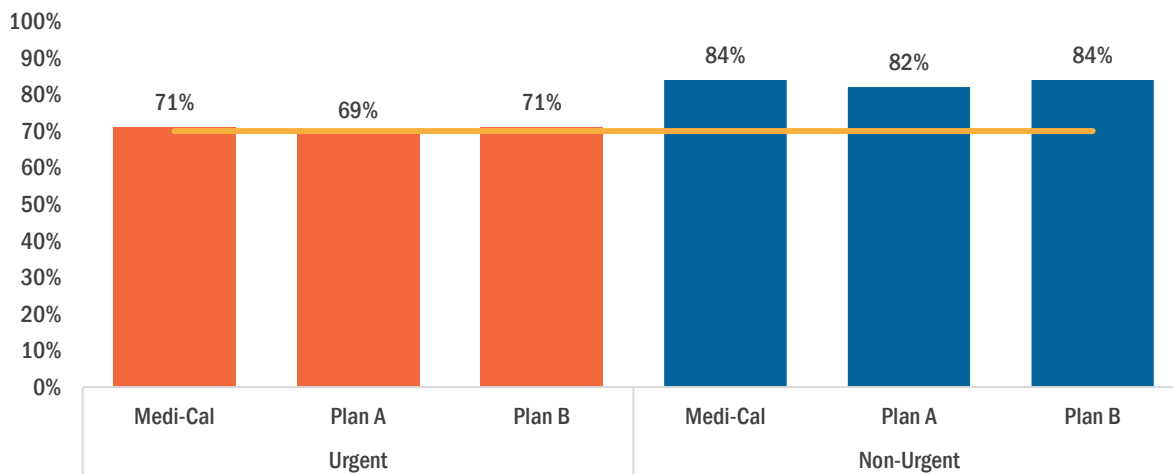
provider satisfaction, and other key metrics, such as initial prenatal appointment availability, Initial Health Appointment (IHA) rates, in-office wait times, and others, CCHP assesses its performance in meeting regulatory standards while ensuring quality and timely service for its members.

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 across all lines of business for non-urgent appointments. For urgent appointments, the only line of business to fall short of the standard of 70% was Plan A with a rate of 69%.

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

CCHP met appointment availability standards for Urgent and Non-Urgent appointments in Medi-Cal and Plan B networks but fell short in Plan A

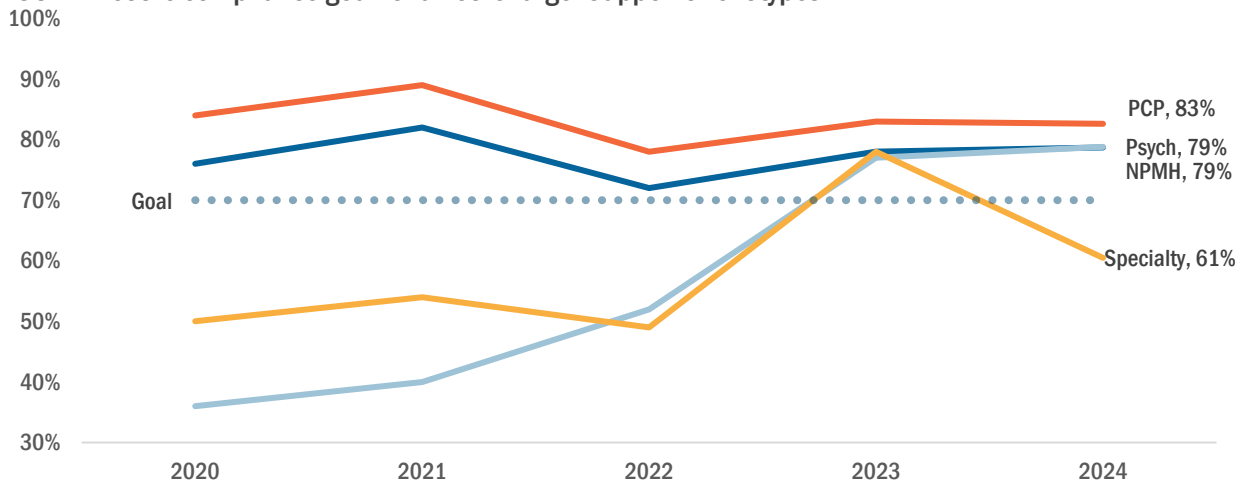


When stratifying urgent appointments by provider type, CCHP saw an increase across most provider types, with primary care, non-physician mental health, and psychiatry experiencing an increase in rating and exceeding the threshold. However, specialty urgent appointments experienced a decrease in rating of 17 percentage points between 2023 and 2024, bringing the rating below the threshold of 70%.

Figure 2. PAAS Urgent Appointment Compliance Over Time

Only Specialty appointment availability decreased in MY 2024.

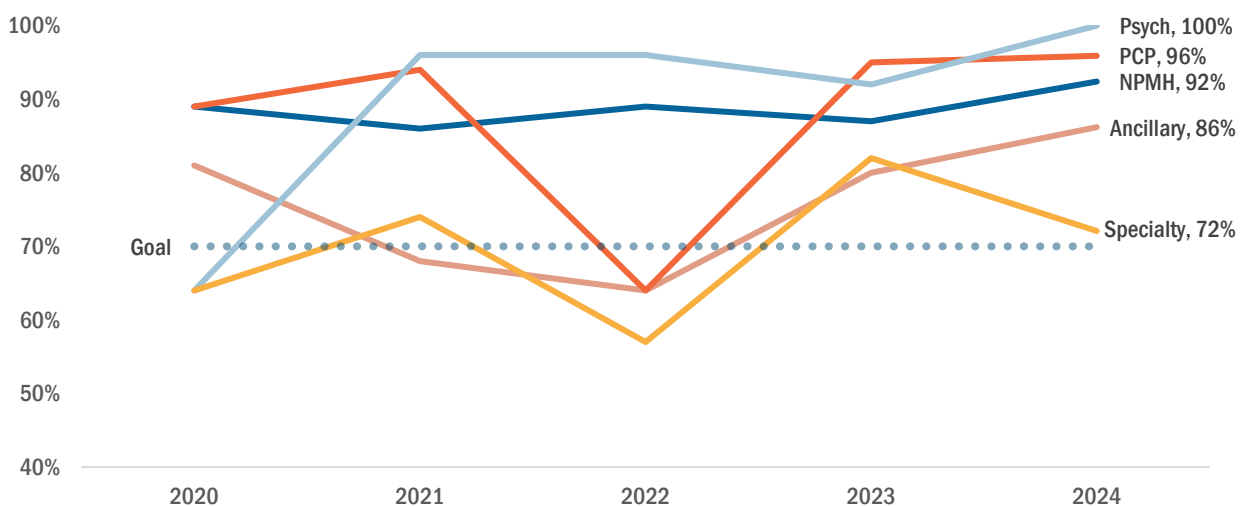
CCHP met the compliance goal for all other urgent appointment types.



Similarly, non-urgent appointments saw an increase across several provider types in 2024 compared to 2023. Notably, psychiatric appointments increased from 92% to 100%, and ancillary appointments increased from 80% to 86%. Specialty appointments were the only type to experience a decrease in rating, dropping by 10 percentage points between 2023 and 2024. All non-urgent appointment types met the threshold of 70%.

Figure 3. PAAS Non-Urgent Appointment Compliance Over Time

All non-urgent appointment types met compliance goal in MY 2024



CCHP implemented several targeted interventions based on the opportunities for improvement identified in the MY 2023 Access and Availability Report. The three main priorities were improving provider education on appointment standards, increasing the specialty network, and improving patient education around after-hours and behavioral

healthcare. More comprehensive information about how CCHP assesses its network adequacy can be found in the [2024 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 (SNFs) and other institutional Long-Term Care (LTC) settings receive high quality services. This report, written in 2025, analyzes quality data from 2024, reviewing primary and secondary sources to present a comprehensive picture of LTC quality. In 2024, CCHP had 1,914 members placed during the reporting period, for a total of 3,182 facility placements. Of these, 1,792 members were placed into an in-network SNF, and 242 members were placed out-of-network.

In 2024, CCHP identified 26 (29.2%) of our facilities had survey deficiencies above the state average and 2 (2.2%) were significantly above average (more than 50% above the state average). Five of our high-volume facilities had higher than average survey deficiencies. For complaints and facility reported incidents, 22.5% of CCHP facilities were above average and approximately 6.7% were significantly above average. Six of our highest volume SNF had complaints and facility reported incidents above the state average.

CCHP reviewed LTC facility 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 rating for in-network LTC facilities was 3.82, 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. When looking at the individual quality measures, CCHP was above or very close to the state average in 8 of the 12 measures but fell below in four measures related to emergency department visits, antipsychotics use and pressure ulcers.

