PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality Improvement
DATE: Aug. 14, 2025
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

The California Public Health Emergency has ended and Q/UAC has now returned to in-person meetings per Brown Act guidelines.
Meeting locations (and call-in information for Partnership staff only) are below and listed on the agenda too.
Please use your personal electronic device for reviewing the packet during the meeting. Hard copies will not be provided.

Meeting Time/Date: 7:30 – 8:55 a.m., Wednesday, Aug. 20, 2025
Meeting Locations:

Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle
2760 Esplanade Ave., Ste 130, Chico 95973 | Temp Conf Room

Other Locations:
Open Door Community Health Center, 770 10th St., Arcata
Chapa-de Indian Health: 11670 Atwood Road, Auburn
Health & Human Services Dept., 5730 Packard Ave., Suite 100, Marysville

Staff and members only may join by Telephone: 1-844-621-3956 Access Code 809 114 256
Partnership Offices: Please use the QUAC Partnership HealthPlan's Personal Room in WebEx
https://partnershiphp.webex.com/meet/quac | 809114256 (Need assistance? Contact IT at least one (1) day prior to the meeting.)

Voting Members:
Choudhry, Sara, MD
Gwiazdowski, Steven, MD, FAAP
Hackett, Emma, MD, FACOG
Lane, Brandy, PHC Consumer Member
Luu, Phuong, MD
Montenegro, Brian, MD
Mulligan, Meagan, FNP-BC
Murphy, John, MD
Quon, Robert, MD, FACP
Strain, Michael, PHC Consumer Member
Swales, Chris, MD
Thomas, Randolph, MD
Wilson, Jennifer, MD, MPH

PHC Staff (Ex-Officio) Members:
Barresi, Katherine, RN, BSN, PHN, NE-BC, Chief Health Equity Officer
Bides, Robert, RN, BSN, Mgr, Member Safety-Quality Investigations, QI
Bontrager, Mark, Sr. Director of Behavioral Health, Behavioral Health
Brown, Isaac, MHA/MBA, *Interim* Sr. Dir. of Quality & Perf. Improvement
Cotter, James, MD, Associate Medical Director
Cox, Bradley, DO, Regional Medical Director, Northeast
DeVido, Jeffrey, MD, Behavioral Health Clinical Director
Esget, Heather, BSN, ACM-RN, Director of Utilization Management
Frankovich, Terry, MD, Associate Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director of Care Management
Glickstein, Mark, MD, Associate Medical Director
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jensen, Annika, RN, Associate Director of Clinical Integration, CC
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Leung, Stan, PharmD., Director of Pharmacy Services
Matthews, R. Douglas, MD, Regional Medical Director, Chico
Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Newman, Rachel, RN, BSN, Manager, Clinical Compliance - Inspections
O'Connell, Lisa, MHA, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, MPH, FAAP, Regional Medical Director, Northwest
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Spiller, Bettina, MD, Associate Medical Director
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director, Southeast
Ward, Lisa, MD, Regional Medical Director, Southwest
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

cc:
Andrews, Leigha, Regional Director, Southwest
Bjork, Sonja, JD, Chief Executive Officer
Blake, Jill, Regional Director, Auburn
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, Policy Analyst, Utilization Management
Davis, Wendi, Chief Operations Officer
Devan, James, Manager of Performance Improvement, QI (NR)
Durst, Jennifer, Sr Mgr of Performance Improvement, QI (SE/SW)
Escobar, Nicole, S, Mgr of Behavioral Health, Behavioral Health
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gual, Kristine, Director of Quality Measurement, QI
Harrell, Bria, Project Manager I, Configuration
Innes, Latrice, Manager of Grievance & Appeals Compliance
Isola, Brandy, Mgt of Performance Improvement, QI (Chico/Auburn)
Jarrett-Lee, Kevin, RN, Associate Director, UM
Kerlin, Mary, Senior Director of Provider Relations
Klakken, Vicki, Regional Director, Northwest
Kubota, Marshall, MD, Associate Medical Director
McCune, Amy, MPH, MS, Manager of Quality Incentive Programs, QI
Morris, Matthew, MD, Regional Medical Director, Auburn
Nakatani-Phipps, Stephanie, Manager of Provider Relations Reps
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Sharp, Tim, Regional Director, Northeast
Smith, Christine, Community Health Needs Liaison, Pop Health
Spencer, Ben, Project Coordinator I, Health Equity
Stark, Rebecca, Regional Director, Chico

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE (Q/UAC)
MEETING AGENDA

Date: Aug. 20, 2025 **Time: 7:30 – 8:55 a.m.**

Locations: Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps Conference Room
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle Room
2760 Esplanade Ave., Ste 130, Chico 95973 | Temp Conf Room

Other Locations:
Open Door Community Health Center, 770 10th St., Arcata
Chapa-de Indian Health: 11670 Atwood Road, Auburn
Health & Human Services Dept., 5730 Packard Ave., Suite 100, Marysville

Partnership Staff only may join by Web-ex:
https://partnershiphp.webex.com/meet/quac Meeting # 809 114 256

Partnership Staff only may join by Telephone:
1-844-621-3956 Access Code: 809 114 256

This Brown Act meeting may be recorded. Any audio or video tape recording of this meeting, made by or at the direction of Partnership, is subject to inspection under the Public Records Act and will be provided without charge, if requested.

Welcome / Introductions / Public welcome at cited locations

	Item	Lead	Time	Page #
I.	**Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes**			
1	*Approval of* • June 18 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	5 – 18
2	*Acknowledgment and acceptance of draft minutes of the* • June 10 Internal Quality Improvement (IQI) Committee • May 8 Substance Use Internal Quality Improvement (SUIQI) Committee • May 27 Quality Improvement & Health Equity Committee (QIHEC) • July 22 QIHEC			19 – 66
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isacc Brown, MHA/MBA	7:37	67 – 80
2	HealthPlan Update	Robert Moore, MD	7:45	--
III.	**Old Business – None**			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:52	81
	PQI / PPC 1st and 2nd Qtrs 2025 – *direct questions to Robert Bides, RN – Data Analysis begins on p. 89*			83 – 91
Health Services Departments	**Care Coordination**			
	MPCP2007 – Complex Case Management – *previously MCCP2007*			93 – 101
	MCCP2032 – CalAIM Enhanced Case Management (ECM) **ARCHIVE** *effective 09/10/25*			103 – 132
	Enhanced Health Services			
	MCAP7002 – CalAIM Enhanced Case Management (ECM) – *previously MCCP2032*			133 – 162
	Quality Improvement			
	MPQP1048 – Reporting Communicable Diseases			163 – 164

	Item	Lead	Time	Page #
	Utilization Management			
	MCUP3053 – Acute Inpatient Administrative Days – **ARCHIVE** *effective 09/10/25*			165 – 166
	MCUP3114 – Physical, Occupational and Speech Therapies			167 – 172
	MCUP3133 – Wheelchair Mobility, Seating and Positional Components			173 – 184
	MCUP3141 – Delegation of Inpatient Utilization Management			185 – 190
	MPUP3006 – Appropriate Service & Coverage (Over/Under Utilization)			191 – 194
	MPUP3042 – Technology Assessment – *previously MCUP3042*			195 – 203
	MPUP3138 – External Independent Medical Review – *previously MCUP3138*			205 – 208
Non HS	**Member Services**			
	MP301 – Assisting Providers with Missed Appointments			209 – 211
	MP316 – Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior			213 – 224
	Network Services			
	MPNET101 – Wellness and Recovery Access Standards and Monitoring			225 – 227
V.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	229 – 230
HS Depts.	**Health Equity**			
	MCED6001 – Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description – *CLEAN copy begins on p. 259*	Mohamed Jalloh, Pharm.D	8:00	231 – 285
	Utilization Management			
	MCUG3024 – Inpatient Utilization Management – *CLEAN copy begins on p. 299*	Tony Hightower, CPhT	8:07	287 – 307
VI.	**Presentations**			
1	HEDIS® MY 2024 / RY 2025 Summary of Performance • The Managed Care Accountability Set (MCAS) Summary of Performance *begins on p. 327* • Both it and the NCQA Health Plan Accreditation (HPA) Summary of Performance will be available by month's end on Partnership's public website and will be part of the Sept. 10 PAC packet	Kristine Gual, PMP, CPHQ	8:14	309 – 371
2	Closeout Summary of FY 2024-2025 QI Work Plan – *approval required* *Excel spreadsheet included under FYI begins on p. 893*	Isaac Brown, MHA/MBA	8:35	373 – 381
3	Summary of QI Trilogy Documents – *approval of the documents below required*			383 – 385
QI Trilogy	2024-2025 QI Evaluation – *Appendices will be included in the Sept. 10 PAC packet*			387 – 557
	2025-2026 QI Program Description (MPQD1001) – *Synopsis of Changes begins on pg. 558*			559 – 713
	• CLEAN MPQD1001			715 – 857
	2025-2026 QI Work Plan			859 – 892
VII. FYI	2024-2025 QI Program Work Plan Final – Excel spreadsheet – *direct any questions to Isaac Brown*			893 – 913
	Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Sept. 17, 2025			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, June 18, 2025 / 7:31 a.m. – 9:25 a.m. Napa/Solano Room, 1st Floor

June is Population Health Month

Voting Members Present:
Sara Choudhry, MD
Emma Hackett, MD, FACOG
Brandy Lane, Consumer Member
Brian Montenegro, MD
Meagan Mulligan, FNP-BC
Robert Quon, MD, FACP
Michael Strain, PHC Consumer Member
Chris Swales, MD
Randolph Thomas, MD

Voting Members Absent: Steven Gwiazdowski, MD, FAAP; Phuong Luu, MD; John Murphy, MD; Jennifer Wilson, MD

Partnership *Ex-Officio* Members Present:
Cox, Bradley, DO, Regional Medical Director (Northeast)
DeVido, Jeff, MD, Behavioral Health Clinical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management
Glickstein, Mark, MD, Associate Medical Director
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Leung, Stan, Pharm.D, Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
O'Connell, Lisa, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Ruffin, DeLorean, DrPH, Director of Population Health
Spiller, Bettina, MD, Associate Medical Director
Steffen, Nancy, Senior Director of Quality and Performance Improvement
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director (Southeast)
Ward, Lisa, MD, Regional Medical Director (Southwest)
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

Partnership *Ex-Officio* Members Absent:
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI
Cotter, James, MD, Associate Medical Director
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)
Kerlin, Mary, Senior Director of Provider Relations

Guests:
Akintan, Folo, MBBS/MD, MPH, MBA, Epidemiologist, Population Health
Bontrager, Mark, Senior Director, Behavioral Health
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MBA/MHA, Director of Quality Management, QI
Brunkal, Monika, Associate Director, Population Health
Campbell, Anna, Health Policy Analyst, Utilization Management
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Manager of Performance Improvement (Redding)
Erickson, Leslie, Program Coordinator II, QI (scribe)
Frankovich, Terry, MD, Associate Medical Director
Friedman, Greg Allen, Project Coordinator II, Population Health
Gaul, Kristine, PMO, CPHQ, Director of Quality Measurement, QI
Hermosillo, Jesus, Cultural Community Manager, Health Equity
Matthews, Richard "Doug," MD, Regional Medical Director, Chico
Morris, Matthew, MD, Regional Medical Director, Auburn
Nakatani-Phipps. Stephanie, Lead Senior Provider Relations Rep, PR
Payumo, Desiree, RN, Manager of Utilization Management, UM
Santos, Rose, RN, Supervisor, Member Safety & Quality Investigations, QI
Smith, Christine, Community Health Needs Liaison, Population Health
Stone, Kelly, RN, Director of Care Coordination

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Introductions Approval of Minutes	Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:31 a.m. He welcomed epidemiologist Folo Akintan, MBBS/MD, MPH, MBA, a new member of the Population Health department aiding our QIHEPT (Quality Improvement Health Equity Process Transformation) team. The May 21, 2025 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • May 13 Internal Quality Improvement (IQI) Committee • May 22 Member Grievance Review Committee (MGRC) • April 30 Over/Under Utilization Workgroup	Motion to **approve the Q/UAC minutes:** Brian Montenegro, MD Second: Robert Quon, MD *Approved unanimously* Motion to **accept the other minutes:** Robert Quon, MD Second: Chris Swales, MD *Approved unanimously*
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Nancy Steffen, Senior Director of Quality and Performance Improvement, QI*	• The Health Rules Payor (HRP) implementation delay means the Primary Care Provider Quality Incentive Program (PCP QIP) network need not experience a two-week blackout of e-Reports in July that would have facilitated the cutover from our current core claims system, Amisys. • Partnership has funded 10 retinal cameras in imaging center deserts across the network. Partnership has received several MOUs from providers and has started issuing payments for devices to impact MY 2025 under this Quality Measure Score Improvement (QSMI) program overseen by the Chronic Disease Management workgroup. • We've been talking over the last few months about working with Exact Sciences and our provider network as a forum to help our providers order Cologuard kits. We did an earlier push around Colorectal Cancer Screening Awareness Month early in March and we are going to offer another multi-patient order opportunity July through September, allowing kits to be received by our members by the end of September and thereby also affecting a really important measure in our QIP. Most recently we worked hard to provide, with our Population Health team, some educational videos on this opportunity, as well as what is a FIT test, in addition to some of the logistics that our providers might benefit from taking on this opportunity. These are detailed on a new web page: https://www.partnership.org/Providers/Quality/Pages/Cologuard.aspx • Pediatric lead prevention is a key Managed Care Accountability Set (MCAS) measure we have made great progress on these last 12-18 month and will continue to do so by offering funding for points of care lead testing devices to eligible providers. • We successfully submitted our HEDIS® (Healthcare Effectiveness Data Information Set) rates for both our accreditation project as well as our Department of Health Care Services (DHCS) managed care accountability project. We will be coming back to you in August to report on those annual rates as well as give a status update on our Member Experience CAHPS® (Consumer Healthcare Providers and Systems) survey. The team is now analyzing those preliminary results. • Much work has been done by many to timely submit many forms of evidence for NCQA (National	*For information only*. Robert Quon, MD, noted that Kaiser had a similar retinal imaging project but had issues finding ophthalmologists to read results and then treat, if necessary. He wondered how Partnership is handling this. Manager of Performance Improvement James Devan replied that these devices come with vendor agreements to read and interpret any findings. "The whole goal is to ease access on optometrists and ophthalmologists in the communities," James said. "These are places that (may) have those providers, (but they may be) very impacted. We are trying to cut down on the screenings to traditional optometry and save the follow up. So far, we haven't seen any instances where there's issues

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Committee for Quality Assurance) Health Equity Accreditation. The results of this first HEA effort will be reported to this and other committees in September.	with follow-up."
2. HealthPlan Update *Robert Moore, MD Chief Medical Officer*	• In the packet we have the updates on performance in the PCP QIP. The checks are going out. We have a list of the sites that did over 90%, as well as what has happened with performance year to year and the reasons for the changes. The 2024 10-county geographic expansion increased the number of participating sites from 252 to 390. Approximately $52.5 million was earned in total, including just over $1 million in Unit of Service (UOS) incentives. o Two private practices, three medical groups, and 14 Federally Qualified Health Center sites each scored 90% or better. o Among Tribal Health Centers, Lake County Tribal sites had their best year ever. Both Round Valley Tribal Health and K'ima:w Medical Center made dramatic improvements above their previous year performance. • The Quality Factor Score for 2023 for all the different health plans is also in the packet. This is old because the State usually delivers in September but didn't until April or so, and so we have finally calculated that. The big summary is that our four regions that were still in place in 2023 show a wide variety of different levels of performance related to the underlying socio demographic factors we have talked about in the past. • As you have been hearing over the years, we have been planning to implement a new core claims system called Health Rules Payor or Health Edge. In the final testing phase, we found some substantial issues needing many, many months of work to resolve, thus preventing us from going live this month as planned. Unfortunately, this postponement has a cascading effect. We had a new core management system called Jiva, which was going live after Health Edge. And the Jiva system was essential for us to be able to go live with our Dual-Eligible Special Needs Plan (D-SNP). So, we notified DHCS that we are unable to go live with our Medicare product on Jan. 1, 2026. We were prepared to go live in so many ways: we had a perfect score on our Model of Care. Our bid was ready to go in. We had already selected our optional benefits. We were about halfway through all the policy revisions that needed to happen, so it wasn't for a want of effort; it was this unexpected problem with an upstream issue, our core claims system. Going live with the core claims system problems unfixed would have resulted in a massive nonpayment to our providers, which is unacceptable, plus it would put the entire Plan as risk on the core Medi-Cal business. We told DHCS we had to delay until Jan. 1 2027, and they are processing a monitoring plan to watch the status of our activities towards that goal. • Many of you are following the status of the State and Federal budgets. Both have major potential impacts on Medicaid. The US Senate is leaning towards bigger Medicaid cuts to prevent a larger deficit. The State went in the opposite direction. The State Assembly has a budget that calls upon larger borrowing to cover projected shortfalls. That sets it up for the Governor to make the line cuts to balance the budget. We'll have more of a sense in a couple of weeks. None of these activities	*For information only*. Q/UAC Consumer Member Michael Strain asked if current Medi-Medi members will be affected by the D-SNP implementation delay. Dr. Moore replied that those with current Medi-Medi coverage will not be affected as they will retain their existing coverages. Opting in to Partnership Advantage (D-SNP) will remain a choice for Partnership's eligible Medi-Cal members who live in the eight counties when the product goes live Jan. 1, 2027.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	instantly affect Partnership. Many of the changes proposed kick in over six months, a year or two years. Our Finance Committee is reviewing the year-long budget that Partnership is proposing, and Partnership's tentative plan is to come back with a six-month revision when we have the more information from both State and Federal entities.	
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Consent Calendar	G&A PULSE Report / Issue 17 / June 2025 ***Health Services Policies*** <u>Care Coordination</u> MCCP2024 – Whole Child Model for California Children's Services (CCS) MPCP2014 – Continuity of Care – *new policy number and title change ("Medi-Cal" dropped as policy will apply to Medicare too. The policy is bundled here without its 400-page list of codes known as Attachment C)* <u>Population Health</u> MCNC9004 – Regulatory Required Notices *(new title)* MPNP9007 – Lactation Policy and Guidelines – *the former MCCP2020 in CC is now archived* MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program – *the former MCCP2021 in CC is now archived* <u>Quality Improvement</u> MPQP1004 – Internal Quality Improvement Committee MPQP1006 – Conflict of Interest Policy for QI Activities MPXG5009 – Lactation Clinical Practice Guideline <u>Utilization Management</u> MCUG3134 – Hospital Bed/Specialty Mattress Guidelines MCUP3044 – Urgent Care Services MPUG3010 – Chiropractic Services – *previously MCUG3010* MPUP3039 – Direct Members – *previously MCUP039* MPUP3111 – Pulmonary Rehabilitation – *previously MCUP3111*	Motion to **approve slate as presented:** Robert Quon, MD Seconds: Randy Thomas, MD & Meagan Mulligan. FNP *Approved unanimously* <u>Next Steps</u>: Aug. 13 Physician Advisory Committee (PAC)
V. New Business – Discussion Policies		
Policy Owner: Care Coordination – *Presenter: Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance*		
MCCP2036 – Memorandum of Understanding (MOU) Requirements for Medi-Cal	**This new policy outlines** that Partnership shall negotiate in good faith and execute an MOU with Third Party Entities as required under the Medi-Cal Managed Care Contract (MCP Contract) with the Department of Health Care Services (DHCS). MOU Policy includes the following: • A designated point of contact responsible for the oversight and supervision of the terms of all MOUs. • All Subcontractors, Downstream Subcontractors, and Network Providers are required to comply with any applicable provisions.	Motion to **approve as presented:** Robert Quon, MD Seconds: Brian Montenegro, MD, & Meagan Mulligan, FNP *Approved unanimously*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Managed Care Plans and Third-Party Entities – **NEW POLICY**	• MOU parties must work collaboratively to ensure Members are referred to appropriate programs and/or services and coordinate Members' access to care and services that incorporate all the requirements noted in the MOU. • MOUs must be reviewed annually for any needed modifications or renewal of responsibilities and obligations. For each MOU Partnership will hold regular meetings with the MOU parties, at least quarterly, to address policy and practical concerns. • The MOU parties may develop Quality Improvement (QI) activities specifically for the oversight of the requirements of the MOU. • The MOU parties must support the timely and frequent exchange of Member information and data. • The MOU parties must develop policies and procedures to mitigate the effects of disaster and emergency preparedness • Partnership and MOU parties shall negotiate in good faith and execute MOUs to ensure coordination of Medi-Cal services, delineate the responsibilities of each respective party, and afford for a dispute resolution process. • Partnership or the MOU parties may seek to remedy a dispute informally through discussion and dialogue. Shannon stated that this new policy touches many things, including the Whole Child Model, local health departments, and different behavioral health entities we contract with too. The BHP definition was added at IQI. Robert Quon, MD, commented that such MOUs can pose issues when the Plan's quality metrics are not part of vendors' deliverables. He urged caution and recommended that Partnership look at adding in a "broad, vague" quality statement contract by contract to the effect of "in order to be one of our vendors, these are the quality aspects you must uphold." Dr. Moore replied that we can look at language additions as we have leverage over those whom we pay; however, this policy mainly covers community-based and county-based organizations where no money is exchanged. "The State has asymmetrically said 'Partnership, you must do an MOU' but they have not told those other entities that they are required to do an MOU," Dr. Moore noted.	Next Steps: Aug. 13 PAC
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*		
MCUP3041 – Treatment Authorization Request (TAR) Review Process	**Section I:** Two Related Policies were added J. MPUP3139 – Criteria and Guidelines for Utilization Management K. MCUP3064 – Communication Services **Section V.** An outdated reference to processing of RAFs was deleted from the Purpose section. This policy now describes only TAR processing. **Section VI.A.2.** In the description of criteria used for review decisions, we added a reference to our policy MPUP3139 Criteria and Guidelines for Utilization Management. **Section VI.A.5** was removed. This paragraph discussed records retention which is the topic of another policy, CMP30 Records Retention and Access Requirements, which is listed in Section I. as a Related Policy. **Section VI.B.2.b.** This paragraph was added per DHCS request to state that requests for DME for dually eligible Medi-Cal/ Medicare Members are exempt from the requirement to submit a TAR with written	*There were no questions.* Motion to **approve as presented:** Robert Quon, MD Second: Randy Thomas, MD *Approved unanimously* Next Steps: Aug. 13 PAC Dr. Moore noted that the

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	verification from Medicare that the benefits have been exhausted. This is because Medicare does not issue denials and Explanations of Benefits (EOBs) for non-covered DME services. **Section VI.B.2.b.** Added language to say TARs are not required for "certain" services because the list has been growing and we did not want to limit services to only those specified . **Section VI.B.4.** Removed "diagnostic imaging" from the list of services limited to a 6-month authorization period because we are no longer requiring a TAR for CT or MRI **Section VI.F.** Removed the entire Communication Services section because the language is duplicate in policy MPUP3064 Communication Services, which has been listed at the top in Section I. as a Related Policy. **Attachment A:** Policy numbers updated throughout. **H. Diagnostic Studies;** Paragraphs 1. CT Scans and 2. MRI: were both deleted as we no longer require a TAR for these services. Tony prefaced the above synopsis by saying many of the edits were a general clean-up and removing language redundant to a few of our other policies, as well as adding in some language per DHCS guidance. A significant change was the removal of TAR requirements for CT scans and MRIs.	implementation of removing most TARS for CTs and MRIs may take Configuration until September to arrange, and he urged Q/UAC members to have their organizations continue with business as usual until such time as Partnership informs providers that the reconfiguration is complete.
MPUP3139 – Criteria and Guidelines for Utilization Management – *previously MCUP3139*	**This policy has been updated for Partnership Advantage (Medicare) applicability, effective Jan. 1, 2027.** **Section VI.B.2.a. 2)** Added description of Medicare standards that may be used for UM decisions including NCDs and LCDs. **Section VII.B and C.** Added two new references for "Contractual obligations with the Department of Health Care Services (DHCS)" and "Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Section 40 Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations (11/18/2024)" **Attachment A:** Added Criteria for Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Tony noted that this policy was updated for the now delayed Medicare product line, affecting the hierarchy of criteria sets.	*There were no questions.* Motion to **approve as presented:** Chris Swales, MD Second: Robert Quon, MD *Approved unanimously* Next Steps: Aug. 13 PAC
Policy Owner: Population Health – *Presenter: Greg Allen Friedman, Project Coordinator II, Pop Health*		
MPNP9001 – Population Health Management Strategy & Program Description – *previously MCND9001*	**Changed to MPND9001 to reflect applicability also to the coming D-SNP program.** Annual update includes revisions and additional contract and APL references to further align the document with NCQA and state requirements. Many small changes for grammar, clarity, and/or readability. Highlights below: **P. 5 Introduction:** new paragraph explaining Partnership's Medi-Cal and D-SNP services, and Partnership Advantage. **P. 6 Data Analysis and Strategy:** fine-tuned explanations of PHM processes, its Work Plan, and other analysis and policies. **P. 8-11 under Data Analysis and Strategy:** updated the graphic showing the relationship of PHM and county CHA/CHIP activities, moved PNA Committee explanation from p. 11 to p. 14.	*There were no questions.* Motion to **approve as presented:** Brian Montenegro, MD Second: Meagan Mulligan, FNP *Approved unanimously* Next Steps: Aug. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	P. 13 under Population Needs and Community Needs Assessments: added language about Community Advisory Committee (CAC). **P. 16-17 under Social Drivers of Health and Community Needs:** added language about covered behavioral health services for Medicare Advantage members. **P. 22 Basic Population Health Management:** added language mentioning Community Health Worker services, and reports being reviewed for members who may be at risk of diabetes. **P. 36 Practitioner Education and Training; Health Education Interventions: re**written to reflect DEI offerings for providers, and eliminated references to the QIHETP/C&L Work Plan in the context of Health Education. **P. 39-42 under Community Engagement and Coordination of PHM Programs:** updated explanation of Partnership systems, including its case management system and plans to switch to JIVA later in 2025. Updated vendor names and terminology and added qualifiers for possible different services for Medi-Cal and Partnership Advantage members. Updated list of organizations with MOUs effective January 2025. P. 47 Population Health and Health Education Delegation Oversight and Monitoring: added details explaining Partnership's monitoring of performance for delegates. **P. 48-51 under Team Roles and Responsibilities**: updated descriptions of various roles, including Chief Medical Officer, Director of Population Health, Health Educator, Healthy Living Coach, and others. Greg went through the synopsis. Dr. Moore commented that this program description has undergone extensive review: he has read it twice himself.	
Policy Owner: Population Health – *Presenter: Christine Smith, Community Health Needs Liaison, Pop Health*		
MPND9002 – Cultural & Linguistic Program Description – *previously MCND9002*	**Changed to MPND9002 to reflect applicability also to the coming D-SNP program.** This policy was updated to align with DHCS APL 25-005 Review Tool and other organizational changes. Due to the timing of APL 25-005, additions were needed since the previous April approvals: **Alignment with DHCS Review Tool** Added reference to the regulatory required notices Attachment A & Attachment B (pg.8). Added details around written information in either traditional or simplified Chinese characters (pg.11). Updated details on the content of the Nondiscrimination notice to include information on how to file discrimination grievance with the with Partnership, DHCS' OCR, and HHS' OCR (pg.9). Added details on the use of quick response codes, otherwise known as QR codes alongside printed notices however cannot be replaced or to be used in lieu of the regulatory required notices (pg.9). Clarified that Members with limited English proficiency (LEP) or disabilities are not required to provide or pay for their own interpreters, nor rely on unqualified staff for interpretation (pg.12). Included language affirming Members' right to free interpreter services, and that interpreter use will not affect service quality or confidentiality (pg.14). Added provisions requiring documentation in the medical record when a Member refuses free interpreter services and requests a family member, friend, or minor to interpret (pg.14). **DSNP Language** Changed policy name from MCND9002 to MPND9002 throughout document	*There were no questions.* Motion to **approve as presented:** Randy Thomas, MD Second: Chris Swales, MD *Approved unanimously* Next Steps: Aug. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Updated the list of member correspondence items to include "Notices of Organization and Coverage Determinations to encompass DSNP notices" *(pg.9*) **Attachments A-E updated with new "MPND" policy coding.** Other specifics below. **Updating Attachment D:** Process for Translation Services Document from our translations vendor updated with branding reflecting that they are now owned by Propio. **Updating Attachment E:** Community Advisory Committee Name changed from "*Consumer*" to "*Community* Advisory Committee." More detailed diversity statement added. Edits made to include the committee's feedback on the subject of CHA/CHIP work with counties. Added members who receive Long-Term Supports Services (LTSS), and/or individuals representing those members to list of examples of how CAC members may reflect Partnership's member population. Added detail about representation ratios. Added a new paragraph explaining responsibilities of the CAC Coordinator, Facilitators, and CAC selection committee. Updated member responsibilities, adding a qualifier for members with ADA-qualifying disabilities allowing remote attendance. Responsibilities for choosing replacement members now shared between the CAC Coordinator, Facilitators, and CAC selection committee. Removed a sentence which described how regional representatives reporting to the Partnership Board of Commissioners would be rotated from region to region. Updated references to DHCS's Medi-Cal Member Advisory Committee (MMAC). Updated Partnership office addresses. After Christine presented the synopsis, Medical Director for Quality Mark Netherda, MD, thanked her and Greg for "great presentations on complicated policies" and for explaining "QR Codes" as "quick response codes," a definition he had not heretofore known.	
VI. Presentations		
Population Health Grand Analysis, including the Population Health Impact Analysis, Segmentation Report, and Work Plan *DeLorean Ruffin, DrPH, Director of Population Health*	DeLorean introduced the Grand Analysis by saying that these three documents meet our NCQA standards and that opportunities exist to include other measures to better streamline this in future. We realize that not all goals were met; however, we are continuously striving for improvement. Today's presentation includes mostly those measures that showed significant statistical difference in 2024, and not all current measures encompassed by the PHM program at-large. **Our Growing Together Program has three pillars: Healthy Moms, Healthy Babies, Healthy Kids.** This is where we get into our prenatal section of outreach where we enroll members as identified as pregnant to receive targeted program outreach and support. Our staff offers support for prenatal care and reinforces the importance of Tdap vaccinations during pregnancy. We remind them of the importance of postpartum care and well-child visit (WCV) vaccinations in the first months following delivery. In 2024, the flu vaccinations were added as an incentivized component of this program; however, some of those results are not reviewed in the Impact Analysis.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	The first goal for the prenatal intervention was that 75% of members engaged in the program during 2024 would have had a Tdap vaccination within 120 days or four months prior to delivery. The rate of our engaged members was 73%. Engaged members had a statistically significant higher rate of completing the Tdap vaccination before delivery compared to member who were declined, members who were unable to reach and members who were not referred. Our current campaign is making some measurable difference within our Hispanic population; however, further analysis may be warranted due to the small sample size of other ethnic groups. Although this goal was narrowly missed, the engaged results are looking good, DeLorean continued. While the data shows statistical significance in the engaged category compared to other campaign categories, the control groups are not randomized to the degree necessary to account for any bias that may have resulted from conversations with the Pop Health staff. So, if propensity for answering the phone and having a conversation with Partnership (staff is associated with probability of also seeking out and obtaining vaccination), then the additional effect of the educational intervention can't be determined. (We can't account for the engagement bias by having two different phone messages given to those who answer the phone and are willing to engage. One group can conclude information from the Tdap vaccine while another group can focus on consideration for breastfeeding their baby; e.g., this builds in a control group with a subset of members who are otherwise equally engaged.) Our Growing Together Postpartum Program also offers a campaign for members to attend their postpartum care visits and encourages early interests in their care by bringing their child to those well-child visits (WCVs). The postpartum goal was for 75% of members engaged to attend a postpartum visit within 60 days of delivery. We met that goal. The white population had a statistically significant lower rate of members with postpartum visits when compared to American Indian, Asians and Hispanics. This data seemed to demonstrate that our current campaign is making a measurable difference in the lives of our non-white population. This may be due to that phone conversation and/or the individual member incentives for the postpartum visits, but analysis may be affected by underlying differences in the population willing to be engaged with this effort. Our Growing Together Healthy Babies Program enrolls infants under the age of 12 months. Incentives are also offered for this program for completing their well-child visits with immunizations throughout the duration of the program. The goal was for 80% of members engaged in the program to be compliant with at least 50% of their vaccinations during that program period. The goal was met at 92%. The secondary goal was that 25% of engaged members would attend **all** the well-child visits within 12 months of engagement. This was met at 67%. Note that the engaged white population had a statistically significant lower rate of completing vaccinations and WCVs compared to the Hispanic population. *In July 2024, the enrollment age was modified to include infants under 24 months, and this will be reflected in next year's report.* Significantly more members completed vaccines from July 2023 through June 2024 than in the 2022-23 fiscal year. This may be associated with the county expansion in 2024. In total, 3,629 members were compliant with all of those recommended well-child visits. A subset of this goal was that 65% of engaged members would be compliant with **at least half** of those recommended WCVs. This goal was met at 89%. Engaged members had a strategically higher rate of completing those visits when compared to other categories. The white population had a statistically significant lower rate of completing 3+ or 2+ WCVs (83%) when compared to Hispanics (92%). In January 2023, Partnership transitioned away from the Healthy Kids pilot to create a program designed to reach all children between the ages of three to six. The program aims to reach all these children who have not had a well-child visit in the last 11 months of longer. Once identified, members were incentivized to complete the well-child visit prior to their next birthday.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	The goal was that 50% of members in the program would have a well-child visits within 120 days of the phone call. At 32%, that goal was not met. However, the higher statistical significance found among the engaged members (79%) compared to the other campaign categories suggests that the program is making some impact among the eligible member population. Our Transitions of Care focuses on members who are transitioning across settings or the benefit structure. Partnership's Care Coordination team provides to the vulnerable populations to ensure implementation of the discharging facilities' transition plan and connects members to medical care and community resources that support health and wellness following a transition. At the close, a Partnership coordinator contacts the member by phone to complete a member satisfaction survey: responses are agreed, neutral, disagree or no response. In our weighted responses, members also have the opportunity to provide commentary. In 2024, 191 adults completed the transition of care services; 150 of them completed surveys. The first goal was that 75% of members surveyed would agree with each statement of the Adult TOC Satisfaction Survey. This goal was met. Goal 2 was that 75% of the pediatric members would agree with each statement of the satisfaction survey. Sixty-five members completed the TOC interventions, and 41 of them completed the survey, revealing a high satisfaction rate among families reporting good outcomes for our pediatric members. Complex Case Management is support for members who have multiple chronic conditions, social determinants of health barriers, and/or having difficulties navigating a healthcare system without the intensive support of a care coordinator and individualized care plan. Individual goals are timebound; however, a member may remain in complex case management for an extended period of time. [The goal that 75% of members would agree with each statement of the member satisfaction survey was met for both adult and pediatric populations, although the sample size was too small or members had insufficient time with the program per NCQA standards to quality for a satisfaction survey in 2024.] In summary, our member experience measures for CCM and TOC programs were met and demonstrate the significant value of these programs for Partnership. Our Hispanic members have statistically significant higher results than other races and ethnicities for attendance in postpartum visits, well-child vaccinations in the first years of life, attendance at well-child visits and attendance at well-child visits from three to six years old. While not all our NCQA goals were met, we are continuously striving for improvement, and most individuals demonstrated improved outcomes compared to those not engaged or referred. We will continue to explore more means to leverage new benefits and resources offered through the CalAIM initiative to bolster member support and improve the overall health of our population. Dr. Netherda clarified that the scales used ran from zero to 3. He pointed out that one slide must be corrected before the Aug. 13 PAC presentation: pediatric members are define as those under the age of 21, not 20. Dr. Quon said he was happy to see in the documentation that Partnership is looking at adding texting campaigns in future efforts to engage members, speculating that today's parents fall in a demographic that doesn't answer the phone. He found lower participation among white populations to be of interest and wondered if this is because diversity, equity, and inclusion efforts are working "or are we alienating somebody because the goal is to leave no one behind"? DeLorean replied that there had not been that deep a dive; however, she would like to work closely with QI, Health Equity and Health Analytic staff to create a framework for short- and long-term reviews of what and where the disparities are, and where she can best deploy both Health Education and PHM teams for further outreach and resource/support services.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Randy Thomas, MD, was curious whether the white population disparities were uniform across the network or more concentrated in certain areas. DeLorean said disparities were more concentrated in rural areas. Dr. Thomas said that he had suspected this, adding that vaccine hesitancy can keep some members from pursuing well checks. DeLorean acknowledged this and said she has been conversing with Partnership's Regional Directors and staff about how best to further combat misinformation through our health education strategies and approaches. Dr. Thomas, noting our effort to get pregnant persons their Tdaps, asked if it is just information that is shared with them or videos too? "Videos of babies with pertussis is very compelling," he said. DeLorean said that right now it's just information but she is exploring different means to mitigate hesitancy: "visuals are imperative." Regional Medical Director Colleen Townsend, MD, also noted that in speaking with providers in our perinatal network, they are always asking for tools, for information they can share while they are waiting. She invited Dr. Thomas to share with her any resources he has found of help. Dr. Netherda commented that during one outbreak of pertussis in California perhaps 20 years ago, there was an ad campaign directed at pregnant persons, adding that the Jennifer Lopez narrated ads had audio of babies coughing and was very effective in getting pregnant persons to get Tdap vaccines. Brian Montengro, MD, as a newborn doctor, said that "we have been seeing for years a decrease in the amount of uptake in the newborn period of the three routine vaccinations or medications that newborns are administered, specifically Hepatitis B." He is increasingly concerned and notes that since the Covid pandemic some parents are refusing vitamin K for their newborns. He has seen an uptick in this in the last six months. "I can guarantee that we're going to start to see newborns show up in the ER with GI bleeds, with intracranial bleeds," Dr. Montenegro said. "It's a tough thing to change a parent's mind in the newborn nursery period. It would be helpful to target this in prenatal visits." He has slides he said he will share with DeLorean. (Dr. Thomas asked if parents refusing vitamin K shots for their newborns were accepting oral vitamin K. Dr. Montenegro said that is not the standard of care and "the efficacy is questionable.") Dr. Quon asked if Partnership has its own YouTube, Slack, or other such channel. "The way people get information today is via influencers, via what is online," he said. "Something that gets a million likes will end up in everyone's inbox. We can't counter all the misinformation or the inaccurate information, but we can put out the information we want our members to see and hear." He wondered if vaccine hesitancy has aways been present. Dr. Montenegro said the misinformation really got started during Covid and continues to worsen in today's political environment. DeLorean sees opportunities to do something different but said DHCS has erected some barriers and that Partnership staffing availability may not be adequate. She wondered if this could be "stood up in our Communications department." Dr. Moore replied that generally Partnership "is not going to be a content generator for primary health advocacy materials. That's a necessity that we meet through our Health Education program. We love links to high quality materials that are put out by others, which we can amplify through our social media presence and through our communications. We've used Kaiser's over the years." **Motion to accept and approve the Population Health Grand Analysis in all its parts:** Robert Quon, MD; Second: Randy Thomas, MD. *Approved unanimously.*	
UM 2A Clinical Criteria for UM Decisions Factors 4 and 5 – Annual	Tony noted that InterQual® is a clinical decision tool developed and continuously peer reviewed based on the principles of evidence-based medicine. It is utilized by our medical directors and nursing staff to support medical necessity determinations. InterQual® is designed for integration on both the payor side and into TAR processing platforms. As a tool, it supports our move toward interoperability between payors and providers and assures that our members receive appropriate care. In the event that InterQual criteria is not available for a service request,	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Review of UM and InterQual® Criteria *Tony Hightower, CPhT, Assoc. Dir., UM Regulations* and *Desiree Payumo, RN, Manager of UM*	Partnership refers to our in-house hierarchy of criteria, which is outlined in our policy discussed earlier, MPUP3139 Criteria and Guidelines for Utilization Management. Partnership purchases new InterQual® criteria modules as needed. Presently, Partnership utilizes 14 modules in its UM decision-making process, including four that are new to us this year: Level of Care (LOC) Criteria Long-term Acute Care 2025 LOC Criteria Inpatient Rehabilitation 2025 LOC Criteria Subacute/Skilled Nursing Facility 2025 Medicare: Post Acute & Durable Medical Equipment Criteria 2025 In the future, we may purchase other modules relating to Medicare as we move closer to our D-SNP product, Partnership Advantage, now scheduled to go-live Jan. 1, 2027. A summary of content for each of the 14 modules Partnership utilizes is provided in today's agenda packet. Arrangement can be made to provide further criteria for review upon request to UMHelpDeskSR@partnershiphp.org. Before demonstrating the InterQual® tool, Desiree disclaimed that the case and member information being presented was fictitious in compliance with HIPAA. She then exemplified the tool's utility via Acute Adult Criteria and then General Surgical Criteria subsets in evaluating a 72-year-old female who had fallen and fractured her hip, her evaluation in the ER, and what happened after her admittance to a general med/surg floor for surgery the next day. "Jane's" condition, however, changed on day three, so the general surgical subset no longer applied. Desiree demonstrated clearing InterQual® and resetting it with another subset as suggested by a key word being typed into its search engine. "Jane" met that criteria, and her treatment continued. If at any time during "Jane's" stay she did not meet InterQual® criteria, her case would be sent to a Partnership Medical Director for secondary review. Dr. Moore commented that it was nice to see demonstrated a case over several days wherein the situation and thus the criteria changes. Dr. Quon asked why some modules were blacked out on the initial criteria page included in the packet. Anna Campbell replied this was because Partnership has not purchased those modules. Dr. Quon suggested footnoting an explanation to that affect, and Dr. Moore agreed that was a good idea. There were no other questions. **Motion to approve the use of InterQual® as part of our UM process:** Robert Quon, MD; Second: Brian Montenegro, MD. *Approved unanimously* **Post-meeting note:** *Corrected InterQual summary documents were sent out to the committee after the meeting. Anna removed the redactions and instead highlighted the modules Partnership has purchased.*	
Annual Grievance & Appeals Report CY 2024 *Kory Watkins, MBA-HM, Director, Grievance & Appeals*	The Grievance & Appeals department – in concert with the Medical Directors and various departments including Provider Relations, Transportation, Compliance, Member Services, and Quality Improvement – ensures that member concerns are heard, addressed, and resolved in alignment with regulatory standards and health plan policies, with a focus on timeliness, fairness, and improving the overall member experience. G&A works closely with the Medical Director for Quality, who reviews all clinical grievances flagged by nurses for potential quality issues (PQI). Additionally, interrater reliability reviews (IRR) are conducted quarterly to assess the appropriateness of cases not referred for PQI review. In 2024, 207 grievances were referred for PQI review. G&A in 2024 partnered with the Transportation department to capture the names of individual drivers (not just the company) involved in transportation-related concerns. This change allows for more precise data analysis and better identification of driver specific trends. Once a case is received from a member, the Member Services department or other source, a clinical assessment occurs where appropriate, and	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	G&A contacts the member and sends an acknowledgment letter to let them know the complaint is under review. (This contact is not mandated but is considered best practice.) An investigation is conducted, followed by a letter of resolution and call. G&A processes member complaints about dissatisfaction with services, care, or experience within 30 days; "exempt" grievances are resolved quickly without the formal grievance process ; "expedited" grievances within 72 hours in situations where loss of function, limb and/or life is possible; appeals wherein a member disagrees with a denied service or treatment; and state fair hearings before an administrative law judge regarding a denied service. Annual case volume is increasing each year, although the reasons why vary, so trending analysis is difficult. G&A closed 7,556 cases (8.34 per 1,000 members) in 2024 which saw 10 new counties join Partnership, compared to 5,690 (8.39 per 1,000 members) in 2023 when Transportation came in-house, and 4,085 (6.40 per 1,000 members) in 2022 when Covid-19 was still concerning. In 2024, just 35% of grievances received were clinical in nature; however, 63% of appeals involved clinical concerns. Just 28 of 213 case filings were deemed to meet the criteria for expedited resolution. As in years past, the most typical 2024 filer was a white, English-speaking middle-aged female residing in a northern county where access concerns are most prevalent. The top three counties by grievances per 1,000 members were Lassen (15.4), Modoc (13.6) and Siskiyou (12.3). (Transportation-related issues drove these numbers.) Sutter County had the fewest grievances (3.7). The top grievance categories were Transportation (49%); Provider Service (24%); Access (17%), and Partnership Service (10%). In 2024, Partnership provided 1,166,701 rides and received 4,472 transportation-related concerns (< .4% of total rides, down from .6% in 2023.) Excluding Transportation, Provider Services accounted for 46% of concerns (down from 50% in 2023) and Access accounted for 34% (up from 30% in 2023). Treatment plan disputes accounted for 39% of provider issues; long wait times for appointments accounted for 37% of access issues. Members may allege discrimination for many reasons, Kory noted; however, this report contains only substantiated findings of civil rights allegations, which may fall into one or more of 16 categories, the top two of which are disability and race or ethnicity. In 2024, just 10% of civil rights allegations were substantiated, down from 22% in 2023. After we have done our full investigation, such matters are reviewed by our Health Equity team. We have certified civil rights coordinators that do these reviews; in some of these cases, our medical directors will take a look. A member may feel they were discriminated against because of their disability and their age, and we will count those individually so that all voices are heard in all aspects The top Appeals in 2024 were Transportation related (49%); followed by Treatment Authorization Requests (TARs) (35%): most of these had to do with DME, primarily wheelchairs. Referral Authorization Forms (RAFs) came in at 12% of appeals; and Claims (4%). Most claims appeals had to do with reimbursement of services paid out of pocket by the member. In 2024, 69.6% of Appeals filed were upheld, while 15.5% were overturned, largely because more clinical or other information was received. In cases that were referred to an administrative law judge, 45.8% were withdrawn before any hearing; 28.2% were dismissed; and 17.6% were upheld. In 2024, only 53 state hearings actually occurred before an administrative law judge, and just 11% of those were overturned in full or in part. Kory concluded her presentation by saying that 2025 department performance is thus far meeting goals, an improvement above some 2024 quarters wherein the 98.6% timeliness threshold was narrowly missed for case closures and acknowledgement letters because of staffing, training, or other issues, including the addition of 10 counties. G&A has now instituted a multi-step nurse review protocol: when one nurse determines documentation is essential, a second nurse now confirms or disagrees. If disagreement occurs, the case is escalated to a Medical Director for a final decision. This process ensures cases are pended only when necessary (e.g., left open while awaiting a provider's response) and improves oversight on delayed resolutions.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	In 2025, G&A is looking forward to the Jiva implementation because our current case management platform is antiquated, Kory said. G&A is working on a Behavioral Health transition as Partnership ends some delegation to Carelon. (We are bringing in-house substance use disorder and mental health grievances.) Staffing has accordingly ramped up. And although Partnership Advantage go-live has been delayed one year, G&A is still preparing to ready staff for the CMS reporting the department must do. Dr. Moore found it "striking" that the civil rights allegations went up quarter by quarter in 2024 and he wondered if the reasons why might be internal or external. Kory replied it was a little of both. Members, she said, are more aware of their rights than they used to be, and they do not need to use the word "discrimination" for staff to flag incidents as possibly such. There were no further questions. **Motion to accept this annual report:** Brian Montenegro, MD; Second: Robert Quon, MD. *Approved unanimously*	
VII. FYI Attachments and Adjournment		
FYI: PHM Final Work Plan Update – *refer questions to DeLorean Ruffin, DrPH*		
Q/UAC adjourned at 9:25 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, Aug. 13, 2025 – **No meeting in July**		