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)

In 2024, CCHP's rate Outpatient ED Visits per 1,000 Long Stay Resident Days (LTC-OED) increased significantly to 4.31 compared to 2023's rate of 1.86, which was more closely aligned with benchmarks.

Table 6. Comparison of LTC MCAS Measures to State and National Average.

	RY 2023			RY 2024			CCHP % Change
	CCHP	CA Avg	National Avg	CCHP	CA Avg	National Avg	
LTC-HAI	5.45%	NA	6.9%	5.43%	NA	7.1%	-0.4%
LTC-OED	1.86	1.38	1.65	4.31	1.53	1.74	+131.7%
LTC-PPR	0.77%	NA	10.5%	2.84%	NA	10.5%	+268.8%

*Lower is better

The report presents strengths and areas for improvement within the LTC facilities 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 [2024 Long Term Care Quality Assurance and Performance Improvement Report](#).

6.5 OTHER QUALITY MEASUREMENT ACTIVITIES

In 2025, 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 2025 was the improvement of sharing quality information with network providers. CCHP expanded the reporting available in the CCHP Provider Portal from provider empanelment reports, lead screening reports, and gap in care reports available to also include reports informing providers about their members due for Initial Health Appointments, Medi-Cal Redetermination, and those who had ED visits & hospitalizations in past 30 days. 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 require 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 2025, CCHP submitted MY2024 data and a summary of implemented interventions for the 2023-2026 DHCS PIPs. Both PIPs met 100% of the methodological evaluation elements and received high confidence rating for methodology. 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 2024, CCHP achieved the 90th percentile for the W30-6 measure, with 79.03% 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 2024 rates up +24.68 percentage points.

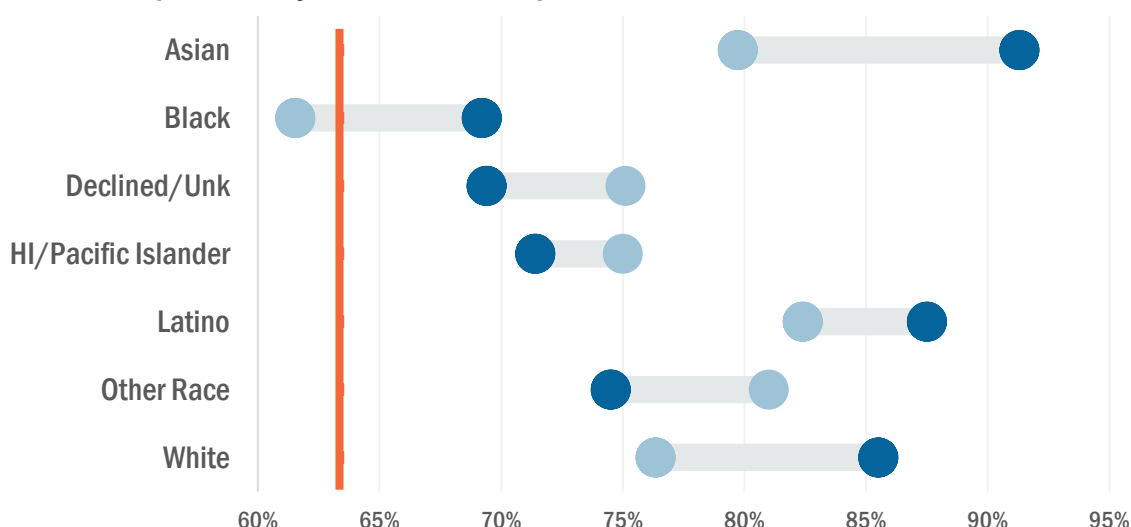
However, despite CCHPs performance, disparities in WCV completion rates exist between racial categories. In MY 2024, Latino members had a W30-6 completion rate of 82.4%, compared to only 61.54% of Black/African American members. If the completion rate for Black members was the same as for Latino, 14 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 have further downstream effects on the W30-6 completion rate for this population.

Though these disparities are present in the W30-6 measure for Black/African American members, there was a great amount of progress in the rating for this group. The rate increased by 7.7 percentage points between MY 2023 and MY 2024, leading to a rate of 69.24%, exceeding the established MPL of 63.4% by 5.8 percentage points.

Figure 4. W30-6 Rates by Race, 2024-2025.

All races exceeded the **MPL**, with Asian, Black, Latino, and White races seeing improvement in preliminary **2025** rates compared to **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.

In 2025, CCHP health education staff placed 539 calls to 384 members, contact was made with a caregiver for 154 (40.1%) members. Overall, 125 (29.1%) patients who received an outreach call had a completed WCV within 75 days of patient outreach. The average time from the call to visit was 34.3 days and the average age at the time of visit was 7.7 months. Despite outreach efforts, CCHP knew that the stated goal would not be achieved. In Q3 of

2025, CCHP partnered with Contra Costa Black Infant Health to conduct focus groups with parents/caregivers of Black/African America infants within the county to determine barriers for WCV. From this focus group, a mailer informing parents/caregivers of the WCV cadence was developed to be tested in Q1 of 2026.

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. Enrollment in ECM and CM within 14 days of the ED visit increased from 0.9% in 2023 to a rate of 1.5% in 2024, an increase of 0.6%-points (+66.7%) (most recent reporting year). Efforts in 2025 focused on engaging with ED providers to increase follow-up with the Access Line.

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 2024 (reported in 2025) CCHP identified lead screening and topical fluoride application as low performing measures.

7.2.1 Lead Screening in Children

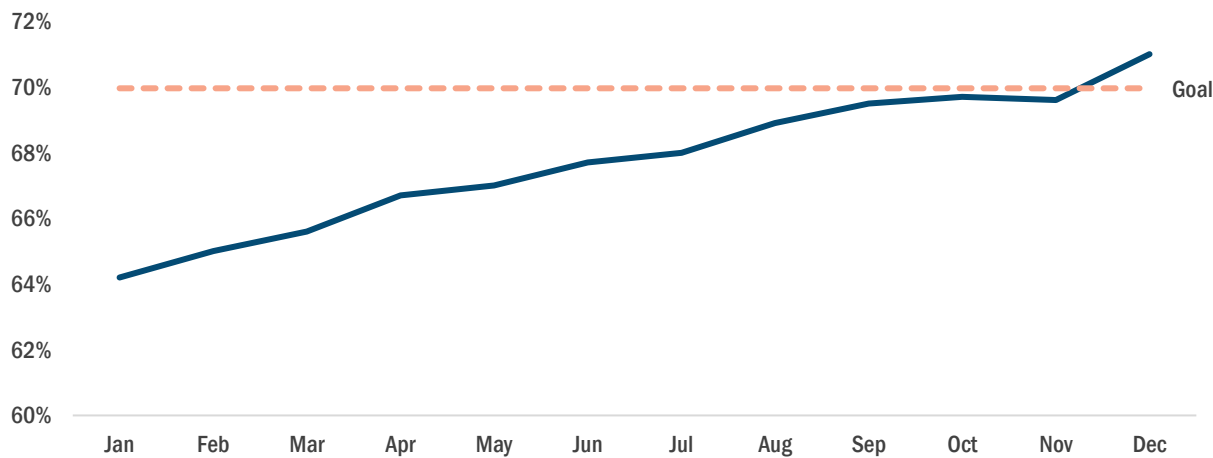
Lead Screening in Children (LSC) is a measure that CCHP must perform at the 50th percentile or better when compared to other HMO Medicaid plans. LSC rates have increased considerably since MY2021, rising from 44.23% to 66.10%, exceeding the 63.84% target in MY2024. The target for LSC increased considerably in MY2025, to 69.96%, so CCHP sustained the lead outreach campaign initially implemented in 2024. This multimodal outreach strategy includes outreach by health education staff to caregivers of

members approaching their second birthday who have not had the recommended blood lead test, as well as quarterly lead mailings. For the health education outreach, caregivers are called and informed of the importance of lead screening and how their child can get screened. In 2025, a total of 709 calls were made to 382 members’ caregivers (avg. 1.9 calls/person) and a caregiver was reached for 280 (73.3%) of members. Ultimately, 62 (16.2%) of members who were outreached had a lead test that was collected within two weeks of outreach. In total, 202 (52.9%) members in this population had a lead screening by the end of 2025, with 61 (16.0%) of these screenings occurring before the member’s second birthday. Members were eligible for the lead mailing campaign if they were overdue for a lead screen and their second birthday was in quarter following the mailing, leading to 1,165 packets sent in 2025. Mailers included a letter informing patients of their overdue lead screening status, as well as educational fliers that had been previously developed with the Contra Costa Health Public Health department. Of the 1,165 members mailed a letter, 213 (18.3%) had a lead screen by the end of 2025, with 103 (8.8%) of those screenings occurring before the member’s second birthday. CCHP partnered with the Contra Costa Lead Poisoning Prevention Program to present about lead to the Stege Elementary School community in May 2025 and for Lead Poisoning Prevention Week in October 2025.