Respectfully submitted by: Leslie Erickson, Program Coordinator II, QI

Signature of Approval: _____ Date: _____

Robert Moore, MD, MPH, MBA
Chief Medical Officer and Committee Chair

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, June 10, 2025 / 1:32 – 3:41 PM

Members Present:	Kubota, Marshall, MD, Associate Medical Director
Andrews, Leigha, MBA, Regional Director (Southwest)	Leung, Stan, Pharm.D, Director of Pharmacy Services
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI	Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
Bontrager, Mark, Sr. Director of Behavioral Health, Behavioral Health	Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
Brown, Isaac, MHA/MBA, Director of Quality Management, Quality Improvement	Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Brundage O'Connell, Lisa, MHA, Director of Enhanced Health Services	Randhawa, Manleen, Senior Health Educator, Population Health
Brunkal, Monika, RPh, Assoc. Dir., Population Health	Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Campbell, Anna, Policy Analyst, Utilization Management	Sharp, Tim, Regional Director (Northeast)
DeVido, Jeff, MD, Behavioral Health Clinical Director	Steffen, Nancy, Senior Director of Quality and Performance Improvement
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director, Care Management	Stone, Kelly, RN, Director of Care Coordination, Care Coordination
Hightower, Tony, CPhT, Associate Director, UM Regulations	Townsend, Colleen, MD, Regional Medical Director (Southeast)
Innes, Latrice, Manager of Grievance & Appeals Compliance	Villasenor, Edna, Senior Director, Member Services and G&A
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer	Ward, Lisa, MD, Regional Medical Director (Southwest)
Jones, Kermit, MD, JD, Medical Director for Medicare Services	
Members Absent:	
Ayala, Priscila, Director of Network Services	Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Bjork, Sonja, JD, Chief Executive Officer	Kerlin, Mary, Senior Director, Provider Relations
Davis, Wendi, Chief Operating Officer	Klakken, Vicki, Regional Director (Northwest)
Esget, Heather, RN, BSN, ACM, Director of Utilization Management	Turnipseed, Amy, Senior Director of External and Regulatory Affairs
Guests:	Jensen, Annika, RN, Assoc. Dir., Clinical Integration, Care Coordination
Akintan, Folo, Epidemiologist, Population Health	Kim, Amanda, Senior Project Manager, Quality Improvement
Arrazola, Kelcie, Lead Trainer, Provider Relations	Kubota, Marshall, MD, Associate Medical Director
Bikila, Dejene, Manager of Data Science, Finance	Lee, Donna, Manager of Claims, Claims
Boyle, Shannon, RN, Manager, Care Coordination Regulatory Performance	Morris, Matthew, MD, Regional Medical Director (Auburn)
Broadhead, Candi, Project Manager II, QI	Nguyen, Tom, Manager of Health Analytics, Finance
Caldwell, Mariyah, Administrative Assistant II, Network Services	Power, Kathryn, Regional Director (Southeast)
Chebolu, Radha, Senior Health Data Analyst II, Finance	Quichocho, Sue, Manager, Quality Measurement, QI
Clark, Kristen, Mgr, Quality & Training, Member Services	Rathnayake, Russ, Senior Health Data Analyst I, Finance
Conner, Maria, Improvement Advisor, QI (Auburn)	Robertello, Kimberley, PhD, Sr. Medicare QI Program Manager
Conners, Denese, Improvement Advisor, QI (Auburn)	Roberts, Dorian, Sr. Mgr of PR Representatives, Provider Relations
Cook, Dawn R., Program Manager II, QI (NCQA)	Romero, Liz, MPH, MCHES, Improvement Advisor, QI (Northeast)
Cunningham, Aryana, Policy Analyst, Care Coordination	Sackett, Anthony, Program Manager II, QI
Devan, James, Manager of Performance Improvement, QI (Northeast)	Salehi, Tiphanie, Sr. Health Data Analyst I, Finance
Donahue, Celena, Improvement Advisor, QI (Eureka)	Seale, J'aime, PR Lead, Network Services
Erickson, Leslie, Program Coordinator II, QI (scribe)	Shorter, Ayana, Supervisor of Credentialing, Network Services
Friedman, Greg Allen, Project Coordinator II, Population Health	Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance
Gual, Kristine, Director of Quality Measurement, QI	Smith, Christine, Community Health Needs Liaison, Population Health
Harris, Vander, Senior Health Data Analyst I, Finance	Stark, Rebecca, Regional Director (Chico)
Hermosillo, Jesus, Cultural Community Manager, Health Equity	Stokes, Sarah, Project Coordinator II, QI

Isola, Brandy, Manager of Performance Improvement, QI (Chico/Auburn)	Thomas, Andrea, Project Manager I, QI
Jamali, Shahrzad, Improvement Advisor, QI (Chico)	Trosky, Renee, Manager of Provider Relations Compliance
	Vance, Brooke, Program Manager I, Network Services

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

I. Call to Order
• Introductions
• Approval / Acceptance of Minutes
	Chief Medical Officer/Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 1:32 p.m.
	• Several staff in IQI attendance for the first time introduced themselves:
	  o Jesus Hermodillo, is Health Equity's new Cultural Community Manager
	  o Greg Allen Friedman, Project Coordinator, Pop Health, attended to present a program description
	  o Christine Smith, Community Health Needs Liaison, Pop Health, attended to present two policies
	  o New Improvement Advisors Denese Conners and Maria Conner each work out of the Auburn office under Brandy Isola's leadership
	• Approval of the May 13 IQI Minutes
	• Acceptance of the draft minutes of the
	  o April 30 Over/Under Utilization Workgroup
	  o May 22 Member Grievance Review Committee (MGRC)
		Motion to **approve IQI Minutes**: Katherine Barresi, RN
		Second: Lisa O'Connell, MHA
		
		Motion to **accept other minutes**: Lisa O'Connell, MHA
		Second: Tony Hightower, CPhT

II. Old Business - None		
III. New Business Consent Calendar (Committee Members as applicable)		
G&A PULSE Report / Issue 17 / June 2025 ***Health Services Policies*** <u>Pharmacy</u> MCRP4064 – Continuation of Prescription Drugs MCRP4068 – Medical Benefit Medication TAR Policy MPRP4062 – Drug Wastage Payments <u>Population Health</u> MPNP9007 – Lactation Policy and Guidelines – *the former MCCP2020 in CC is now archived* MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program – *the former MCCP2021 in CC is now archived* <u>Quality Improvement</u> MPQP1004 – Internal Quality Improvement Committee – ***pulled for update*** MPQP1006 – Conflict of Interest Policy for QI Activities MPXG5009 – Lactation Clinical Practice Guideline <u>Utilization Management</u> MCUG3134 – Hospital Bed/Specialty Mattress Guidelines MCUP3044 – Urgent Care Services MPUG3010 – Chiropractic Services – *previously MCUG3010* MPUP3111 – Pulmonary Rehabilitation – *previously MCUP3111* ***Non-Health Services Policies*** <u>Network Services (Credentialing)</u>	Motion to **approve slate without the pulled policies**: Richard "Doug" Matthews, MD Second: Mohamed Jalloh, Pharm.D <u>Next Steps</u>: Health Services policies go to June 18 Quality/Utilization Advisory Committee (Q/UAC) and to Aug. 13 Physician Advisory Committee (PAC) Credentialing policies go to July 9 Credentials Committee. Member Services' MC341 goes to the department for director approval/signature

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	MPCR700 – Assessment of Organizational Providers MPCR701 – Ancillary Care Services Provider Credentialing and Re-credentialing Requirements *Credentialing Staff prior to the meeting **pulled** the following policies for more work and will bring them back to Aug. 12 IQI:* • MPCR15 – Doula Credentialing and Re-credentialing Criteria • MPCR100 – Credential and Re-credential Decision Making Process • MPCR200 – Credentials Committee and CMO Credentialing Program Responsibilities • MPCR602 – Reporting Actions to Authorities • MPNET101 – Wellness and Recovery Access Standards and Monitoring <u>Member Services</u> MC341 – Distribution of Member Rights and Responsibilities – Wellness and Recovery Program – *previously MC305A* ***– pulled for discussion*** Associate Medical Director Marshall Kubota, MD, **expressed wording concerns about MCUG3134**'s pediatric beds **and MCUP3044.** Anna noted that both policies soon will be coming back with more changes but asked that they be passed as presented today, and Dr. Moore agreed. Anna explained that the Urgent Care policy is long overdue because it was being held back in anticipation of the formation of a workgroup charged with reviewing urgent care services. The workgroup has just recently been convened and will require multiple meetings, so the policy is being reviewed now with only minimal updates, and will return to committee with additional changes after the workgroup completes its review. She said the language in the policy is focused on site review and provider credentialing and as such probably does not belong in UM. This policy, she added, will most likely be archived and with language dispersed into other exiting policies, and Dr. Moore concurred. **Both policies were approved as presented under the Matthews/Jalloh motion.** **MPQP1004 was pulled** to add two positions mistakenly left off the staff voting list: Senior Director, Behavioral Health and Policy Analyst, Utilization Management. VI.A.5 was amended to read "Voting: Standing Members, including the Regional Medical Directors and Associate Medical Directors specifically assigned by the CMO to sit on this committee, will vote and the Chair will acknowledge consensus." **Motion to approve with these changes: Anna Campbell/Kermit Jones, MD, JD** Anna **pulled MC341** to note that three counties will be overlapping the Medi-Cal and the coming Partnership Advantage (Medicare) program, wondering if this policy should be marked as a straight Medi-Cal-only ("MC") policy. Dr. Moore noted that Medicare will supersede the entire W&R program. Mark Bontrager concurred that the first payer would be Medicare once Partnership Advantage goes live, adding that providers seeing "Medi-Medi" patients already know to bill Medicare first. Dr. Moore said this policy will remain noted as "MC." **Motion to approve: Lisa O'Connell/Mark Bontrager**	
IV.	**New Business – Discussion Policies –** *Dr. Moore explained the "MC," "MP," and "PA" policy nomenclature for the benefit of new staff.*	
Policy Owner: Care Coordination – *Presenter: Shannon Boyle, RN, Manager, Care Coordination Regulatory Performance*		
MCCP2024 – Whole Child Model for California Children's Services (CCS)	**Policy edits due to DHCS WCM Readiness Deliverables** **Related Policies Updated:** MCCP2014 renamed to MPCP2014 MCCP2030 renamed to MPTP2503 **Definition Updated:.** Whole Child Model (WCM): A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with CCS eligible conditions insured by Partnership.	*There were no questions.* Motion to **approve as presented**: Stan Leung, Pharm.D Second: Isaac Brown, MHA/ MBA <u>Next Steps</u>:

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	VI.A.3. added via fax or secure File Transfer Protocol (SFTP) as a form of communication to transmit referrals to the counties **VI.C.1. added:** Partnership WCM case management and care coordination is a member and family centered care approach which ensures needed clinical and non-clinical services for the CCS eligible condition. Partnership collaborates with the WCM member, member's family, or authorized representative of the WCM member to identify needs, goals, and preferences in accessing such diagnostic and treatment services. **VI.C.5.e.2. added:** Partnership identifies needs, goals, barriers, and interventions to access diagnostic and treatment services including access to primary and specialty care by a CCS-Paneled Provider and preventive care services with specialty care services through the collaborative case management and care coordination process with WCM members. Partnership evaluates Risk Assessments, ICP's, AMR's, ongoing case management with the WCM Member, family or authorized representative, and available data to identify referred services in plan of care and confirm member received referred treatments. **VI.C.5.g. added:** If a member chooses to receive both CCS Case Management and ECM services, Partnership may assign some or all CCS Case Manager functions to be delivered by qualified ECM Providers. ECM providers must meet all existing CCS and WCM requirements to provide Case Management services. ECM providers must have previous experience directly providing CCS Case Management and/or CCS clinical services. **VI.J.3.a-d added:** Disputes submitted to DHCS via email with subject "Request for Resolution" will include a summary of the disputed issue(s) and a statement of the desired remedies, a history of the attempts to resolve the issue(s), justification of the desired remedy and any additional documentation that are relevant to resolved the dispute, if applicable. **Reference updated:** DHCS APL 23-029- Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (*Revised* 01/08/2025)	June 18 Q/UAC Consent Aug. 13 PAC
MCCP2036 – Memorandum of Understanding (MOU) Requirements for Medi-Cal Managed Care Plans and Third-Party Entities – **NEW POLICY**	**NEW Policy** To describe and define the intent of the Memorandum of Understanding (MOUs) required to be entered into by Partnership HealthPlan of California (as the Medi-Cal Managed Care Plan [MCP]) and Third Party Entities. This policy outlines that Partnership shall negotiate in good faith and execute an MOU with Third Party Entities as required under the Medi-Cal Managed Care Contract (MCP Contract) with the Department of Health Care Services (DHCS). MOU Policy includes the following: 1. A designated point of contact responsible for the oversight and supervision of the terms of all MOUs. 2. All Subcontractors, Downstream Subcontractors, and Network Providers are required to comply with any applicable provisions. 3. MOU parties must work collaboratively to ensure Members are referred to appropriate programs and/or services and coordinate Members' access to care and services that incorporate all the requirements noted in the MOU. 4. MOUs must be reviewed annually for any needed modifications or renewal of responsibilities and obligations. For each MOU Partnership will hold regular meetings with the MOU parties, at least quarterly, to address policy and practical concerns. 5. The MOU parties may develop Quality Improvement (QI) activities specifically for the oversight of the requirements of the MOU.	Motion to **approve as amended**: Anna Campbell Second: Kermit Jones, MD, JD Next Steps: June 18 Q/UAC Discussion Aug. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	6. The MOU parties must support the timely and frequent exchange of Member information and data. 7. The MOU parties must develop policies and procedures to mitigate the effects of disaster and emergency preparedness 8. Partnership and MOU parties shall negotiate in good faith and execute MOUs to ensure coordination of Medi-Cal services, delineate the responsibilities of each respective party, and afford for a dispute resolution process. 9. Partnership or the MOU parties may seek to remedy a dispute informally through discussion and dialogue. Dr. Moore asked whether quarterly meetings with individual counties have started and if some counties will "bundle" together so there might not need to be, for example, 24 "First Five" meetings. Senior Director of Care Management Brigid Gast, RN, replied that some meetings have occurred, and that bundling too will happen should participants agree. In addition, some public health agencies are asking for *ad hoc* meetings. Mark Bontrager noted that Partnership also does bundle Behavioral Health MOU meetings. Dr. Moore also asked whether this policy makes it clear that the templates may change and if we link interested persons to the executed MOUs. Anna Campbell noted that we are displaying executed MOUs on a webpage on the external Partnership website. .**Shannon will check if it is appropriate to add a link in the Reference section before this policy goes to Q/UAC June 18.** Anna noted that **Related Policy B and E alphanumerics must be updated.** Chief Health Services Office Katherine Barresi, RN, noted the first MOU was created in 2023 as part of Partnership meeting its 2024 DHCS Contract. Brigid added that this new policy and our WCM as presented today have been delivered to DHCS, which has yet to provide feedback.	
MPCP2014 – Continuation of Care – *new policy number and name change: "Medi-Cal" is dropped as policy will now apply to Medicare too*	**This policy was updated to include regulations for Partnership Advantage D-SNP line of business that will be effective Jan. 1, 2027.** Policy number updated from MCCP2014 to MPCP2014 to reflect Multi Plan Policy **Related Policies Updated:** MCUP3143 updated to reflect new policy number MCAP7001- CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) MCUP3142 updated to reflect new policy number MCAP7003- CalAIM Community Supports (CS) **1. Definitions Added:** Dual Eligible Special Needs Plans (D-SNPs) Partnership Advantage (PA) **Purpose: added additional population the policy applies to:** Members newly enrolled in Partnership Advantage's Dual Eligible Special Needs Plan (D-SNP) **VI.E.1. revised to include** Prior to the date of the members' initial enrollment in the D-SNP for a non-emergency visit as an additional way for Partnership to determine that the member has an ongoing relationship with the provider **VI.E.3. added** Current Medicare fee schedule **VI.E.7. Partnership Advantage members section added:** D-SNPs are network based for Partnership Advantage members, with the following exceptions:	Motion to **approve as presented**: Brigid Gast, RN Second: Anna Campbell Next Steps: June 18 Q/UAC Consent Aug. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	1. Partnership Advantage members are allowed to continue receiving care from an out-of-network provider for up to 12 months after enrolled if they have an acute or serious chronic medical condition as referenced in VI.A.3. 2. Partnership Advantage members must submit a request to their Medicare plan including documentation from current medical provider. **VI.F. added** D-SNP to the section **VI.H.2 updated** County Mental Health Plans (MHPs) to County Behavioral Health Plans (BHPs) **VI.L.8.d. added:** D-SNP retroactive requests for Partnership Advantage members must be accepted if submitted more than 30 days after the first service if the provider can document that the reason for the delay is that the provider unintentionally sent the request to the incorrect entity and the request is sent within 30 days of the denial from the other entity. **References Updated:** DHCS All Plan Letter 24-015: California Children's Whole Child Model Program (12/02/2024) **References Added:** DHCS CalAIM Dual Eligible Special Needs Plan Policy Guide- Contract Year 2026 (2025) Medicare Managed Care Manual: Chapter 11- Medicare Advantage Application Procedures and Contract Requirements, Rev. 83 (04/25/2007) **In response to a question posed by Dr. Moore**, Senior Director of Behavioral Health Mark Bontrager clarified that this policy is an umbrella of sorts, providing oversight of BHPs, some of which may be delegated by individual counties. Anna Campbell noted that the draft 2026 Member Handbook utilizes the new term "Behavioral Health Plan (BHP)" instead of "Mental Health Plan (MHP)" to refer to the county side.	
Policy Owner: Pharmacy – *Presenter: Stan Leung, Pharm.D, Director of Pharmacy Services*		
MPRP4001 – Pharmacy & Therapeutics (P&T) Committee	**Definition G is added**: **Biosimilar:** a biologic medication that is highly similar to and has no clinically meaningful differences from an existing FDA-approved biologic, called a reference product. **B.1.g.1) is added:** Upon market launch or assignment of a HCPCS code, biosimilar products will be assigned to the same criteria as their reference product in PHC's MDL while they await annual class review. This automatic assignment will not require P&T committee approval, and the effective date will be the date of market launch and/or the date of code activation.	*There were no questions.* Motion to **approve as presented**: Stan Leung, Pharm.D Second: Kermit Jones, MD, JD Next Steps: July 10 P&T Committee Aug. 13 PAC
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*		
MCUP3041 – Treatment Authorization Request (TAR) Review Process	**Section I:** Two Related Policies were added J. MPUP3139 – Criteria and Guidelines for Utilization Management K. MCUP3064 – Communication Services **Section V.** An outdated reference to processing of RAFs was deleted from the Purpose section. This policy now describes only TAR processing.	*There were no questions.* Motion to **approve as presented**: Doug Matthews, MD

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.A.2. In the description of criteria used for review decisions, we added a reference to our policy MPUP3139 Criteria and Guidelines for Utilization Management. **Section VI.A.5** was removed. This paragraph discussed records retention which is the topic of another policy, CMP30 Records Retention and Access Requirements, which is listed in Section I. as a Related Policy. **Section VI.B.2.b.** This paragraph was added per DHCS request to state that requests for DME for dually eligible Medi-Cal/ Medicare Members are exempt from the requirement to submit a TAR with written verification from Medicare that the benefits have been exhausted. This is because Medicare does not issue denials and Explanations of Benefits (EOBs) for non-covered DME services. **Section VI.B.2.b.** Added language to say TARs are not required for "certain" services because the list has been growing and we did not want to limit services to only those specified . **Section VI.B.4.** Removed "diagnostic imaging" from the list of services limited to a 6-month authorization period because we are no longer requiring a TAR for CT or MRI **Section VI.F.** Removed the entire Communication Services section because the language is duplicate in policy MPUP3064 Communication Services, which has been listed at the top in Section I. as a Related Policy. **Attachment A:** Policy numbers updated throughout. **H. Diagnostic Studies;** Paragraphs 1. CT Scans and 2. MRI: were both deleted as we no longer require a TAR for these services. Dr. Moore noted that Partnership is already implementing these changes to no longer require prior authorization for CT scans or MRIs, which Configuration will communicate to the Provider Network after Aug. 13 PAC approval.	Second: Kermit Jones, MD, JD Next Steps: June 18 Q/UAC Discussion Aug. 13 PAC
MPUP3014 – Emergency Services – *previously MCUP3013*	**Section VI.F:** A new section was added to describe coverage for Services Rendered Outside of the United States, including Canada and Mexico. **Section VII.G**: A new Reference was added for the Medicare Claims Processing Manual Chapter 1 (Rev. 12909, Issued: 10-24-24), Section 10.2.1 FI Payment for Emergency and Foreign Hospital Services (Rev. 1, 10-01-03)	*There were no questions.* Motion to **approve as presented**: Anna Campbell Second: Kermit Jones, MD, JD Next Steps: June 18 Q/UAC Consent Aug. 13 PAC
MPUP3039 – Direct Members – *previously MCUP3039*	This policy has been updated for Partnership Advantage (Medicare) applicability, effective Jan. 1, 2027. It has also been updated with a crosswalk to show new "Health Conditions" categories that will be used when go live with the HRP core claims system in the future. **Section III.C.** Definition of Partnership Advantage has been added. **Section IV.** The title of Attachment A was updated to "Direct Member/ Health Conditions Category Designation Grid." **Section VI.A** Clarifying language was added to say we will have Medicare providers in our network as applicable to Partnership Advantage Members.	Motion to **approve as presented**: Anna Campbell Second: Lisa Ward, MD Next Steps: June 18 Q/UAC Consent Aug. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.B. Footnote describing CCS counties is deleted because all counties are now Whole Child Model counties. **VI.E.1.c.2:** Statement was added to say that Partnership Advantage Members may appeal a Direct Member status decision according to the process outlined in Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (ODAG). **Section VII.C.:** New Reference was added for Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Section 40 Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations **Attachment A:** The Direct Member Designation Grid was updated to include "Health Condition Categories throughout. A new column was added to "crosswalk" current Direct Member Designations to future Health Condition Categories that will be used when HRP goes live. **H5 Continuity of Care/ Transplant Category**: Added language to include CAR T-cell therapy and gene therapy with Bone Marrow transplants and change time period from one year to two years for when a Direct Member receiving those services would become eligible for assignment to PCP Dr, Moore noted that a subgroup is working on this policy, which will likely get a major revision and new title closer to Medicare go-live. **"Effective when HRP is activate" will replace the erroneous Q3 2025 effective date placeholder at the top of the Attachment A Health Conditions Category Designation Grid**	
MPUP3139 – Criteria and Guidelines for Utilization Management – *previously MCUP3139*	**This policy has been updated for Partnership Advantage (Medicare) applicability, effective Jan. 1, 2027.** **Section VI.B.2.a. 2)** Added description of Medicare standards that may be used for UM decisions including NCDs and LCDs. **Section VII.B and C.** Added two new references for "Contractual obligations with the Department of Health Care Services (DHCS)" and "Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Section 40 Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations (11/18/2024)" **Attachment A:** Added Criteria for Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance	*There were no questions.* Motion to **approve as presented**: Kermit Jones, MD, JD Second: Anna Campbell Next Steps: June 18 Q/UAC Discussion Aug. 13 PAC
Policy Owner: Population Health – *Presenter: Christine Smith, Community Health Needs Liaison, Population Health*		
MCNP9004 – Regulatory Required Notices **NEW Title**	**This policy's name was updated from Regulatory Required Notices and Taglines to simply "Regulatory Required Notices."** This policy was updated to reflect changes per APL 25-005 - Standards For Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, And Alternative Formats (Supersedes APL 21-004) and organizational changes: **I. Related Policies -** Cultural and Linguistic Program Description policy number updated from MCND9002 to MPND9002 **III. Definitions** • Updated references from APL 21-004 to the new APL 25-005. • Updated citations within the nondiscrimination notice description. • Updated "Language Assistance Taglines" to their new name, "Notice of Availability." **IV. Attachments**	*There were no questions.* Motion to **approve as presented**: Anna Campbell Second: Katherine Barresi, RN Next Steps: June 18 Q/UAC Consent Aug. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Updated name of attachment B to "Notice of Availability." **VI. Policy/Procedure** • Revised: MCPs must adhere to the nondiscrimination notice and *notice of availability* requirements in *APL 25-005* when sending the required grievance and appeals notifications to members. • Added reference to MPND9002 (formerly MCND9002) Cultural and Linguistic Program description. **VII. References** • Reference section is updated with hyperlinked citations and language from APL 25-005: o California Welfare and Institutions Code (WIC) 14029.91(e)(1)-(5) o California Department of Health Care Services (DHCS) APL 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services and Alternative Formats (02/12/2025) o U.S Department of Health and Human Services (HHS) 45 CFR section 92.10(a) **Attachment A:** Nondiscrimination Notice updated to current February 2025 version **Attachment B:** Notice of Availability updated to version going live August 2025 **Attachment C:** NOA Your Rights under Medi-Cal Managed Care updated to current December 2024 version **Attachment D:** NAR Your Rights under Medi-Cal Managed Care updated to most current December 2024 version	
Policy Owner: Population Health – *Presenter: Greg Allen Friedman, Project Coordinator II, Population Health*		
MPNP9001 – Population Health Management Strategy & Program Description – *previously MCND9001*	**Changed to MPND9001 to reflect applicability also to the coming D-SNP program.** Annual update includes revisions and additional contract and APL references to further align the document with NCQA and state requirements. Many small changes for grammar, clarity, and/or readability. Highlights below: **P. 5 Introduction:** new paragraph explaining Partnership's Medi-Cal and D-SNP services, and Partnership Advantage. **P. 6 Data Analysis and Strategy:** fine-tuned explanations of PHM processes, its Work Plan, and other analysis and policies. **P. 8-11 under Data Analysis and Strategy:** updated the graphic showing the relationship of PHM and county CHA/CHIP activities, moved PNA Committee explanation from p. 11to p. 14. **P. 13 under Population Needs and Community Needs Assessments:** added language about Community Advisory Committee (CAC). **P. 16-17 under Social Drivers of Health and Community Needs:** added language about covered behavioral health services for Medicare Advantage members. **P. 22 Basic Population Health Management:** added language mentioning Community Health Worker services, and reports being reviewed for members who may be at risk of diabetes. **P. 36 Practitioner Education and Training; Health Education Interventions: re**written to reflect DEI offerings for providers, and eliminated references to the QIHETP/C&L Work Plan in the context of Health Education. **P. 39-42 under Community Engagement and Coordination of PHM Programs:** updated explanation of Partnership systems, including its case management system and plans to switch to JIVA later in 2025. Updated	*There were no questions for Greg,* who said he would update an APL and a p. 11 Reference before resubmitting the policy for Q/UAC's consideration June 18. Motion to **approve as will be amended prior to Q/UAC**: Kermit Jones, MD, JD Second: Anna Campbell Next Steps: June 18 Q/UAC Discussion Aug. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	vendor names and terminology and added qualifiers for possible different services for Medi-Cal and Partnership Advantage members. Updated list of organizations with MOUs effective January 2025. P. 47 Population Health and Health Education Delegation Oversight and Monitoring: added details explaining Partnership's monitoring of performance for delegates. P. 48-51 under Team Roles and Responsibilities: updated descriptions of various roles, including Chief Medical Officer, Director of Population Health, Health Educator, Healthy Living Coach, and others.	
Policy Owner: Population Health – *Presenter: Christine Smith, Community Health Needs Liaison, Population Health*		
MPND9002 – Cultural & Linguistic Program Description – *previously MCND9002*	**Changed to MPND9002 to reflect applicability also to the coming D-SNP program.** This policy was updated to align with DHCS APL 25-005 Review Tool and other organizational changes. Due to the timing of APL 25-005, additions were needed since the previous April approvals: **Alignment with DHCS Review Tool** • Added reference to the regulatory required notices Attachment A & Attachment B (pg.8). • Added details around written information in either traditional or simplified Chinese characters (pg.11). • Updated details on the content of the Nondiscrimination notice to include information on how to file discrimination grievance with the with Partnership, DHCS' OCR, and HHS' OCR (pg.9). • Added details on the use of quick response codes, otherwise known as QR codes alongside printed notices however cannot be replaced or to be used in lieu of the regulatory required notices (pg.9). • Clarified that Members with limited English proficiency (LEP) or disabilities are not required to provide or pay for their own interpreters, nor rely on unqualified staff for interpretation (pg.12). • Included language affirming Members' right to free interpreter services, and that interpreter use will not affect service quality or confidentiality (pg.14). • Added provisions requiring documentation in the medical record when a Member refuses free interpreter services and requests a family member, friend, or minor to interpret (pg.14). **DSNP Language** • Changed policy name from MCND9002 to MPND9002 throughout document • Updated the list of member correspondence items to include "Notices of Organization and Coverage Determinations to encompass DSNP notices" *(pg.9*) **Attachments A-E updated with new "MPND" policy coding.** Other specifics below. **Updating Attachment D:** Process for Translation Services • Document from our translations vendor updated with branding reflecting that they are now owned by Propio. **Updating Attachment E:** Community Advisory Committee • Name changed from "*Consumer*" to "*Community* Advisory Committee." • More detailed diversity statement added. • Edits made to include the committee's feedback on the subject of CHA/CHIP work with counties. • Added members who receive Long-Term Supports Services (LTSS), and/or individuals representing those members to list of examples of how CAC members may reflect Partnership's member population. • Added detail about representation ratios. • Added a new paragraph explaining responsibilities of the CAC Coordinator, Facilitators, and CAC selection committee.	*There were no questions.* Motion to **approve as presented**: Kermit Jones, MD, JD Second: Katherine Barresi, RN Next Steps: June 18 Q/UAC Discussion Aug. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Updated member responsibilities, adding a qualifier for members with ADA-qualifying disabilities allowing remote attendance. • Responsibilities for choosing replacement members now shared between the CAC Coordinator, Facilitators, and CAC selection committee. • Removed a sentence which described how regional representatives reporting to the Partnership Board of Commissioners would be rotated from region to region. • Updated references to DHCS's Medi-Cal Member Advisory Committee (MMAC). • Updated Partnership office addresses	
V. Presentations		
QI Update – *Nancy Steffen, Senior Director, Quality Improvement and Performance*		
	Nancy noted that the printed report was submitted before it was known that the Health Rules Payor (HRP) claims system implementation would be delayed. Therefore, the QIP team has no need to do a changeover: **no two-week blackout period to the PCP QIP will be necessary in July.** • The Chronic Disease Workgroup continues to work on getting retinal cameras into imaging center deserts across the network to increase access to retinal screenings for diabetic members. Partnership has so far funded 10 cameras. • The new provider-facing webpage is now available on Partnership's website to support colorectal cancer screening efforts. The page includes a variety of internal and external materials, including educational videos. The Cologuard overview outlines all available screening options and includes guidance on how to effectively access care gaps. Interested providers can begin submitting their orders for testing kits on July 21. • Partnership continues to support the Partnering for Pediatric Lead Prevention (PPLP) program, which provides funding for point-of-care lead testing devices to eligible practices. Applications are accepted year-round. Click this link. • Consumer Assessment of Healthcare Providers and Systems results are coming in and our CAHPS team is validating them. Give the Healthcare Effectiveness Data Information Set team a shout out: HEDIS® will be reported out in August IQI, Q/UAC, and PAC. • Our Health Equity Accreditation Initial Survey is scheduled for June 17. Our evidence has been submitted. Some persons may be asked to do additional work this summer. Official accreditation notice is likely to be received in September.	*For information only.* Dr. Moore asked if the PCP QIP payments will go out this week. Nancy said yes. Dr. Moore will announce this at June 11 PAC.
Population Health Management Grand Analysis – *DeLorean Ruffin, DrPH, Director of Population Health*		
	DeLorean introduced the Grand Analysis by saying it covers both the Pop Health Impact Analysis and the Segmentation Report. The Analysis mainly meets NCQA standards but there is an opportunity to include other measures in the future. This presentation mainly covers the results showing statistically significant differences, so not all measures are covered in the oral presentation. The 2024 Impact Analysis looks at all parts of our Growing Together Program (GTP) and some member feedback from other Partnership programs. This presentation today looks at statistically significant results for one or two goals for the Prenatal Program and the GTP Postpartum (together known as Healthy Moms), the GTP Healthy Babies (0-30 months), the GTP Healthy Kids (ages 3-6), and Transitions of Care. Data was drawn from a variety of sources, including Partnership and DHCS claims data, and immunization data available through the California Immunization Registry (CAIR). DeLorean went through the "engagement categories," defining "engaged" as members who qualified for the program, were reached by phone and opted in to program participation. Goal One of the Prenatal Program was that 75% of engaged members would have a Tdap vaccine within 120 days (four months) of delivery. The goal was barely missed at 73%. Still, engaged members (38% of 1,212 deemed eligible to participate) had a statistically	There are some opportunities that exist to improve the design of PHM interventions along with broader systemic factors addressing the environment of care. Partnership will explore means to leverage new benefits and resources offered through the CalAIM initiative to bolster member support and improve