Preliminary MY 2025 HEDIS results for CCHP demonstrate increased improvement in LSC to 72.55%, which exceeds the MY2025 target.

Figure 5. Lead Screening Rate by Month in 2025.

CCHP performance on LSC steadily increased throughout the year and is projected to exceed the target.



7.2.2 Topical Fluoride Varnish

While CCHP increased performance on TFL from 15.21% in MY 2023 to 22.31% in MY 2024, CCHP anticipates marginal improvements in MY 2025 rates and the MPL has

increased to 21.60%. 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 over 4,500 calls to parents/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. 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. In addition to outreach calls, CCHP distributed over 500 Denti-Cal fliers at 34 distribution sites throughout 2025.

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. These projects were completed at the end of quarter one in 2025.

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 from 11.0% to 48.1% by March 2025. At the end of this collaborative, which included activities such as weekend morning clinics and a social media campaign, while Brighter Beginnings did not achieve the stated goal of 48.1% of 18-21-year-olds completing a WCV, they did increase performance in this group by 107% to 22.8%. In Q3 of 2025, CCHP started Round 2 of the Child Health Equity Collaborative, this time focusing on improving well child visits in the first 15 months of life and from 15-30 months of life with the Contra Costa Regional Medical Center.

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 by the end of Q1 2025. Interventions including improved data reporting utilizing Admission, Discharge, and Transfer feeds, outreach by the Behavioral Health Access Line, and in-service presentations to local ED staff. By the end of the collaborative, CCHP achieved a 13.5% increase in FUA rates, but only a 2.5% increase in FUM rates. In addition to the improvements in FUM and FUA rates, the Access Line completed over 2,500 outreach calls, 344 connections were made to mental health and AOD services, and 41 patients were enrolled into Enhanced Care Management (ECM). CCHP decided to participate in round two of the collaborative, with participation from, and an enhanced focus on, an Emergency Department with lower linkage rates and high patient volumes.

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 2025, 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.

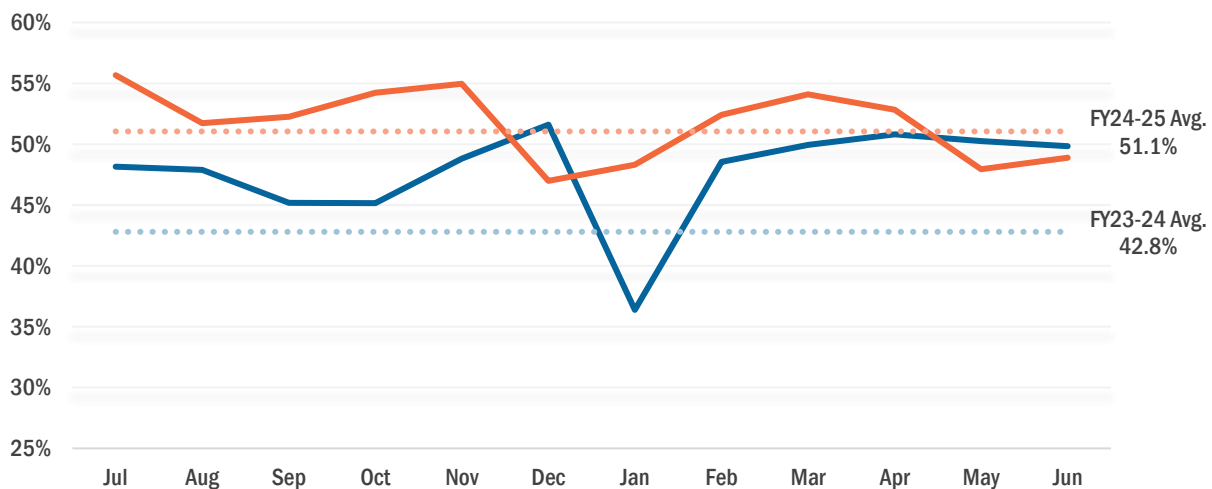
In addition to CCHP efforts, collaborative efforts with the Public Health Department's epidemiologist and quality team were initiated to align with Contra Costa's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). CCHP was an active stakeholder in Contra Costa County's CHA, which began planning in 2025, and participated in 14 meetings as a key member of the CHA steering committee.

8.2 INITIAL HEALTH APPOINTMENTS

CCHP ensures that adult and pediatric members receive timely initial health appointments and comprehensive preventive services upon enrollment with the plan. CCHP previously identified improving IHA completion rates as a priority and has undertaken several efforts to increase rates over the past two years. Efforts in 2025 included chart audits of the largest provider groups with feedback on compliance, provider education on IHA requirements via the Provider Network Training and provider bulletins, and on-demand reports on the CCHP Provider Portal showing members due for an IHA. Figure 6 demonstrates the improvement in IHA rates in FY24-25 compared to FY23-24. Compared to FY22-23, IHA completion rates are up 8.0 percentage points (+18.6% change), demonstrating the success of efforts to improve rates.

Figure 6. IHA Completion rates FY23-24 to FY24-25.

IHA completion rates were higher in FY24-25 compared to FY23-24.



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 2025, CCHP expanded on previous work that developed infrastructure to utilize ADT feeds for risk identification and program eligibility. These data have then been leveraged to automatically identify and refer people to services, without the need of a practitioner referrals. CCHP was able to expand referrals to include Transitional Care Services referrals for recently hospitalized pregnant members assigned to the RMC network and ECM referrals for the Birth Equity population of focus.

In summer 2025, DHCS launched Medi-Cal Connect, a platform to aggregate individual and population-level data from various state data sources in order to risk stratify members. CCHP has reviewed the initial risk segmentation data from Medi-Cal Connect and is working to incorporate it into the population health program.

Finally, CCHP launched an annual reassessment of LTSS and Children with Special Health Care Needs (CSHCN) to ensure that these especially vulnerable members are reassessed at least annually and connected to relevant resources. Since this project was implemented, over 3,300 letters have been mailed and approximately 2.7% of members have returned an assessment form.

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 7 outlines the number of individuals who received these services in 2025. CCHP significantly increased utilization of Medically Tailored Meals, Nursing Facility Transition/Diversion to Assisted Living Facilities, Day Habilitation Programs, Respite Services, Environmental Accessibility Adaptations, and Recuperative Care (Medical Respite) services in 2025 compared to 2024. CCHP Care Coordination Services and the

number of unique members receiving CHW services also increased significantly in 2025 compared to 2024. After targeted patient and provider education improvement efforts in 2025, the number of patients receiving doula services increased over 400%.

Table 7. Number of Members Receiving Basic Population Health Services

Program	2023	2024	2025	Trend	% Change 2024 to 2025
Community Supports	1,743	5,664	7,469		31.9%
Medically-Supportive Food/Medically Tailored Meals	600	3,384	5,421		60.2%
Housing Transition/Navigation Services	719	2,110	1,787		-15.3%
Nursing Facility Transition/Diversion to Assisted Living Facilities	-	95	244		156.8%
Personal Care/Homemaker Services	-	228	243		6.6%
Short-Term Post-Hospitalization Housing	84	180	157		-12.8%
Housing Tenancy and Sustaining Services	105	130	154		18.5%
Day Habilitation Programs	-	33	124		275.8%
Respite Services	-	21	122		481.0%
Housing Deposits	-	72	95		31.9%
Environmental Accessibility Adaptations	-	20	84		320.0%
Recuperative Care (Medical Respite)	48	27	61		125.9%
Asthma Remediation	86	83	30		-63.9%
Community Transition Services/Nursing Facility Transition to a Home	-	8	8		0.0%
CCHP Care Coordination Services	1,537	2,170	2,765		27.4%
Members Receiving CHW Services	920	2,038	2,665		30.8%
Doula Services	5	48	257		435.4%

8.4.1.2 Wellness, Prevention, and Health Education

CCHP works with providers on getting members into primary care and addressing care gaps. CCHP undertook a number of projects in 2025 to help connect members into services. Building on the work done in 2024, in Q1 2025 CCHP mailed the first set of pediatric wellness letter reminders to patients assigned to the RMC network who are overdue for health maintenance topics. The wellness letter includes a personalized list of items the child is overdue for and provides information for members on how to make an appointment. In 2025, CCHP and RMC sent out over 18,000 letters to patients overdue for at least one health maintenance topic, with 1,629 (8.7%) of patients completing one or more health maintenance topics within 60 days of letter mailing. CCHP also conducted telephonic outreach for four separate projects to connect members to care. For Blood Pressure Control, CCHP made 296 calls to 290 patients who were due for a blood pressure check or recheck, and 30 of these patients (10.1%) completed an appointment that was scheduled within two weeks of outreach. For colon cancer screening, CCHP conducted 3,060 to 2,368 patients to remind members to return a Fecal Immunochemical Test (FIT) kit sample. Of the patients who were called, 245 (8.0%) returned a FIT test within 60 days of outreach. CCHP also conducted outreach for Cervical Cancer Screening, placing 2,560 calls to 2,164 patients to connect them to care. Of these, 153 patients (6.0%) completed an

appointment that was scheduled within two weeks of the outreach. The least successful outreach campaign was the Assigned Not Seen project, where pediatric members were contacted if their last well-care visit was greater than 18 months in the past to try and reconnect them to care. Of the 2,589 calls to 1,339 patients, only 34 appointments (1.3% outcome success) were scheduled within two weeks of outreach. While the successes in the Assigned Not Seen group were low, this was expected as this group had received a round of outreach in 2024, and this was the third and fourth outreach attempts for many of these members.

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 at 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.

After the Health Education team expanded in 2024, efforts were undertaken to increase the presence of the CCHP within the community. In 2025, the Health Education Team demonstrated an unwavering commitment to improving community health through education, outreach, and collaboration. The three-person team attended more than eighty events across Contra Costa County, ensuring a strong presence in Central, East, and West regions, as well as through virtual platforms. Their efforts included recurring sessions at the Concord and Pittsburg libraries, at the Richmond and Antioch Mobile Farmers Markets, participation in major community gatherings such as the County Block Party, Senior Health Fair, and Food Bank Agency Summit, and partnerships with clinics including La Clinica, Brighter Beginnings, and Lifelong Medical Care. They also delivered monthly movement sessions to the virtual Food as Medicine classes in English and Spanish.

Throughout the year, the team distributed over 17,500 health education materials, including brochures, booklets, and Contra Costa Health branded items. In addition to distribution, the team developed thirty-seven original health education documents to address priority topics such as prenatal and maternal health, child and family preventive care, chronic condition management, and access to coverage. They also produced three annual newsletters and introduced topic-specific e-newsletters for families, maternal health, and mental health, new initiatives that began in 2025 to strengthen communication and engagement with our community.

Community engagement was further strengthened through strategic partnerships with public health and Regional Medical Center clinics, which amplified distribution and education efforts. High-demand items such as stress balls, pens, hand sanitizers, and totes consistently enhanced visibility and participation at events. These engagement tools, combined with targeted educational materials, allowed us to meet residents where they are and address their most pressing health needs.

8.4.1.3 Behavioral Health

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

In 2024, CCHP was required to develop a Non-Specialty Mental Health Services (NSMHS) Outreach and Education Plan to increase member and provider awareness of behavioral health services and increase equity in those who access behavioral health services. In addition, the 2024 administration of the ECHO survey demonstrated that member awareness of different behavioral health treatment options was an area for improvement. Given this, in 2025 CCHP developed seven one-page information sheets with a health education article on one side and local county behavioral health resources on the back. Topics include maternal mental health, adult mental health, child mental health, and what to know about stress. Over 600 of these materials were distributed at over 30 events, including outreach at providers offices, county libraries, and regional health fairs. In addition to the one-pagers, a mental health focused e-newsletter was developed and six issues were produced. The newsletter covered topics such as depression, child and teen behavioral health and wellness, healthy coping, and hope and recovery. Notably, the Information About Treatment Options composite score in the 2025 ECHO survey increased over 10% compared to the 2024 administration, and the NSMHS penetration increased from 4.1% in 2024 to 4.5% in 2025.

8.4.1.4 Maternal Health

In 2024, CCHP strengthened its commitment to improving maternal health and aligning with statewide priorities. In 2025, this work continued to grow through sustained collaboration with community partners, public health programs, and network providers.

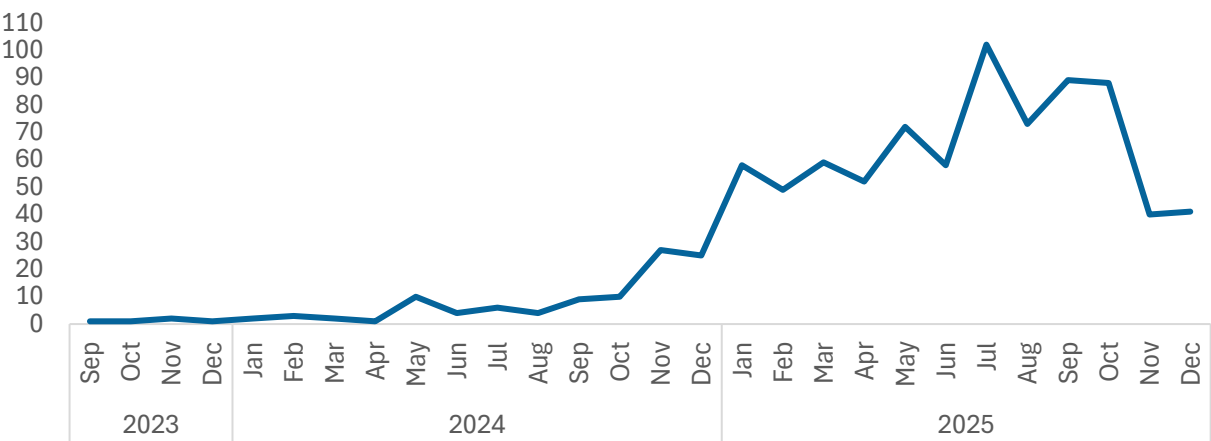
CCHP’s Health Education team plays a central role in community outreach and engagement. In 2025, the team participated in 46 events serving pregnant and postpartum individuals. These included Women, Infants, and Children (WIC) Breastfeeding Week activities across the county, outreach at perinatal care sites, the Black Infant Health (BIH) Holiday Fair, and other community gatherings. Through these efforts, CCHP distributed more than 5,000 maternal health education materials over the year.

CCHP also continued to expand support for both contracted and prospective doulas, recognizing their critical role in improving maternal health outcomes. Support efforts included online doula office hours and quarterly joint operations meetings. In September, CCHP partnered with Family, Maternal, and Child Health (FMCH) and FIERCE Advocates, a local community-based organization, to host an in-person doula provider workshop. This event offered doulas the opportunity to connect directly with CCHP staff and receive assistance with contracting and claims processes. As a result of these ongoing efforts, doula service utilization increased substantially, with a 701% rise in paid doula claims compared to 2024. The number of CCHP patients who received doula services increased from 47 in 2024 to 257 in 2025.

Figure 7. Doula claims 2023-2025.

Doula Claims paid in 2025 increased significantly compared to 2024

Clean claims paid for doula services increased by 701% with continued educational outreach and support for both members and providers



Collaborating with community partners and providers enables CCHP to connect members to vital resources early in their pregnancy. However, some members may choose not to engage with these services or may not be identified until after delivery. To ensure support during the critical postpartum stage, CCHP launched automated referrals to Transitional Care Services (TCS) in 2025.

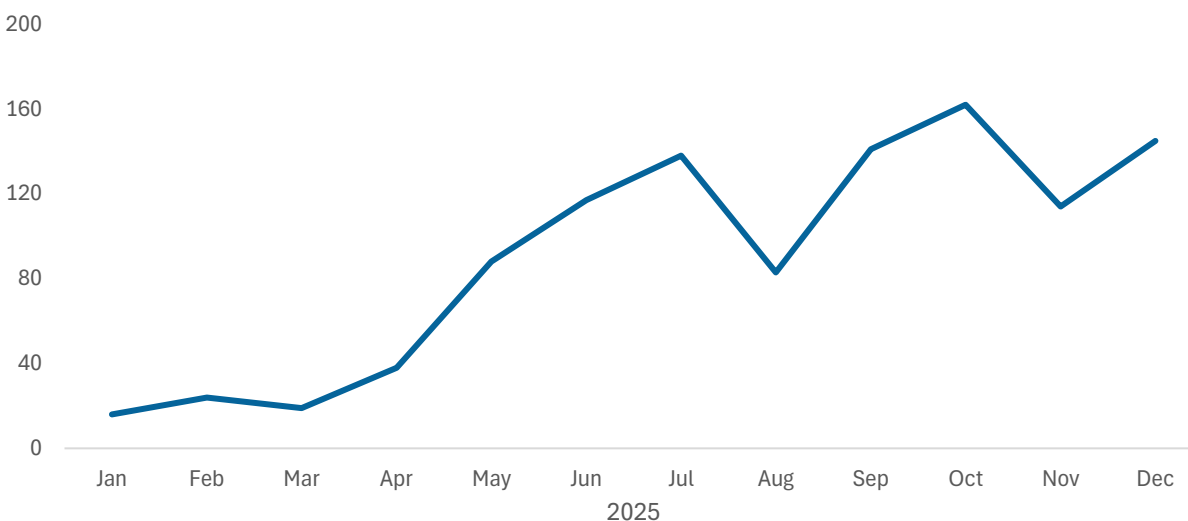
TCS helps new mothers navigate a smooth transition between levels of care and provides specialized assistance for those experiencing delivery complications, including coordination of complex needs. Beyond clinical support, TCS addresses social determinants of health by linking mothers and their babies to essential community resources and programs.