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	significant higher rate of completing the vaccine compared to members who declined to participate. The engaged white population had a statistically significant lower rate of completing the Tdap (65%) compared to the Hispanic population at 80%. Further analysis may be warranted because of the small sample size for some groups. Goal One of the Postpartum Program was that 75% of engaged members would attend a postpartum visit within 60 days of delivery. The goal was met. The white population had a statistically significant lower participation rate (63%) than did American Indians (86%), Hispanics (81%), and other/unknown (73%). The data demonstrates that the campaign made a measurable difference in the lives of certain non-white population groups, although the sample size for some was small. Members engaged only in the postpartum program had a statistically significant lower rate of attending a postpartum visit within 60 days of delivery when compared to members who were engaged in the prenatal program. Population Health enrolls infants under 12 months of age in the Healthy Babies GTP the month they become Partnership members. (In July 2024, the enrollment age was modified to include infants under 24 months of age; this shift will be reflected in next year's report.) The program provides health education and promotion of well-child visits and timely vaccinations. Incentives are offered. Goal One was that 80% of engaged members would be compliant with 50% or more of their vaccinations during the program period. This goal was met at 92%. Engaged members has a statistically higher rate of completing 9+ or 4+ vaccines than did non-engaged members. The engaged white population has a statistically lower rate of completing 9+ or 4+ (79%) than did Asians (96%), Hispanics (97%), and other/unknown (89%). Goal 2.1 was that 25% of engaged members would attend all the well-child visits. This goal was met at 67%. Goal 2.2 was that 65% of engaged members would be compliant with at least one-half of the recommended well-child visits. This goal was met at 89%. Once again, for both goals the white population had lower compliance rates than did other racial/ethnic groups. The engaged member result for Healthy Babies vaccines "looked pretty good," DeLorean reported. Significantly more members completed vaccines between July 2023 and June 2024 than in the previous period (1,424 compared to 514); however, this increase may be associated with Partnership's 10-county expansion that occurred in January 2024. Overall, the Healthy Babies campaign made a measurable difference in the lives of our Hispanic population. Healthy Kids aims to reach all children ages 3 through 6 who have not had a well-child visit in the prior 11 months or longer. Once identified, these members are offered an incentive to encourage complete an annual well-child visit before their next birthday. Goal One was that 50% of engaged members would have a WCV within 120 days of agreeing by phone to participate. This goal at 32% was not met; however, engaged members had a statistically significant higher completion rate than non-engaged members, suggesting that the program continues to have an impact. In all, 1,947 (23%) of 8,411eligible children were engaged, and 1,535 (79%) of those engaged completed a WCV during the fiscal year. There was no significant difference between the white population and other ethnic groups. Transitions of Care (TOC) services focus on members who are transitioning across settings or benefit structures. Partnership's Care Coordination team provides TOC to the vulnerable population to ensure implementation of the discharging facility's transition plan and connects members to medical care and community resources that support health and wellness. Adult member TOC criteria includes discharging home from an acute care after hospital length of stay longer than four days, or discharging home from an out-of-county hospital with any length of stay, or having more than one admission in 10 days. (It excludes members in long-term care or in a long-term care psychiatric facility.) Pediatric members (i.e., under the age of 21) qualify by discharging home from an acute care hospital stay with an admissions date longer than 60 days from date of birth and having any length of stay. At the close of the TOC services, Partnership contacts the members by phone to complete a weighted member experience survey that includes opportunity for comment. TOC goals were that both 75% or adult members and 75% of pediatric members would agree with each of the eight statements of the relevant survey. These goals were met, each survey question well exceeding the goal average of 2.5 (on a one to three scale).	the overall health outcomes of the population. Isaac Brown asked if, when messages are left, members call us back. Most often they do not call back, DeLorean replied. In response to further questions from Isaac, DeLorean said that member interactions can change depending on whether the pregnancy is a first or not. She did not know if members used these interactions with Partnership to pose unrelated questions. Nancy Steffen thanked DeLorean for the presentation and suggested that we build on these results via provider engagement. DeLorean observed that promoting the GTP with providers does help: we have seen this in the CHA/CHIP (Community Health Assessment/Community Health Improvement Plan) efforts. **Motion to accept all parts of the Grand Analysis** (PD, Impact Analysis, Segmentation Report and Work Plans): Kermit Jones, MD, JD Second: Nancy Steffen Next Steps: June 18 Q/UAC Aug. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Finally, Complex Case Management is a support for members who have multiple chronic diseases, social determinants of health barriers and/or have difficulty navigating the healthcare system without the intensive support of a care coordinator and an individualized care plan. Individual goals are time-bound; however, a member may remain in CCM for an extended period. Goals one and two were that 75% of adult and pediatric members, respectively, would agree (score of "3") with each statement of the relevant CCM satisfaction survey. These goals were met but for "I feel my ability to manage my child's healthcare needs is better after working with CM," which scored just 2.5. In 2024, Partnership refined its program offerings based on insights and successes from previous years. Lessons learned have shown that the most effective program utilizes multiple modalities of reaching members, such as combining mailings with phone calls and with incentives to maximize engagement. Among the clinical measures, program goals were met for vaccination rates among infants enrolled in the Healthy Babies program. For utilization measures, we met our goal of newborns attending well child visits who are linked to members engaged in the prenatal and postpartum program. We also met the goal for members to attend postpartum visit among members enrolled in the postpartum program. Furthermore, we met the goal for members to attend well child visits who were enrolled in the Healthy Babies program and one of the goals for kids to attend well child visits who were enrolled in the Healthy Kid's program. As for member experience measures, we met all but one goal under both the Transitions of Care and Complex Case Management programs. A significant finding that has carried on through 2024 is the feedback from members about the ongoing challenges around scheduling well child visits due to the lack of provider availability to serve the member population in a timely manner. This finding, based on both member and provider-level data, highlights the greatest areas of need for innovative solutions and will inform multidisciplinary efforts to support providers in delivering this essential service. Member experience measures highlighted the significant value that Partnership's programs provide. In 2024, Partnership integrated member experience questions into a broader range of member interactions to gain deeper insight into member barriers to care and to promote the overall experience members have with Partnership. In 2024, Partnership conducted analyses of program outcomes stratified by race and ethnicity. An interesting finding was the white population had statistically significant lower rates for certain well-child attendance visit goals, and postpartum visits when compared to other racial groups. Under the Prenatal Program, there was no statistical significance between the white population and other non-white populations for the linked newborns to well child visits measure. Moreover, Partnership's members enrolled in Population Health Management (PHM) programs demonstrated improved outcomes compared to those who were not engaged or not referred to the programs.	
Annual Review of UM and InterQual® Criteria – *presentation only; demonstration will occur at June 18 Q/UAC – Tony Hightower, CPhT*		
	Tony noted that InterQual® is a clinical decision tool developed and continuously peer reviewed based on the principles of evidence-based medicine. It is utilized by our medical directors and nursing staff to support medical necessity determinations. InterQual® is designed for integration on both the payor side and into TAR processing platforms. As a tool, it supports our move toward interoperability between payors and providers and assures that our members receive appropriate care. In-house, Partnership maintains a policy library, which is especially useful when there is no InterQual® set for a specific service or procedure. Partnership purchases new InterQual® criteria modules as needed. Presently, Partnership utilizes 14 modules in its UM decision-making process, including four that are new to us this year: • Level of Care (LOC) Criteria Long-term Acute Care 2025	*There were no questions.* Desiree Payumo, RN, will demonstrate inpatient use of the criteria at the June 18 Q/UAC.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• LOC Criteria Inpatient Rehabilitation 2025 • LOC Criteria Subacute/Skilled Nursing Facility 2025 • Medicare: Post Acute & Durable Medical Equipment Criteria 2025 In future, we may purchase other modules relating to Medicare as we move closer to our D-SNP product, Partnership Advantage, now scheduled to go-live Jan. 1, 2027. A summary of content for each of the 14 modules Partnership utilizes is provided in today's agenda packet. Arrangement can be made to provide further criteria for review upon request to UMHelpDeskSR@partnershiphp.org.	
Annual Grievance & Appeals Report CY 2024 – *Kory Watkins, MBA-HM, Director, Grievance & Appeals*		
	The Grievance & Appeals department – in concert with the Medical Directors and various departments including Provider Relations, Transportation, Compliance, Member Services, and Quality Improvement – ensures that member concerns are heard, addressed, and resolved in alignment with regulatory standards and health plan policies, with a focus on timeliness, fairness, and improving the overall member experience. G&A works closely with the Medical Director for Quality, who reviews all clinical grievances flagged by nurses for potential quality issues (PQI). Additionally, interrater reliability reviews (IRR) are conducted quarterly to assess the appropriateness of cases not referred for PQI review. In 2024, 207 grievances were referred for PQI review. G&A in 2024 partnered with the Transportation department to capture the names of individual drivers (not just the company) involved in transportation-related concerns. This change allows for more precise data analysis and better identification of driver specific trends. Once a case is received from a member, the Member Services department or other source, a clinical assessment occurs where appropriate, and G&A contacts the member and sends an acknowledgment letter to let them know the complaint is under review. (This contact is not mandated but is considered best practice.) An investigation is conducted, followed by a letter of resolution and call. G&A processes member complaints about dissatisfaction with services, care, or experience within 30 days; "exempt" or "expedited" grievances within 72 hours in situations where loss of function, limb and/or life is possible; appeals wherein a member disagrees with a denied service or treatment; and state fair hearings before an administrative law judge regarding a denied service. Annual case volume is increasing each year, although the reasons why vary, so trending analysis is difficult. G&A closed 7,556 cases (8.34 per 1,000 members) in 2024 which saw 10 new counties join Partnership, compared to 5,690 (8.39 per 1,000 members) in 2023 when Transportation came in-house, and 4,085 (6.40 per 1,000 members) in 2022 when Covid-19 was still concerning. In 2024, just 35% of grievances received were clinical in nature; however, 63% of appeals involved clinical concerns. Just 28 of 213 exempt case filings were deemed to meet the criteria for expedited resolution. As in years past, the most typical 2024 filer was a white, English-speaking middle-aged female residing in a northern county where access concerns are most prevalent. The top three counties by grievances per 1,000 members were Lassen (15.4), Modoc (13.6) and Siskiyou (12.3). (Transportation-related issues drove these numbers.) Sutter County had the fewest grievances (3.7). The top grievance categories were Transportation (49%); Provider Service (24%); Access (17%), and Partnership Service (10%). In 2024, Partnership provided 1,166,701 rides and received 4,472 transportation-related concerns (< .4% of total rides, down from .6% in 2023.) Excluding Transportation, Provider Services accounted for 46% of concerns (down from 50% in 2023) and Access accounted for 34% (up from 30% in 2023). Treatment plan disputes accounted for 39% of provider issues; long wait times for appointments accounted for 37% of access issues.	*There were no questions for Kory.* "Goals and Focus Areas for 2025" dates will be updated before this document goes to June 18 Q/UAC: • Jiva Implementation – Launching a new case management platform in *2025* to enhance… • Partnership Advantage Prep – Preparing for January *2027* launch of the new D-SNP line of business…

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Members may allege discrimination for many reasons, Kory noted; however, this report contains only substantiated findings of civil rights allegations, which may fall into one or more categories, the top two of which are disability and race or ethnicity. In 2024, just 10% of civil rights allegations were substantiated, down from 22% in 2023. Kory said her department is working closely with Southeast Regional Medical Director Colleen Townsend, MD, to outreach to involved providers so they do not repeat any discriminatory practices. The top Appeals in 2024 were Transportation related (49%); Treatment Authorization Requests (TARs) (35%); Referral Authorization Forms (RAFs) (12%); and Claims (4%). In 2024, 69.6% of Appeals filed were upheld, while 15.5% were overturned, largely because more clinical or other information was received. In cases that were referred to an administrative law judge, 45.8% were withdrawn before any hearing; 28.2% were dismissed; and 17.6% were upheld. Only 2.8% were overturned. Kory concluded her presentation by saying that 2025 department performance is thus far meeting goals, an improvement above some 2024 quarters wherein the 98.6% timeliness threshold was narrowly missed for case closures and acknowledgement letters because of staffing, training, or other issues, including the addition of 10 counties. G&A has now instituted a multi-step nurse review protocol: 1. When one nurse determines documentation is essential, a second nurse now confirms or disagrees 2. If disagreement occurs, the case is escalated to a Medical Director for a final decision This process ensures cases are pended only when necessary (e.g., left open while awaiting a provider's response) and improves oversight on delayed resolutions.	
FYI: PHM Final Work Plan Update – *refer questions to DeLorean Ruffin, DrPH*		
VI. Adjournment		
Dr. Moore adjourned the meeting at 3:41 p.m. IQI will meet next on Tuesday, Aug. 12, 2025. **There is no meeting in July.**		

Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement

Approval Signature: *Date:*

Robert Moore, MD, MPH, MBA
Chief Medical Officer and Committee Chair

this page left blank

MEETING AGENDA / MINUTES

Meeting/Project Name:	**Substance Use Internal Quality Improvement Committee Meeting (SUIQI)**		
Date of Meeting:	**05/08/2025**	**Time:**	**10:00 AM – 12:00PM**
Meeting Facilitator:	**Stephanie Wilson**	**Location:**	**Webex**

Meeting Objective/s

A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use Services* oversight. Activities and progress are reported to the IQIC.

Meeting Agenda

Topic	Person(s) Responsible	Time Allotted
1) Welcome and Introductions	Stephanie Wilson	5 Minutes
2) Review and Approve Minutes from January 23, 2025	Stephanie Wilson	5 Minutes
3) Behavioral Health Director Update a. Behavioral Health Transformation b. CPP Process	Mark Bontrager	5 Minutes
4) Wellness and Recovery Program Updates, Enhancements, and Highlights a. Audit Updates i. HSAG ii. DMC-ODS & SUBG b. IGA/New Integrated Contract c. Access Line Update d. Treatment Perception Survey	Nicole Escobar Stephanie Wilson	20 Minutes
5) Monitoring and Oversight a. Grievances & Appeals i. FY24/25 3rd Quarter Report 1. Supplemental Data ii. Pulse Report	Stephanie Wilson Kory Watkins	10 Minutes
6) Population Health a. Population Needs Assessment Review	Hanna O'Leary	15 Minutes
7) Monitoring and Oversight a. New Providers for Quarter i. J. Cole Recovery Homes ii. Women's Recovery Services	Stephanie Wilson Cindy Wilson	10 Minutes

iii. Redwood Recovery Center b. Credentialed Network providers c. Provider Compliance Summary i. Open Admissions CalOMS Reporting ii. Provider CAP Compliance – No CAPs iii. DATAR Reporting		
8) Monitoring and Oversight a. Utilization Management i. TARs and TAR Denials ii. Member Utilization by Level and County iii. Timely Access iv. Transitions of Care v. Transportation	Cindy Wilson Stephanie Wilson	10 Minutes
9) Monitoring and Oversight a. Claims Processing i. Timeliness of Claims Processing for Quarter ii. Denial Rates iii. DHCS Short Doyle Acceptance Rate	Stephanie Wilson	5 Minutes
10) Monitoring and Oversight a. Quality Improvement Program Activities i. W&R Provider Site Reviews	Alicia Kay	5 Minutes
11) Monitoring and Oversight a. Member Services i. Beneficiary Access Line/Call Center Statistics ii. Member Correspondence	Kara Kusalich	5 Minutes
12) Monitoring and Oversight a. Compliance i. BHINs & Policy Updates 1. 25-003 Certification of Alcohol and Other Drug Programs 2. 25-005 Allocation of Funding for SUBG FY24/25 & 25/26 3. 25-007 Traditional Health Care Practices Benefit Implementation 4. 25-009 Coverage BH-Connect Evidence Based Practices 5. 25-010 Medi-Cal Peer Support Program Standards	Nicole Escobar	5 Minutes

6. 25-013 Network Certification Requirements 7. 25-014 Grievance and Appeal Requirements 8. 25-017 SUD Treatment Recovery and Treatment Facility Fee Increase		
13) Walk-on Items	Stephanie Wilson	5 Minutes
14) Wrap Up and Closing	Stephanie Wilson	5 Minutes

Attendees		
Name	**Department/Division**	**Attended**
Deanna Bay	Humboldt County	X
Michelle Thomas	Humboldt County	X
Joshua Bradley	Lassen County	X
Kevin Branetche	Lassen County	X
Lori Griffith	Lassen County	X
Tiffany Armstrong	Lassen County	X
Angie Lewis	Mendocino County	X
Jill Ales	Mendocino County	X
Terry Toste	Mendocino County	X
Dolores Navarro-Turner	Modoc County	X
Peggy Clevinger	Modoc County	X
Hannah O'Leary	Partership	X
Alicia Kay	Partnership	X
Becky Miller	Partnership	X
Cindy Wilson	Partnership	X
Diana Rose	Partnership	X
Kara Kusalich	Partnership	X
Kory Watkins	Partnership	X
Mark Bontrager	Partnership	X
Nicole Escobar	Partnership	X
Stephanie Wilson	Partnership	X
Tim Sharp	Partnership	X
Bailey Cogger	Shasta County	X
Joanna Chirpenning	Shasta County	X
Nicole Bayless	Shasta County	X

Rachel Ibarra	Shasta County	X
Sarah Collard	Siskiyou County	X
Ruth Leonard	Solano County	X

Agenda Topic	Minutes
Agenda Item #1 Welcome *Speaker: SW*	➢ Request to make print bigger
Agenda Item #2 Review and Approve Minutes *Speaker: SW*	➢ Minutes approved by Jill Ales
Agenda Item #3 BH Director Update *Speaker: MB*	➢ Challenge of BH Transformation -Community Planning process – have not heard from the counties -want to be helpful – we have leads ready to help. Data/NSMH data available. No comments
Agenda Item #4 W&R Program Updates, Enhancements and Highlights *Speaker: NE/SW*	➢ No comments for HSAG/DHS DMC-ODS ➢ Asked for timeline share IGA– no response ➢ Access – de-delegating beneficiary access line in Sept will go live – phone number remains the same. Phone line transfer is partially responsible for delays. A new system is being brought on for county communication and help with reporting. Impacts from in-house of access line – hoping for improvement in quality MH or SUD/direct scheduling/direct connection with provider staff/be a resource to providers/share community offering/CBO. Ensuring members are wrapped in services. May be bumpy starting up. Excited for more direct connection and real time experience. Will keep them updated. ➢ Shasta wants a copy of HSAG ➢ TPS (Treatment Perception Survey) – included adult and youth reports included in SUIQI data packets. 63% decrease in responses. 2023 surveys counted 2024 surveys counted for the county instead of Partnership. Hilltop survey champion 2023 had a large quantity – Lake County had great response. Will work with UCLA to clarify responsibility Youth surveys all in English ➢ SW TPS survey summary results – her slide – Mark asked how it compares to state data. Nicole said state data is not released yet. ➢ Jill appreciates the youth response. Keep trying to connect with youth for increased performance over the years.
Agenda Item #5 Monitoring and Oversight	➢ SW slide – no comments ➢ Kory report on Pulse – 4th quarter calendar year – pg 44 of packet review. 14 G filed. Program Req 5/ Interpersonal Relationship

Speaker: SW/KW	issues 9. Nicole asked Kory to explain what the Pulse report is. Trend seeking, all voices being heard. Specific provider issues. Communicate with Partnership and providers. Joanna from Shasta asks to see this report on a consistent basis in this meeting. Nicole says providers previously indicated did not provide what they were looking for. Jill asks about solution resolution – Kory says resolutions are sometimes included. Resolutions typically come from other departments.
Agenda Item #6 Population Health *Speaker: HO*	➢ Population Needs Assessment preliminary findings presentation in packet. NCQA requires the report. No questions
Agenda Item #7 Monitoring and Oversight *Speaker: SW/CW*	➢ New Providers: J Cole/Women's Recovery Services/Redwood Recovery Services ➢ Cal-OMS reporting – over 14 months out of compliance – reviewing records, being addressed. Do we need to submit a ticket regarding errors? ➢ Question from Deanna about getting error messages or getting kicked out. SW requested an email ➢ No questions
Agenda Item #8 Monitoring and Oversight *Speaker: CW/SW*	➢ TAR graph showed year-over-year data with percentages, 0 denials ➢ LOS 46 days is average of averages ➢ DATAR 3Q 100% on time reporting ➢ Transportation 55% of scheduled trips are from Regional Model counties. .59 of 1% are cancelled by provider in Regional Model, .3 of 1% when all counties are measured ➢ Nicole shared the Tableau transportation dashboard ➢ Member Utilization by level and county ➢ Timely Access ➢ Transitions of Care ➢ No questions
Agenda Item #9 Monitoring and Oversight *Speaker: SW*	➢ Timeliness of Claims Processing for the Quarter ➢ Denial Rates ➢ DHCS Short Doyle acceptance rate ➢ No questions
Agenda Item #10 Monitoring and Oversight *Speaker: AK*	➢ Quality Improvement Program Activities- provider site reviews ➢ No questions
Agenda Item #11 Monitoring and Oversight *Speaker: KK*	➢ Beneficiary Access Line/Call Center Statistics:15% increase in call volume increase. Higher level of care is needed causing backlog. – no questions. ➢ Member Correspondence ➢ Deanna asks if they are doing our own calls – yes, we do – touch calls in to Carelon screening is meeting expectation. Service verification.

Agenda Item #12 Monitoring and Oversight *Speaker: NE*	➢ BHIN summary of 25-017 fee increase ➢ 25-014 new language for NOA reporting denials or grievances, ➢ 25-013 DMC-ODS 274 submitted by 5/10 no concerns for submission ➢ 25-010 Peer support program standards ➢ 25-009 BH-CONNECT enhanced community workers lots of duplications available in the community ➢ 25-007 IHPP providers would be eligible if not DMC certified but no contracting from Partnership, reduces financial risk. Counties would not be fully reimbursed ➢ 25-005 n/a ➢ 25-003 certification of Alcohol and other Drug Programs ➢ 25-001 collecting information discharging clients into Cal-OMS ➢ Joanna asks about Tribal clarification – billing/site reviews. DMC-ODS in regional model would bill PHC. No contract – which limits reimbursement. Refer not contracted to the state. Provider must be certified DMS-ODS to contract. They can provide services AI/AN. Counties reimbursed through the client aid code. County would need to close the gap. IHCP request from county.
Agenda Item #13 Walk on Items *Speaker: SW*	➢ No items discussed
Agenda Item #14 Wrap Up and Closing *Speaker: SW*	➢ No items discussed
Next Meeting	*Not scheduled yet; will be scheduled soon*

Action Items		
Action	**Owner**	**Due Date**
1.		
2.		
3.		

4665 Business Center Drive
Fairfield, California 94534

MEETING Minutes

Meeting & Project Name: Quality Improvement & Health Equity Committee (QIHEC)

Date: 5/27/25 **Time**: 7:30 a.m.- 9:30 a.m.

Facilitator: Mohamed Jalloh, HEO

Coordinator: Bethany Hannah

Meeting Locations:

- WebEx

Attendees:

Shannon Boyle, Isaac Brown, Monika Brunkal, Anna Campbell, Kristina Coester, Dawn Cook, Nicole Curreri, James Devan, Jeffery DeVido, Heather Esget, Margarita Garcia-Hernandez, Kristine Gual, Bethany Hannah, Tony Hightower, Mohamed Jalloh, Amanda Kim, Mary Kerlin, Marshall Kubota, Yolanda Latham, Sue Lee, Stan Leung, Amanda McNair, Robert Moore, Mark Netherda, Rachel Newman, Hannah O'Leary, Sue Quichocho, Manleen Randhawa, Denise Rivera, Liz Romero, Delorian Ruffin, Anthony Sacket, Rebecca Stark, Wendy Starr, Nancy Steffen, Amanda Smith, Christine Smith, Ben Spencer, Chloe Ungaro, Vicquita Velazquez, Edna Villasenor, Emily Wellander, Kory Watkins

Absent: Priscilla Ayala, Katherine Barresi, Robert Bides, Sonja Bjork, Mark Bontrager, Cathryn Couch, Wendi Davis, Noemi Doohan, Greg Allen Friedman, Shandi Fuller, Brigid Gast, Ledra Guillory, Nisha Gupta, Latrice Innes, Vicky Klakken, Rachel Newman, Katheryn Power, Dorian Roberts, Lynn Scuri, Tim Sharp, Stephen Stake, Amy Turnipseed, Liat Vaisenberg

4665 Business Center Drive
Fairfield, California 94534

External Advisory Members

Name	Affiliation	Org Type	1/21/25	3/18/25	5/20/25	7/15/25	9/16/25	11/18/25
Jason Cunningham, MD Chief Executive Officer	West County Health Centers	FQHC		X	X			
Eugene Durrah Equity Services Manager	Solano County	County						
Hendry Ton, MD Associate Vice Chancellor	UC Davis	Health System		X				
Shandi Fuller, MD Maternal Child and Adolescent Health	Solano County	Public Health Department			X			
Lisa Wada Senior Manager, Quality Improvement	Providence	Health System	X		X			
Valerie Padilla Director of Quality and Patient Safety	Open Door Community Health	Health System		X	X			
Arlene Pena Senior Program of Quality Improvement	Aliados Health	Community Based Org	X	X	X			
Jeremy Plumb Systems Director, Quality Division	Northbay Medical Center	Hospital	X	X				
Lelia Romero Health Program Specialist - Health Equity	Lake County	Public Health Department		X	X			
Robin Schurig, MPH, CPH Executive Director	Health Alliance of Northern California	Community Based Org	X	X				
Candi Stockton, MD Health Officer of Humboldt County	Humboldt County	Public Health Department	X		X			

Tiffani Thomas Case Manager	Solano County Superior Court	Local Government	X	X	X			
Brandon Thornock Chief Executive Officer	Shasta Community Health Center	Health System	X					
Denise Whitsett Quality Improvement Coordinator	Community Medical Centers	Health System	X	X				

***FQHC= Federally Qualified Health Center

*****Members who do not attend at least half of meetings will be considered for removal per vote of committee.

Agenda Topic	Notes	Action Item
Agenda Item 1 **Introductions**	A. Dr. Jalloh conducted a roll call for external advisory members to mark their attendance. B. Quorum was met by having 7 members present.	

Agenda Item 2
 	
HE Updates
 	
Speaker: Dr. Jalloh
	A. Program and Initiative Updates
	1. Quality Improvement Program (QIP) Updates
	• A new pay-for-performance (P4P) model was launched, rewarding systems with bonuses (3–70%) for closing equity gaps in key health measures:
	  ○ Blood pressure control
	  ○ Well-child visits
	  ○ Breast and colorectal cancer screenings
	• Health systems self-identified interest, and the QIP team supported rollout and monitoring.
	2. Diversity, Equity, and Inclusion (DEI) Training Launch
	• DEI training will launch in **July**.
	• Feedback from a pilot led by Communicare Ole was incorporated.
	• **Naz Sattari** introduced herself as the new Supervisor for Health Equity Training. Her team will review discrimination grievances and assign appropriate DEI training when needed.
	3. Renaming DEI Training
		• Dr. Jalloh will bring name suggestions to the Executive Team.

Agenda Topic	Notes	Action Item

	• Due to politicization of the term “DEI,” alternative names are being considered.
	• Suggested new name: **"Community, Culture, and Belonging Training"**
	• Additional ideas discussed:
	  ○ “Improving Health Outcomes for All People”
	  ○ “Improving Communication with All People”
	  ○ “Health for All People and Communities”
	  ○ “Building Community Excellence”
	  ○ “Pathways to Healthy Communities”
	  ○ “Bridge Builders”
	  ○ “Together Forward”
	  ○ “Whole Person Health”
	  ○ “People/Patent centered care”
	  ○ “Access and Opportunity”
	  ○ “Building Pathways/Bridging Gaps”
	• Members expressed concerns about public perception, legal risks, and funding implications.
	• Final name will be selected by the Executive Team by mid-June to support the July training launch.	

Agenda Item
 	
CMO Health Plan Updates
 	
Speaker: Dr. Moore
	3. Accreditation and Program Updates (Dr. Robert Moore)
	• **Health Equity Accreditation:**
	  ○ First submission will be made in **June**; mock surveys have been successful.
	• **2024 HE Disparities Project:**
	  ○ Clinical quality results will be finalized by **August**.
	  ○ Results are under internal review.
	• **Medicare Advantage (Partnership Advantage):**
	  ○ Launching in **January 2026** in 8 counties.
	  ○ Network deemed adequate by CMS; ongoing contract work continues.
	• **Regional Medical Director Meetings:**	

Agenda Topic	Notes	Action Item
	○ Notes posted on CMO webpage (leader and clinician versions available). • **Board of Commissioners Strategic Planning (April):** ○ Focused on federal policy impacts and maintaining community engagement activities. • **Legislative/Budget Updates:** ○ Federal proposals include Medicaid restrictions (provider tax freeze, work requirements, etc.) ○ California facing budget deficits. ▪ Proposal for $100 monthly premium for Medi-Cal enrollees with unsatisfactory immigration status (effective 2027). ▪ Restriction on new enrollments (starting 2026).	
Agenda Item 4 **CA Association Updates** Speaker: Arlene Pena and Robin Schurig	**4. California Association Updates (Arlene Pena)** • Ongoing work on: ○ Geomapping for breast and cervical cancer screenings. ○ Pediatric dashboards and risk-scoring tools (with Marin Community Clinics).	
Agenda Item 5 **Meeting Minutes**	A. Motion to approve meeting minutes from March. 1st Candy Stockton 2nd Cathryn Couch	Motion to approve meeting minutes from March. 1st Candy Stockton 2nd Cathryn Couch

Agenda Topic	Notes	Action Item

Agenda Item 7
 	
Grand Analysis:
 	
Speaker: Kory Watkins
	Kory Watkins then presented a detailed report covering the 2024 calendar year data from the Grievance and Appeals (GNA) Department. Key components of the presentation included:
	• **Department Overview and Process:** Kory explained that the GNA Department manages grievances, appeals, and state fair hearings in alignment with healthcare regulations. Every case goes through a clinical review and classification as clinical or non-clinical, with consistent member communication.
	• **Case Volume and Trends:** There was a **33% increase** in grievance and appeal cases from 2023 to 2024, corresponding with a similar increase in membership.
	• **Case Intake Channels:** The majority of cases were received via phone (~7,000), with smaller volumes coming through the online portal, mail, fax, in-person visits, and email.
	• **Case Classification:**
	  ○ 65% of grievances were **non-clinical**, commonly concerning transportation or communication.
	  ○ Appeals were predominantly **clinical** in nature (63%).
	  ○ Only 0.4% of cases met the criteria for **expedited** review.
	• **Geographic Heat Map:** Grievances per 1,000 members were highest in **rural counties** (e.g., Lassen, Modoc, Siskiyou), suggesting access and transportation-related issues.
	• **Demographics:** Disparities were identified:
	  ○ **White members** were overrepresented in grievance filings relative to their membership proportion.
	  ○ **Hispanic and Spanish-speaking members** were underrepresented.	