This enhanced referral system also identifies members who deliver at external hospitals, ensuring timely TCS outreach. Since its implementation in April 2025, we have seen a significant increase in member enrollment in care coordination services for maternal and infant health.

Figure 8. Enrollment in Care Management Services for Maternal Health, 2025.

Enrollment in Transitional Care Services (TCS) and Care Coordination Services increased significantly in 2025

Enrollment into maternal and infant care management services increased following implementation of autoreferrals in April



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 2025, 18 Reasons served 1,961 CCHP members and delivered over 17,000 boxes of groceries. CCHP's Health Education Team also expanded its involvement with FAM groups by offering movement breaks and health education sessions. The team facilitated 46 classes for groups experiencing pediatric and adult obesity, as well as diabetes. These sessions highlighted the benefits of regular physical activity and included simple, at-home demonstrations to help members build confidence in incorporating movement into their daily routines. Members enrolled in FAM for diabetes lowered their A1c 11% compared to patients who were not enrolled, a difference that achieved statistical significance. For pediatric patients with obesity, patients who participated in FAM saw increases in BMI, however, these increases in BMI were 5% less on average than those who were not enrolled, another statistically significant difference.

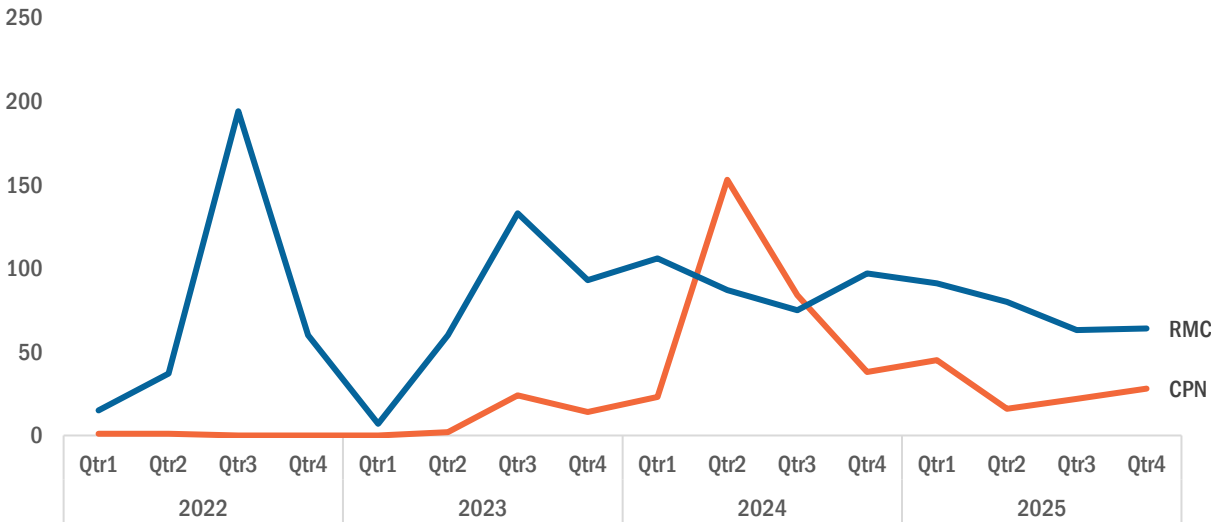
8.4.2.2 Remote Patient Monitoring for Diabetes and Hypertension

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 2025, CCHP contacted 2,115 members with uncontrolled diabetes and referred 431 (20.4%) RMC patients into the program, with 246 enrolling. Ultimately in 2025, 411 members were newly enrolled into the diabetes remote patient monitoring program, with 72.5% of enrolled members coming from the RMC network. CPN providers enrolled 111 members, about one-third of the patients enrolled in 2024. Since the program began in 2022, CCHP has enrolled 1,726 patients into the diabetes RPM program. CCHP has also seen improvement in the HEDIS Glycemic Status Assessment -Poor Control (>9.0%) and Control (<8.0%) measures and performed at the 90th percentile for both in MY 2024.

Figure 9. Enrollment into the Diabetes RPM Program by Network.

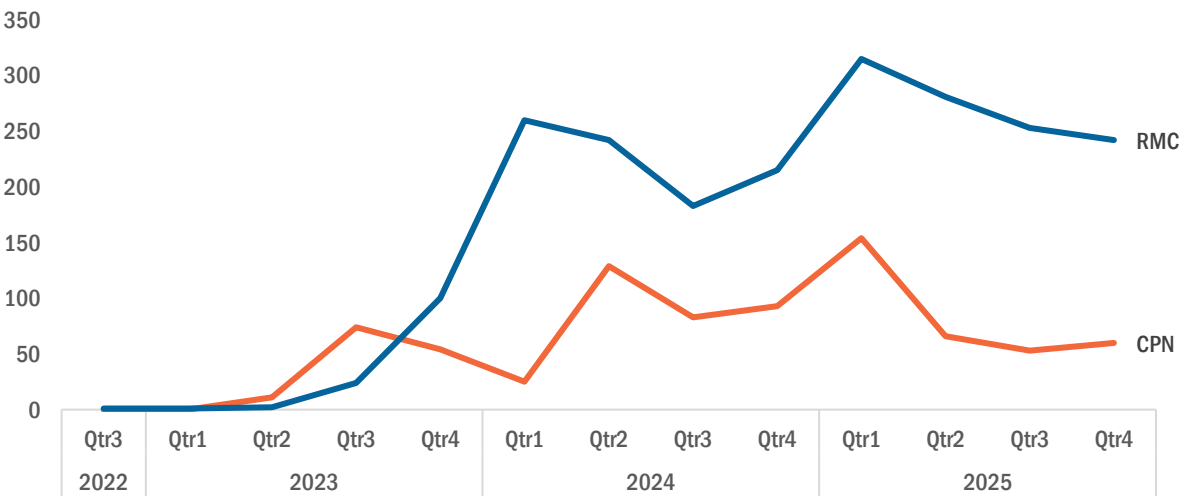
RMC patients have been consistently enrolling in RPM since the launch of bulk referrals



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 2025, Gojji enrolled 1,434 members in the hypertension RPM program. To date, 2,947 patients have been enrolled.

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

1,434 people were dispensed HTN cuffs in 2025



8.4.2.3 Asthma

In 2025, CCHP participated in the RMC Ambulatory Care Redesign project specifically focused on Alternative Care Models for patients with moderate to severe asthma. These patients were contacted and invited to participate in a nurse-led population health clinic to

better address asthma medication management and education. Recruitment for these clinics -were conducted by the CCHP Health Education Specialist beginning in Q1 2025. The population health nurse clinic was piloted between February 4, 2025, and December 31, 2025, at West County Health Center. Eligible patients included those ages 4 and older, assigned to West Center Health Center or North Richmond Health Center, and met a set criteria of moderate to severe asthma. The CCHP Health Education Specialist conducted 688 outreach calls to eligible patients, including 370 (53.8%) reached attempts. A total of 362 patients were contacted. Patients were informed about the nurse appointments for asthma education and control available as a 4-hour clinic, 3 days a week. Initial intake appointments were scheduled over-the-phone using a standardized outreach script. During an initial visit, the population health registered nurse will assess patient understanding of the disease process and medication use, inhaler techniques, asthma control test score, and asthma triggers. Based on this initial assessment, appropriate education is provided by the registered nurse and follow-up appointments are scheduled at 4-6 weeks. Patient “no show” rates were evaluated to identify scheduling barriers and streamline the process. Telephone appointment reminders were provided by CCHP at least a day to a week prior to scheduled appointments. In-person, telehealth video, and telephone audio visit options were also available to help address no shows. A total of 133 patients were successfully scheduled or had completed a nurse appointment made within 14 days. Development of standardized procedures for the asthma population health clinic and implementation will continue into Q1 2026. Further collaboration will aim to explore the potential expansion of the population health nurse clinic to additional RMC clinics and chronic disease focus, including diabetes and hypertension.

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. 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 2025, 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 for patients in the Birth Equity POF, high utilizers, and those with SMI/SUD.

Table 8. Comparison of Enrollment in Care Management Programs

Care Management Program	2023	2024	2025	Trend	% Change 2024 to 2025
ECM Population of Focus	6,488	7,706	7,959		3.3%
Adult Homelessness Individual	1,081	1,707	1,990		16.6%
Adult High Utilizer	836	1,916	1,672		-12.7%
Adult SMI/SUD	806	1,595	1,480		-7.2%
Child/Youth High Utilizer	453	1,278	1,305		2.1%
Adult LTC	30	321	526		63.9%
Adult Nursing Facility Transition	30	215	484		125.1%
Child/Youth SED/CHR	138	510	392		-23.1%
Adult Incarceration Transition	490	409	280		-31.5%
Child/Youth CCS/WCM	149	303	243		-19.8%
Adult Homelessness Family	56	262	171		-34.7%
Child/Youth Homelessness Family	71	153	132		-13.7%
Child/Youth Homelessness Individual	30	138	132		-4.3%
Adult Birth Equity	-	41	94		129.3%
Child/Youth Welfare Hx	48	83	57		-31.3%
Child/Youth Birth Equity	-	18	10		-44.4%
Child/Youth Incarceration Transition	32	30	8		-73.3%
Case Management	981	3,425	6,940		102.6%
Transitional Care Services	634	2,882	6,408		122.3%
Complex Case Management	200	400	431		7.8%
CCS Transitions	147	143	101		-29.4%

CCHP notably increased the number of members served in 2025 compared to 2024 for the Adult Long Term Care, Adult Nursing Facility Transition, and Adult Birth Equity populations of focus (POF). The number of members receiving Care Management services also saw a significant increase, raising by 102.6% between 2024 and 2025. The increase in overall Care Management volume was primarily driven by growth in Transitional Care Services, which saw an increase of 122.3% between 2024 and 2025. 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.

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 2025, 6,408 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 122.3% compared to the number of members in TCS in 2024.

Throughout 2025, analyzed the DHCS Acute Stays with an Ambulatory Follow-Up Visit within 7-Days measure, which indicated 35.4% 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. After the implementation of these auto referrals both the number of patients and the overall percentage of patients with a CM visit per quarter have increased. CCHP will continue to trend these metrics over time and implement improvement activities as needed.

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.

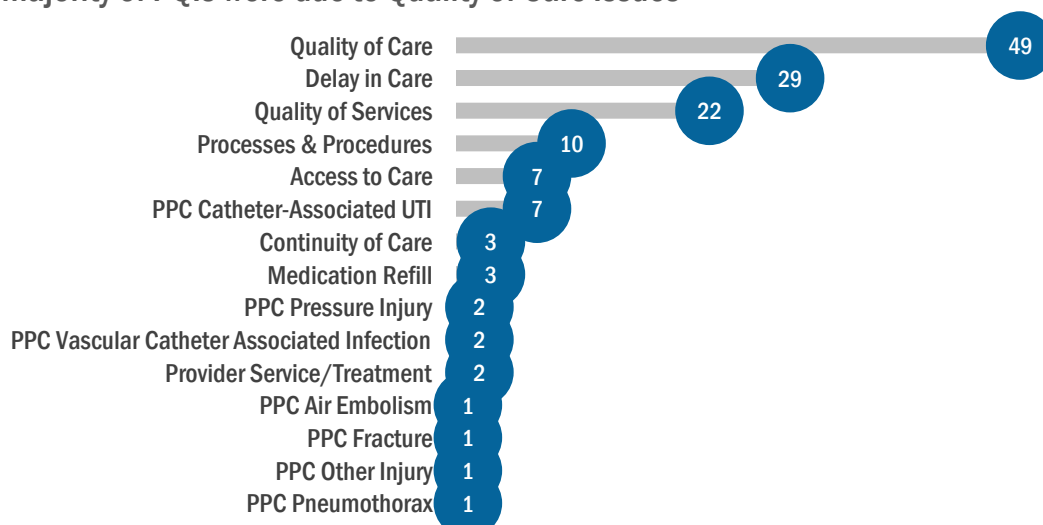
9.1 POTENTIAL QUALITY ISSUES AND PROVIDER PREVENTABLE CONDITIONS

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 2025, CCHP reviewed 300 cases, primarily referred through grievances, followed by utilization review. Of those cases 158 were determined to have no quality issue (level 0), 76 had minor issues (level 1), 56 moderate issues (level 2), and 10 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 11. PQIs by Issue Type.

The majority of PQIs were due to Quality of Care Issues



Compared to 2024, there was a slight increase 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 14 of 67 members being treated for Hepatitis C to ensure completion of therapy. Additionally, 28 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 2025, CCHP completed 33 Facility Site Reviews, with 29 providers undergoing medical record reviews, totaling 431 records. This comprehensive assessment process identified areas for improvement, resulting in the formulation of 27 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 68 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 2025, CCHP completed Joint Operations Meetings with hospitals, SNFs, ECM, CS, and 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 2025, CCHP expanded 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 2025, 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 2025, CCHP successfully completed and met a large majority of the ambitious goals and objectives outlined in the 2025 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 Dual Eligible Special Needs Plan proved to be demanding. This project rollout required meticulous execution amidst competing priorities while ensuring ongoing compliance with existing statutes and organizational goals.

A significant barrier that CCHP encountered in 2025 has been planning for the upcoming Medi-Cal eligibility changes resulting from H.R. 1. This policy shift is anticipated to reduce membership significantly and likely impacted HEDIS rates as members lost coverage and failed to meet continuous enrollment criteria.

Compounding these challenges, CCHP operated in an uncertain environment where immigrant families expressed reluctance or hesitation to seek care. Fear of immigration enforcement and confusion around eligibility created barriers to accessing services, even for those who remain eligible. This climate of distrust made outreach and engagement more difficult and resulted in delayed or forgone care for some members.

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 20 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 ECHO survey, with several measures increasing significantly.

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, and 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 2025 QUALITY WORK PLAN AND EVALUATION OF ACTIVITIES

2025 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 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	Met. CCHP reviewed and approved the annual quality documents at the February 2025 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 2025 QIHETP Program Description, incorporating structural changes identified in the evaluation	
1.3			Develop annual 2025 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 and health equity 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 2025. 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	
1.6		Ensure there are policies and procedures to meet regulatory and operational needs	Review CCHP policies annually and upon any new APL changes	

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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	Partially Met. CCHP convened 3 Equity Council meetings in 2025. 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.	
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 6 new members recruited in 2025. Four meetings covered all required topics; additional topics such as Crisis Response Team (A3), Medi-Cal re-determination and transportation services were presented based on member's interests.

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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.	Met. CCHP successfully submitted all required documentation within required timelines.
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.	Met. CCHP received the Health Outcomes Accreditation in August 2025.
3. Measurement, Analytics, Reporting, and Data Sharing				
3.1	HEDIS Reporting and Quality of Clinical Care (DHCS, NCQA, DMHC)		Complete all annual HEDIS, MCAS, and HEQMS activities, ensuring compliance with quality measurement regulatory agencies, including NCQA, DHCS, EQRO, and DMHC.	
3.2			Complete annual HEDIS MY2024 report, analyzing yearly trends and identifying areas for improvement. Incorporate report into Population Health Needs Assessment.	
3.3			Identify areas of opportunity for data systems and data sources for MY2025	

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3.4		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	Develop and implement improvement projects targeting at risk measures and those measures that align with other strategic goals of CCHP	Met. CCHP achieved 4.5 stars in Health Plan ratings and high performance (over the 90th percentile nationally) in 20 MCAS measures. No measure was below the MPL in 2025. Data system improvements included improving coverage tables, reviewing enrollment files, expanding supplemental data sharing with community groups, and improving local mapping on the following measures: FUM, FUA, EED, PPC, BCS, CCS, TFL-CH.
3.5	CCHP Quality Measurement Infrastructure	Create quality dashboard and quality monitoring program with feedback loop to providers to	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-

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3.6		allow for ongoing tracking of all HEDIS MCAS measures, including measuring disparities, trends by year, and current rates	Maintain quality feedback mechanism for providers, which shares performance rates by provider group on CCHP priority measures and identify unique areas of opportunities	month measurements for MY2025 MCAS MPL measures. CCHP updated the reports available to provider via the Provider Portal to include Patients due for Initial Health Appointment, Patients due for Redetermination, and Patients Hospitalized within Past 30 Days. These reports are updated daily and available on demand, allowing CCHP to exchange data with providers in a secure fashion.
3.7			Maintain system of data sharing gap in care lists with CPN network to allow for ongoing quality improvement	
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 grievancesDevelop 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, member experience surveys for the
3.9			Host internal CAHPS think tank to gather insights into member experience from cross-functional teams	
3.10			Review and analyze the limited English enrollee survey	

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3.11			Review and analyze behavioral health specific member experience surveys	diabetes remote patient monitoring and asthma home remediation programs, and a new member survey. These experience surveys were administered and results analyzed, with trending and comparison to benchmarks when available. CCHP partnered with UC Berkeley to develop a
3.12			Develop report on MY2024 member experience	
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	
3.14			Develop survey tool to assess member experience with Case Management, conduct survey, analyze results	
3.15			Conduct new member survey to assess comprehension of new member materials	
3.16			Collect member experience on population health programs	

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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.	Case Management experience survey that was administered in late 2025. Results from this survey are still being analyzed. 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 2025. The input from the CAC was incorporated into the SB1019 workplan and other population health documents.