Agenda Topic	Notes	Action Item
	○ Women accounted for 63% of cases filed, though they make up 51% of membership. ○ The highest grievance filings occurred in the **45–64 age group**. • **Top Categories of Grievances:** ○ **Transportation** (49%) – Most concerns were around missed rides, driver behavior, and scheduling. ○ **Provider Services** – Common issues included treatment plan disputes and poor communication. ○ **Access** – Included long wait times and limited provider availability. ○ **Partnership Services** – Included complaints about staff, website usability, phone systems, and mailings. • **Transportation Grievances Detail:** Watkins clarified the difference between **NMT (Non-Medical Transportation)** and **NEMT (Non-Emergency Medical Transportation)**: ○ NMT (curb-to-curb) accounted for **90%** of transportation-related grievances. ○ Despite over **1 million rides provided in 2024**, transportation grievances accounted for less than **0.5%** of rides. • **Civil Rights Allegations:** Watkins reframed what were previously called "discrimination allegations" to **"civil rights allegations"**—only including those that fall under legally protected classes (e.g., disability, race/ethnicity). ○ **Disability** and **race/ethnicity** were the most common civil rights-related concerns. ○ 9.8% of the allegations were **substantiated** after internal review by civil rights coordinators and the health equity team. ○ All civil rights cases, whether substantiated or not, are **reported to the State (DHCS)**. **Follow-Up Discussion:**	

Agenda Topic	Notes	Action Item
	• Dr. Jalloh thanked Watkins for the clear presentation and for emphasizing key disparities and civil rights considerations. • Jason Cunningham inquired about changes in grievance volumes after the organization assumed responsibility for **non-medical transportation** services. Watkins indicated a rise in both services provided and grievances filed but noted no clear evidence of increased dissatisfaction.	
Agenda Item 8 **Community Information** Speaker: Dr. Stockton	Dr. Candy Stockton, Health Officer for Humboldt County, presented a detailed overview of how her office has navigated data collection, sharing, and analysis in the context of overdose deaths and health disparities, particularly affecting Native American communities. Noting that the county lacked a dedicated epidemiologist for an extended period, Dr. Stockton shared how her early observations of overdose trends on death certificates prompted deeper analysis and community engagement. Key highlights of Dr. Stockton's presentation included: • **Challenges with Small-Number Data Restrictions:** Dr. Stockton explained the limitations imposed by state guidelines on reporting datasets involving 11 or fewer individuals, which can obscure patterns in small communities. • **Innovative Data Inclusion Methods:** Her team developed a method for more accurately capturing racial and ethnic identities, especially for individuals identifying with multiple races, by manually reviewing race fields on death certificates rather than relying on single-value codes. • **Responsive Community Data Sharing:** Through conversations with tribal partners, the health department designed a monthly report identifying individuals who died from accidental, suspicious, or undetermined causes, facilitating culturally appropriate outreach by tribal wellness programs. • **Race-Specific Mortality Analysis:** By extending the data review period (up to 15 years for smaller populations), Dr. Stockton's team was able to provide more granular insights into causes of death by racial group, revealing stark	

Agenda Topic	Notes	Action Item
	disparities, especially in overdose and heart disease rates among Native American populations. • **Collaborative Maternal Health Data Project:** In response to a request from Anties on the River (a Native doula collective), the team is working on developing meaningful maternal health data tailored to the needs of Native communities, with an emphasis on actionable and culturally relevant indicators. Dr. Stockton emphasized the importance of shifting from a default "no" to a mindset of **"**how do we get to yes" in public health data sharing. Her approach centers on respecting data sovereignty, ensuring community ownership of the information provided, and tailoring data outputs to the specific needs and capacities of local partners. • **Dr. Mohamed Jalloh** asked if there were any questions for Dr. Stockton. • **Dr. Kubota** provided positive feedback, praising Dr. Stockton's individualized data approach and raised a question regarding the alignment of general public health priorities with specific community mortality trends—particularly referencing the Native American population and liver disease prevalence. • **Dr. Candy Stockton** acknowledged the difficulty in aligning broader public health priorities with community-specific data but emphasized the importance of democratizing data access. She stated that data should be shared openly and ethically without gatekeeping, particularly with community-based organizations and tribal nations. • She expressed her internal conflict around desiring to guide communities on data usage while recognizing the need to build trust by offering data without conditions. She reiterated that communities are capable of independently using the information to meet their needs. **Reflections by Committee Members** • **Dr. Mohamed Jalloh** expressed appreciation for Dr. Stockton's ethical reflection and her insistence on disaggregating data to highlight racial	

Agenda Topic	Notes	Action Item
	disparities, especially when previously advised not to due to small sample sizes. **Practical Application of Findings** • Dr. Stockton noted COVID-19 as a top-five cause of death specifically for the Latino population in Humboldt County, which was not seen in other populations. She discussed the operational impact—emphasizing targeted communication or partnership with local Promotora groups to optimize outreach with limited resources. • **Dr. Kubota** commented on how Latino communities had disproportionate exposure during the pandemic due to being in public-facing roles.	
Agenda Item 9 **Key Policy Discussion** **DEI Policy** Speaker: Dr. Jalloh	Dr. Jalloh introduced the updated DEI training policy (MCEP6004) required by the state, noting revisions made based on previous feedback. • The policy outlines specific roles and healthcare systems required to undergo DEI training. • **Motion to Approve:** Dr. Candy Stockton • **Seconded By:** Leila Romero • **Outcome:** Motion passed without opposition; policy will be submitted to the Internal Quality Improvement (IQI) Committee for final approval.	Motion to approve DEI Policy: 1st: Candy Stockton 2nd : Leila Romero
Agenda Item 10: Disparity Discussions: **Interventions**	One intervention discussed showed limited impact on prenatal/postpartum access but improved parental knowledge. • Dr. Stockton asked if ROI or cost implementation analysis was available for the interventions specific to the Family Spirits study. Dr. Jalloh responded that an ROI was not part of the original study but noted that community health workers involved were internal employees, not contractors, and he would follow up on that detail. **Approval of Proposed Interventions:**	Motion to approve interventions: 1st: Tiffani Thomas 2nd Denise Whitsett • Dr. Jalloh to follow-up on status of ROI analysis.

Agenda Topic	Notes	Action Item
Speaker: Dr. Jalloh	• **Motion to Approve:** Tiffáni Thomas • **Seconded By:** Denise Whitsett • **Outcome:** Approved. Interventions will be shared with the QI and Population Health Management Team, as well as external clinics.	
Agenda Item 10 **Next Meeting** Speaker: Dr. Jalloh	Next Meeting: July 15, 2025, 7:30 a.m. – 9:00 a.m.	

this page left blank

4665 Business Center Drive
Fairfield, California 94534

MEETING Minutes

Meeting & Project Name: Quality Improvement & Health Equity Committee (QIHEC)

Date: 7/22/25 **Time**: 7:30 a.m.- 9:30 a.m.

Facilitator: Mohamed Jalloh, HEO

Coordinator: Bethany Hannah

Meeting Locations:

- WebEx

Attendees:

Shannon Boyle, Isaac Brown, Monika Brunkal, Anna Campbell, Kristina Coester, Dawn Cook, Nicole Curreri, James Devan, Jeffery DeVido, Heather Esget, Margarita Garcia-Hernandez, Kristine Gual, Bethany Hannah, Tony Hightower, Mohamed Jalloh, Amanda Kim, Mary Kerlin, Marshall Kubota, Yolanda Latham, Sue Lee, Stan Leung, Amanda McNair, Robert Moore, Mark Netherda, Rachel Newman, Hannah O'Leary, Sue Quichocho, Manleen Randhawa, Denise Rivera, Liz Romero, Delorian Ruffin, Anthony Sacket, Rebecca Stark, Wendy Starr, Nancy Steffen, Amanda Smith, Christine Smith, Ben Spencer, Chloe Ungaro, Vicquita Velazquez, Edna Villasenor, Emily Wellander, Kory Watkins

Absent: Priscilla Ayala, Katherine Barresi, Robert Bides, Sonja Bjork, Mark Bontrager, Cathryn Couch, Wendi Davis, Noemi Doohan, Greg Allen Friedman, Shandi Fuller, Brigid Gast, Ledra Guillory, Nisha Gupta, Latrice Innes, Vicky Klakken, Rachel Newman, Katheryn Power, Dorian Roberts, Lynn Scuri, Tim Sharp, Stephen Stake, Amy Turnipseed, Liat Vaisenberg

4665 Business Center Drive
Fairfield, California 94534

External Advisory Members

Name	Affiliation	Org Type	1/21/25	3/18/25	5/20/25	7/15/25	9/16/25	11/18/25
Jason Cunningham, MD Chief Executive Officer	West County Health Centers	FQHC		X	X	X		
Eugene Durrah Equity Services Manager	Solano County	County						
Ian Kim Chief Medical Officer	Communicare+ Ole	FQHC				X		
Hendry Ton, MD Associate Vice Chancellor	UC Davis	Health System		X		X		
Shandi Fuller, MD Maternal Child and Adolescent Health	Solano County	Public Health Department				X		
Eva Julien Senior Manager, Quality Improvement	Providence	Health System	X		X	X		
Valerie Padilla Director of Quality and Patient Safety	Open Door Community Health	Health System		X	X	X		
Arlene Pena Senior Program of Quality Improvement	Aliados Health	Community Based Org	X	X	X	X		
Jeremy Plumb Systems Director, Quality Division	Northbay Medical Center	Hospital	X	X				
Lelia Romero Health Program Specialist - Health Equity	Lake County	Public Health Department		X	X			
Robin Schurig, MPH, CPH Executive Director	Health Alliance of Northern California	Community Based Org	X	X				

Candi Stockton, MD Health Officer of Humboldt County	Humboldt County	Public Health Department	X		X	X		
Tiffani Thomas Case Manager	Solano County Superior Court	Local Government	X	X	X			
Brandon Thornock Chief Executive Officer	Shasta Community Health Center	Health System	X					
Denise Whitsett Quality Improvement Coordinator	Community Medical Centers	Health System	X	X				

***FQHC= Federally Qualified Health Center

*****Members who do not attend at least half of meetings will be considered for removal per vote of committee.

Agenda Topic	Notes	Action Item
Agenda Item 1 **Introductions**	A. Dr. Jalloh conducted a roll call for external advisory members to mark their attendance. B. Quorum was met by having 8 members present.	
Agenda Item 2 **HE Updates** Speaker: Dr. Jalloh	**A. NCQA Health Equity Accreditation Update** • PHC has submitted its response to preliminary findings from NCQA's Health Equity Accreditation review. • Awaiting final decision in Fall 2025. • Organizations interested in the process are encouraged to reach out for insights.	
Agenda Item 3 **CMO Health Plan Updates** Speaker: Dr. Jones	3. **Health Plan Updates (Presented by Dr. Kermit Jones on behalf of Dr. Moore**) **HRP Jiva & Medicare Advantage Delay:** - Project launch delayed to January 2027. - Executive discussions rescheduled for early August. **State & Federal Budget Updates** State Budget Highlights (FY25-26):	

Agenda Topic	Notes	Action Item
	- Total Budget: $320B; Medi-Cal Allocation: $194.5B - Medi-Cal enrollment freeze begins Jan 2026 - Monthly premiums introduced for undocumented adults 26–49 years old - Delay in implementation of MLTSS and dental benefit reforms - Shift in funding responsibility for DPP and CHW benefits **Federal Budget Impacts** (HR1 Proposal): - Work requirements for Medicaid beneficiaries ages 19–64 - Removal of temporary federal redetermination flexibilities - Reduction in federal matching assistance percentage (FMAP) from 90% to 80% by Oct 2027 - Potential changes in provider taxes and quality assurance fees **PCP QIP** (Primary Care Provider Quality Improvement Program) Results - Expansion from 252 to 390 sites - Overall score: 59% in 2024 (down from 68% in 2023) - Legacy counties: Slight improvement from 68% to 69% - New counties: Lower performance (52%) - ~$52.2 million in incentive payments distributed **NCQA Health Plan Accreditation** (Health Plan Level) - Anticipated star rating: 3.5 stars (same as previous year) - **CAHPS** Scores: - Pediatric and adult satisfaction measures improved - Preventive care metrics remained stable - Decline noted in treatment performance metrics due to documentation and system challenges in expansion counties	

Agenda Topic	Notes	Action Item
Agenda Item 4 **CA Association Updates** Speaker: Arlene Pena and Robin Schurig	- Arlene: No updates - Gabriel Decker (HANC): Absent	
Agenda Item 5 **Meeting Minutes**	A. Motion to approve meeting minutes from May. 1st Candy Stockton 2nd Eva Julien	Motion to approve meeting minutes from May. 1st Candy Stockton 2nd Eva Julien
Agenda Item 6 **Grand Analysis:** Speaker: Dr. Delorean Ruffin and Greg Allen Friedman	Greg Allen Friedman and Dr. Delorian Ruffin then presented a grand analysis: MCND9001 PHM Strategy & Prog Description, Impact Analysis Segmentation Report PHM Work Plan. Key components of the presentation included: • Greg Allen Friedman provided a brief overview of MPND 9001 (Population Health Strategy and Program Description Policy), which is being updated and will be published on the public website in August. **Key elements include:** • Population health strategy • Use of population needs assessments • Collaboration with counties • Risk stratification processes • Health education services	

Agenda Topic	Notes	Action Item
	• Policy code changed from MCND to MPND to reflect multi-program coverage, including future Medicare Advantage and D-SNP programs (launching January 2027).	
	Impact Analysis & Key Findings (Dr. DeLorean Ruffin) • Population Health Grant Analysis Overview • Combined impact and segmentation analysis reviewed. • Focused on outcomes with statistically significant differences. • Opportunities exist for improving streamlining and goal alignment with NCQA standards.	
	Growing Together Program Components: Prenatal Program • Intervention: Outreach to pregnant members for prenatal care and TDAP vaccinations. • Goal: 35% of members to receive TDAP vaccination within 120 days prior to delivery. • Result: 73% engaged members received the vaccine (goal not met). • Engaged members had significantly higher rates of vaccination than those not reached. • Disparity: White members had significantly lower vaccination rates than Hispanic members. • b. Postpartum Program • Goal: 75% of engaged members attend postpartum visits within 60 days of delivery. • Result: Goal met; statistically significant difference among engaged members. • White members had lower attendance than Hispanic, Asian, and Native American groups.	
	Healthy Babies Program	

Agenda Topic	Notes	Action Item
	• For infants under 12 months (recently expanded to under 24 months). • Goal 1: 80% compliance with ≥50% vaccinations. • Result: 92% compliance (goal met). • Goal 2.2: 65% compliance with ≥50% well-child visits. • Result: 89% compliance (goal met). • White population showed lower rates than Hispanic population.	
	Healthy Kids Program • Pilot for children aged 3–6 who have not had well-child visits in 11+ months. • Goal: 50% of engaged members to complete a well-child visit within 120 days. • Result: 32% (goal not met). • Engaged members still showed significantly higher completion rates than others.	
	Transition of Care Program • For members transitioning between care settings. • Care coordinators support discharge plans and connect members to services. • Member Experience Surveys: • Adult: 79% completion; avg. scores 2.62–2.9 (goal: ≥2.5). • Pediatric: 63% completion; avg. scores 2.6–2.9 (goal met**).**	
	Complex Case Management • Supports members with multiple chronic conditions and SDOH barriers. • Satisfaction Survey: • Low response due to program duration and member availability. • Adult surveys (n=2): Avg. score >2.5 (goal met). • Pediatric surveys: Avg. score = 3.0 (goal met).	
	Summary & Next Steps	

Agenda Topic	Notes	Action Item
	Goals met: • Prenatal TDAP vaccinations (for Hispanic population) • Postpartum visit rates • Healthy Babies vaccination and well-child visit compliance • Goals not met: • TDAP vaccination rate overall • Healthy Kids well-child visit rate • Opportunities: • Improve program design, outreach, and health equity • Leverage CAL AIM initiatives to expand resources and improve outcomes **Goals not met:** • TDAP vaccination rate overall • Healthy Kids well-child visit rate **Opportunities:** • Improve program design, outreach, and health equity • Leverage CAL AIM initiatives to expand resources and improve outcomes .	
Agenda Item 7 **Key Policy Discussion** **QIHETP and QIHEC Policy** Speaker: Dr. Jalloh	**Key Policy Discussions and Updates: *Quality Improvement in Health Equity and Transformation Program Description Review (MCEP6001) & Quality Improvement in Health Equity Committee Policy Review (MCEP6002)*** Summary of Updates Presented by Dr. Mohamed Jalloh: • Committee members were directed to review the updated program description beginning on page 53 of 80 in the meeting packet. • The description outlines key departmental activities aligned with DHCS requirements for DEI training and Community Reinvestment Key Updates:	Motion to approve Policy Changes: 1st: Arlene Pena 2nd : Candy Stockton • Submit approved policy updates to IQI and Q/UAQ committees. • Begin development of a revised acronym for QI HETP. • Plan for inclusion of Health Equity Strategic

Agenda Topic	Notes	Action Item

	• Employee Descriptions: Revised to reflect updated team roles and responsibilities as per DHCS Corrective Action Plan (CAP) guidance.
	• **Community Reinvestment**: Added details about funding requirements and strategies for community engagement.
	• **Annual Plan:** Included updates on the TGI (Transgender, Gender-Diverse, and Intersex) training. Noted intentions to analyze trends in DEI training and community reinvestment efforts.
	• Future updates will include:
	  ○ Revising the QIHETP acronym for clarity.
	  ○ Integrating the 3-year Health Equity Strategic Plan into the next program description update
	
	Key Policy Discussions and Updates*:*
	Quality Improvement in Health Equity Committee Policy Review (MCEP6002)
	
	Agenda Item: Other Policies
	Quality Improvement/Health Equity Committee:
	No changes were made or required for this policy according to DHCS.
	.
	_____
	Motions and Approvals
	Motion to Approve Policy Changes:
	Motion made by: Arlene Pena
	Seconded by: Dr. Candy Stockton
	Opposed: None
	Outcome: Motion passed unanimously.
	Updates will be submitted to the IQI and Q/UAQ committees.
	_____
		Plan in the next policy iteration.

Agenda Topic	Notes	Action Item
Agenda Item 8 Disparity Discussions: **Community Engagement** Speaker: Dr. Jesus Hermosillo	**Introduction of Jesus Hermosillo – Community Cultural Manager** Jesus recently joined the Health Equity Department as Community Cultural Manager. • Jesus has a background of a master's in public health with a focus on policy and health promotion; extensive qualitative research experience, including neurodevelopmental disorders and community health assessments. • His role is to conduct qualitative focus groups to gather insights into community experiences, barriers, attitudes, and behaviors not visible in claims data. • The first focus group is scheduled for July 29 on Black Maternal and Child Health, focusing on disparities such as well-child visits and screenings. • He will collaborate across departments, including Population Health, to strengthen community presence and outreach. _____ Agenda Item 2: Population Health Outreach Data Between July 2024 and July 2025, the Population Health team attended 185+ community events. Opportunities identified to increase outreach through food banks and farmers markets due to their consistency and accessibility. Jesus will provide recommendations for future community engagement sites. _____ _____	Motion to approve Ian Kim: 1st: Tiffani Thomas 2nd Denise Whitsett

Agenda Topic	Notes	Action Item
	_____ _____	
Agenda Item 9 Open Forum – External Member Updates and Requests	Leila Romero – Lake County Planning health literacy workshops to address gaps in healthcare communication due to limited providers in rural, low-income communities. Request for support in standardizing health education materials and help with understanding coverage layers and patient advocacy. Response: Dr. Jalloh offered collaboration and connection to Member Services and potential partnership attendance at events. Candy Stockton – Humboldt County Shared findings from recent race/ethnicity analysis of birthing data showing higher Black birth rates than previously assumed. Difficulty connecting with doulas for outreach. Response: Dr. Jalloh to connect her with Dr. Thompson, a leader in doula outreach, for collaboration. Denise Whitsett – CMC, Solano County Working on postpartum visit attendance among African American patients. Interested in community-based strategies and focus groups. Response: Dr. Jalloh shared a creative intervention (photo shoots) and offered a follow-up to connect with Jesus Hermosillo for focus group strategy development. Ian Kim – CommuniCare+OLE Raised concerns about federal and state-level health policy threats, including: Medicaid cuts ICE access to IRS data	

Agenda Topic	Notes	Action Item
	Low public awareness of healthcare changes Called for organizing, advocacy, and awareness-building before policy impacts reach communities. Response: Dr. Jalloh invited Dr. Kim for an offline strategy meeting and reaffirmed Partnership's commitment to state accountability and member education. Lilian Merino Recommended bringing county enrollment staff and member services representatives to events to help with real-time Medi-Cal and CalFresh support. Shared a successful model from Marin County. Edna Villasenor offered to support Lake County with member services engagement.	
Agenda Item 10 **New Committee Member(s)**	New Committee Member Nominee: Dr. Ian Kim Motion to approve: Candy Stockton Seconded by: Leila Romero Opposed: None Outcome: Motion passed. Dr. Kim is officially welcomed to the committee. Follow-up paperwork to be sent. Committee members are encouraged to continue sharing local needs and opportunities for collaboration.	
Agenda Item 11	*Tuesday September 16, 2025 7:30 am to 9:00 am PST*	

Agenda Topic	Notes	Action Item
Next Meeting Speaker: Dr. Jalloh		

this page left blank

QI Department Update
August 2025
Prepared by Nancy Steffen
Senior Director, Quality and Performance Improvement

Quality Incentive Programs (QIPs)

PROGRAM	UPDATE
Primary Care Provider (PCP) QIP	• MY2026 measure development is in progress. • Measurement Year (MY) 2024 payment was distributed to all providers in June. • MY2024 Top Performers to be recognized at Partnership's Board Meeting this month, include:

Provider Parent Organization	Provider Site Name
Marin Community Clinics	Marin Community Clinics, Larkspur
Mendocino Coast Clinics	Mendocino Coast Pediatric Medical Group
Comminicare+Ole	Ole Health, St. Helena
Santa Rosa Community Health Ctrs	SRCH Lombardi Campus
Petaluma Health Center	Petaluma Health Center
Northbay Healthcare	NorthBay Center for Primary Care, Hilborn Rd.
Comminicare+Ole	Ole Health, Calistoga
Marin Community Clinics	Marin Community Clinics, Novato
Marin Community Clinics	Marin Community Clinics, 3110 Kerner Blvd.
Comminicare+Ole	Ole Health, South Napa Campus
Marin Community Clinics	Marin Community Clinics, 3260 Kerner Blvd.
Marin Community Clinics	Marin Community Clinics, South Novato
West Marin Medical Center	West Marin Medical Center
St. Joseph Heritage Healthcare	Queen of the Valley Medical Associates, Trancas St.
Marin Community Clinics	Marin Community Clinics, Greenbrae
Shasta Family Care	Shasta Family Care
Sutter Medical Foundation-West	Sutter Medical Group Yolo, Ste. 2000
Petaluma Health Center	Pt. Reyes, Sonoma

Palliative Care QIP	• No Updates
Perinatal QIP	• Fiscal Year (FY) 2024/2025 payment processing has begun. • Kick off for FY2025/2026 was in July. The biggest programmatic change is the new gateway measure that includes contracting and data extraction from DataLink, Partnership's certified NCQA HEDIS Data Aggregator (DAV). Both are required by 06/30/2026 for participants to qualify for any incentive in the PQIP.
Enhanced Care Management QIP	• No Updates
Hospital QIP	• The 2025-26 Hospital QIP (HQIP) Measurement Set, as approved by Partnership's Physician Advisory Committee (PAC) in April, is now in full effect as of 07/01/2025 through 6/30/2026. In January 2025, there was much discussion in quality committees about how the QIP team was applying lessons learned from its annual evaluation of FY 2023-2024 Hospital QIP to measure development for FY 2025-2026.

	• As an update to this discussion, it is important to note that FY 2025-2026 includes a new Vaccines for Children (VFC) Program Enrollment measure incentivizing birthing hospitals' enrollment in the California Department of Public Health program. This CDPH program provides vaccines to hospitals at a lower cost for the Medi-Cal population. Three of the 17 birthing hospitals in the HQIP are currently enrolled, and two more are in the contracting process. The measurement set includes links to the VFC program website that explains the program requirements and enrollment process. Troy Foster, HQIP Program Manager, will connect with hospital quality directors throughout the year to monitor and encourage enrollment status. • Additionally, in FY 2025-2026 Partnership continues to encourage its hospitals to engage in advancing health equity by including a health equity measure in the HQIP that now aligns with the Centers for Medicare & Medicaid Services (CMS). This HQIP measure requires hospitals with ≥ 25 Licensed General Acute (LGA) beds to submit a copy of their most recent CMS program attestation for the Hospital Commitment. This measure challenges hospitals to commit to health equity in measurable ways as points are only earned through attestations demonstrating fulfillment of all 5 domains set forth by CMS.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	• 2025 PQD is in development and on track to launch by the end of Q3 2025.
EREPORTS	• No Updates

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE
STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	**DHCS-required PDSAs** **Southern Region (Children's Health Domain):** Work continues improving lead screening, working with a large provider to implement in-house lead testing. Fluoride code update projects continue in all regions. Internally, Partnership PI staff are using a Fluoride Varnish dashboard to monitor compliance and have seen a dramatic increase in fluoride varnish applications in Marin County during the first and second quarter of 2025 compared to the full year in 2024. We are anticipating higher compliance rates, which should begin showing up in eReports data sometime in Q3, 2025. The next step is to identify the strategies for success in Marin and work to spread this throughout the region. **Northern Region (Children's Health, Chronic Disease, Reproductive Health and Cancer Prevention Domains):** Partnership has multiple interventions underway in the Northern Counties ranging from expediting newborn membership enrollment, academic detailing for medication-based measures like asthma and diabetes, increasing mammography access through mobile mammography and fixed-imaging, and more. Partnership submitted its first round of project updates to DHCS in June and

	received initial feedback from its DHCS nurse consultants and are cleared to submit the next round of updates in October 2025.
Quality Measure Score Improvement	Brief status highlights from the domain specific Quality Measure Score Improvement workgroups at Partnership: **Elder Care**: This workgroup is on hiatus as we are preparing for the new D-SNP launch in January 2027. The next full workgroup meeting will take place in December 2025. Until then, a smaller planning group will continue to meet monthly. **Women's Health & Perinatal**: • Creating verbiage for Well Child Visit Measure Best Practices to include discussing sexual and reproductive health and screening for chlamydia. • Updating cervical cancer screening measure best practices to include hrHPV self-collection as an option. **Chronic Disease Management**: • Six out of nine grantees have purchased a retinal eye camera and sent receipt for reimbursement. Check request forms have been sent to AP for processing. • Continuing to send out monthly emails for updates on this grant process and support if needed in the purchasing process. • Connecting grantees who have already purchased the device with those who have not for guidance. **Pediatrics:** No updates. **Behavioral Health**: The Community Health Worker (CHW) grant funding for placing CHWs in Emergency Departments (ED) has been extended through 12/31/2025. This grant bridges the gap between existing Substance Use Navigators and enables CHWs to work in EDs to facilitate and support substance use interventions that connect members to follow-up care. Partnership receiving claims from several hospitals while others manually submit data and work to build the data exchange capabilities with their EHRs.

Improvement Academy	• We are planning for fiscal year 2025-2026 offerings which will consist of:
	  ○ Foundational ABCs of Quality Improvement in-person training sessions
	  ○ Webinars focused on improving specific quality measures
	  ○ Publishing and promoting micro learnings, for just-in-time on demand access across our network.

Joint Leadership Initiative (JLI)	In July, Partnership had two (2) JLIs: • On 07/01/2025 Fairchild had their JLI and have graduated out of JLI • On 07/09/2025 Adventist Health had their JLI which included all represented sites within Partnership's network. In October, Partnership has three (3) JLIs scheduled: • 10/14/2025 Wellspace Health • 10/20/2025 Oroville Hospital • 10/21/2025 Shasta Community Health Center

	In November, Partnership has two (2) JLIs scheduled: • 11/03/2025 Ampla Health • 11/17/2025 Mendocino Community Health Center In December, Partnership has two (2) JLIs scheduled: • 12/08/2025 Western Sierra Medical Center • 12/09/2025 Solano County Family Health Services
REGIONAL IMPROVEMENT MEETINGS	• **Santa Rosa Regions:** Regional Medical Director, Dr. Lisa Ward has collected feedback on topics and logistical considerations for a new regional quality meeting series. A regular cadence of meetings will be scheduled by the end of Q3 2025. • **Redding and Eureka Regions:** The Performance Improvement team is starting to schedule the Q3 2025 meetings in both regions. • **Chico and Auburn Regions:** Regional Quality meetings were held on 07/21/2025 and 07/24/2025. The turnout at both meetings was strong and we are collecting evaluation responses to see how we can make the next meetings even better. Next meeting dates will likely be in October 2025 but have not yet been scheduled.

Note: Detailed information and recordings of Performance Improvement related webinars are posted to the PHC Website: http://www.partnershiphp.org/Providers/Quality/Pages/PIATopicWebinarsToolkits.aspx

QI PROGRAM & PROJECT MANAGEMENT

ACTIVITY	UPDATE
CAHPS SURVEY PROGRAM - MEDI-CAL PRODUCT LINE AND FY 24/25 ORG GOALS AND FY 25/26 ORG GOALS	**CAHPS® Regulated Measurement Year (MY) 2024 / Report Year (RY) 2025 Survey - Closed** • Analysis of the CAHPS® regulated Measurement Year (MY) 2024 / Report Year (RY) 2025 survey results are currently underway. • Review of survey results with internal, cross-departmental stakeholders is planned for September/October. • The plan's Patient Experience rating is projected to achieve 2.5 with the submission of the Child CAHPS® results. This reflects a notable 0.5 STAR improvement in the Patient Experience rating as compared to MY2023. **Additional Updates** • Completion of the NCQA required Member Experience Grand Analysis (ME7) report is underway. The ME 7 report will be presented to the Internal Quality Improvement Committee, Quality/Utilization Advisory Committee, Consumer Advisory Committee (CAC), and Board members starting early fall through December 2025. • To ensure continued focus on member experience, a CAHPS® team member will be present at the September CAC meeting for active listening.

	• The CAHPS team is working closely with our certified survey vendor, Press Ganey, to finalize a multi-phase project. Phase One centers on the design and refinement of survey questions to ensure they are relevant, easy to understand, and aligned with core measurement goals. This foundational work will help improve the quality and consistency of member feedback. Once Phase One is complete, the team will move into Phase Two—developing standardized reporting formats and data presentation tool, which is targeted to begin in November 2025. These reports will be designed to support actionable insights and drive improvement across programs. **Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)** • The kickoff for the Member Experience Organizational Goal was held in late July.
EXACT SCIENCES: PROMOTING COLORECTAL CANCER SCREENINGS	**Colorectal Cancer Web Page** The new provider facing webpage is now available on Partnership's website to support colorectal cancer screening efforts. The page includes a variety of internal and external resources, including: • Educational videos on Cologuard for providers to share with their patients, developed by the Population Health Team • Information on how to order FIT tests • Links to materials for providers and patients The Cologuard overview outlines all available screening options and includes guidance on how to effectively address care gaps. If you are interested in reviewing the page, you can find it at https://www.partnershiphp.org/Providers/Quality/Pages/Cologuard.aspx **Partnership Facilitated Order** Partnership is hosting its second multi patient order where orders are submitted on behalf of providers to Exact Sciences. The timing of this effort aligns with the timeline for addressing 2025 and 2026 PCP QIP Measures. Hosting this order removes the two hundred (200) patient minimum barrier that some providers face when wanting to place a bulk order directly with Exact Sciences. ○ Submissions will be accepted Monday, 07/21/2025 through Monday, 08/18/2025 with the Cologuard kits having a tentative shipping date of Monday, 09/29/2025. ○ A kickoff webinar was hosted with Exact Sciences on Wednesday, 07/23/2025 to go over all the necessary materials and details. ○ An open office hour session was hosted with Exact Sciences on Tuesday, 08/05/2025 for providers to receive support and/or clarification to help them submit orders.

	Bulk Order Offering vs Program If the bulk order requirements are met, any provider can participate in bulk ordering Cologuard this year, without any pre-approval from Partnership or admission into a program to do so. For more information visit the Cologuard webpage.

EQUITY & PRACTICE TRANSFORMATION PROJECT	**Program Overview**
	The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative aimed at advancing health equity while reducing COVID-19 driven care disparities. The funding is divided between three (3) programs; the Initial Planning Incentives Payments (IPIP), the Provider Directed Payment Program (PDPP), and the Statewide Learning Collaborative (SLC).
	
	PDPP Participation and Deliverables
	• All twenty-seven (27) provider organizations invited by DHCS to participate in the PDPP accepted by the 01/26/2024 deadline. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. Accepted provider organizations span Partnership's sub-regions, including five (5) from the 2024 - 10 county expansion, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's Enhance Provider Engagement (EPE) program.
	• Following statewide budget revisions, DHCS recalculated the final PDPP award amounts. While other MCP's experience a 5% dropout rate in their EPT cohorts, all 27 of Partnership participating providers have remained enrolled and actively engaged. DHCS has recalculated the final award amounts, due to budget revisions.
	• As part of their continued participation, practices that were unable to submit their required 2024 deliverables by the original 11/01/2024 deadline now have until 11/01/2025 to fulfill those requirements. These deliverables include:
	  ○ the Empanelment Assessment and Policy & Procedure under the Empanelment and Access milestones
	  ○ the Data Governance and HEDIS Reporting Assessment, along with a corresponding Policy & Procedure under the Population Health Management (PHM) milestones
	• Similarly, practices that did not submit the May 2025 deliverables by the 05/01/2025 deadline are also granted an extension to 11/01/2025. These deliverables include the PHM Implementation Plan and stratified HEDIS-like measures.
	• Practice who did not complete the Year 2 PhmCAT by the initially extended date of 05/19/2025 have been granted another extension to complete this deliverable by 08/21/2025.
	  ○ The PhmCAT submission is required by DHCS for continued participation in the EPT program.

- If a practice has completed other deliverables without the PhmCAT, DHCS requires a completed PhmCAT in order to release payment for those submissions.
- This impacts three (3) practices; United Indian Health Services, Lassen Indian Health Center, and Solano County Family Health Services Clinics.

- PHLC sent MCPs a status update on a practice's EPT engagement and accumulative milestone submission. The EPT PM team will work with the Performance Improvement team on how to support practices with low engagement and milestone submissions.

Revised EPT Payment Methodology

DHCS delayed the 2024 EPT payments due to CMS required changes. In response, MCPs and EPT practices received an updated payment methodology and detailed explanation for the delay. One key change from CMS was the exclusion of D-SNP members from assigned member counts. This adjustment prompted DHCS to request new member counts from participating MCPs, which were then used to recalculate payment amounts.

- Under the original methodology, each practice was eligible for a total potential payment of $250K regardless of their assigned member counts. Practices with more than 2,001 assigned lives earned an additional $20 per assigned life. The new payment methodology introduces a tiered system, where payments are based on specific member count ranges and the per-member payment rate decreases as the number of assigned lives increases.
- This change had a mixed impact on practices. While some saw an increase in their maximum potential payment, six (6) of our participating practices experienced a reduction.
- 2024 EPT Payments were distributed to the practices on 07/03/2025.

Statewide Learning Collaborative

- The Statewide Learning Collaborative (SLC) is meant to support practices awarded PDPP funding in the implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of quality and equity goals stated in their PDPP applications. Participation in the SLC is a requirement for all participants in the PDPP.
  - To align with the measure focus of the EPT practices, the Practice Tracks are now categorized by Population of Focus rather than practice type.
  - Milestone deliverable templates are published on PHLC's website to help EPT prepare for the November 2025 submission period.
  - Office Hours will be offered to support practices completing their milestone deliverable; topics covered will range from Access, General EPT, Improving Care Gap Closures, and an Artificial Intelligence (AI) toolbox where practices can leverage AI tools to help reduce workforce burnout and advanced value-based care.

Preventative Care Bridge Project (Formerly: Locum Pilot Initiative)	**Overview of the Preventative Care Bridge Project** The Preventive Care Bridge Project was developed as a short-term solution to provide access to clinicians with the goal of improving HEDIS performance in preventative care, specifically well-child visits and cervical cancer screenings. This offering was designed as a limited grant program; whereby select provider organizations are granted funds to hire a Locum Tenens Provider for a 4-week period in Pilot 1. **Pilot 1 Summary and Funding Model** A total budget of $250,000 was approved for Pilot 1 with some funding remaining; participants received up to: • $45,000 when hiring a Physician. • $31,600 when hiring an Advanced Practicing Clinician. The Grant was paid in two installments: • 50% upon signing the agreement. • 50% upon completion of the four-week assignment and submission of a post-program survey. **Program Implementation and Participation** The initial cohort of providers was selected from those participating in the PCP Modified QIP. Out of six extended invitations, four applications were received and approved. The Locum assignment periods were carried out asynchronously through January of 2025. Weekly Provider check-ins and data collection were conducted by a Partnership Improvement Advisor throughout the Locum Provider's employment. Locum Providers alleviated a backlog of Well-Child and Adolescent Visits (WCV) while enabling urgent care coverage and allowing patients to schedule visits with their preferred physician. **Pilot 1 Provider Specific Outcomes** Hill Country Community Clinic, Community Medical Center, and Pit River Health Services completed their grant requirements. Despite an extension through May 2025, Round Valley Indian Health was ultimately unable to recruit a locum and complete the grant-related activities. **Pilot 2 Funding and Planning** Pilot 2 has been approved with a total budget of $480,000, to support up to five (5) locum providers for three-month assignments aiming to: • Increase provider capacity; • Reduce appointment backlogs; • Improve WCV and CCS HEDIS® priority preventive care measures. By addressing access barriers through targeted locum support—and by proactively guiding providers to maximize these resources through clear onboarding, scope

alignment, and data tracking—the pilot offers a cost-effective, high-impact strategy for improving clinical quality scores, reducing quality withholds and sanctions tied to low visit rates, and enhancing the overall member experience.

Pilot 2 Objectives:

- Refine effective strategies for using short term locum support to increase preventive care visit rates in the near term.
- Develop a practical locum toolkit that providers can integrate into their practices with a high probability of success with minimal disruption.

Pilot 2 Implementation: Four providers have submitted applications and will be awarded up to $96,000:

- Ampla Health
- Western Sierra Medical Clinic
- Shasta Community Health
- Open Door Community Health

Participating providers will be required to meet obligations outlined in the agreement and will be monitored through weekly progress reports and regular check-ins with the Partnership program team.

Kick-off meetings were held with staff from all four participating providers to establish structured support during the recruitment and preparation period. Providers aim to have locums in place in time to optimize well-child visit capacity during the critical summer months.

Provider	Locum Start Date	Summary
Open Door	July 14	Contracted with NP through Jan 2026 for WCV and CCS at Eureka site.
Western Sierra Medical	June 30	Focus primarily on WCV at Auburn, Penn Valley and Grass Valley sites
Ampla Health	Aug 4	Credentialing process delays, focus will be WCV and CSS at Yuba City site.
Shasta Community Health	July 28	Extended contract with existing locum, focus will be on WCV and CCS at two sites.