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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.	Met. CCHP sent out a provider experience survey at the end of 2025. Results have not yet been received at time of the evaluation report.
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	Partially 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, except for urgent, Plan A appointments. The only appointment type below goal were urgent, specialty appointments. The
3.20			Develop process for DHCS quarterly access monitoring	
3.21			Create comprehensive annual access report that identifies trends and identifies areas for opportunities	

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3.22			Develop feedback loop to providers on their results from the annual PAAS/NCQA survey, providing education and timely access standards.	report was submitted to DMHC, presented to Quality Council and results were communicated back to provider groups.
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	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.
3.24			Complete DHCS quarterly CalAIM ECM-CS Quarterly Monitoring Reports, reporting enrollment and utilization of CalAIM services	
3.25			Complete the monthly JSON CalAIM reporting	
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	Met. CCHP updated REAL and SOGI data collection according to NCQA Health Equity/Health Outcome Accreditation standard, CCHP also has more than 90% of race/ethnicity data on membership.
3.27			Develop baseline measurement for SOGI data collection and establish targets.	

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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	Met. The results were presented at March Equity Council meeting.
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	Met. CCHP successfully completed the encounter data validation study with a 96.8% submission rate, higher than the state average of 92.4%. Omission rates for encounter data were consistently well under the 10% benchmark with high accuracy rates.
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	Met. The report was completed and presented at October Quality Council.

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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	Met. CCHP increased the percentage of eligible members enrolled into care management by 66.7% compared to prior year, though this result did not achieve statistical significance.
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.	Partially met. Despite targeted efforts, the disparity gap between Asian and Black/African American members increased in MY2024 compared to MY2023. However, Black/African American children performed above the 50th percentile nationally in this metric and has seen marked improvement in the preliminary MY2025 rates.

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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.	Partially met. CCHP partnered with Brighter Beginnings and while the Well Care Visit completion rate increased 107% by the end of the collaborative, the stated goal of 48.1% was not achieved. In Q3 of 2025, CCHP started Round 2 of the Child Health Equity Collaborative, this time focusing on improving well child visits in the first 15 months of life and from 15-30 months of life with the Contra Costa Regional Medical Center.

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4.4			Complete IHI Behavioral Health Collaborative with CCBHS.	Partially met. By the end of the collaborative, CCHP achieved a 13.5% increase in FUA rates exceeding the 5% goal, but only a 2.5% increase in FUM rates, for mixed results. In Q3 of 2025, CCHP began participation in round two of the collaborative, with participation from, and an enhanced focus on, an Emergency Department with lower linkage rates and high patient volumes.

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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	Met. CCHP achieved the 50th percentile in the LSC measure for MY2024 and is projected to meet the target again for MY2025. Efforts to address this measure included outreach calls and mailers to patients due for screening.
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 topical fluoride treatment in the last 12 months, develop and distribute dental benefits material.	Met. CCHP conducted more than 4,500 outreach calls to member who did not have topical fluoride treatment in the last 12 months and distributed over 500 Denti-Cal flyers at community events throughout the year.

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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.	Partially Met. CCHP conducted over 2,100 calls to African American and Native Hawaiian/Pacific Islander children and 84 completed a well care visit that was scheduled within two weeks of outreach. However, neither group reached the 50th percentile in MY2024.
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.	Met. In Q4, CCHP hired a Planner/Evaluator Level B to oversee the DSNP Stars program and develop a strategy for quality performance. Areas for opportunity include hypertension management and the Care for Older Adults measures.

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4.9	ED Workgroup	Understand areas for improvement with regards to ED utilization	Convene workgroup to analyze ED utilization and identify areas for opportunity.	Met. CCHP analyzed ED visits and identified an intervention to attempt to reduce ED utilization. An Advice Nurse callback program was launched in summer 2025 to attempt to reduce the percentage of patients with repeat ED visits and to increase awareness of the Advice Nurse line. The impact of these efforts will be analyzed in early 2026.

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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), well-care visits (W15, W30, and WCV), controlling blood pressure (CBP), and cervical cancer screening (CCS). Outreach efforts were also implemented for FIT kit completions to impact the COL measure.
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	Met. CCHP completed a population needs assessment and presented to the Quality Council. Additionally, CCHP joined the cross
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	

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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.	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.
5.4	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.
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	Provide streamlined new member experience, with regards to	Monitor ongoing HIF/MET and HRA completion rate and follow-up for positive screenings	Partially Met. 1. Met: All positive

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5.7		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	Implement electronic HIF/MET and HRA screenings utilizing myChart questionnaires	screenings are referred to CHW providers. 2. Partially Met: DSNP HRA screenings can be completed utilizing MyChart. However, electronic HIF/MET and LTSS screenings utilizing MyChart has been deferred to 2026.
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	Partially Met.1. Met: CCHP completed IHA audits and presented the findings at the May Quality Council.2. Met: IHA rates increased from 42.8% in FY23/24 to 51.1% in FY24/25. Text message and email reminders to complete the IHA were deferred.
5.9			Implement text message and email reminder for patients to complete Initial Health Appointment	

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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.	Met. CCHP has reviewed Medi-Cal Connect data and is currently convening a workgroup to determine how to incorporate these data.
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	Met. CCHP is currently utilizing the HIF/MET assessment for new members to triage members with positive LTSS questions. Annual reassessment mailings were implemented in Q3 of 2025 to ensure the annual reassessment of LTSS and CSHCN members.

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5.12	Ongoing Engagement with PCP	Increase regular engagement with PCPs Close Member gaps in preventive care	Utilized disengaged member reports and connect Members with PCPs & close care gaps	Met. CCHP participated in and provided significant support for the Contra Costa Health Assigned Not Seen project. Outreach staff conducted over 2,500 calls to patients ages 0-17 who had fallen out of care for over 12 months; leading to 34 appointments completed by patients at the end of 2025. Other initiatives to close care gaps targeted cervical cancer screening, blood pressure control, and colorectal cancer screening.
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	Met. CCHP completed closed loop referrals for ECM and CS per DHCS guidance.

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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	Met. CCHP implemented a referrals process to CHW providers based on identified social needs.
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	Met. CCHP educated providers and staff about health education tools via provider newsletter, provider network trainings, and by sharing information in regularly scheduled quality meetings. Staff participated in biweekly FAM classes teaching a movement based activity.
5.16			Develop in person and telehealth classes to be facilitated by CCHP Health Educators	

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5.17	Colorectal Cancer Screening	Increase colorectal cancer screening rates	Send out FIT kits monthly to Members due for colorectal cancer screening	Met. CCHP staff conducted over 3,000 calls to members reminding them to mail in a completed FIT kit. 245 members had a resulted test within 60 days of outreach. Projected COL-E rates for MY2025 are about the same as MY2024, when CCHP performed in the 90th percentile.
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	Met. CCHP monitored activities in these programs and conducted PDSAs related to diabetes prevention and asthma education & remediation.
5.19	Chronic Conditions: Diabetes Management Program	Reduce number of CCHP members with uncontrolled diabetes	Provide medically tailored meals to patients with uncontrolled diabetes. Evaluate efficacy of MTM.	Met. CCHP achieved the 90th percentile for the Glycemic Status Assessment for Patients with
5.20		Increase the number of people	Continue expansion of remote blood glucose monitoring partnership with Gojji	

5.21		enrolled in the Diabetes Prevention Program	Conduct PDSA with DPP provider to increase referrals & enrollment of prediabetic Members	Diabetes- Control and -Poor Control in MY2024 and was exceeding the target for the measure for MY2025. In 2025, CCHP referred 431 RMC members to Gojji and 298 enrolled. CPN patients saw increased access to Gojji services, with 111 enrolling in Gojji's diabetes RPM program in 2025. CCHP increased referrals to the contracted DPP provider from 169 in 2024 to 221 in 2025, with 32 completing at least one visit and 2 members continuing with the program for 12 months. Additionally, 7 members received diabetes self-management education.
5.22			Develop brochures for pregnant Members	

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5.23	Maternal Health Outcomes	Improve key maternal health outcomes across quality measures	Increase the number of pregnant Members receiving Transitional Care Services (TCS)	Met. CCHP developed a comprehensive prenatal services brochure that details services available to pregnant and postpartum members in the CCHP service area. Over 2,500 of these brochures were distributed to network providers, community based organizations, and community members at events throughout the county. The number of patients receiving TCS increased to 736 in 2025, with a significant monthly increase in enrollment after the development of automated referral pathways.