Mobile Mammography Program

Completed Event Days (FY 24/25 Q4) - Finalized

Completed Event Days 04/01/2025 – 06/30/2025			
Region	**# of Provider Organizations**	**# of Provider Sites**	**# of Event Days**
Auburn	2	2	2
Chico	1	2	2
Eureka	4	4	4
Fairfield	1	2	2
Redding	4	4	4
Santa Rosa	2	2	2
Plan Wide	**14**	**16**	**16**

- Upcoming Event Days for FY 25/26 Q1 (July – September)

Upcoming Event Days 07/01/2025 – 09/30/2025			
Region	**# of Provider Organizations**	**# of Provider Sites**	**# of Event Days**
Auburn	0	0	0
Chico	1	2	2
Eureka	3	9	9
Fairfield	2	4	4
Redding	2	3	4
Santa Rosa	2	2	2
Plan Wide	**10**	**20**	**21**

- Scheduling for Mobile Mammography event days for FY 25/26 Q2 (October – December 2025) is currently in progress.

Partnering for Pediatric Lead Prevention Program

LeadCare II Device Access

Partnership continues to support the Partnering for Pediatric Lead Prevention (PPLP) program, which provides funding for point-of-care lead testing devices to eligible practices. Applications are now accepted year-round. Details can be found on the PLPP page on Partnership's website. PPLP Webpage

	FY Q4 Program Distribution 3 LeadCare ll Point of Care (POC) devices have been distributed including: ○ 2 devices to Dignity Health ○ 1 device to Butte County Department of Public Health Laboratory In collaboration with our Population Health department and Butte County Public Health (BCPH) on their Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP), a device was granted to Butte County Department of Public Health Laboratory to improve point-of-care testing in Butte County. A Memorandum of Understanding (MOU) was developed with the expectation being set that Butte County will provide testing support to all Butte County Medi-Cal providers and will implement a courier service to do so.
QI TRILOGY PROGRAM	• Updates for the FY2024/25 QI Work Plan have been finalized. • Updates for the FY2024/25 QI Evaluation have been finalized • Goal submissions for the FY2025/26 QI Work Plan have been finalized • All Trilogy documents (FY2025/26 QI Program Description; FY2024/25 QI Work Plan; FY2024/25 QI Evaluation; and FY2025/26 QI Work Plan) have been submitted for formal quality committee approval.

D-SNP

ACTIVITY	UPDATE
	• The QI Department is continuing its collaboration with Wakely (part of HMA) to develop a HEDIS visualization dashboard and a Stars analytics tool. • "Capturing Patient Acuity through Coding Part 2", a webinar addressing coding acuity for D-SNP, is tentatively scheduled on Wednesday, 10/08/2025 at 12 p.m. and will be led by Dr. Kermit Jones, Medical Director of Medicare Services at Partnership. The webinar will be promoted to physicians and coding support personnel in the Partnership Advantage counties. Attendees will be eligible for 0.75 CME/CE credits upon completing the post-webinar evaluation. Forty-seven (47) individuals from twenty-two (22) organizations have registered for the webinar. Registration is available here.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: 07/01/2025 TO 07/27/2025	• 22 PQI referrals were received with 17 coming from Grievance and Appeals, 3 from an Associate Medical Director, 1 from Utilization Management and 1 from Care Coordination • 20 cases were processed and closed. • 67 PQI cases are currently open. • Two cases were discussed at Peer Review Committee (PRC) on 07/16/2025 and there is one case awaiting PRC review. • One case was referred to an external SME physician for review. • We are conducting a focus review on a provider following a case review by PRC. • The upgrade of the Sugar CRM PQI application (Processing, Documentation, and Tracking System) is ongoing and currently in the testing phase, with an updated completion target set for August 2025.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: 5/26-7/25/2025	• As of 7/28/2025, we have a total of 478 PCP and OB sites with an additional 38 reviews due to multiple check-ins (totaling 516 reviews). **Primary Care and OB Reviews:** **Region** / **# of FSR conducted** / **# of MRR conducted** / **# of FSR CAP issued** / **# of MRR CAP issued** Auburn: 2 / 4 / 1 / 3 Chico: 13 / 14 / 1 / 8 Eureka: 8 / 7 / 2 / 5 Fairfield: 4 / 5 / 3 / 3 Out of Area: 2 / 0 / 1 / N/A Redding: 4 / 3 / 2 / 2 Santa Rosa: 7 / 7 / 0 / 3 New sites opened this period → • Chico: Family Medicine Residency Clinic • Eureka: Plaza Community Health Center, OB • Out of Area: Sutter West Bay Medical Group – 2 OB sites • Redding: Mt. Shasta Alternative Health Center • Santa Rosa: Sutter Primary Care Rohnert Park

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	• The MY2024 HEDIS Annual project is complete. Partnership received its Final Audit Report from Health Services Advisory Group (HSAG) for the Managed Care Accountability Set (MCAS) measure set on 07/15/2025. The NCQA Health Plan Accreditation (HPA) audit is also complete. Partnership anticipates receiving NCQA's final MY2024 Health Plan Rating in September 2025.
HEDIS® Program Overall	• The HEDIS Annual Summaries of Performance for the DHCS MCAS and NCQA HPA programs will be shared within Partnership, with the Physicians Advisory Committee (PAC) and the Quality Advisory Committee (QUAC), and the Board of Commissioners in August 2025. • In MY2024, MCAS measure rates were reported to HSAG/DHCS as one Plan-Wide rate for each measure. Partnership also reported county-level data to DHCS in MY2024, and DHCS has shared its intention to use county-level data to sanction Managed Care Plans for measures in the Accountable measure set that did not perform at the Minimum Performance Level (MPL). Geographic sanctions, as well as geographic quality withholds based on measure performance, will be applied only to Partnership's legacy fourteen (14) counties in MY2024. DHCS will share more specific information about their methodologies for applying sanctions and withholds based on MY2024 performance later in 2025.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	• Evidence submission for the HPA Mock Renewal Survey scheduled for 10/27-30/2025 has begun. The NCQA Program Management Team will review all evidence received and provide feedback to Business Owners, as needed. Evidence is due by 08/22/2025. The agenda for each of the four (4) days of the HPA Mock Renewal Survey, including the opening and closing sessions, has been finalized and individual invitations have been sent for each session. • As a next step from the HPA Mock File Reviews held with our NCQA Consultant, Managed Healthcare Resources (MHR), in April and May 2025, targeted Mock File Reviews will be conducted with selected teams prior to the start of the look-back period in September 2025. These file reviews will confirm the issues identified during the previous file reviews have been corrected and are now in compliance. The Mock File Reviews will be based on the 2025 HPA Standards and Guidelines and MHR will review selected files from each team. The NCQA Program Management Team will work with Business Owners to ensure any further

<table>
<tr><td></td><td>recommendations from MHR are addressed promptly to ensure compliance prior to the start of the look-back period.</td></tr>
<tr><td>NCQA Health Equity Accreditation (HEA)</td><td>

Partnership received our Initial Issues Report from NCQA for the HEA Initial Survey, with four (4) issues identified. These issues were discussed with NCQA during our survey conference on 07/16/2025, where we were able to get clarification from NCQA prior to submitting our formal responses on 07/21/2025. The Closing Conference Call took place on 08/04/2025. During this call NCQA reviewed several topics with Partnership including strengths, opportunities, remaining issues, and next steps. Per the applicable points received, Partnership's estimated Accreditation status is Accredited. Partnership expects to receive our final Accreditation status from NCQA in September 2025. The remaining key activities for the HEA Initial Survey include:

<table>
<tr><th>Date</th><th>Activity</th></tr>
<tr><td>Week of 08/11/2025*</td><td>NCQA provides the preliminary report with scoring and assessment</td></tr>
<tr><td>08/12-25/2025*</td><td>Comment period on preliminary report; provide final responses to NCQA</td></tr>
<tr><td>September 2025*</td><td>Official Accreditation notice received</td></tr>
</table>
*Estimated dates
</td></tr>
</table>

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

QUALITY/UTILIZATON ADVISORY COMMITTEE (Q/UAC)

Consent Calendar

Aug. 20, 2025

Items on the Consent Calendar have minor or no changes and are recommended by staff for approval.

Some Medi-Cal ("MC") policies are being updated as "MP" to apply to both Medi-Cal and Medicare (Partnership Advantage, eff. ~ Jan. 1, 2027)

		Pages
	PQI / PPC 1st and 2nd Qtrs 2025 – *direct questions to Robert Bides, RN – the Data Analysis begins on p. 89*	83 – 91
Health Services Departments	**Care Coordination**	
	MCCP2032 – CalAIM Enhanced Case Management (ECM) **ARCHIVE** *effective 09/10/25*	93 – 101
	MPCP2007 – Complex Case Management – *previously MCCP2007*	103 – 132
	Enhanced Health Services	
	MCAP7002 – CalAIM Enhanced Case Management (ECM) – *previously MCCP2032*	133 – 162
	Quality Improvement	
	MPQP1048 – Reporting Communicable Diseases	163 – 164
	Utilization Management	
	MCUP3053 – Acute Inpatient Administrative Days – **ARCHIVE** *effective 09/10/25*	165 – 166
	MCUP3114 – Physical, Occupational and Speech Therapies	167 – 172
	MCUP3133 – Wheelchair Mobility, Seating and Positional Components	173 – 184
	MCUP3141 – Delegation of Inpatient Utilization Management	185 – 190
	MPUP3006 – Appropriate Service & Coverage (Over/Under Utilization)	191 – 194
	MPUP3042 – Technology Assessment – *previously MCUP3042*	195 – 203
	MPUP3138 – External Independent Medical Review – *previously MCUP3138*	205 – 208
Non – HS Departments	**Member Services**	
	MP301 – Assisting Providers with Missed Appointments	209 – 211
	MP316 – Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior	213 – 224
	Network Services	
	MPNET101 – Wellness and Recovery Access Standards and Monitoring	225 – 227

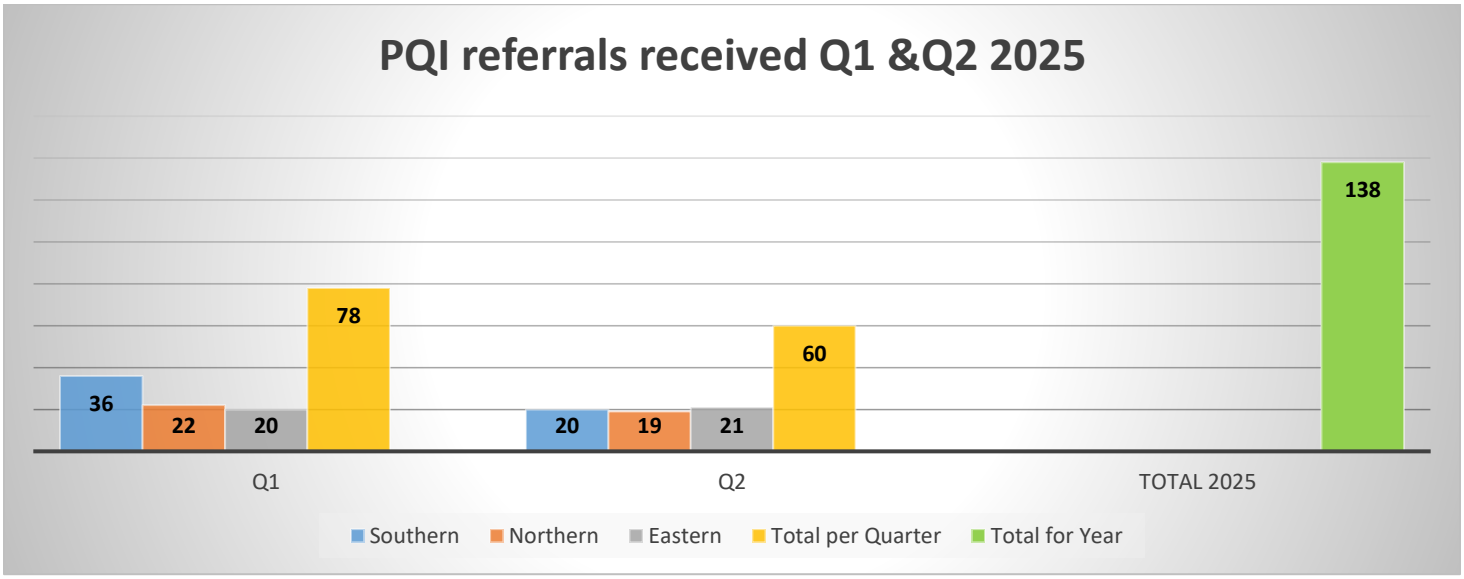
this page left blank

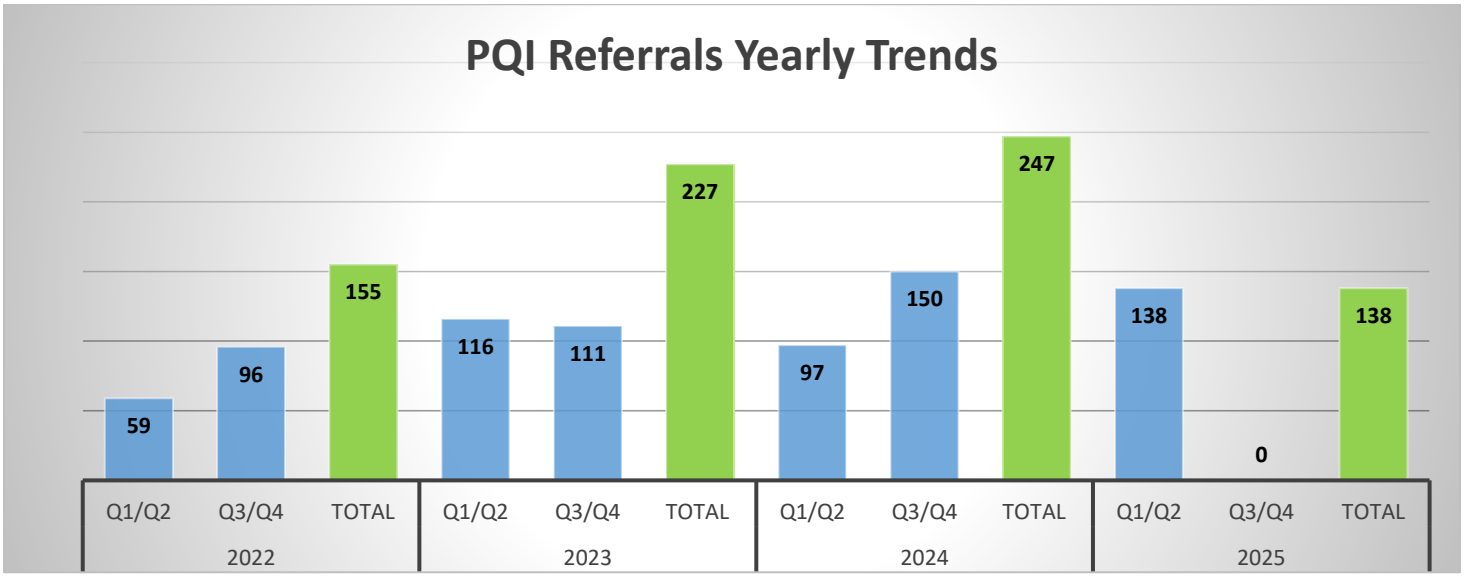
PQI Report Q1Q2 2025

For IQI/QUAC meeting August 2025

POTENTIAL QUALITY ISSUE (PQI) REPORT

PQI (Potential Quality Issue) is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQI requires further investigation to determine whether an actual quality issue or an opportunity for improvement exists. PQI is referred internally to the Quality Improvement (QI) department via the PQI Referral Intake System found on PHC4Me. Referrals from external sources are sent via the PQI@partnershiphp.org inbox using the PQI referral form.

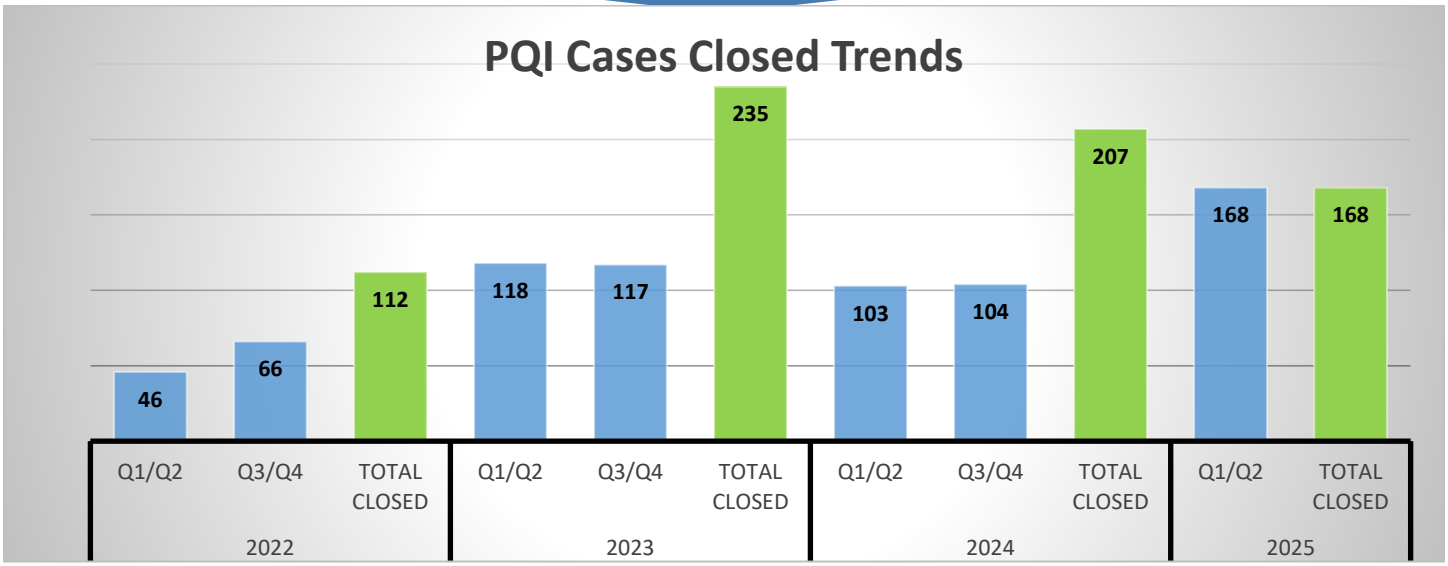




Top 3 Referral Sources: Grievance & Appeals, Other Sources, and Utilization Management.
Top 3 PQI count by Referral Type: Assessment/Treatment/Diagnosis, Communication/Conduct, and Access/Availability.
Top 3 PQI count by Provider Type: Primary Care Provider, Specialist, and Hospital.
** see attachment A for the full list of sources and types.

PQI Report Q1Q2 2025

For IQI/QUAC meeting August 2025



Timeframe for case completion: 120 calendar days from the date the PQI referral is received

Summary of Closed Cases by Provider County and Type: 202 practitioners/providers were involved in the 168 PQI closed cases. The following is a breakdown of the types of providers and total per Provider County:

PROVIDER COUNTY	PCP	SPECIALIST	HOSPITAL/ER	SNF/LTC	OTHER	TOTAL
SHASTA (N)	19	9	3	1		32
SOLANO (S)	20	4	1	1	1	27
PLACER (E)	16	1	2	1		20
SONOMA (S)	8	4	6		1	19
YOLO (S)	9	3	3	1	1	17
*OTHER	4	2	3	1	3	13
BUTTE (E)	7	2	3		1	13
MARIN (S)	10		2	1		13
HUMBOLDT (N)	7	2				9
MENDOCINO (S)	5			1	1	7
YUBA (E)	5		2			7
TEHEMA (E)	5		1			6
NAPA (S)		1	1	2		4
SISKIYOU (N)	2				1	3
LAKE (S)	1		2			3
NEVADA (E)	3					3
SUTTER (E)	1	1				2
GLENN (E)	1					1
DEL NORTE (N)	1					1
LASSEN (N)			1			1
TRINITY (N)			1			1
MODOC (N)						0
CALUSA (E)						0
PLUMAS (E)						0
SIERRA (E)						0
TOTAL	**124**	**29**	**31**	**9**	**9**	**202**

(N) - Northern region, (S) - Southern region, (E) Eastern region, Provider County: OTHER (Non-PHC Counties)

PQI Report Q1Q2 2025

For IQI/QUAC meeting August 2025

Summary of Referrals and Closed Case Trends: PQI case referrals continue to rise as expected due to the expansion into 14 additional Eastern counties. QI/Q2 2025 PQI referrals totaled 138, a 42% increase above the 97 logged in Q1/Q2 2024. Forty-one (30%) involved Eastern County members. The Member Safety Quality Investigations team closed 168 cases in 2025 compared to 103 cases for the same period in 2024. This 63.25% increase in cases closed was achieved by adding another Nurse Investigator and changing processes.

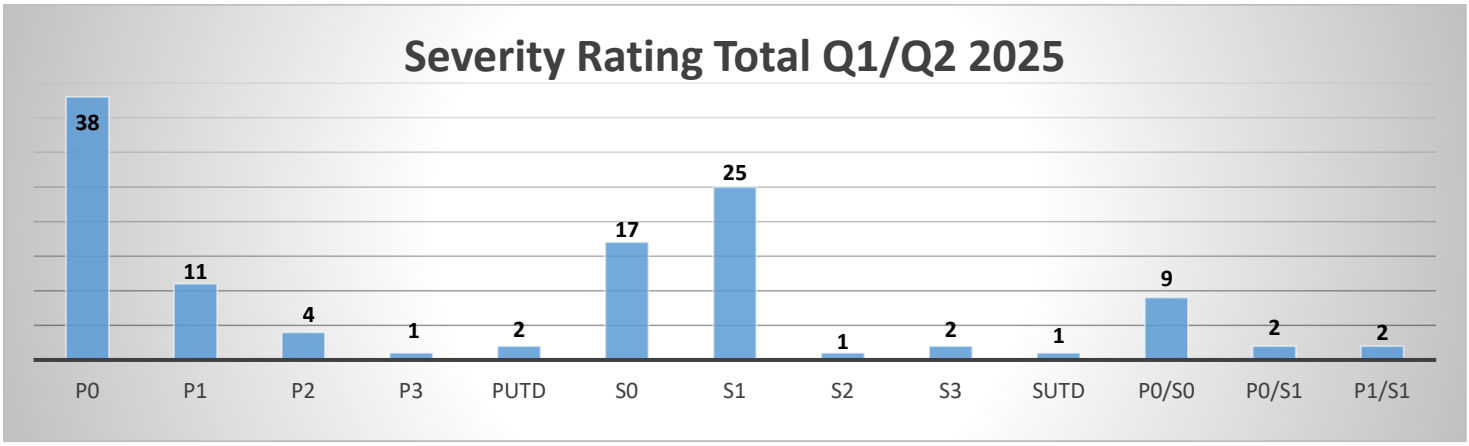
Severity Ratings and Actions: The Member Safety Quality Investigations team (QI) led by the Medical Director for Quality, together with other Medical Directors, the Behavioral Health Clinical Director, and Pharmacy personnel, review all PQI referrals. The cases are discussed and assigned a severity rating based on quality issues identified. Cases receive a "P" score for "Provider Issues" and/or an "S" score for "System Issues". All PQI cases designated severity level P2 or S2 or higher are referred to the Peer Review Committee (PRC) consisting of external clinicians and internal Partnership staff as described above for additional review, discussion, and final determination. If the PRC determines that a PQI case requires a second opinion, the PRC authorizes review by a specialty physician or other subject matter expert.

Practitioners Performance and Systems Scores Grid

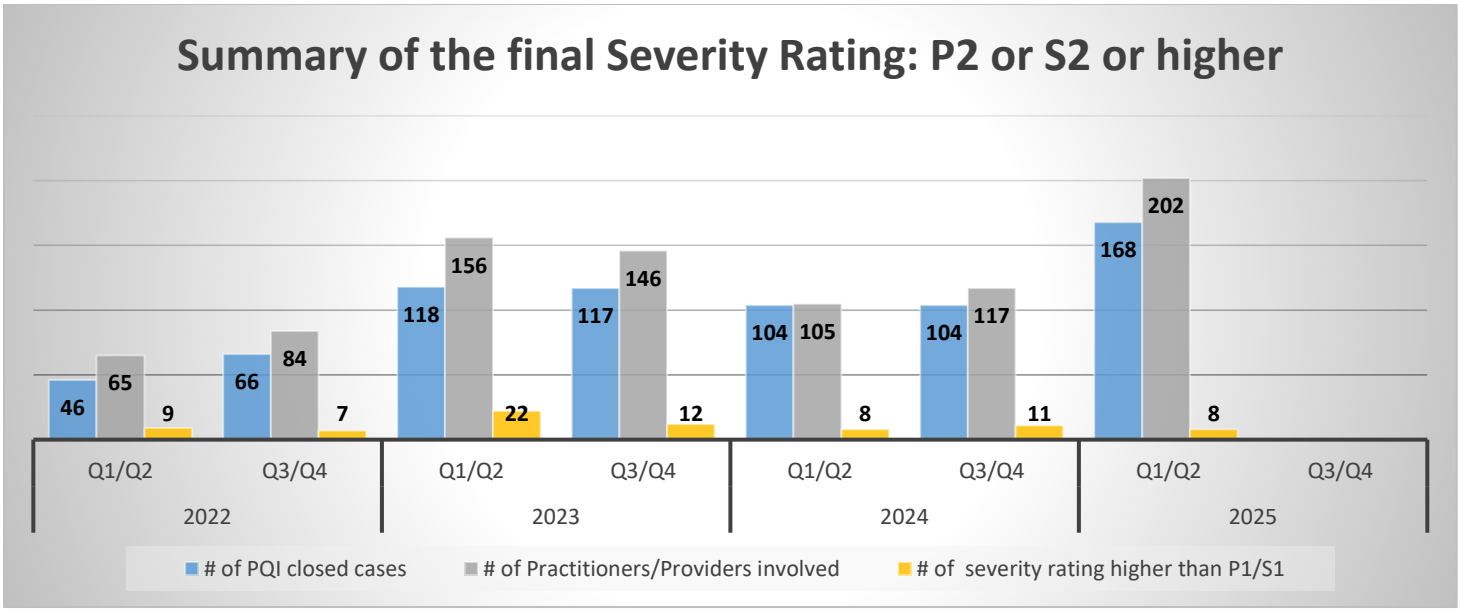
Practitioner Performance (P Score)	Systems Issue(S Score)	Definition and Action
P0	S0	Care is appropriate, no action required
P1	S1	Minor opportunity for improvement. The reviewer will send a letter and/or secure email to the provider. Response may or may not be required.
P2	S2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for minor or moderate adverse outcome to member. A letter is sent to the provider of concern, requiring a response. May recommend CAP and/or other interventions.
P3	S3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for significant adverse outcome to members. ASAP communication by certified letter, secure email and/or direct phone call to provider of concern requiring a response. Requires a CAP and/or other interventions. May be referred to Credential Committee with recommendations from the PRC.
PUTD	SUTD	Use whenever PQI cannot be leveled or unable to make a determination due to several factors. Referral to Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC). If none identified, may be through direct contact with management of the FOC or with oversight of the POC. Refer to the appropriate licensing entity, if indicated.

PQI Report Q1Q2 2025

For IQI/QUAC meeting August 2025



Q1/Q2 2025 Peer Review Committee: All cases designated a severity level higher than P1/S1 during the internal PQI rounds are referred to the PRC. The PRC reviewed and scored nine PQI cases – PQ1106, PQ1181, PQ1197, PQ1199, PQ1205, PQ1210, PQ1228, PQ1232, and PQ1245 – recommending various actions and next steps depending on the severity level of each case. Actions could include a requirement for the providers to undergo educational courses, or for the facility staff to review current protocols, policies and procedures to ensure best practices are implemented and external regulatory bodies' mandates are realized.



Focus Review

The PRC will note when a clinician or practice site is involved in more than one PQI and will initiate a "focus review" when the following threshold is met:
1) Two or more P2 or above quality-of-care scores in the last 24 months; or
2) Significant trend of service or quality complaints exceeding the established thresholds.

Summary: Two focus reviews were initiated on the PRC's recommendation:
1) A surgeon's care and treatment was reviewed by an external Subject Matter Expert reviewer and
2) A pediatrician's care and treatment is currently being completed.

Subject Matter Expert Medical Reviews

Upon PRC determination that a PQI case requires a second opinion review by a specialty physician or subject matter expert, the Member Safety Investigation team will initiate a request for investigational review and response. Currently, Partnership uses Medical Review Institute of America (MRIoA) or National Medical Review (NMR) for independent SME reviews. Two cases were sent for SME review:

1) The care provided by a surgeon was reviewed by the SME as a part of the Focus Review.
2) The care provided by a specialist was reviewed by an SME to determine if the care provided meets standard of care.

Provider Track and Trend Summary

The Q1/Q2 2025 PQI Track and Trend summary reports including Provider Sites/Individual practitioner with multiple PQIs will be presented at the Aug. 20, 2025 Peer Review Committee meeting. There were eight providers with multiple PQIs, however, there were no reoccurring concerns that required additional actions.

Provider Preventable Conditions (PPC)

PPC (Provider Preventable Condition) is specified and defined as Health Care Acquired Condition (HCAC or HAC) or Other Provider Preventable Condition (OPPC). HCAC are medical conditions or complications that a patient develops during a hospital stay or ambulatory surgical encounter that was not present at admission. OPPC are also known as "never events" (wrong surgery, wrong patient, or wrong body part) that are reportable if occurring in any health care setting. Providers must report potential PPCs directly via online reporting to the Department of Health Care Services (DHCS) Audits & Investigations Unit (A&I) after the discovery of the event. Providers, after confirming that the patient is a Medi-Cal beneficiary, must also report directly to Partnership.

Q1/Q2 2025 PROVIDER PREVENTABLE CONDITIONS (PPC) – All reported to DHCS

PQI	Brief Synopsis	Findings	Confirmed PPC □ yes □ no
PQ1497 **Referral Date:** 2/5/2025 **Closed Date:** 4/23/2025	HCAC - Health Care - Acquired Condition in an acute inpatient setting Catheter Associated Urinary Tract Infection	Facility performance/System Issue: Minor opportunity for improvement	Confirmed. No recoupment required.
PQ1449 **Referral Date:** 1/14/2025 **Closed Date:** 5/14/2025	HCAC - Health Care - Acquired Condition in an acute inpatient setting: fall with injury.	No quality issues identified. The case was initially reported as a PPC, however, additional information was obtained that the injury occurred prior to the fall. Requested to retract PPC report.	Not a PPC and no recoupment required.

PQI Report and Data Analysis provided by: Robert R Bides, RN
Manager, Member Safety Quality Investigations/Quality Improvement (QI)/Health Services

Attached supporting documentation: PQI Data Analysis Q1&Q2 2025

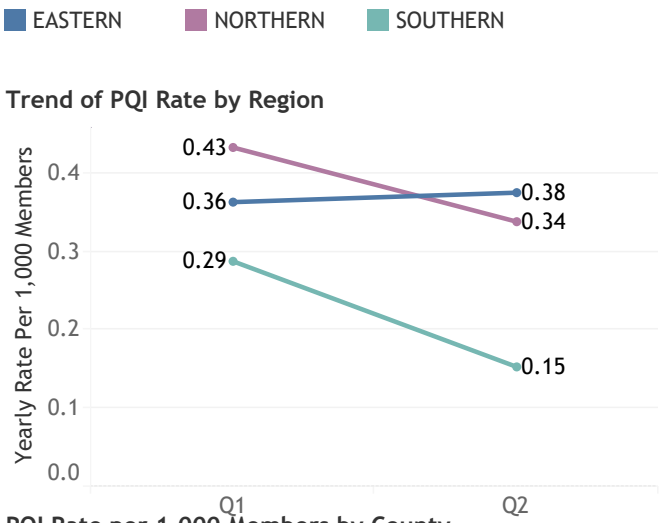
Potential Quality Issues
Referral Dates: Q1&Q2 2025

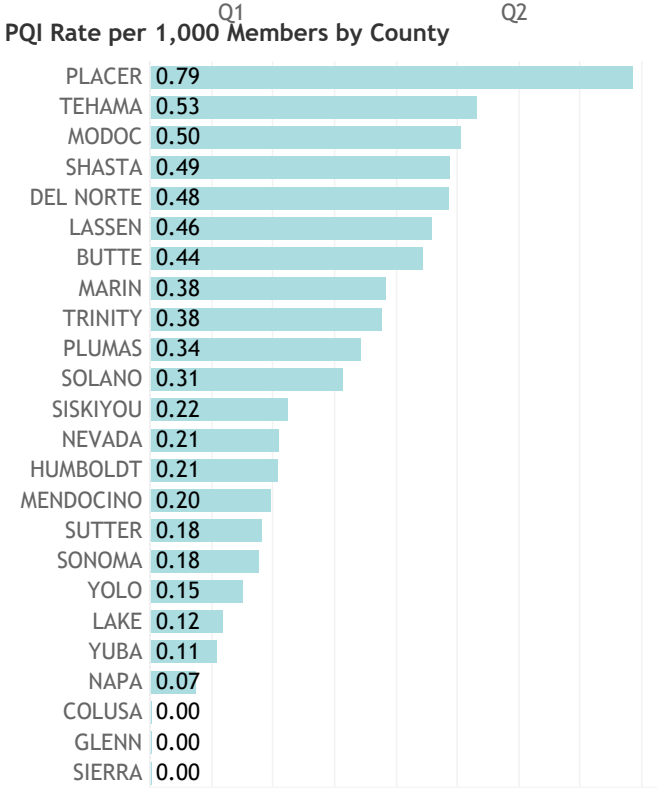
PQI Rate, Count and Membership

	2025 Q1			2025 Q2			Total
	EASTERN	NORTHERN	SOUTHERN	EASTERN	NORTHERN	SOUTHERN	
Member Months	858,226	609,220	1,250,111	862,544	602,556	1,253,859	5,436,516
PQI Count	26	22	30	27	17	16	138
Yearly Rate Per 1,000 Members	0.36	0.43	0.29	0.38	0.34	0.15	0.30

Count, Membership and Rate per 1,000 Members by County

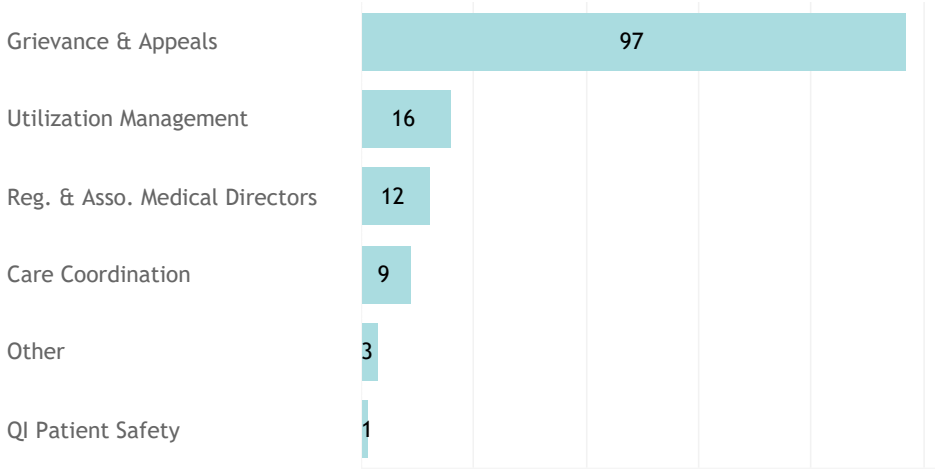
	Member Months	PQI Count	Yearly Rate Per 1,000 Members
PLACER	366,746	24	0.79
TEHAMA	180,601	8	0.53
MODOC	23,802	1	0.50
SHASTA	393,235	16	0.49
DEL NORTE	74,294	3	0.48
LASSEN	52,553	2	0.46
BUTTE	514,705	19	0.44
MARIN	280,867	9	0.38
TRINITY	31,882	1	0.38
PLUMAS	35,046	1	0.34
SOLANO	615,604	16	0.31
SISKIYOU	106,770	2	0.22
NEVADA	171,869	3	0.21
HUMBOLDT	348,639	6	0.21
MENDOCINO	244,858	4	0.20
SUTTER	262,409	4	0.18
SONOMA	673,081	10	0.18
YOLO	320,659	4	0.15
LAKE	204,981	2	0.12
YUBA	221,211	2	0.11
NAPA	163,920	1	0.07
COLUSA	61,585	0	0.00
GLENN	82,006	0	0.00
SIERRA	5,193	0	0.00



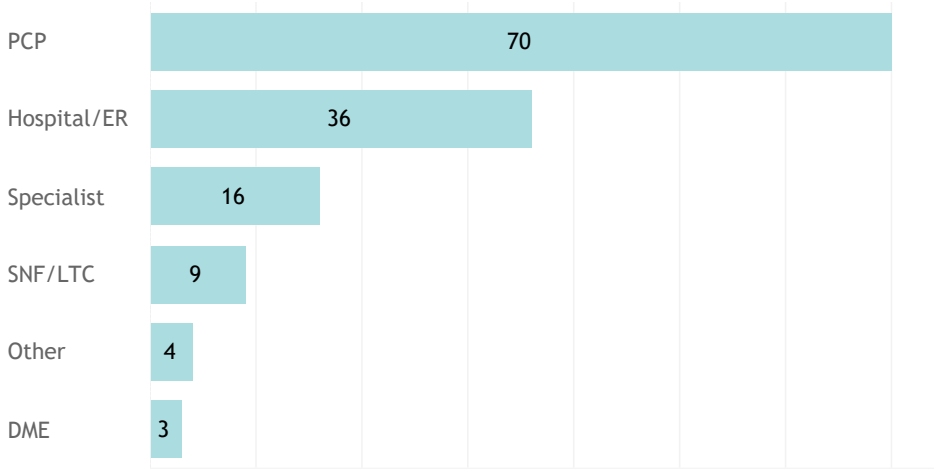


Potential Quality Issues
Referral Dates: Q1&Q2 2025

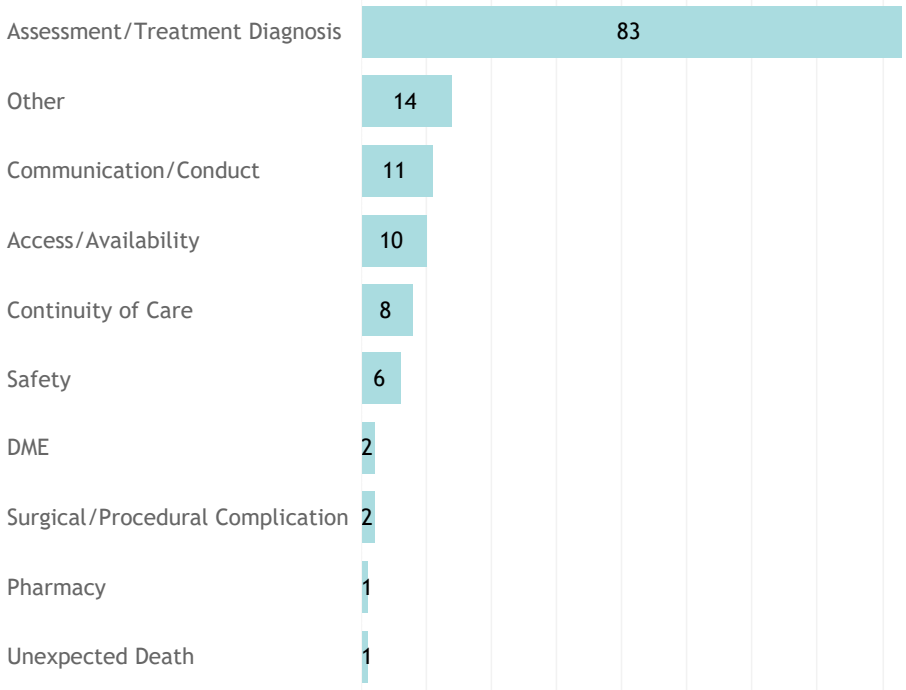
PQI Counts by Referral Source



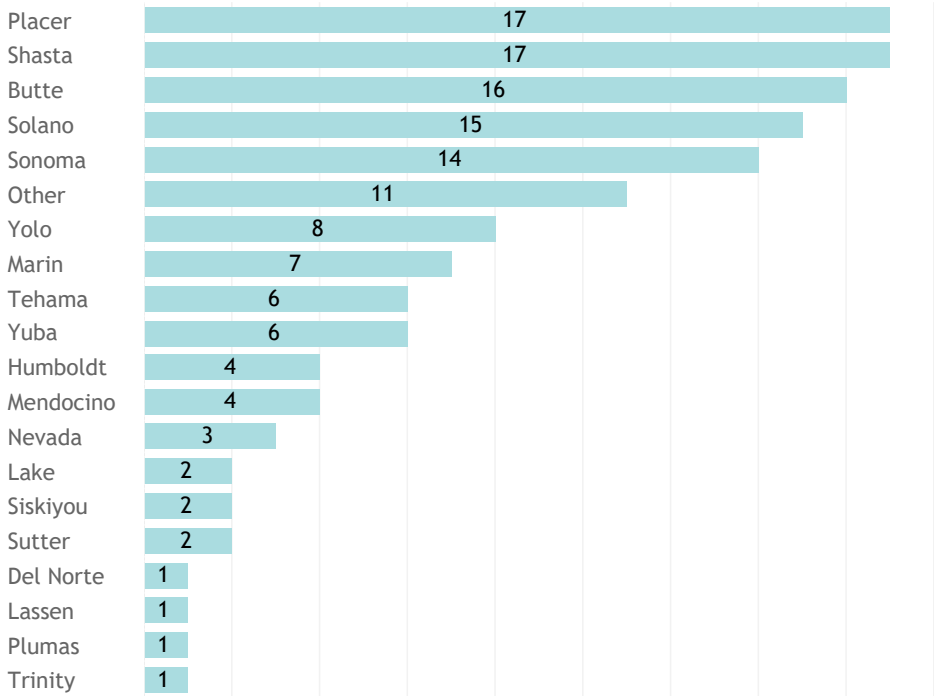
PQI Counts by Provider Type



PQI Counts by Referral Indicator



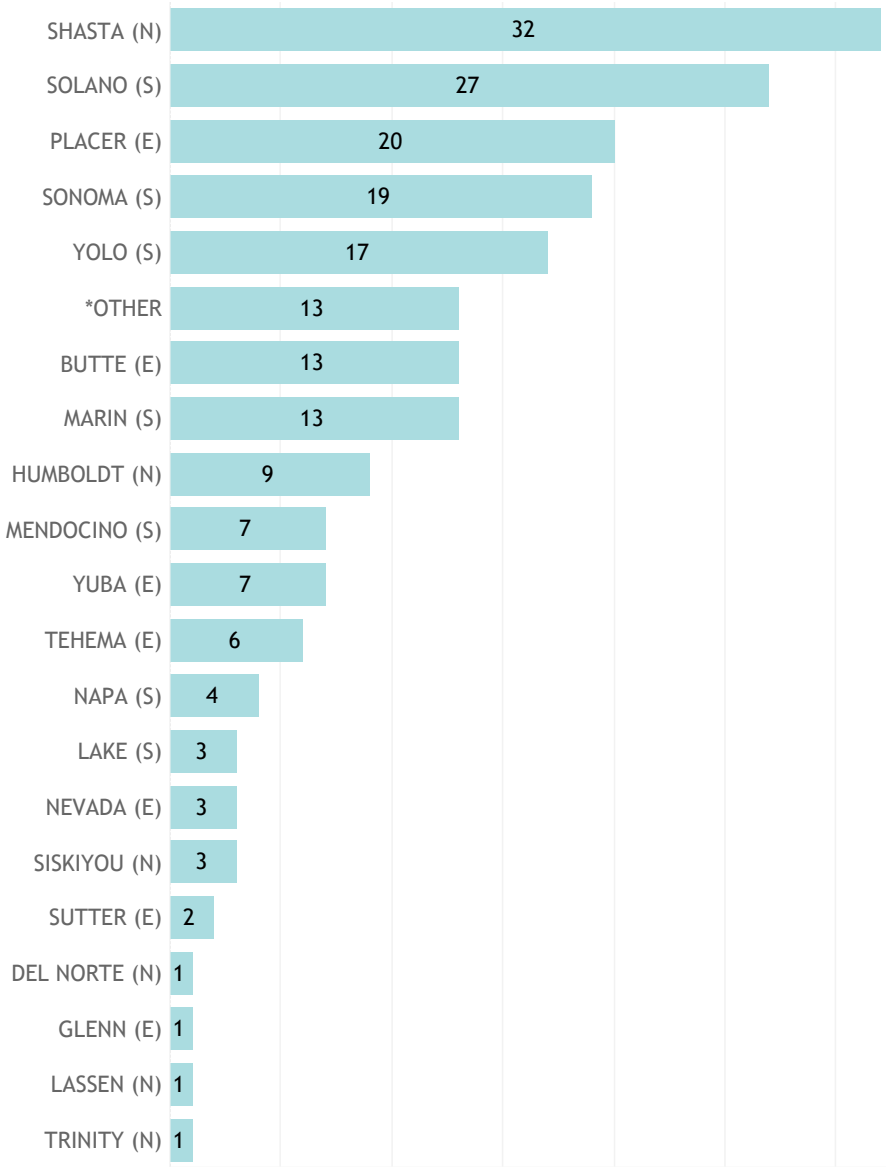
PQI Counts by Provider County



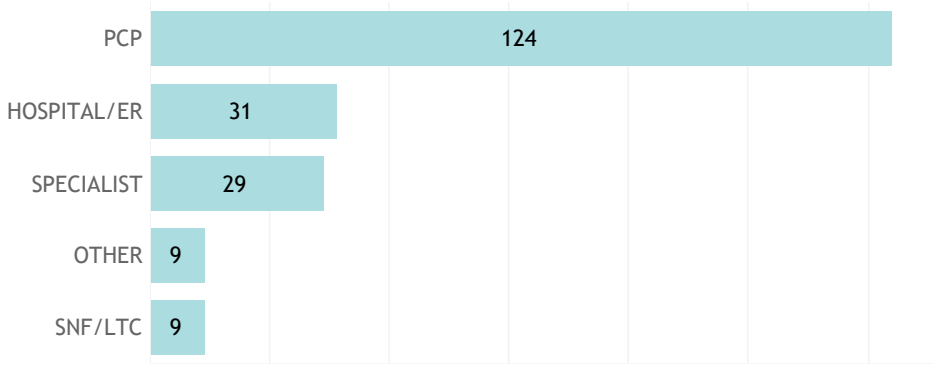
Potential Quality Issues

168 cases were closed and 202 practitioners/providers involved in Q1&Q2 2025

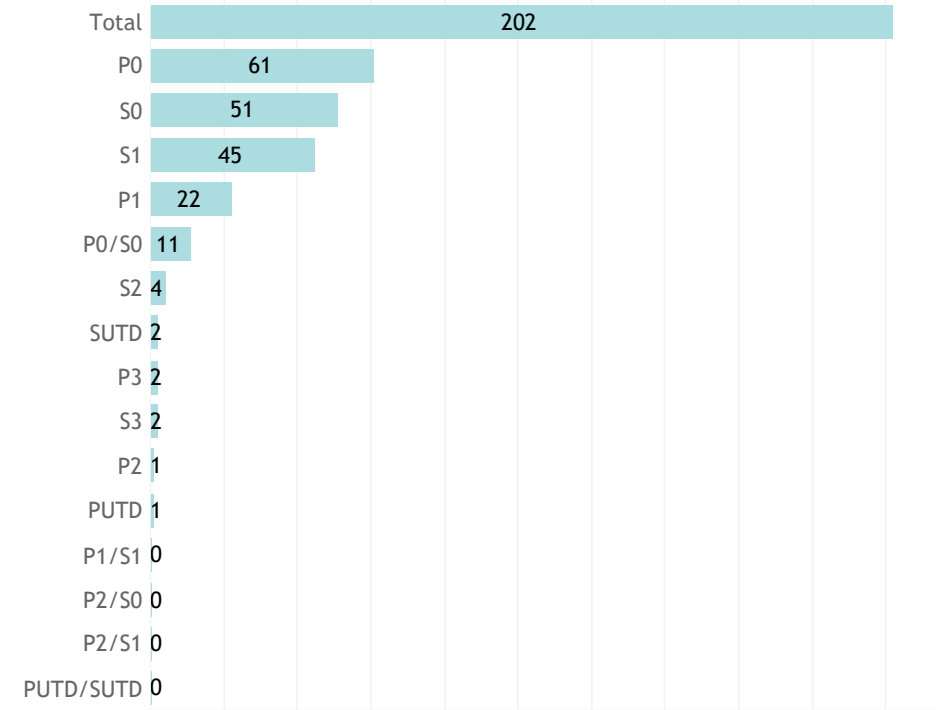
SUMMARY OF CLOSED CASES
by Provider County



SUMMARY OF CLOSED CASES
by Provider Type



SUMMARY OF CLOSED CASES
by Severity Rating



this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPCP2007~~MCCP2007~~ (previously MCCP2007, MPCP2007)				**Lead Department: Health Services** Business Unit: Care Coordination	
Policy/Procedure Title: Complex Case Management				☒**External Policy** ☐ **Internal Policy**	
Original Date: 06/20/2012			**Next Review Date:** ~~09/11/2025~~09/10/2026 **Last Review Date:** ~~09/11/2024~~09/10/2025		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~09/11/2024~~09/10/2025	

I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description
B. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
C. MP~~C~~CP2014 – Continuity of Care
D. MCCP2024 – Whole Child Model for California Children's Services (CCS)
E. MCAP7002~~MCCP2032~~ – CalAIM: Enhanced Care Management (ECM)
F. MCND9001 – Population Health Management Strategy & Program Description
G. MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities
H. MPQP1038 - Physician Orders for Life-Sustaining Treatment (POLST)
I. MP~~C~~QP1047 - Advance Directives
~~I.~~J. MPCP2034 - Transitional Care Services (TCS)

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. California Children's Services (CCS): A State program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Complex Case Management (CCM): The process of applying evidence-based practices to individual Members to assist them with the coordination of their care and promote their well-being.
C. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
D. HIPAA: The Health Insurance Portability and Accountability Act
E. Individualized Care Plan (ICP): A Member-focused care plan designed to optimize the Member's health, function, and well-being.
~~E.~~
F. Medical Home: The provider identified as the member's medical home or primary care provider (PCP) is responsible for managing the member's primary care needs.
~~F.~~G. Partnership Advantage: Effective January 1, 2027, Partnership HealthPlan of California will

operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

~~G.~~H. Partnership CC: Partnership HealthPlan of California's Care Coordination department

~~H.~~I. Seniors and Persons with Disabilities (SPD): A group of Medi-Cal beneficiaries who are most vulnerable to adverse health outcomes.

J. Whole Child Model (WCM): A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with CCS eligible conditions insured by Partnership.~~In participating counties, this program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for Partnership HealthPlan of California (Partnership) pediatric Members with a CCS-eligible condition(s).~~

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the process by which Partnership HealthPlan of California's (Partnership's) Members are reviewed for the Complex Case Management (CCM) program. CCM is a voluntary program that provides interventions aimed at both improving the Member's self-management of their health, and also increasing appropriate usage of health and medical resources while reducing the inappropriate utilization of healthcare resources. These goals are achieved by working with the Member/caregiver and Member's interdisciplinary care team to do the following:

A. Educate the Member about their benefits with managed care and how to use available resources
B. Identify and help the Member understand their medical condition(s)
C. Support and encourage self-management skills to promote and optimize the Member's personal health goals and well-being
D. Coordinate necessary health care services, and
E. Refer to appropriate medical or social community resources, when applicable

VI. POLICY / PROCEDURE:

A. Identification of Participants
   1. Operating within HIPAA regulations, Partnership proactively identifies Members eligible for CCM services from many data sources that may include:
      a. New Member a~~A~~ssessments such as the Health Information Form (HIF), Health Risk Assessment (HRA), or Pediatric Health Risk Assessment (PHRA)
      b. Internal Reports such as:
         1) Weekly Hospital Discharge Report
         2) Monthly Utilization Report
         3) Monthly Pediatric Case Finding Report
      c. Referrals from other Care Coordination interventions when a Member meets the criteria for inclusion in CCM. Examples of s~~S~~ervices that may provide a source of referral include:
         1) Access to Care
         2) Transitional Care Services (TCS)~~ns of Care~~
         3) Growing Together Program (GTP)
      d. Member/Caregiver self-referral: via telephone, or through Partnership's Member Portal

e. Provider referral: via telephone or Provider website referral form
f. External Reports such as:
   1) County CCS enrollment
   2) Members served by Targeted Case Management Services

2. Additional Sources of r~~R~~eferrals
   a. Partnership performs outreach activities such as meetings and education notices to primary care providers (PCPs) within Partnership's network to discuss the CCM program and to identify Members who may benefit from the program. Partnership's outreach activities extend beyond PCPs; education regarding the CCM program, participant eligibility, and referral process is also shared. Referral sources may also include, but not limited to: ~~with~~:
      1) Internal Department Referrals: Claims, Utilization Management, Pharmacy, etc.
      2) Vendor/Delegated Entity Reports including: Advice Nurse Report, etc.
      3) Specialists
      4) Hospital Discharge Planners
      5) Ancillary Providers
      6) Behavioral Health Specialists
      7) Community Partners (~~i.e.,~~e.g., Case Managers, County Public Health Departments, etc.)
      8) Regional Centers
      9) California Children's Services (CCS)
      10) Enhanced Care Management (ECM) Providers
   b. Members or their caregiver/representative are provided information on the CCM program through Member newsletters, the Partnership Member Portal, from their providers, and through direct outreach by Partnership's Care Coordination team, and may request CCM assistance at any time.

B. Eligibility

To be eligible for CCM services, Members must have Partnership Medi-Cal as their primary health plan~~insurer,~~ be a Partnership Advantage Member, or have an eligible condition for which Partnership may be responsible (e.g., Partnership is secondary). Partnership Members cannot be enrolled in CCM and the ECM benefit simultaneously. For more information on the ECM benefit, see Partnership policy MCAP7002~~MCCP2032~~ CalAIM Enhanced Care Management (ECM). Partnership will identify Members ~~Members from any age~~ who meet at least one of the following criteria as potential candidates for CCM services:

1. Members who have barriers to managing their care without the support of CCM, (e.g., poor support systems, fragmented care, health literacy barriers), or
2. Seniors and Persons with Disability identified as needing CCM to reduce risk of adverse effects, according to the parameters outlined in policy MCCP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services, or
3. Pediatric Members identified as needing CCM to reduce risk factors according to the parameters outlined in policy MCCP2024 Whole Child Model for California Children's Services or
4. One (1) or more California Children's Services (CCS~~)~~ ~~)~~ eligible conditions and requiring the support of an individualized care plan; or
5. Two (2) or more chronic medical conditions (e.g. Chronic Kidney Disease [CKD], Chronic Obstructive Pulmonary Disease [COPD], Congestive Heart Failure [CHF], Diabetes Mellitus [DM], Hypertension [HTN], hyperlipidemia), and requiring the support of an individualized care plan.

~~0.~~

~~D.~~C. Initial Assessment

1. Members identified as candidates for the CCM program will be contacted within 30 days of identification and offered the opportunity to enroll in CCM. If the Member agrees to enrollment, the assigned Partnership Care Coordination (CC) ~~Staff will~~Staff will initiate a detailed assessment of the Member, which will be completed within 60 days of identification. Partnership CC Staff will make

two (2) attempts to reach the referred Member by phone, followed by a mailed letter inviting the Member to participate in the CCM program. These three attempts will be completed within 14 calendar days. If the Member does not respond to outreach efforts, the case will be closed. The case may be re-opened at any time should the Member opt in to participation in the program.

2. When a Member agrees to participate in the CCM program, Partnership CC Staff performs a Complex Case Management Assessment to address and document the Member's self-reported health status. This assessment gathers information about the Member, including the Member's medical history (e.g., major procedures and surgeries and the dates these interventions occurred, when known), current medical conditions (e.g., the presence or absence of comorbidities), ability to manage condition-specific issues, caregiver ability and willingness to participate in care, current and past medications (including schedules and doses), mental and behavioral health status, ability to perform self-care, and their engagement in enjoyable activities.
    a. In select cases, the initial assessment may be performed in person.
3. Assessments will be tailored to the needs of the individual Member. Branching logic will be utilized to prevent Members from being asked questions that may not apply (e.g., if a Member says they are completely independent in daily activities, we will not ask if they get help when they need it). In addition to the Adult Complex Case Management Assessment, there is a Perinatal Complex Case Management Assessment for pregnant Members. Pediatric cases will be assessed using a Pediatric Complex Case Management Assessment (through an interview with the Member's parent or caregiver) along with an Age-Specific Questionnaire that will be updated each year to capture developmental and psychosocial changes. In cases where cognition, literacy, or other issues limit a Member's ability to accurately complete the assessment, the staff member will be prompted to seek other means of gathering the appropriate and necessary information to evaluate the Member's needs.
4. All efforts and methods to contact the Member to complete the assessment will be documented in the case management system. In certain events beyond Partnership's control, the CCM assessment may not be completed within 30 days of enrollment in the CCM program. In these instances, the case status will be updated to show the reason for delay/incompletion of the assessment; these circumstances include the following:
    a. Member is hospitalized during the initial assessment period
    b. Member cannot be contacted or reached through telephone, letter, e-mail, or fax after at least three attempts over two or more weeks
    c. Natural disaster
    d. Member is deceased~~ead~~
    e. Member is no longer eligible for Partnership managed care services
5. Through the i~~I~~nitial a~~A~~ssessment process, Partnership CC Staff will collect, document and review the information below. The information collected during the assessment process will be analyzed by the Partnership CC Staff to develop the Individualized Care Plan (ICP) for the Member. A summary statement of this analysis is captured at either the end of each question or at the end of the Complex Case Management assessment. For any area of the assessment where the information below is considered inappropriate or not applicable to the Member, Partnership CC Staff will indicate an 'N/A' on the assessment next to that question followed by a clear reason or explanation why the assessment was marked N/A. If a Member is unable to recall information on the assessment or refuses to answer a particular question on the assessment, Partnership CC Staff will notate applicable areas.
    a. The referral source and condition that led to the Member's eligibility for CCM.
    b. A comprehensive clinical history of medical conditions based on available medical records from the 30 days prior to referral to the CCM program, and retrieved from provider offices for diagnostic and treatment information, plan of care and medications. Other resources of treatment history may be obtained by Treatment Authorization Requests (TARs), Service

Authorization Requests (SARs), and Medical ~~-~~/ ~~-~~Pharmacy Claims.

c. Member's ability to function with or without assistance to perform activities of daily living (e.g., grooming, dressing, bathing, toileting, continence, eating, transferring, walking), caregiver availability and involvement, as well as Member's ability/motivation for self-management.
d. Age specific questions including developmental milestones, school-related concerns, family interactions, etc.
e. History of alcohol or other substance use disorders along with any treatment(s) for these conditions, as well as the use of tobacco products and willingness to quit.
f. Evaluation of mental health status, memory/retention, and cognition. The Patient Health Questionnaire-2 (PHQ-2) is administered to assess for depression, and how often the Member feels lonely. Questions included in the assessment ask if the Member has trouble getting thoughts out, remembering things, or understanding directions, and Partnership CC staff are prompted to evaluate the Member's understanding and retention throughout the assessment process.
g. Potential social barriers to health that may include Member's education, economic stability, or access to safe housing, transportation, food, social support and the healthcare system.
h. Whether Member has family, caregivers, friends and/or care providers who may help make decisions about Member's health. Partnership CC Staff will explain and offer Advanced Care Directive and Physician's Orders for Life-Sustaining Treatment (POLST) forms to the Member if they do not currently have these forms completed and available for use. See Partnership policies MP~~C~~QP1047 Advance Directives and MPQP1038 Physician Orders for Life-Sustaining Treatment for more details.
i. Evaluation of language preference, cultural or religious beliefs, health literacy, mental health, cognition, memory and understanding, as well as communication needs that include possible visual and hearing accommodations.
j. Information about available benefits and resources within Partnership and the community. This includes, but is not limited to, information regarding copays or pharmacy benefits, dental benefits, enhanced benefits, the authorization process, and community resources on mental health, wellness, nutrition, transportation, In Home Support Services (IHSS) and palliative care programs. The assessment will also evaluate the Member's awareness of their available benefits and determine whether the benefits and resources available to the Member are adequate to fulfill the treatment plan.
k. The Member's readiness to change existing behaviors to improve their health and which behavior(s)/health condition(s) are the Member's priorities. Included in this assessment is an evaluation of the caregiver's involvement in and decision-making about the care plan, and how adequate that support is for the Member's needs.
l. Provider(s)' treatment plan and objectives.

~~E.~~D. All Partnership CC activities are documented in an electronic case management system that automatically documents the ID of the staff member who completed the activity as well as the date and time completed. Screening and assessment questions and interventions are built on evidenced-based protocols such as the PHQ-2 for depression screening, the Alcohol Use Disorders Identification Test (AUDIT-C) for substance use, etc. Automated prompts direct staff to schedule further assessments and interventions to support the goals of the care plan. The staff user manual includes detailed instructions and workflows for how to perform and document case management activity by program. ~~(Reference the Essette Care Coordination Training Manual).~~

~~F.~~E. Upon completion of the assessment, Partnership CC Staff and the Member/caregiver collaborate to develop the person-centered Individualized Care Plan (ICP), comprised of the following:

1. Identified and prioritized goals (high, medium, low) that address personal, clinical, and psychosocial needs identified during the assessment process. The prioritization of which goals are

addressed during the CCM program will be a collaborative decision between Partnership CC staff and the Member/caregiver. Each prioritized goal will be specific, measurable, and have a targeted completion date.

2. Barriers to achieving each goal are identified by Partnership CC staff or the Member.
3. Identification of evidence-based interventions to overcome barriers and advance the plan of care. Reminders to follow up on the interventions can be scheduled for future dates through the case management system and are tracked through system reports.
4. Identification, referral and coordination for community resources beyond the benefits available through Partnership when/where applicable (e.g., Energy Assistance Programs, In-Home Support Services, Meals on Wheels, health education classes, wellness programs, local food banks, parenting/caregiving support programs, etc.).
5. A schedule for when follow-up calls will occur.
    a. Partnership CC staff will attempt to contact Members enrolled in CCM at a minimum of every 30 days. Follow-up calls may be scheduled after:
        1) planned physician visits
        2) transitions across care settings
        3) therapy visits
        4) other scheduled activities
        5) as agreed for follow-up and support
    b. Partnership CC staff will also follow up on referrals to community resources, wellness programs, and other means by which Members may demonstrate increasing self-management and engagement in their care.
6. As the Member's care plan is developed, Partnership CC Staff will educate/reinforce self-management activities that the Member can adopt. The Member/caregiver will select up to three behaviors to target as their self-management plan, to be incorporated into the ICP.
7. Partnership CC Staff sends a confirmation letter to the Member advising of their enrollment into CCM, providing contact information for the CCM team, and giving the Member the option to withdraw from the program at any time. Partnership CC Staff also sends a letter and a copy of the ICP to the Member (if desired) and to the Member's ~~(~~PCP and/or specialist(s) to advise them of their enrollment into CCM and to promote communication between the interdisciplinary care team.
8. A timeline for meeting the overall goals of the ICP. The ICP will be reviewed at scheduled intervals to assess overall progress toward the goals of the care plan. The initial re-evaluation will take place 60 days after enrollment. The case may be closed at this point or remain open for on-going case management for as long as the Member remains with Partnership and has an appropriate medical need.
9. A strategy to ensure communication of care needs across transitions of care, (e.g., hospitalizations, transitioning to a new provider(s), or transitioning from pediatric providers to adult providers).
10. Discussion of health plan benefits, Member's eligibility for these benefits, and any concerns the Member may have with limitations to the benefits.

~~G.~~F. Ongoing Case Management

1. Partnership CC Staff collaborate with the Member and/or the Member's caregiver to help the Member reach the goals outlined in the ICP through the use of Member engagement, motivational interviewing techniques, continual review of the ICP goals, barriers, and overall progress of the case.
2. As the case progresses, goals and barriers and the Member's self-management plan will be reviewed and updated. New goals and behaviors may be identified through the collaboration between the Member/caregiver and Partnership staff. Should a Member be admitted to a facility and have a length of stay longer than 30 days, the Member will be re-assessed after discharge and upon resumption of case management activities.
3. Over the course of the ICP, the Member/caregiver has the opportunity to participate in discussions

or decisions about any treatments or services offered. The Member/caregiver may request the involvement of additional family/friends or professionals of their choosing in the case management process. Partnership CC Staff will coordinate family/provider conferences when requested by the Member/caregiver or when the case will benefit from a collaborative multi-disciplinary discussion.

4. Partnership Clinical Supervisors perform case-reviews on the caseloads of their assigned Partnership CC Staff. Cases are reviewed to ensure adherence to CCM policy, that the Member's ICP is followed, and that barriers to care are addressed in a timely manner. If there are concerns about the trajectory or needs of a specific case, the Clinical Supervisor may escalate the concern to CC Leadership and/or to a Partnership Medical Director.
5. Partnership CC staff maintain frequent communication with the Member/caregiver, PCP, and other m~~M~~embers of the Member's care team and support system throughout the duration of the CCM program.
6. In instances where the Member has multiple care coordination services, Partnership will collaborate with other care providers to ensure there is no duplication in services.

~~H.~~G. Case Closure

Partnership CCM services are voluntary and based on active participation from the Member. Members who do not demonstrate active participation, are uncooperative, whose behavior or environment is unsafe for staff, or those who would be better managed in another care program, will be reviewed for disenrollment from CCM services. Partnership Staff may recommend the Member be transitioned to another case management program or that the Member be disenrolled from Partnership's case management. Examples of when Partnership may discontinue CCM services include:

1. The Member elects to participate in CCM services, but after 45 days of enrollment the Member is non-responsive to Partnership's outreach attempts.
2. Agreement by Partnership CC Staff and Partnership Clinical Leadership that the Member is uncooperative as evidenced by not demonstrating consistent adherence to the ICP.
3. Goals and self-management behaviors identified on the ICP have been reached per agreement between Partnership CC Staff and the Member, and the Member has demonstrated readiness to be transitioned from CCM services.
4. Member has been established with their Medical Home as evidenced by one or more visits with Primary Care/Medical Home with additional visit(s) scheduled, and Member/caregiver agrees that their care needs are met in that environment.
5. The Member has been enrolled in Partnership's Enhanced Care Management (ECM) benefit.
6. Members found to have either Severe Mental Illness (SMI) or a Substance Use Disorder (SUD) upon initial assessment will be referred to alternative case management programs according to their county of residence, and CCM interventions will focus on coordination of care between Partnership-contracted providers and the Member's other service providers.
7. Members who have been closed to case management may be considered for re-enrollment if there is a change in their condition or desire to engage in CCM.

~~I.~~H. CCM Services Outcome Measurement

1. Outcomes associated with Partnership's CCM services are reviewed and analyzed no less than annually by Partnership. Tools utilized to analyze CCM program outcomes include:
   a. Aggregate outcomes for ~~M~~member satisfaction surveys received by Partnership
   b. A series of measures that evaluate m~~M~~ember utilization data as specified below, and how that data has trended with the intervention of CCM:
      1) Number of ED Visits
      2) Number of Hospital Stays
      3) Total Number of Hospital Days
      4) Number of Outpatient Visits
2. The data will compare three (3) data collection points: the six (6) months prior to CCM program enrollment, six (6) months from the start of CCM services and, when available, the six (6) months

after the case has been closed to CCM.

3. Partnership CC Staff will obtain reports from Grievance and Appeals department on m~~M~~ember concerns regarding the services they received in the CCM program. Information is to be collected and analyzed in order to help Partnership identify opportunities to better identify candidates for the CCM program, to improve CCM services, and to make timely adjustments to CCM services to better meet the needs of our Members, providers and communities.

VII. REFERENCES:

A. National Committee for Quality Assurance (NCQA) Health Plan Standards 2025~~3~~4. Population Health Management 5 Complex Case Management
B. Partnership Complex Case Management Assessment
~~C. Partnership Essette Care Coordination Training Manual~~
~~D.~~C. The Playbook (2024~~2~~). Institute for Healthcare Improvement. Retrieved from https://www.bettercareplaybook.org/
~~E.~~D. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-032 Enhanced Care Management Requirements (12/22/2023 *supersedes* APL 21-012)

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2027)
N/A

Medi-Cal
05/21/14; 01/20/16; 04/19/17; *02/14/18; 04/10/19; 11/13/19; 04/08/20; 06/10/20; 06/09/21; 03/09/22; 03/08/23; 02/14/24; 09/11/24; 09/10/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
Partnership Advantage:
PACP2007, MPCP2007 - 04/16/2008 to 01/01/2013

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and

the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCCP2032				**Lead Department: Health Services**	
Policy/Procedure Title: CalAIM Enhanced Care Management (ECM)				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 03/09/2022 **Effective Date:** 01/01/2022 vs. DHCS			**Next Review Date:** ~~11/13/2025~~N/A **Last Review Date:** 11/13/2024		
Applies to:	☒ **Medi-Cal**			☐ **Employees**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				~~Approval Date: 11/13/2024~~ Archived Date: 09/10/2025	

Archived 09/10/2025 - Refer to MCCP2002

I. RELATED POLICIES:

A. MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports
B. MPCD2013 – Care Coordination Program Description
C. MCCP2007 – Complex Case Management
D. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
E. MCND9001 – Population Health Management Strategy & Program Description.
F. MPCR100 – Credential and Re-credential Decision Making Process
G. MPPR200 – Partnership Provider Contracts
H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
I. MCCP2024 – Whole Child Model for California Children's Services (CCS)
J. MCUP3037 – Appeals of Utilization Management / Pharmacy Decisions
K. CMP36 – Delegation Oversight and Monitoring
L. MCCP2033-Community Health Worker (CHW) Services Benefit
M. MCCP2034 Transitional Care Services (TCS)

II. IMPACTED DEPTS:

A. Claims
B. Configuration
C. Compliance
D. Enhanced Health Services
E. Finance
F. Grievance and Appeals
G. Utilization Management
H. Member Services
I. Project Management Office
J. Provider Relations

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Closed Loop Referral: means bidirectional information sharing between two or more parties to

communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and/or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.

C. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

D. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(C) delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

E. Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).

F. Enhanced Care Management (ECM): a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

G. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community- based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

H. Individualized Care Plan (ICP): A Member-focused care plan designed to optimize the Member's health, function, and well-being.

I. Lead Care Manager (LCM): A Member's designated care manager for ECM, who works for the ECM Provider organization. The Lead Care Manager operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any Community Support (CS). To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non- duplication of services.

J. Point Click Care (PCC) A contracted external vendor platform designated as Partnership HealthPlan of California (Partnership)'s ECM data sharing and information exchange system. The use of the platform will be to advance communication and share information between ECM Members' care teams, integrate services, improve health outcomes, and streamline the ECM benefit delivery.

K. Release of Information (ROI): The process of providing access to Protected Health Information (PHI) to an individual or entity authorized to receive or review it.

L. Release of Information (ROI) Consent Form for ECM: A valid ROI form including the Member's signature and specified time frame to allow Partnership, ECM provider(s), lead case manager, community organizations, and relevant affiliates or entities of the Member's

Archived 09/10/2025- Refer to MCAP7002

care team to share their health information.

M. Substance Use Disorder (SUD): A complex condition in which there is the uncontrolled recurrent use of a substance, which causes harmful consequences such as clinically significant impairment, health problems, and disabilities.

N. Serious Mental Health (SMH): A diagnosed mental, behavioral, or emotional disorder resulting in serious functional impairment that interferes with or limits the quality of life.

O. Whole Child Model (WCM): A comprehensive program for the whole child encompassing care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member insured by Partnership.

P. Whole Person Care (Whole Person Care): A five-year pilot program under California's 1115 Medicaid waiver to service high-risk populations using a collaborative approach across public and private entities to integrate and coordinate health, behavioral health, and social services. Partnership's Counties participating in the WPC pilot program were Marin, Mendocino, Napa, Shasta, and Sonoma.

IV. ATTACHMENTS:

A. Individualized Care Plan Example

B. Enhanced Care Management (ECM) Release of Information Form (ROI)

V. PURPOSE:

To describe Partnership HealthPlan of California's (Partnership's) Enhanced Care Management (ECM) benefit for Partnership Medi-Cal eligible Members, and to outline the collaboration between Partnership, ECM providers, and other community partners in the delivery of ECM services pursuant to the California Department of Health Care Services (DHCS) All Plan Letter (APL) 23-032. The ECM benefit is unique and distinct from other care management programs. ECM builds on both the design and the learning from California's Whole Person Care Pilots (WPC) and Health Home Program (HHP). ECM, with Community Supports (CS), replaces both models, scaling up the interventions to a statewide care management approach. ECM offers comprehensive, "whole person" care management to high-need, high-cost Partnership Members. ECM services primarily:

A. Are delivered in-person to Members and/or their caregivers, Authorized Representative (AR), parents/guardians wherever Members may live, seek care, or prefer to access services within their community.

B. Focus largely on Social Determinants of Health (SDOH) such as housing/shelter, food instability, transportation and community supports to improve medical health outcomes and healthcare costs.

C. Populations of Focus within Partnership's membership that often need to access six or more separate delivery systems for care, benefits and/or support (e.g. Partnership, Medi-Cal fee-for-service, mental health, substance use disorder, developmental, dental, In Home Supportive Services, etc.).

D. Have goals and interventions that aim to improve care coordination, integrate the delivery of services, facilitate community resources and improve health outcomes, while decreasing inappropriate health care utilization.

VI. POLICY / PROCEDURE:

A. ECM ELIGIBILITY

1. Member must be assigned to Partnership for Medi-Cal benefits.
2. ECM is voluntary, Members can decline or end ECM services upon initial outreach and engagement, or at any other time.
3. Member must be identified as meeting criteria in one of the following Populations of Focus eligible for ECM benefits:
   a. Adult Populations of Focus: Homelessness, At Risk for Avoidable Hospital or ED

Archived 09/10/2025 - Refer to MCAP7002

Utilization, Serious Mental Health (SMH) or Substance Use Disorder (SUD), Transitioning from Incarceration, At Risk of Institutionalization / Eligible for Long-Term Care Services, Nursing Facility Residents Transitioning to the Community, and/or Pregnant and Postpartum; Birth Equity.

b. Children & Youth Populations of Focus: Homelessness, At Risk for Avoidable Hospital or ED Utilization, Serious Mental Health (SMH) and/or Substance Use Disorder (SUD), Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond CCS Condition, Involved with Child Welfare, Intellectual or Developmental Disability (I/DD), and/or Pregnant and Postpartum; Birth Equity.