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5.24	Keeping Members Healthy: Gaps in Care	Notify members of gaps in care for needed preventive services	Continue mailing adult birthday letters	Met. Over 91,000 letters were mailed to adult CCHP patients, with over 13,000 patients (14.3%) completing a health maintenance topic within 60 days of outreach. Pediatric wellness letters and health education handouts were first mailed in March 2025, with over 16,000 letters mailed and over 1,300 (8.2%) completing a health maintenance topic within 60 days of outreach.
5.25			Develop specific pediatric birthday letter that provider more specific information to members in terms of gaps in care	

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5.26			Publish member facing newsletter three times per year	

5.27	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.	Conduct outreach events at health clinics, CBOs, and other relevant locations.	Met. The CCHP Member Newsletter, Healthy Sense, was published in Spring, Summer, and Fall 2025. Printed copies were mailed to each member household and email newsletters were sent to members with a valid email address on file. Additional printed copies were distributed to network providers for display in patient waiting rooms. The health education team attended more than 80 events throughout the county, including at county libraries, local farmers' markets, major community events, and providers offices. They distributed over 17,500 health education materials
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				and Contra Costa Health branded items.
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	Met. CCHP continues to facilitate translation and interpreter services for providers and provide training related to culturally and linguistically competent care. All CCHP staff completed required DEI Training and TGI Training. Provider training deadline was postponed to 2026 following DHCS guidance. Cultural & Linguistic Manager continue to review all grievances related to discrimination, language access and trans-inclusive care.
5.29			Facilitate translation and interpreter services request of educational materials, website, forms, and other documents.	
5.30			Ensure all CCHP staff complete Transgender, Gender Diverse, or Intersex (TGI) by February 2025.	
5.31			Ensure all CCHP staff and providers complete Diversity, Equity, and Inclusion (DEI) training by December 2025.	
5.32			Educate and advocate interpreter services to CCHP members.	
5.33			Review, monitor and track all grievances related to discrimination, language access and trans-inclusive care.	
5.34	EPSDT / Medi-Cal for Teens and Kids	Ensure coverage of and timely access to all medically necessary EPSDT	Monitor and trend denials for Members <21 years old	Met. CCHP placed over 3,700 calls to

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5.35		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.	Conduct outreach and education for identified Members who have fallen off of the pediatric well care visit periodicity.	over 2,100 CCHP members overdue for well care visits in order to connect members back into care, with over 100 patients completing an appointment that was scheduled within 2 weeks of outreach. CCHP notifies members about their EPSDT benefits and services through the Member Newsletter and online at the cchealth.org website. CCHP has developed a report to identify providers who are non-compliant with the DHCS EPSDT training, which is emailed monthly to relevant stakeholders for follow-up. Quarterly monitoring is in progress for all activities.
5.36			Annual notification to Members <21 years old regarding EPSDT services	
5.37			Ensure and monitor bi-annual DHCS EPSDT training	

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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	Met. Auto referrals are in place to identify members eligible for ECM high utilizer population of focus (POF), unhoused POF, justice involved POF, SMI/SUD POF, and birth equity POF. Auto referrals are in place to identify members eligible for CCM based on polypharmacy, for patients who have recently delivered, and for psychiatric admissions.

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5.39	Justice-Involved Reentry Coordination	Ensure coordinated, comprehensive care for members transitioning from correctional facilities to the community.	• Maintain policies and procedures for coordination with correctional facilities and pre-release care managers, in alignment with the CaAIM Justice-Involved Initiative Policy and Operational Guide. • Designate a Justice-Involved liaison to serve as the primary point of contact for correctional facility coordination • Assign ECM providers upon post-release in coordination with pre-release providers • Establish processes to coordinate transition of care from pre-release to post-release, including data sharing protocols. • Ensure access to medically necessary covered services including ECM, physical and behavioral health care, Community Supports, NEMT, and NMT.	Met. CCHP CaAIM Director served as the Justice-Involved liaison and met regularly with the Justice and Re-entry coalition that includes county correctional health partners, reentry coordinators, and other stakeholders involved in the planning, implementing & supporting services for justice-involved populations. MOUs are in development to receive members from correctional facilities in surrounding counties

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5.40	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.	Met. Completed regulatory review and needs assessment of the Medicare population, the development and implementation of a comprehensive care improvement program will begin in Q1 2026.
5.41	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.	Met. A number of automated referral pathways were implemented to ensure the successful connection of eligible members to TCS, with enrollment in TCS up over 122% compared to 2024. The has a dedicated phone number for low-risk members to contact for discharge care coordination that is placed into local area hospital discharge instructions.
5.42			Develop oversight process on discharge planning process	
5.43		Ensure transitional care services support for low risk members	Provide phone number for low risk members to access transitional care services	

Item #	Program/ Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
5.44	Managed Care Liaisons	Ensure the designation, training, and notification processes for liaisons to support coordination, compliance, and oversight across key program areas.	Designate Tribal, LTSS, Transportation, CCS, Child Welfare, Dental, Justice, IHSS, MOUs, and Regional Center liaisons and provide training on rules, referrals, care coordination, and authorizations.	Met. CCHP had all required liaisons to ensure coordination, compliance, and oversight of key programs.
5.45	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	Met. CCHP conducted outreach at over 30 events throughout the county in 2025 and distributed over 600 behavioral health specific resources at these events. Health education information was published onto the website to make it easier for members to find relevant resources and advice.
5.46			Conduct outreach at Farmers' Markets, Open Air (Flea) Markets, and health clinic locations to inform members about NSMHS benefits.	
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.	Met. CCHP met timeframes on all PQIs.

Item #	Program/ Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
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	Develop a standard over-under utilization report and develop standards with how reporting is used to improve care	Define measures to track and identify areas of opportunity for improvement initiatives	Met. CCHP has developed an anomalous billing dashboard to explore areas of opportunity for improvement. DME was identified as a target area to explore in 2026.
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. 28 letters were sent to providers altering them of their patients who were currently taking the dangerous drug therapy combination. The number of providers receiving these letters has decreased over the past three years.

Item #	Program/ Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
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	Met. Prescribers were provided reports on their patients who were co-prescribed these medications.
6.6		Antipsychotic, anti-depressant and mood stabilization prescriptions for children	Quarterly audit to determine if these medications that are being prescribed to children have a qualifying diagnosis	Met. CCHP completed quarterly audits.
6.7		Improve Hepatitis C medication adherence	Review HepC medication to ensure that members are fully completing their course of treatment	Met. 67 members receiving medication were tracked and only 14 needed intervention.
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 created an automatic referral to Complex Case Management if a patient is identified with polypharmacy.
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.	Met. Completed ED visit audit and educated pharmacies on benefits.

Item #	Program/ Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
6.10		Reduce prescription opiate abuse	Review potential unsafe prescriptions where members have multiple opiate prescriptions from multiple prescribers and pharmacies—refer to case management for potential follow up with members and providers	Met. Reviewed unsafe combinations and referred individuals to case management for review.
6.11	Facility Site Reviews	Ensure PCP sites operate in compliance with all applicable local, state, and federal regulations, and that sites can maintain patient safety standards and practices.	Complete an initial Facility Site and Medical Record Review and the Physical Accessibility review Survey for newly contracted PCPs. Conduct periodic full scope reviews for PCPs. Complete corrective action plans for cited deficiencies.	Met. Completed all scheduled FSR, MRR, and PARs. Developed and tracked corrective action plans with providers.
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	Partially Met. Clinical Practice Guidelines were distributed in the Q2 2025 Provider Bulletin and during the Q1 2025 Provider Network Training.
6.14			Distribute and educate providers on Clinical Practice Guidelines during quarterly provider trainings and in quarterly newsletter	
7.Provider Engagement				

Item #	Program/ Project Area	Goals and Objectives	Planned Activities to Meet Objectives	Evaluation of Activities
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	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	Met. CCHP produced 4 Provider Network News bulletins.
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	Met. CCHP met with all FQHC provider groups on a bimonthly basis throughout 2025.
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.	Met. The VBP program successfully completed payments to providers in Q3 2025 and expanded to additional provider groups in 2026.

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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.	Met. CCHP has eight reports available on demand to providers via the CCHP Provider Portal. These reports were updated in 2025 to include (1) patients due for Initial Health Appointment, (2) patients due for Medi-Cal redetermination, and (3) patients with recent ED visits and hospitalizations.
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.	Met. CCHP conducted site visits at Regional Medical Center clinic locations.
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	Partially Met. CCHP DEI Training was rolled out to all providers in September 2025, deadline of completion of training is extended to end of 2026 by DHCS.

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7.8	Shared Decision-Making Aids	Ensure all provider received evidence based shared decision making aids	Update website and provide evidence based decision aids to providers through regular communications	Met. The CCHP website for providers has been updated with Shared Decision Making resources and an email was sent to providers in Q3 to inform them of available resources.
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.	Met. CCHP reviewed activities and determined that quality and population health activities are not delegated and do not need delegation oversight.