4. Adult Specific ECM Population of Focus Eligibility Criteria are defined as:
   a. Effective through June 30, 2023, Individuals Experiencing Homelessness – Adults 21 years of age or older and their families who:
      1) Have at least one complex physical, behavioral, or developmental health need with an inability to successfully self-manage for whom coordination of services would likely result in improved health outcomes and/or decrease in utilization of high-cost services, and
      2) Are experiencing homelessness defined as meeting one or more of the following conditions defined by the U.S. Department of Health and Human Services (HHS) 42 CFR §11302 criteria:
         a) Lacking adequate nighttime residence
         b) Having a primary residence that is a public or private place not designed for or ordinarily used for habitation
         c) Living in a shelter
         d) Exiting an institution into homelessness
         e) Will imminently lose housing in next 30 days
         f) Fleeing domestic violence, dating violence, sexual assault, stalking and other dangerous, traumatic, or life-threatening conditions relating to such violence
   b. Effective July 1, 2023, Individuals Experiencing Homelessness – Adults 21 years of age or older without dependent children/youth living with them who:
      1) Have at least one complex physical, behavioral, or developmental health need with an inability to successfully self-manage for whom coordination of services would likely result in improved health outcomes and/or decrease in utilization of high-cost services, and
      2) Are experiencing homelessness defined as meeting one or more following conditions defined by the U.S. Department of Health and Human Services (HHS) 42 CFR § 11302 criteria:
         a) Lacking adequate nighttime residence
         b) Having a primary residence that is a public or private place not designed for or ordinarily used for habitation
         c) Living in a shelter
         d) Exiting an institution into homelessness
         e) Will imminently lose housing in next 30 days
         f) Fleeing domestic violence, dating violence, sexual assault, stalking and other dangerous, traumatic, or life-threatening conditions relating to such violence
         g) Defined as homeless under other federal statutes
   c. At risk for Avoidable Hospital or ED Utilization – Adults, 21 years of age or older who:
      1) Have five (5) or more Emergency Department (ED) visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment

Archived 09/10/2025 – Refer to MCAP7902

adherence, and/ or

2) Have three (3) or more unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

d. SMH or SUD – Adults, 21 years of age or older who:
   1) Meet the eligibility criteria for participation in or obtaining services through:
      a) Specialty mental health services (SMHS) delivered by the county's Mental Health Plan (MHP)
   2) The Drug Medi-Cal Organized Delivery System (DMC-ODS) or the Drug Medi-Cal (DMC) program, and are actively experiencing at least one complex social factor influencing their health, and
   3) Are experiencing at least one complex social factor influencing their health, and
   4) Meet one or more of the following criteria:
      a) High risk for institutionalization, overdose and/or suicide
      b) Use crisis services, emergency rooms, urgent care, or inpatient stays as the sole source of care
      c) Two or more ED visits or two or more hospitalizations due to SMH or SUD in the past 12 months
      d) Pregnant and post-partum Members (12 months from delivery)

e. Transitioning from Incarceration – Adults 21 years of age or older who:
   1) Are transitioning from a correctional facility or transitioned from a correctional facility within the last 12 months, and
   2) Have at least one (1) of the following conditions:
      a) Mental illness
      b) Substance Use Disorder (SUD)
      c) Chronic Condition/Significant Clinical Condition
      d) Intellectual or Developmental Disability (I/DD)
      e) Traumatic Brain Injury (TBI)
      f) HIV/AIDS
      g) Pregnancy or Postpartum

f. At Risk for Institutionalization & Eligible for Long-Term Care – Adults, 21 years of age or older who are:
   1) Living in the community who meet the Skilled Nursing Facility (SNF) Level of Care (LOC) criteria; or who require a lower-acuity skilled nursing, such as a time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury; and
   2) Actively experiencing at least one complex social or environmental factor influencing their health; and
   3) Able to reside continuously in the community with wraparound supports

g. Nursing Facility Residents Who Want to Transition to the Community – Adults, 21 years of age or older who are:
   1) Interested in moving out of the institution, and
   2) Likely candidates to do so successfully, and
   3) Able to reside continuously in the community

h. Birth Equity – Adults, who are:
   1) Pregnant or Postpartum (through 12-month period); and
   2) Meet one of more of the following conditions:
      a) Eligible in any other adult or youth ECM Population of Focus;
      b) Effective January 1, 2024 - Subject to racial and ethnic disparities as defined by

Archived 09/10/2025 - Refer to MCAP7002

California public health data on maternal morbidity and mortality.

5. Children and Youth Specific ECM Population of Focus Eligibility Criteria are defined as:
   a. Effective July 1, 2023, Individuals Experiencing Homelessness – Homeless Families or Unaccompanied Children/Youth who:
      1) Are experiencing homelessness as defined by the U.S. Department of Health and Human Services (HHS) 42 CFR § 11302 criteria:
         a) Lacking adequate nighttime residence
         b) Having a primary residence that is a public or private place not designed for or ordinarily used for habitation
         c) Living in a shelter
         d) Exiting an institution into homelessness
         e) Will imminently lose housing in next 30 days
         f) Fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence
      2) Sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;
         a) Living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations
         b) Living in emergency or transitional shelters
         c) Abandoned in hospitals or unable to discharge from the hospital to a safe place
   b. At Risk for Avoidable Hospital or ED Utilization – children and youth under the age of 21 who:
      1) Have three (3) or more Emergency Department (ED) visits in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence, and/ or
      2) Have two (2) or more unplanned hospital and/or short-term skilled nursing facility stays in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.
   c. SMH or SUD – Children and youth under the age of 21 who:
      1) Meet the eligibility criteria for participation in, or obtaining services through:
         a) SMHS delivered by MHPs
         b) The DMC-ODS or the DMC program.
   d. Transitioning from Incarceration – Children and youth under the age of 21 who are:
      1) Transitioning from a youth correctional facility or transitioned from being in a youth correctional facility within the past 12 months.
   e. Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition – Children and youth under the age of 21 who are:
      1) Enrolled in CCS or CCS WCM; and
      2) Experiencing at least one complex social factor influencing their health.
         a) Lack of access to food,
         b) Lack of access to stable housing,
         c) Difficulty accessing transportation
         d) Have a high measure (four or more) of ACEs screening;
         e) History of recent contacts with law enforcement, or crisis intervention services related to mental health and/or substance use symptoms.
   f. Children and Youth Involved in Child Welfare – children and youth who meet one or more of the following conditions:
      1) Under age 21 and are currently receiving foster care in California;
      2) Under age 21 and previously received foster care in California or another state within the

Archived 09/10/2025- Refer to MCAP7002

last 12 months;
3) Aged out of foster care up to age 26 in California or another state
4) Under age 18 and are eligible for and/or in California's Adoption Assistance Program;
5) Under age 18 and currently receiving or have received services from California's Family Maintenance program within the last 12 months.

g. Intellectual and Developmental Disability (I/DD) – children and youth who are:
1) Diagnosed I/DD
2) Eligible in any other adult ECM Population of Focus

h. Pregnancy, Postpartum and Birth Equity – children and youth who are:
1) Pregnant or Postpartum (through 12-month period); and
2) Meet one of more of the following conditions:
a) Eligible in any other adult or youth ECM Population of Focus;
b) Effective January 1, 2024 - Subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

6. ECM may be offered to Members who do not meet DHCS' Population of Focus criteria but would benefit from the services. Partnership will handle these requests on a case-by-case basis.

B. JUSTICE INVOLVED MANAGED CARE TRANSITION
1. Partnership will use the DHCS Member assignment data when the Member's pre-release service aid code is activated and identified to ensure the Member receives coordination of care.
2. Partnership will support the creation and development of the reentry care plan for individuals as requested by the pre-release care management provider and/or their team of the ECM provider. This includes the following but is not limited to:
a. Receiving Member data
b. Warm handoff
c. Pre-release and post release
d. Receipt of person-centered care
e. Behavioral health links
f. Ensuring post-release ECM provider participates in behavioral health transition meetings, warm handoffs, follow-up planning, and ensure that warm handoffs include follow up-planning, including confirming transportation.
g. Assist with appointment scheduling for behavioral health services.
3. Partnership will ensure that the ECM provider supports scheduling for required post-release physical, behavioral health, and social services.
4. Partnership will ensure that the ECM provider connects individuals with needed services such as Community Supports, and benefits like Non-Emergency Medical Transportation, to assist the Member with reentering the community.

C. ECM EXCLUSION CRITERIA:
1. The following Members are excluded from receiving ECM benefit:
a. Member is sufficiently well managed through self-management or through another care management program.
b. Member is enrolled in Hospice or Intensive Outpatient Palliative Care.
c. Member enrolled in County-based Target Case Management (TCM) programs.
1) DHCS has allowed a one-year exception from July 1, 2024 to June 30, 2025 for cases where the member is receiving County-based TCM for addressing a communicable disease or for the sole purpose of receiving a home visiting program supporting the healthy development and well-being of children and families.
d. The Member is unresponsive to outreach attempts.
e. The Member displays unsafe or threatening behavior.

Archived 09/10/2025- Refer to MCAP7002

f. Member's physical environment poses a safety or security risk.
g. The member is receiving the Community Health Worker services benefit.
h. The Member is currently enrolled in duplicative care management waiver or DHCS demonstration programs such as:
   1) Multipurpose Senior Services Program (MSSP)
   2) Assisted Living Waiver
   3) Home and Community-Based Alternatives (HCBA) Waiver;
   4) HIV/AIDS Waiver
   5) HCBS Waiver for Individuals with Developmental Disabilities (DD)
   6) Self-Determination Program for Individuals with I/DD
   7) Cal MediConnect
   8) Fully Integrated Dual Eligible Special Needs Plans (FIDESNPs)
   9) Program for All-Inclusive Care for the Elderly (PACE)
   10) Family Mosaic Project
   11) California Community Transitions (CCT) Money Follows the Person (MFTP)
i. The Member is currently enrolled in Partnership's Basic Case Management or Complex Case Management Programs. For these Members, Partnership Care Coordination staff will work with the Member, their caregiver, Authorized Representative, and/or interdisciplinary care team to evaluate and coordinate the appropriate level of case management support.

D. ECM CORE SERVICE COMPONENTS:
1. The ECM benefit is to be delivered primarily in-person where a Member seeks or receives care. If the ECM provider is unable to connect with the Member in-person, or the Member has expressed an alternative communication method, outreach and engagement may be performed by teleconferencing, telehealth, televideo, or other protected communication tool in an effort to help build relationships as a supplement to in-person visits.
2. An assigned Lead Care Manager will act as the Members' primary point of contact and is responsible for coordinating care, at minimum, across the following delivery systems, including but not limited to: medical, behavioral, developmental, dental, long-term care supports and community resources/supports, Community Supports, regardless of setting or payor.
3. The ECM Provider will designate a Lead Care Manager who may be any of following: a nurse, a social worker, a care navigator, a housing navigator, or a community health worker. The Lead Care Manager is responsible for the delivery of ECM services as outlined in the ECM core services components below, and shall possess the appropriate experience and expertise in servicing the Member's Population of Focus.
4. If the Member has other Care Managers assisting or supporting them, it is the responsibility of the Member's ECM Lead Care Manager to coordinate with those individuals and/or entities to ensure a seamless experience for the Member, and to ensure non-duplication of services.
5. Partnership will ensure all ECM enrolled Members receive the following ECM core service components from their assigned ECM provider:
   a. Outreach and engagement
      1) The ECM provider shall use available data to prioritize outreach and engagement of Members addressing Members with the most immediate needs first.
      2) The ECM provider will maintain regular contact with Members to ensure there are not gaps in the activities designed to address an individual's health and social service needs. Upon engagement, the ECM Provider shall obtain the Member's, the Member's parent/guardian or authorize representative's written consent for ECM services using the attached ROI form in

Archived 09/10/2025- Refer to MCAP7002

Attachment B.

a) The ECM Provider shall store a copy of this executed ROI form with the Member's ICP in the Point Click Care Platform to communicate back to Partnership the Member's data sharing preferences.

b. Comprehensive Assessment
   1) The ECM provider will perform a comprehensive assessment and/or risk screening to determine ECM engagement level and to inform the Member's ICP.
   2) Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care
   3) For Members with long-term services and supports (LTSS) needs, the Lead Care Manager shall utilize approved assessments and tools to develop care plans in accordance with federal requirements under 42 CFR 438.208(c), including:
      a) The ability for the Member to include people of their choosing to participate in the care planning process;
      b) The necessary information and support to ensure that the Member/individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
      c) Reflects cultural considerations of the Member and is conducted by providing information in plain language and in a manner that is accessible to the Member with disabilities and persons who are limited English proficient;
      d) Includes strategies for solving conflict or disagreement between Members and their care managers within the process, and also includes or references clear conflict-of-interest guidelines for all planning participants;
      e) Offers choices regarding the services and/or supports the Member may receive and from whom;
      f) Includes a method for the Member/individual to request updates to the plan as needed
      g) Records the alternative home and community-based settings that were considered in the care planning process with the Member/individual
      h) When available, Partnership shall share the results of the Health Risk Assessment (HRA), which includes the required LTSS referrals questions, with ECM providers when a Member is assigned to them.
      i) The ECM provider shall use the Members' responses to the HRA in developing the Members' Individualized Care Plan (ICP).

c. Individualized Care Plan (ICP)
   1) The ECM provider shall work with the Member, guardian, caregiver, AR, and/or other authorized person(s) as appropriate to assess strengths, risks, needs, goals and preferences to make recommendations for service needs.
   2) The Lead Care Manager is responsible for documenting and updating the Member's ICP as needed to ensure there are no gaps in care.
   3) The ICP shall contain at minimum, needs, strategies, and patient prioritized goals surrounding care coordination needs for services including but not limited to the following
      a) Physical health
      b) Mental health
      c) Developmental health
      d) Substance Use Disorder (SUD)
      e) Long Term Support Services (LTSS)

Archived 09/10/2025–Refer to MCAP7002

f) Oral health
g) Necessary community-based and/or social services
h) Health Promotion
i) Transitional Care Needs
j) Member and/or Family Supports

4) The Lead Care Manager shall make available to the Member a copy of the ICP upon enrollment in ECM and/or upon Member request.
5) The ECM Provider shall ensure that the Member's ICP contains appropriate clinical oversight.

d. Enhanced Coordination of Care
1) Organizing patient care activities, as laid out in the ICP, and sharing information with those involved as part of the Member's multi-disciplinary care team.
2) Implementing activities identified in the Member's ICP.
3) Maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team, whose input is necessary for successful implementation of Member goals and needs.
4) Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, long-term support services (LTSS), oral health trauma-informed care, and necessary community-based and social services, including housing, as needed.
5) Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment.
6) Communicating the Member's needs and preferences timely to the Member's multi- disciplinary care team in a manner that ensures safe, appropriate, and effective person- centered care.
7) Ensuring regular contact with the Member and their family member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s), when appropriate, consistent with the Individualized Care Plan (ICP).

e. Health Promotion
1) Working with Members to identify and build on successes and potential family and/or support networks
2) Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health
3) Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

f. Transitional Care Services
1) Develop strategies to reduce avoidable Member admissions and/or readmissions to acute or skilled settings.
a) For Members who are currently hospitalized, the ECM Lead Care Manager shall provide Transitional Care Services pursuant to the DHCS Population Health Management (PHM) Strategy Guide. At minimum, the ECM Lead Care Manager shall:
1) Prior to discharge, compete a discharge assessment to assess the Member's risk of re-institutionalization, re-hospitalization, and risk of SMH and/or SUD;

Archived 09/10/2025-Refer to MCAP7002

2) Ensure that medication reconciliation is conducted pre- and post-transition;
3) Ensure Closed Loop Referrals to Community Supports and coordination with county social service agencies and waiver agencies for In-Home Support Services (IHSS) and/or other Home and Community Based Services are coordinated as appropriate;
4) When applicable, ensure Members with SUD and mental health needs receive treatment for those conditions upon discharge;
5) Provide a discharge planning document to the Member, Member's parents, legal guardians, or authorized representatives, as appropriate, when being discharged from a hospital, institution or facility. This discharge plan must include information about the hospital, institution or facility to which the Member was admitted; the Member's pre-admission status (ex: living arrangements, physical and mental function, SUD needs, social support, DME uses, etc.); pre-discharge factors (ex: medical condition(s), physical and mental function, financial resources, social supports at the time of discharge, etc.); recommendations made for the Member after discharge (ex: placement, DME, follow-up, etc.); summary of the nature and outcome of participation of Member, Member's parents, legal guardians, or authorized representatives in the discharge planning process; anticipated problems in implementing post-discharge plans, and information regarding available care, services, and supports that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.
6) Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members.
7) Coordinating medication review/reconciliation
8) Providing adherence support and referral to appropriate services.

g. Member and Family Supports, which shall include, but are not limited to:
1) Documenting a Member's authorized family member(s), guardian, Authorized Representative, caregiver, and/or other authorized support person(s) and ensuring all required authorizations are in place to ensure effective communication between the ECM Providers; the Member and/or their family member(s), Authorized Representative, guardian, caregiver, and/or authorized support person(s)
2) Activities to ensure the Member and/or their family member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s), with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, state, and local privacy and confidentiality laws.
3) Ensuring the Member's ECM Lead Care Manager serves as the primary point of contact for the Member and/or family member(s), guardian, Authorized Representative, caregiver, and/or other authorized support person(s)
4) Identifying supports needed for the Member and/or their family member(s), Authorized Representative, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services
5) Providing for appropriate education of the Member and/or their family member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s) about care instructions for the Member

Archived 09/10/2025 – Refer to MCAP7002

6) Ensuring that the Member has a copy of their ICP and information about how to request updates

h. Coordination of and Referral to Community and Social Support Services
   1) Determining appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services offered by Contractor as Community Supports (CS) under CalAIM, see Partnership Policy MCUP3142 CalAIM Community Supports.
   2) Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").

6. Members enrolled in the ECM benefit shall participate in differing levels of engagement as determined by both the Member and ECM Provider through the development of the Member's ICP. At minimum, Partnership expects that the ECM provider attempts and/or makes successful engagement with the Member once a month via in-person, telehealth, telephonic or televideo where appropriate.
7. Through the delivery of ECM both the ECM provider and/or Member's Lead Care Manager shall use culturally and linguistically appropriate methods of communication with the Member.
8. Partnership shall recruit ECM Providers that have diverse care management staff reflecting the populations they serve.

D. MEMBER IDENTIFICATION & AUTHORIZATION OF ECM SERVICES

1. In accordance with Partnership's Population Health Management Program and activities, Partnership proactively screens, stratifies, segments and assigns risk tiers for Partnership's Membership population using Partnership's proprietary Risk Score Model and additional Member demographic, utilization, and social data. Through this process, Partnership identifies and prioritizes those Members who present with the highest needs and risks and directs them to appropriate interventions and services; including the Enhanced Care Management benefit. See policy MCND 9001 Population Health Management Strategy & Program Description.
2. Partnership will also proactively analyze data and/or information received directly from DHCS, counties, providers, members and/or others to identify additional Members eligible for the ECM benefit. Sources may include, but are not limited to:
   a. Enrollment data
   b. Utilization/claims data including
      1) Encounter data
      2) Pharmacy data
      3) TAR clinical data (ex: Minimum Data Set Survey data from LTCs, CBAS Individualized Plan of Care, etc.)
      4) Laboratory data, as available
   c. Screening or assessment data (ex: Health Risk Assessment for Seniors or Persons with Disabilities (SPD), etc.)
   d. Clinical information on physical and/or behavioral health
   e. SMH/SUD data, as available Risk stratification information for children in Partnership's Whole Child Model (WCM) program
   f. Information about social determinants of health, including standardized assessment tools and/or current ICD codes
   g. Regional Center data feeds
   h. Results from any available Adverse Childhood Experience (ACE) screening
   i. Other cross-sector data and information, including housing, social services, foster care, criminal

Archived 09/10/2025–Refer to MCAP7002

justice history, school absentee or truancy and other information relevant to the ECM Populations of Focus (e.g., Homeless Management Information System (HMIS), available data from the education system, etc.).

j. Plan Data Feed from DHCS
k. 1915c waiver wait lists
l. Claims, laboratory, request for services and/or encounters shall be used to internally identify Members who are pregnant or postpartum and meet other ECM Population of Focus criteria.
m. Other data and/or risk stratification reports

3. Partnership shall compile a monthly report of potentially eligible ECM Members based upon Partnership's available data and analysis.
   a. The list of Members on this report shall be prioritized; with the Members believed to have the immediate needs and in need of outreach and engagement listed first.
   b. This prioritized report shall be shared and assigned to the appropriate ECM provider(s) so that outreach and engagement with Members can be initiated.
4. In addition to using available data, Partnership encourages direct referrals for Members to access ECM services. Information on directly referring Members to ECM, along with Partnership's ECM referral form can be found on Partnership's website as well as information in the Partnership Member/provider newsletter. In addition, Partnership shares information about how to refer Members for ECM services at community partner meetings, provider roundtables and/or community events.
5. Direct referrals for ECM can come from a multitude of sources, including but not limited to:
   a. Providers, ECM providers, and/or community-based organizations via phone, mail, or fax.
   b. Members and/or their family Member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s) via phone, mail, or Partnership Member portal.
   c. Partnership Care Coordination Department
   d. Internal Partnership Department (ex: Claims, Utilization Management, Pharmacy, Member Services, Population Health Management, etc.)
   e. County partners (ex: Health and Human Services, Behavioral Health, Public Health, Social Services, Child Welfare, Continuums of Care, etc.)
   f. Hospitals, including CCS Specialty Care Centers
   g. Probation and/or parole departments
   h. Nursing Homes / Skilled Nursing Facilities
   i. Home Health Agencies
   j. Community Based Adult Services (CBAS) providers
   k. Home and Community Based Waiver Providers
   l. Area Agencies on Aging
   m. Centers for Independent Living
   n. Regional Centers
   o. Schools
   p. Local Foster Care Offices
   q. First 5
   r. Community Based Organizations
   s. Local Perinatal Programs
   t. Community Supports Providers
   u. Correctional facilities, prisons, jails, youth/juvenile facilitates
6. Upon receipt of a direct ECM referral, Partnership's designated staff shall conduct an initial screening for ECM services, and assign Members who may qualify for ECM to an in-network ECM provider for a Comprehensive Assessment and ICP.
   a. For Members who meet the initial screening criteria, Partnership's designated staff shall:

Archived 09/10/2025-Refer to MCAP7002

1) Inform the Member and/or their AR of the Member's referral assignment via telephone, mail and/or Member portal when appropriate, and
2) Electronically inform the ECM provider of the referral assignment in the electronic systems denoted below in section VI.H.

7. Partnership will require specific ECM referral information from entities in accordance with DHCS ECM referral standards and form template guidance.
   a. Partnership will acknowledge receipt of the ECM referral.
   b. Partnership will notify the individual or entity if there are errors that must be corrected before submission.
8. For Members who do not meet initial screening criteria, Partnership's Care Coordination Department shall offer other available case management and/or care coordination services (e.g. Complex Case Management, etc.) For Members who qualify for the ECM benefit, Partnership requires that a Treatment Authorization Request (TAR) be submitted to Partnership for review and approval of ECM services. See Partnership policies MCUP3041 - Treatment Authorization Request (TAR) Review Process and MCUP3143 Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS).

E. ECM PROVIDER ASSIGNMENT

1. The Member's assigned ECM provider must meet the following standards:
   a. Must be experienced in serving the ECM Population(s) of Focus they will serve. For Members with long-term services and supports (LTSS) needs, the Lead Care Manager will be experienced and/or have received training in person-centered planning as required by federal law.
   b. Have experience and expertise with the services they provide.
   c. Comply with all applicable state and federal laws and regulations and all ECM program requirements.
   d. Have the capacity to provide culturally appropriate and timely in-person care management activities in accordance with Exhibit A, Attachment 6, Provision 13, Ethnic and Cultural Competency.
2. Members will be assigned to their approved ECM provider after taking into account their known preferences, previous provider relationships, and/or health needs.
   a. If the Member's assigned Primary Care Provider (PCP) is a contracted ECM Provider, Partnership shall assign the Member to the PCP as the ECM Provider, unless the Member has expressed a different preference or Partnership identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
   b. If a Member receives services from a Specialty Mental Health Plan for severe emotional disturbance (SED), substance use disorder (SUD), and/or serious mental health (SMH) and the Member's behavioral health Provider is a contracted ECM Provider, Partnership shall assign that Member to that behavioral health Provider as the ECM Provider, unless the Member has expressed a different preference or Partnership identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
   c. For Members enrolled in Partnership's Whole Child Model for CCS, Partnership shall assign that Member to a CCS Case Manager affiliated with a contracted ECM provider for ECM services, unless the Member or family has expressed a different preference or Partnership identifies a more appropriate ECM Provider given the Member's individual needs and health conditions. For more information on case management and care coordination services provided under the Whole Child Model for CCS, see Partnership Policy MCCP2024.
3. Members can request to change their assigned ECM provider by contacting Partnership's Care Coordination department via phone, mail or Partnership's Member Portal. Upon receipt of a Member's request for reassignment, Partnership's Care Coordination

Archived 09/10/2025 - Refer to MCAP7002

department shall contact the Member to acknowledge the request, and to work collaboratively with the Member for reassignment to a new ECM provider within 30 days of the request date.

4. Partnership will ensure that ECM provider communication of a Member's assignment to designated ECM provider occurs within ten (10) business days of authorization. Partnership shall communicate the Member's assignment using the information platform described in section VI. H.
5. Partnership will document the Member's ECM Lead Care Manager in its internal electronic platform and systems.
6. As contracted network providers, both ECM providers and PCPs alike can work with Partnership's Provider Relations Department representatives to provide feedback regarding ECM referrals or concerns they may have about ECM Member assignments.

F. DISCONTINUATION OF ECM

1. The ECM provider shall notify Partnership, and the interdisciplinary care team, when a Member discontinues ECM services. Examples of discontinuation include:
   a. The Member has graduated and is no longer in need of intensive case management or care coordination services. Graduation criteria for ECM shall include:
      1) The Member has met all identified goals on their ICP addressing any needs for their medical, behavioral health, dental, long-term supports, or community referral needs as indicated. (e.g. connection to primary/specialty care, appropriate utilization of health care services, connection to mental health, connection to dental care, connection to Community Based Adult Services (CBAS) or In-Home Support Services (IHSS), referrals and linkages to Community Supports, etc.).
      2) The Member has demonstrated an ability to self-manage their health. (e.g. able to make their own appointments, understands warning signs or triggers for their medical and/or mental health conditions and can implement strategies to prevent acute exacerbations, ability to manage their medications or treatment regimens, verbalizes an understanding of who to call if new health problems arise, has obtained all necessary durable medical equipment (DME), etc.).
      3) The Member is connected to appropriate community service(s) and/or Community Supports to address their short-term and long-term needs (e.g. housing, meal delivery, transportation, disease management programs/classes, support groups, etc.).
   b. The Member expresses that they no longer wish to receive ECM
   c. The Member is unresponsive or unwilling to engage in ECM outreach & engagement attempts by the ECM provider
   d. The Member, who was previous enrolled in ECM, no longer responds to the ECM provider's attempts to contact, locate or engage the Member
   e. The Member is deceased
   f. The Member loses Partnership Medi-Cal eligibility
   g. The Member moves out of Partnership's service area
   h. The Member becomes incarcerated for more than 30 days
   i. After attempts to reassign the Lead Care Manager or remedy ECM service delivery, the ECM provider can no longer provide services. (ex: patient behavior, unsafe environment, etc.)
   j. The Member is transitioned to an alternative care management or care coordination program/services that can better meet the Member's goals, preferences and care needs.
      1) In order to prevent gaps in care or duplication of ECM services, ECM providers are to plan and coordinate to transfer a Member's care needs within 30 days to an

Archived 09/10/2025-Refer to MCAP7002

alternative care management or care coordination provider. Examples of such providers/programs include, but are not limited to:
   a) Hospice
   b) Partnership's Intensive Outpatient Palliative Care Program
   c) Long-Term Dialysis
2) When appropriate, the ECM provider and care team are to coordinate services and transition the Member to a lower level or alternative care management program based on the Member's needs, goals, preferences and progress on ICP, including but not limited to Partnership's Complex Case Management Program.

2. Upon discontinuation of ECM, Partnership shall:
   a. Notify the ECM provider
   b. Issue a Notice of Action (NOA) to the Member regarding discontinuation of ECM services. The notification will serve to inform the Member of their rights per DHCS, including their right to appeal the decision as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals and APL 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates. For more information, see policy MCUP3037 Appeals of Utilization Management/Pharmacy Decisions.

G. CONTINUITY OF CARE
1. Beginning January 1, 2022 for Members who are in process or currently enrolled in a Whole Person Care Pilot program, who are identified by the WPC Lead Entity as belonging to an ECM Population of Focus, Partnership will automatically authorize ECM services for six (6) months pursuant to DHCS implementation schedule.
   a. Transitioning Members must be assessed within six (6) months of their initial authorization, or other timeframes provided by DHCS, to determine most appropriate level of care management services and ECM benefit eligibility per the criteria as outlined above. ECM providers shall:
      1) Complete a comprehensive assessment, ICP and submit to Partnership a Treatment Authorization Request (TAR) pursuant to Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process for continued ECM services.
      2) Transition Members who no longer meet the criteria for ECM services as outlined in section VI.F. Discontinuation of ECM.
      3) Notify Partnership of transitioning Members who have been discharged as outlined in section VI.F. above.
   b. Partnership shall utilize existing data exchange platforms described in section VI.H. to coordinate with WPC Lead Entities to ensure a smooth transition and warm hand-off for mutual Members entering into or being discharged from the ECM benefit.
   c. Both the WPC Lead Entity and Partnership shall work collaboratively to inform Members via written notice of the transition to the ECM benefit pursuant to DHCS' guidance.
2. Partnership shall attempt to contract with each WPC Lead Entity as an ECM provider to provide Members with ongoing care coordination and continuity of care in WPC Pilot Counties.
   a. Partnership shall submit to DHCS for prior approval any requests for exceptions to the WPC contracting requirement. Permissible exceptions to contracting are:
      1) There is a justified quality of care concern with the ECM Provider(s)
      2) Partnership and ECM Provider(s) are unable to agree on contracted rates
      3) ECM Provider(s) is/are unwilling to contract
      4) ECM Provider(s) is/are unresponsive to multiple attempts to contract
      5) ECM Provider(s) is/are unable to comply with the Medi-Cal enrollment process or

Archived 09/10/2025 Refer to MCAP7002

vetting by the Contractor; and/or

6) For ECM Provider(s) without a state-level pathway to Medi-Cal enrollment, ECM Provider(s) is/are unable to comply with the Partnership processes for vetting qualifications and experience

b. For transitioning Members for whom Partnership is not able to enter into a contract with the WPC Lead Entity, Partnership shall authorize ECM services with an in-network ECM provider.

3. Members transitioning to Partnership from another managed care plan and /or fee-for-service Medi-Cal who are currently enrolled in ECM, shall automatically be authorized for ECM services. For these Members:
   a. Partnership shall use available utilization data to proactively identify any new Members who are in receipt of ECM within the previous 6 months of their assignment to Partnership, and initiate continued ECM authorization.
   b. Newly assigned Partnership Members or their AR may contact Partnership directly to request continued ECM benefits and Partnership shall expedite this request.
   c. If a pre-existing relationship has been established and the ECM provider is part of Partnership's ECM network or agrees to a letter of agreement until an agreement is reached, Partnership will assign the Member to their existing ECM provider to ensure the Member's relationship is not disrupted.
   d. Partnership shall contact and work with the Member's previous health plan and/or ECM provider to obtain access to the Member's ICP and ensure services are connected appropriately.
   e. ECM services shall be authorized for up to six (6) months. At which time, the Member shall be reassessed for services in accordance to the policy criteria shared above in sections VI. A, B, and F.

H. DATA SHARING TO SUPPORT ECM
1. Partnership has an Information Technology (IT) and data analytic infrastructure to support the delivery of the ECM benefit. Key features of Partnership's systems include, but are not limited to:
   a. Systems and agreements with agencies that support the information captured for ECM Member identification as outlined in section VI.D.
   b. Secure data sharing between, Partnership, ECM provider, the Member, and other providers in support of ECM.
   c. The ability to receive, process, and send encounters from ECM providers to DHCS.
   d. The ability to receive and process supplemental reports from ECM providers.
2. ECM providers shall use the "Point Click Care" module of the cloud-based Point Click Care Platform (see III. B) in the delivery of ECM services. This platform shall allow Partnership and ECM providers to:
   a. Share real-time information between ECM Members' care teams and providers.
   b. Serve as a mechanism for Partnership and ECM providers to share ECM Member assignment files (e.g. targeted engagement lists, referrals, discontinuation or disenrollment from ECM services, etc.)
   c. Track Emergency Department and Inpatient Hospital Admissions as they are occurring.
   d. Perform and run periodic reports of performance on certain quality measures and/or metrics.
3. Partnership will use defined Federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM Providers and with DHCS, to the extent practicable.

I. ECM PROVIDER NETWORK DEVELOPMENT
1. Partnership will contract with providers that meet DHCS' and Partnership requirements
2. Partnership will collaborate with other Managed Care Plans (MCP) in the applicable county to

Archived 09/10/2025- Refer to MCAP7002

identify qualified ECM providers with which to contract.

3. Partnership will make every effort to contract and build a sufficient network of ECM providers
4. Partnership will collaborate with other MCPs in the county/counties in which it operates to achieve mandatory overlap of the provider network

J. ECM PROVIDER OVERSIGHT & QUALITY MONITORING

1. Partnership will perform oversight of ECM providers, holding them accountable to all ECM requirements contained in the DHCS Contract amendment and DHCS APL 21-012: Enhanced Care Management Requirements.
   a. Partnership will perform quarterly audits, or more frequently as needed, to evaluate ECM provider performance and compliance to ensure State, Federal, and contractual requirements are met. At a minimum, the following shall be reviewed:
      1) ECM Files:
         a) Visit documentation showing minimum number of visits
         b) Delivery of the Core Services components of ECM
         c) Release of Information (ROI)
      2) ECM provider's policies and procedures as they relate to the delivery of ECM, including but not limited to:
         a) Internal policies
         b) Job descriptions
         c) Training Materials
         d) Organizational charts
         e) Model of Care for Justice Involved providers that includes:
            i. Provisions for a "warm handoff" between ECM providers within the correctional facility and those who will provide ECM services upon release at least 2 weeks prior to date of expected release.
            ii. Ensuring the ECM provider meets the Member within 1-2 days of release wherever possible
            iii. A second follow up ECM appointment occurs within 1 week of release.
            iv. The ECM provider leverages the reentry plan that was developed in the pre-release period as the post-release care management plan.
      3) Quality and monitoring reports to guide improvement across the network
         a) Point Click Care reports
         b) Partnership internal monitoring reports & dashboards
         c) Member experience surveys
         d) Referral patterns
         e) ECM Provider Capacity Reports
   b. Partnership has developed its ECM contracts using the DHCS ECM Provider Standard Terms and Conditions and incorporated all of its ECM provider requirements, including all monitoring and reporting expectations and criteria.
2. Partnership shall support ECM Provider peer sharing meetings to report on activities at a frequency of every two (2) months for new sites, during the first six (6) months of services, and at a frequency of every six (6) months for existing sites or at a frequency deemed appropriate for support as monitored by Partnership.
   a. Topics shall include, but not be limited to: billing, authorizations, best practices for operational efficiencies, successful strategies to improve outreach and engagement efforts, case management and care coordination approaches for complex populations, health equity, ECM policy updates, etc.
3. ECM providers shall conduct Member experience surveys of enrolled Members at least once annually and share a summary of this survey with Partnership.

Archived 09/10/2025-Refer to MCAP7002

4. Over time, Partnership shall review key performance indicators of ECM providers and ECM benefit to provide benefit monitoring and oversight as well as address quality standards and to identify areas of improvement. Examples include, but are not limited to:
   a. ECM Member-level outcomes related to medical cost, utilization and/or health status'
   b. ECM referral sources and patterns
   c. ECM provider key performance indicators, including but not limited to: Member capacity, successful outreach attempts, # of FTEs providing ECM, etc.
   d. Results of ECM Member surveys
5. Partnership will inform PCPs, Members, family Member(s) guardian, caregiver, and/or other authorized support person(s) and community partners about the ECM benefit through routine Member communication pathways, including but not limited to:
   a. Partnership Member Handbook
   b. Partnership Website
   c. Required DHCS notices
   d. Webinars
   e. Member/Provider newsletters

J. HEALTH EQUITY FOR ENHANCED CARE MANAGEMENT (ECM)
1. Health Equity is a priority for DHCS and Partnership. Partnership shall ensure that ECM services are delivered in a culturally relevant, person-centered manner by:
   a. Encouraging ECM providers to hire and train care management staff with experience and expertise in serving the unique Population of Focus' under ECM.
   b. Screen potential ECM providers through Partnership's ECM Readiness Assessment and contracting process
   c. Include Health Equity measures as part of Partnership's oversight and quality monitoring of ECM, such as disparities in engagement, disparities in access and/or patterns of utilization of ECM services for the health plan.

K. ECM SUBCONTRACTOR DELEGATION
1. Partnership may allow an ECM provider to subcontract with other entities to administer ECM services under the following conditions:
   a. The ECM provider maintains the responsibility for oversight and compliance of all of its subcontractors for the delivery of ECM as set forth in this policy and in DHCS APL 21-012. Examples of compliance include, but are not limited to:
      1) Ensure the subcontractor meets the DHCS required provider experience thresholds for the delivery of ECM for the Population(s) of Focus.
      2) Ensure the subcontractor has appropriate staffing ratios and capacities.
      3) Partnership shall provide oversight and monitoring of the ECM provider's ability to perform delegation of the ECM benefit.
      4) Maintain current contracts and make available to Partnership any subcontractor agreements upon DHCS request. Such agreements will contain minimum required information specified by DHCS, including the method and amount of compensation, Population(s) of Focus served, service area, case ratios and ECM capacity.
   b. Partnership will ensure the agreement between ECM delegated entity and subcontractor mirrors the requirements outlined in the DHCS Contract and the ECM provider Standard Terms and Conditions, as applicable to the subcontractor.
   c. Partnership will make every effort to collaborate with its ECM provider delegated entities and subcontractors on the best approach to streamline the ECM experience and minimize the divergence for ECM Members and providers.

Archived 09/10/2025- Refer to MCAP7002

2. Partnership will hold ECM entities and subcontractors to the same ECM provider requirements.
3. Partnership shall maintain appropriate structures and mechanisms to ensure delegation oversight, including pre-delegation evaluation as applicable, no less than annual review of delegation agreement/grid, monitoring of performance data, and oversight auditing of delegated functions. Partnership's delegation oversight is designed to effectively review, evaluate, and verify satisfactory performance and compliance with regulatory and accreditation standards.

L. DHCS ECM OVERSIGHT
1. Partnership will submit the following data and reports to DHCS to support DHCS' oversight of ECM:
   a. Encounter data using national standard specifications and code sets defined by DHCS.
      1) Partnership is responsible for submitting all encounter data to DHCS for ECM services to its Members, regardless of the number of levels of delegation and/or sub-delegation between Partnership and the ECM provider.
      2) In the event the ECM provider is unable to submit the ECM encounters to Partnership using the national standard specifications and codes set by DHCS, Partnership will be responsible for converting the ECM provider's data information before DHCS submission.
   b. Supplemental reporting on a schedule and in the DHCS specified format.
2. Partnership will track and report to DHCS in a DHCS specified format, information about outreach efforts related to potential ECM Members.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment 5 Utilization Management and Attachment 6, Provision 13, Ethnic and Cultural Composition
B. DHCS All Plan Letter (APL)23-032 Enhanced Care Management Requirements(12/22/2023 *supersedes APL 21-012*)
C. DHCS All Plan Letter (APL) 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2021)
D. DHCS All Plan Letter (APL) 22-013 Provider Credentialing / Recredentialing and Screening / Enrollment (07/19/22 *supersedes APL 19-004*).
E. Title 42 Code of Federal Regulations (CFR) Section 438.208(c).
F. Title 42 Code of Federal Regulations (CFR) Section 441.301(c).
G. DHCS ECM Policy Guide (August 2024)
H. DHCS ECM Referral Standards and Form Templates (August 2024)

VIII. DISTRIBUTION:

E. Partnership Department Directors
F. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 10/12/22; 11/08/23; 11/13/24; ARCHIVED 09/10/2025

PREVIOUSLY APPLIED TO:

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with

Archived 09/10/2025- Refer to MCAP7002

involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

Archived 09/10/2025- Refer to MCAP7002

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ECM Care Plan Guide

Date: _____

Patient Information			
First Name:	Last Name:		DOB:
Sex:	Pronouns:	Primary Language:	

Address Information			
Street:			
City:	State:	Zipcode:	County:
Mailing Address Same as Home Address:		☐ Yes	☐ No
Street:			PO Box:
City:	State:	Zipcode:	County:

Contact Information
Email:
Phone #:
Phone #:

Other Contacts		
Family/Caregiver	Name:	May we contact if needed?
Email:		Phone #:
Community Team	Name:	May we contact if needed?
Email:		Phone #:
Program Representative	Name:	May we contact if needed?
Email:		Phone #:

Insurance Information		
Medi-Cal ID:		
Primary Insurance	Plan:	Group #:
Policy #:		Member ID:
Secondary Insurance	Plan:	Group #:
Policy #:		Member ID:

Acuity			Self-Management Assessment		
☐ High Risk	☐ Low Risk	☐ No Risk	☐ Poor	☐ Moderate	☐ Good

Social Determinants of Health	
If current member has any changes to SDoHs, check the box and fill out only the changes: ☐	
Education:	Employment Status:
Income Status:	Food Security:
Housing Stability:	Transportation:
Support Networks:	

Archived 09/10/2025-Refer to MCAP7002 - A

ECM Criteria (Select all that apply)				
Populations of Focus		***For current member, if no longer meets criteria, fill applicable criteria***	***If current member and new criteria identified, fill applicable criteria***	***If new member, fill applicable criteria***
Adult	*Unhoused*	☐	☐	☐
	Individuals At Risk for Avoidable Hospital or ED Utilization	☐	☐	☐
	At Risk of Institutionalization & Eligible for LTC Services	☐	☐	☐
	Nursing Home Transition to the Community	☐	☐	☐
	Serious Mental Health/Substance Use Disorder	☐	☐	☐
	Pregnant and Postpartum at Risk for Adverse Perinatal Outcomes	☐	☐	☐
	Transitioning from Incarceration w/ Complex Health Needs to Community	☐	☐	☐
Child	*Unhoused*	☐	☐	☐
	Individuals At Risk for Avoidable Hospital or ED Utilization	☐	☐	☐
	Serious Mental Health/Substance Use Disorder	☐	☐	☐
	Pregnant and Postpartum at Risk for Adverse Perinatal Outcomes	☐	☐	☐
	Birth Equity	☐	☐	☐
	Transitioning from Incarceration	☐	☐	☐
	Complex Medical / Behavioral / Development Needs	☐	☐	☐
	Involved in Child Welfare	☐	☐	☐
	Enrolled in California Children's Services (CCS) or Whole Child Model (WCM) w/ Additional Needs Beyond CCS Condition	☐	☐	☐

Archived 09/10/2025- Refer to MCAP7002 - A

Physical Health

Active Medical Problems (chronic conditions, fall risk, speech, etc.)	Past Medical History

Not Req'd. for members less than 18		Members with diabetes or who are on antipsychotic medication	
Blood Pressure:	Date:	A1C Levels:	Date: _____ _____A1C%
	____Systolic / ____Diastolic		

Dental/Oral Health

Active Dental Problems/Concerns	
Dental Provider's Name:	Last Visit Date:
Dental's Office:	Next Visit Date:

Mental Health History

	If PHQ-2 Score is normal, do not proceed to PHQ-9 Test. If PHQ-2 Score is not normal proceed to PHQ-9 Test	
	Date:	
	PHQ-2 Score	PHQ-9 Score

If prescribed Antidepressants or Psychotherapy, please provide more information below
(E.g.: adherence to medication regimen; improvements in mental health after therapy)

Substance Use Disorder Screening

Alcohol Use	Drug Use
Frequency:	Frequency: Drug Type
AUDIT-C Score	DAST-10 Score

If other information requires further disclosure, please provide below:

Archived 09/10/2025- Refer to MCAP7002 - A

Hospitalizations	
Admissions in the last 6 mos:	Emergency Dept. visits in the last 6 mos:

Durable Medical Equipment		
___Hospital Bed	___Oxygen	**Other**
___Wheelchair	___Walker	

Physician Visits	
Primary Care Physician visits in the last 6 mos:	Last Visit Date:
Physician's Name:	Physician's Office:
Specialist visits in the last 6 mos:	Last Visit Date:
Specialist's Name:	Specialist's Office:

Medication List	Indication

Allergies

Long-Term Support Services	
Community Based Adult Services (CBAS)	Service Name
Multi-purpose Senior Services Program (MSSP)	Service Name
Home Health Agency	Service Name
Palliative Care	Service Name
Hospice Care	Service Name
In-Home Support Services (IHSS)	Hours/month

Advanced Care Planning			
Surrogate Decision Maker	☐Has One	☐Needs One	☐Does Not Want One
Living Will	☐Has One	☐Needs One	☐Does Not Want One
Advance Directive	☐Has One	☐Needs One	☐Does Not Want One
POLST	☐Has One	☐Needs One	☐Does Not Want One
Power of Attorney	☐Has One	☐Needs One	☐Does Not Want One
Code Status	☐DNR	☐Full Code	☐Limited Interventions

Archived 09/10/2025- Refer to MCAP7002 - A

Goals	
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met

Referrals Needed

Archived 09/10/2025- Refer to MCAP7002 - A

ECM Staff Member Name: Date

ECM Staff Member Signature: Date

ENHANCED CARE MANAGEMENT (ECM) SERVICES

Authorization for Use, Exchange, and/or Disclosure
of My Confidential Health Care and Personal Information

PURPOSE

Health care providers, health payers, and social services agencies have joined together to provide **Enhanced Care Management (ECM) services** to help promote your health and well-being. To allow Partnership HealthPlan of California ("**Partnership**") and/or other entities to share your health care and other personal information with each other to help provide you with these ECM services, you must give your authorization first. By filling out this form, you are authorizing the use and release of your health care and other personal information by the following entities participating in ECM ("**ECM Entities**"): health care providers such as hospitals, physicians, and pharmacies; Partnership and other managed care plans that administer Medi-Cal benefits and pay for services you receive under Medi-Cal; community-based organizations that must comply with health care privacy laws; school-based providers such as nurses, social workers, and counselors; the California Departments of Health Care Services, Public Health, Social Services, and Developmental Services; and county agencies including, but not limited to, mental health plans; and providers and case managers at correctional facilities, but only for the purposes set forth below. Your authorization will permit ECM Entities to use and release your health care and other personal information for the following purposes ("**Purposes**"): (a) to provide you with, refer you to, or help you receive comprehensive care management services, including coordinating health and health-related care services and case management ("**Services**") to meet your needs; (b) to identify, support, coordinate, improve and arrange payment for Services that may be provided to you; and (c) to help Partnership provide better care through evaluation, reporting, and population health management. The information may be shared in a secure electronic format, in writing, or verbally to coordinate Services for you.

Archived 09/10/25- Refer to MCAP/002-B

Member Information

First Name:	Last Name:
Address:	
Phone Number: ( )	Date of Birth:
Member ID/CIN:	

I authorize and ask that **Partnership HealthPlan of California** and **participating ECM Entities** named in **Attachment A** to use and share any of my health care or other personal information with each other for the purpose stated in this Authorization.

Choose ONE of the following options:

INITIAL HERE	**Consent for communication by ECM Program:** By putting my initials here, I am allowing ALL of the ECM Entities listed in **Attachment A** to use and share my health care and other personal information about my medical history, physical and mental condition, and receipt of social services, and to communicate with each other in order to provide ECM Services. The types of health and other confidential information that I am authorizing to be shared between ECM Entities include: (a) Protected health information ("**PHI**"), including information regarding my health

	care, medical history, lab test results, and current or future conditions and treatment; (b) Mental health information, including current and past diagnoses and treatments of my mental health conditions, excluding psychotherapy notes which are only shared if I sign a separate consent form; (c) Individualized Education Program information and other information about social services provided in school; (d) Medi-Cal eligibility/enrollment information, which includes income and certain other demographic and geographic information pertaining to my eligibility for Services and benefits; (e) Housing/homelessness information, including my housing status, history, and supports; and (f) Limited criminal justice information, including booking data, dates and location of incarceration, and supervision status. My consent does not apply to my criminal history, charges, and immigration status.
INITIAL HERE	**Decline to participate in ECM:** I understand that the ECM program allows ECM Entities to be in contact with each other to coordinate my care. I decline to participate in the ECM program. I can ask to participate in case management programs for which I am eligible.

Further, by putting my initials below, I specifically authorize the release of the following information (this information will NOT be released unless you specifically authorize it)

INITIAL HERE	Mental health information, including diagnosis, treatment plan, and provider name. This does not include psychotherapy notes, which are only shared if I sign a separate consent form.
INITIAL HERE	HIV Test Results (Health & Safety Code § 120980 (g))

Substance Use Disorder Information

Substance use disorder ("**SUD**") records are protected by federal confidentiality rules (42 CFR Part 2). The federal rules do not allow any further release of information that finds a patient as having or having had a substance use disorder either by reference to publicly available information, or through proof of such identification by another person unless further release is permitted by the written consent of the person whose information is being given or as otherwise permitted by 42 CFR Part 2. The federal rules restrict any use of the information to investigate or prosecute, with regard to a crime, any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. By filling out this section, you are authorizing ECM Entities to use and release the following SUD information for the Purposes described in this form: your current and past drug or alcohol use diagnoses, medications, treatment, lab tests, trauma history, facility discharges, and any other SUD information about you that comes from a substance/alcohol use disorder provider subject to federal SUD confidentiality regulations (42 C.F.R. Part 2). SUD records (or information therein) that are used or disclosed for treatment, payment, or health care operations by certain ECM Entities, including health care providers, health plans and other third-party payors, may be redisclosed as permitted in the federal HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you. Your SUD counseling notes will not be shared unless you sign a separate consent form.

Archived 09/30/25 - Refer to MCAP7002-B

INITIAL HERE	Initial here to allow the ECM Entities in **Attachment A** to use and share your SUD information as described above, excluding SUD counseling notes.

Expiration of Form

Choose ONE of the following two options:

INITIAL HERE	**Standard expiration:** This authorization will expire 1 year from today's date; OR
INITIAL HERE	**Expiration:** This authorization will expire on:_____. This date may not be less than 6 months (to participate in the ECM program), but may be more than 1 year from today's date.

I understand that:

- I can revoke this Authorization at any time by calling Partnership at (800) 863-4115 or by sending a signed revocation request to:

  Partnership HealthPlan of California
  Attn: Enhanced Health Services
  4665 Business Center Drive
  Fairfield, CA 94534
- A revocation is effective when received, but may not apply to information already shared, based on my prior consent to use or release information.
- I can choose to not sign this form and doing so will not affect my treatment or care, my eligibility for or ability to receive Services, or the payment for Services. However, my ability to participate in the ECM program may be affected by not signing this Authorization.
- Even if I do not sign this form, under federal and state privacy laws, some of the ECM Entities may share my confidential information for treatment, payment, and other purposes, but providers subject to federal substance use confidentiality laws generally may not share my substance use disorder information without my consent (42 CFR Part 2).
- The information I authorize for use or release may be re-shared by ECM Entities, but only in compliance with this Authorization and applicable law.
- I can get a copy of the health information that is being shared.
- I have the right to ask for a copy of this form and one will be sent to me.
- I may obtain a list of all ECM Entities to which my information has been disclosed, including those entities identified in **Attachment A**, by contacting Partnership.
- If I voluntarily include my phone number above, I consent to the receipt of texts or calls to communicate with me about my consent choices and how my health and other confidential information may be shared (standard message and data rates may apply).
- Each of the above rights extend to any representative I authorize under applicable law.

[*signature on next page*]

Archived 09/10/25. Refer to MCAP7002-B

Signature of Member

If you are signing this Authorization on your own behalf, fill out the first line. If you are signing on behalf of someone else, fill out the second line. If you are signing on behalf of a minor aged 12-17, the minor should fill out the first line and you should fill out the second line.

Beneficiary's Name	Beneficiary's Signature	Date (mm/dd/yyyy)
Representative's Name	Representative's Signature	Date (mm/dd/yyyy)

Archived 09/10/25- Refer to MCAP70

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCAP7002 (previously MCCP2032)</td><td colspan="3">Lead Department: Health Services
Business Unit: Enhanced Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: CalAIM Enhanced Care Management (ECM)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 03/09/2022
Effective Date: 01/01/2022 vs. DHCS</td><td colspan="3">Next Review Date: ~~11/13/2025~~09/09/2026
Last Review Date: ~~11/13/2024~~09/10/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/13/2024~~09/10/2025</td></tr>
</table>

I. RELATED POLICIES:

A. ~~MCUP3143~~ MCAP7001 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports
B. MPCD2013 – Care Coordination Program Description
C. MCCP2007 – Complex Case Management
D. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
E. MCND9001 – Population Health Management Strategy & Program Description.
F. MPCR100 – Credential and Re-credential Decision Making Process
G. MPPR200 – Partnership Provider Contracts
H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
I. MCCP2024 – Whole Child Model for California Children's Services (CCS)
J. MCUP3037 – Appeals of Utilization Management / Pharmacy Decisions
K. CMP36 – Delegation Oversight and Monitoring
L. ~~MCCP2033~~ MPAP7004-Community Health Worker (CHW) Services Benefit
M. MCCP2034 Transitional Care Services (TCS)

II. IMPACTED DEPTS:

A. Claims
B. Configuration
C. Compliance
D. ~~Enhanced~~ Health Services
E. Finance
F. Grievance ~~&and~~ Appeals ~~Utilization Management~~
G. Member Services ~~Project Management Office~~
H. Provider Relations

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Closed Loop Referral: means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and

format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and/or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.

C. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

D. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(C) delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

E. Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).

F. Enhanced Care Management (ECM): a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

G. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community- based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

H. Individualized Care Plan (ICP): A Member-focused care plan designed to optimize the Member's health, function, and well-being.

I. Lead Care Manager (LCM): A Member's designated care manager for ECM, who works for the ECM Provider organization. The Lead Care Manager operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any Community Support (CS). To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non- duplication of services.

J. Point Click Care (PCC) A contracted external vendor platform designated as Partnership HealthPlan of California (Partnership)'s ECM data sharing and information exchange system. The use of the platform will be to advance communication and share information between ECM Members' care teams, integrate services, improve health outcomes, and streamline the ECM benefit delivery.

K. Release of Information (ROI): The process of providing access to Protected Health Information (PHI) to an individual or entity authorized to receive or review it.

L. Release of Information (ROI) Consent Form for ECM: A valid ROI form including the Member's signature and specified time frame to allow Partnership, ECM provider(s), lead case manager, community organizations, and relevant affiliates or entities of the Member's care team to share their health information.

M. Substance Use Disorder (SUD): A complex condition in which there is the uncontrolled recurrent use of a substance, which causes harmful consequences such as clinically significant impairment, health problems, and disabilities.
N. Serious Mental Health (SMH): A diagnosed mental, behavioral, or emotional disorder resulting in serious functional impairment that interferes with or limits the quality of life.
O. Whole Child Model (WCM): A comprehensive program for the whole child encompassing care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member insured by Partnership.
P. Whole Person Care (Whole Person Care): A five-year pilot program under California's 1115 Medicaid waiver to service high-risk populations using a collaborative approach across public and private entities to integrate and coordinate health, behavioral health, and social services. Partnership's Counties participating in the WPC pilot program were Marin, Mendocino, Napa, Shasta, and Sonoma.

IV. ATTACHMENTS:

A. Individualized Care Plan Example
B. Enhanced Care Management (ECM) Release of Information Form (ROI)

V. PURPOSE:

To describe Partnership HealthPlan of California's (Partnership's) Enhanced Care Management (ECM) benefit for Partnership Medi-Cal eligible Members, and to outline the collaboration between Partnership, ECM providers, and other community partners in the delivery of ECM services pursuant to the California Department of Health Care Services (DHCS) All Plan Letter (APL) 23-032. The ECM benefit is unique and distinct from other care management programs. ECM builds on both the design and the learning from California's Whole Person Care Pilots (WPC) and Health Home Program (HHP). ECM, with Community Supports (CS), replaces both models, scaling up the interventions to a statewide care management approach. ECM offers comprehensive, "whole person" care management to high-need, high-cost Partnership Members. ECM services primarily:

A. Are delivered in-person to Members and/or their caregivers, Authorized Representative (AR), parents/guardians wherever Members may live, seek care, or prefer to access services within their community.
B. Focus largely on Social Determinants of Health (SDOH) such as housing/shelter, food instability, transportation and community supports to improve medical health outcomes and healthcare costs.
C. Populations of Focus within Partnership's membership that often need to access six or more separate delivery systems for care, benefits and/or support (e.g. Partnership, Medi-Cal fee-for-service, mental health, substance use disorder, developmental, dental, In Home Supportive Services, etc.).
D. Have goals and interventions that aim to improve care coordination, integrate the delivery of services, facilitate community resources and improve health outcomes, while decreasing inappropriate health care utilization.

VI. POLICY / PROCEDURE:

A. ECM ELIGIBILITY
   1. Member must be assigned to Partnership for Medi-Cal benefits.
   2. ECM is voluntary, Members can decline or end ECM services upon initial outreach and engagement, or at any other time.
   3. Member must be identified as meeting criteria in one of the following Populations of Focus eligible for ECM benefits:
      a. Adult Populations of Focus: Homelessness, At Risk for Avoidable Hospital or ED Utilization, Serious Mental Health (SMH) or Substance Use Disorder (SUD),

Transitioning from Incarceration, At Risk of Institutionalization / Eligible for Long-Term Care Services, Nursing Facility Residents Transitioning to the Community, and/or Pregnant and Postpartum; Birth Equity.

b. Children & Youth Populations of Focus: Homelessness, At Risk for Avoidable Hospital or ED Utilization, Serious Mental Health (SMH) and/or Substance Use Disorder (SUD), Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond CCS Condition, Involved with Child Welfare, Intellectual or Developmental Disability (I/DD), and/or Pregnant and Postpartum; Birth Equity.

4. Adult Specific ECM Population of Focus Eligibility Criteria are defined as:
   a. Effective through June 30, 2023, Individuals Experiencing Homelessness – Adults 21 years of age or older and their families who:
      1) Have at least one complex physical, behavioral, or developmental health need with an inability to successfully self-manage for whom coordination of services would likely result in improved health outcomes and/or decrease in utilization of high-cost services, and
      2) Are experiencing homelessness defined as meeting one or more of the following conditions defined by the U.S. Department of Health and Human Services (HHS) 42 CFR §11302 criteria:
         a) Lacking adequate nighttime residence
         b) Having a primary residence that is a public or private place not designed for or ordinarily used for habitation
         c) Living in a shelter
         d) Exiting an institution into homelessness
         e) Will imminently lose housing in next 30 days
         f) Fleeing domestic violence, dating violence, sexual assault, stalking and other dangerous, traumatic, or life-threatening conditions relating to such violence
   b. Effective July 1, 2023, Individuals Experiencing Homelessness – Adults 21 years of age or older without dependent children/youth living with them who:
      1) Have at least one complex physical, behavioral, or developmental health need with an inability to successfully self-manage for whom coordination of services would likely result in improved health outcomes and/or decrease in utilization of high-cost services, and
      2) Are experiencing homelessness defined as meeting one or more following conditions defined by the U.S. Department of Health and Human Services (HHS) 42 CFR § 11302 criteria:
         a) Lacking adequate nighttime residence
         b) Having a primary residence that is a public or private place not designed for or ordinarily used for habitation
         c) Living in a shelter
         d) Exiting an institution into homelessness
         e) Will imminently lose housing in next 30 days
         f) Fleeing domestic violence, dating violence, sexual assault, stalking and other dangerous, traumatic, or life-threatening conditions relating to such violence
         g) Defined as homeless under other federal statutes
   c. At risk for Avoidable Hospital or ED Utilization – Adults, 21 years of age or older who:
      1) Have five (5) or more Emergency Department (ED) visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence, and/ or

2) Have three (3) or more unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

d. SMH or SUD – Adults, 21 years of age or older who:
   1) Meet the eligibility criteria for participation in or obtaining services through:
      a) Specialty mental health services (SMHS) delivered by the county's Mental Health Plan (MHP)
   2) The Drug Medi-Cal Organized Delivery System (DMC-ODS) or the Drug Medi-Cal (DMC) program, and are actively experiencing at least one complex social factor influencing their health, and
   3) Are experiencing at least one complex social factor influencing their health, and
   4) Meet one or more of the following criteria:
      a) High risk for institutionalization, overdose and/or suicide
      b) Use crisis services, emergency rooms, urgent care, or inpatient stays as the sole source of care
      c) Two or more ED visits or two or more hospitalizations due to SMH or SUD in the past 12 months
      d) Pregnant and post-partum Members (12 months from delivery)

e. Transitioning from Incarceration – Adults 21 years of age or older who:
   1) Are transitioning from a correctional facility or transitioned from a correctional facility within the last 12 months, and
   2) Have at least one (1) of the following conditions:
      a) Mental illness
      b) Substance Use Disorder (SUD)
      c) Chronic Condition/Significant Clinical Condition
      d) Intellectual or Developmental Disability (I/DD)
      e) Traumatic Brain Injury (TBI)
      f) HIV/AIDS
      g) Pregnancy or Postpartum

f. At Risk for Institutionalization & Eligible for Long-Term Care – Adults, 21 years of age or older who are:
   1) Living in the community who meet the Skilled Nursing Facility (SNF) Level of Care (LOC) criteria; or who require a lower-acuity skilled nursing, such as a time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury; and
   2) Actively experiencing at least one complex social or environmental factor influencing their health; and
   3) Able to reside continuously in the community with wraparound supports

g. Nursing Facility Residents Who Want to Transition to the Community – Adults, 21 years of age or older who are:
   1) Interested in moving out of the institution, and
   2) Likely candidates to do so successfully, and
   3) Able to reside continuously in the community

h. Birth Equity – Adults, who are:
   1) Pregnant or Postpartum (through 12-month period); and
   2) Meet one of more of the following conditions:
      a) Eligible in any other adult or youth ECM Population of Focus;
      b) Effective January 1, 2024 - Subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

5. Children and Youth Specific ECM Population of Focus Eligibility Criteria are defined as:
   a. Effective July 1, 2023, Individuals Experiencing Homelessness – Homeless Families or Unaccompanied Children/Youth who:
      1) Are experiencing homelessness as defined by the U.S. Department of Health and Human Services (HHS) 42 CFR § 11302 criteria:
         a) Lacking adequate nighttime residence
         b) Having a primary residence that is a public or private place not designed for or ordinarily used for habitation
         c) Living in a shelter
         d) Exiting an institution into homelessness
         e) Will imminently lose housing in next 30 days
         f) Fleeing domestic violence, dating violence, sexual assault, stalking and other dangerous, traumatic, or life-threatening conditions relating to such violence
      2) Sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;
         a) Living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations
         b) Living in emergency or transitional shelters
         c) Abandoned in hospitals or unable to discharge from the hospital to a safe place
   b. At Risk for Avoidable Hospital or ED Utilization – children and youth under the age of 21 who:
      1) Have three (3) or more Emergency Department (ED) visits in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence, and/ or
      2) Have two (2) or more unplanned hospital and/or short-term skilled nursing facility stays in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.
   c. SMH or SUD – Children and youth under the age of 21 who:
      1) Meet the eligibility criteria for participation in, or obtaining services through:
         a) SMHS delivered by MHPs
         b) The DMC-ODS or the DMC program.
   d. Transitioning from Incarceration – Children and youth under the age of 21 who are:
      1) Transitioning from a youth correctional facility or transitioned from being in a youth correctional facility within the past 12 months.
   e. Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition – Children and youth under the age of 21 who are:
      1) Enrolled in CCS or CCS WCM; and
      2) Experiencing at least one complex social factor influencing their health.
         a) Lack of access to food,
         b) Lack of access to stable housing,
         c) Difficulty accessing transportation
         d) Have a high measure (four or more) of ACEs screening;
         e) History of recent contacts with law enforcement, or crisis intervention services related to mental health and/or substance use symptoms.
   f. Children and Youth Involved in Child Welfare – children and youth who meet one or more of the following conditions:
      1) Under age 21 and are currently receiving foster care in California;
      2) Under age 21 and previously received foster care in California or another state within the last 12 months;

3) Aged out of foster care up to age 26 in California or another state
4) Under age 18 and are eligible for and/or in California's Adoption Assistance Program;
5) Under age 18 and currently receiving or have received services from California's Family Maintenance program within the last 12 months.

g. Intellectual and Developmental Disability (I/DD) – children and youth who are:
1) Diagnosed I/DD
2) Eligible in any other adult ECM Population of Focus

h. Pregnancy, Postpartum and Birth Equity – children and youth who are:
1) Pregnant or Postpartum (through 12-month period); and
2) Meet one of more of the following conditions:
a) Eligible in any other adult or youth ECM Population of Focus;
b) Effective January 1, 2024 - Subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

6. ECM may be offered to Members who do not meet DHCS' Population of Focus criteria but would benefit from the services. Partnership will handle these requests on a case-by-case basis.

B. JUSTICE INVOLVED MANAGED CARE TRANSITION
1. Partnership will use the DHCS Member assignment data when the Member's pre-release service aid code is activated and identified to ensure the Member receives coordination of care.
2. Partnership will support the creation and development of the reentry care plan for individuals as requested by the pre-release care management provider and/or their team of the ECM provider. This includes the following but is not limited to:
a. Receiving Member data
b. Warm handoff
c. Pre-release and post release
d. Receipt of person-centered care
e. Behavioral health links
f. Ensuring post-release ECM provider participates in behavioral health transition meetings, warm handoffs, follow-up planning, and ensure that warm handoffs include follow up-planning, including confirming transportation.
g. Assist with appointment scheduling for behavioral health services.
3. Partnership will ensure that the ECM provider supports scheduling for required post-release physical, behavioral health, and social services.
4. Partnership will ensure that the ECM provider connects individuals with needed services such as Community Supports, and benefits like Non-Emergency Medical Transportation, to assist the Member with reentering the community.

C. ECM EXCLUSION CRITERIA:
1. The following Members are excluded from receiving ECM benefit:
a. Member is sufficiently well managed through self-management or through another care management program.
b. Member is enrolled in Hospice or Intensive Outpatient Palliative Care.
c. Member enrolled in County-based Target Case Management (TCM) programs.
1) DHCS has allowed a one-year exception from July 1, 2024 to June 30, 2025 for cases where the member is receiving County-based TCM for addressing a communicable disease or for the sole purpose of receiving a home visiting program supporting the healthy development and well-being of children and families.
d. The Member is unresponsive to outreach attempts.
e. The Member displays unsafe or threatening behavior.
f. Member's physical environment poses a safety or security risk.

g. The member is receiving the Community Health Worker services benefit.
h. The Member is currently enrolled in duplicative care management waiver or DHCS demonstration programs such as:
   1) Multipurpose Senior Services Program (MSSP)
   2) Assisted Living Waiver
   3) Home and Community-Based Alternatives (HCBA) Waiver;
   4) HIV/AIDS Waiver
   5) HCBS Waiver for Individuals with Developmental Disabilities (DD)
   6) Self-Determination Program for Individuals with I/DD
   7) Cal MediConnect
   8) Fully Integrated Dual Eligible Special Needs Plans (FIDESNPs)
   9) Program for All-Inclusive Care for the Elderly (PACE)
   10) Family Mosaic Project
   11) California Community Transitions (CCT) Money Follows the Person (MFTP)
i. The Member is currently enrolled in Partnership's Basic Case Management or Complex Case Management Programs. For these Members, Partnership Care Coordination staff will work with the Member, their caregiver, Authorized Representative, and/or interdisciplinary care team to evaluate and coordinate the appropriate level of case management support.

D. ECM CORE SERVICE COMPONENTS:
1. The ECM benefit is to be delivered primarily in-person where a Member seeks or receives care. If the ECM provider is unable to connect with the Member in-person, or the Member has expressed an alternative communication method, outreach and engagement may be performed by teleconferencing, telehealth, televideo, or other protected communication tool in an effort to help build relationships as a supplement to in-person visits.
2. An assigned Lead Care Manager will act as the Members' primary point of contact and is responsible for coordinating care, at minimum, across the following delivery systems, including but not limited to; medical, behavioral, developmental, dental, long-term care supports and community resources/supports, Community Supports, regardless of setting or payor.
3. The ECM Provider will designate a Lead Care Manager who may be any of following: a nurse, a social worker, a care navigator, a housing navigator, or a community health worker. The Lead Care Manager is responsible for the delivery of ECM services as outlined in the ECM core services components below, and shall possess the appropriate experience and expertise in servicing the Member's Population of Focus.
4. If the Member has other Care Managers assisting or supporting them, it is the responsibility of the Member's ECM Lead Care Manager to coordinate with those individuals and/or entities to ensure a seamless experience for the Member, and to ensure non-duplication of services.
5. Partnership will ensure all ECM enrolled Members receive the following ECM core service components from their assigned ECM provider:
   a. Outreach and engagement
      1) The ECM provider shall use available data to prioritize outreach and engagement of Members addressing Members with the most immediate needs first.
      2) The ECM provider will maintain regular contact with Members to ensure there are not gaps in the activities designed to address an individual's health and social service needs. Upon engagement, the ECM Provider shall obtain the Member's, the Member's parent/guardian or authorize representative's written consent for ECM services using the attached ROI form in Attachment B.

a) The ECM Provider shall store a copy of this executed ROI form with the Member's ICP in the Point Click Care Platform to communicate back to Partnership the Member's data sharing preferences.

b. Comprehensive Assessment
   1) The ECM provider will perform a comprehensive assessment and/or risk screening to determine ECM engagement level and to inform the Member's ICP.
   2) Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care
   3) For Members with long-term services and supports (LTSS) needs, the Lead Care Manager shall utilize approved assessments and tools to develop care plans in accordance with federal requirements under 42 CFR 438.208(c), including:
      a) The ability for the Member to include people of their choosing to participate in the care planning process;
      b) The necessary information and support to ensure that the Member/individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
      c) Reflects cultural considerations of the Member and is conducted by providing information in plain language and in a manner that is accessible to the Member with disabilities and persons who are limited English proficient;
      d) Includes strategies for solving conflict or disagreement between Members and their care managers within the process, and also includes or references clear conflict-of-interest guidelines for all planning participants;
      e) Offers choices regarding the services and/or supports the Member may receive and from whom;
      f) Includes a method for the Member/individual to request updates to the plan as needed
      g) Records the alternative home and community-based settings that were considered in the care planning process with the Member/individual
      h) When available, Partnership shall share the results of the Health Risk Assessment (HRA), which includes the required LTSS referrals questions, with ECM providers when a Member is assigned to them.
      i) The ECM provider shall use the Members' responses to the HRA in developing the Members' Individualized Care Plan (ICP).

c. Individualized Care Plan (ICP)
   1) The ECM provider shall work with the Member, guardian, caregiver, AR, and/or other authorized person(s) as appropriate to assess strengths, risks, needs, goals and preferences to make recommendations for service needs.
   2) The Lead Care Manager is responsible for documenting and updating the Member's ICP as needed to ensure there are no gaps in care.
   3) The ICP shall contain at minimum, needs, strategies, and patient prioritized goals surrounding care coordination needs for services including but not limited to the following
      a) Physical health
      b) Mental health
      c) Developmental health
      d) Substance Use Disorder (SUD)
      e) Long Term Support Services (LTSS)
      f) Oral health

g) Necessary community-based and/or social services
h) Health Promotion
i) Transitional Care Needs
j) Member and/or Family Supports

4) The Lead Care Manager shall make available to the Member a copy of the ICP upon enrollment in ECM and/or upon Member request.
5) The ECM Provider shall ensure that the Member's ICP contains appropriate clinical oversight.

d. Enhanced Coordination of Care
1) Organizing patient care activities, as laid out in the ICP, and sharing information with those involved as part of the Member's multi-disciplinary care team.
2) Implementing activities identified in the Member's ICP.
3) Maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team, whose input is necessary for successful implementation of Member goals and needs.
4) Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, long-term support services (LTSS), oral health trauma-informed care, and necessary community-based and social services, including housing, as needed.
5) Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment.
6) Communicating the Member's needs and preferences timely to the Member's multi- disciplinary care team in a manner that ensures safe, appropriate, and effective person- centered care.
7) Ensuring regular contact with the Member and their family member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s), when appropriate, consistent with the Individualized Care Plan (ICP).

e. Health Promotion
1) Working with Members to identify and build on successes and potential family and/or support networks
2) Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health
3) Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

f. Transitional Care Services
1) Develop strategies to reduce avoidable Member admissions and/or readmissions to acute or skilled settings.
a) For Members who are currently hospitalized, the ECM Lead Care Manager shall provide Transitional Care Services pursuant to the DHCS Population Health Management (PHM) Strategy Guide. At minimum, the ECM Lead Care Manager shall:
1) Prior to discharge, compete a discharge assessment to assess the Member's risk of re-institutionalization, re-hospitalization, and risk of SMH and/or SUD;
2) Ensure that medication reconciliation is conducted pre- and post-transition;

3) Ensure Closed Loop Referrals to Community Supports and coordination with county social service agencies and waiver agencies for In-Home Support Services (IHSS) and/or other Home and Community Based Services are coordinated as appropriate;
4) When applicable, ensure Members with SUD and mental health needs receive treatment for those conditions upon discharge;
5) Provide a discharge planning document to the Member, Member's parents, legal guardians, or authorized representatives, as appropriate, when being discharged from a hospital, institution or facility. This discharge plan must include information about the hospital, institution or facility to which the Member was admitted; the Member's pre-admission status (ex: living arrangements, physical and mental function, SUD needs, social support, DME uses, etc.); pre-discharge factors (ex: medical condition(s), physical and mental function, financial resources, social supports at the time of discharge, etc.); recommendations made for the Member after discharge (ex: placement, DME, follow-up, etc.); summary of the nature and outcome of participation of Member, Member's parents, legal guardians, or authorized representatives in the discharge planning process; anticipated problems in implementing post-discharge plans, and information regarding available care, services, and supports that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.
6) Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members.
7) Coordinating medication review/reconciliation
8) Providing adherence support and referral to appropriate services.

g. Member and Family Supports, which shall include, but are not limited to:
1) Documenting a Member's authorized family member(s), guardian, Authorized Representative, caregiver, and/or other authorized support person(s) and ensuring all required authorizations are in place to ensure effective communication between the ECM Providers; the Member and/or their family member(s), Authorized Representative, guardian, caregiver, and/or authorized support person(s)
2) Activities to ensure the Member and/or their family member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s), with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, state, and local privacy and confidentiality laws.
3) Ensuring the Member's ECM Lead Care Manager serves as the primary point of contact for the Member and/or family member(s), guardian, Authorized Representative, caregiver, and/or other authorized support person(s)
4) Identifying supports needed for the Member and/or their family member(s), Authorized Representative, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services
5) Providing for appropriate education of the Member and/or their family member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s) about care instructions for the Member
6) Ensuring that the Member has a copy of their ICP and information about how to request

updates

h. Coordination of and Referral to Community and Social Support Services
   1) Determining appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services offered by Contractor as Community Supports (CS) under CalAIM, see Partnership Policy MCUP3142 CalAIM Community Supports.
   2) Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").

6. Members enrolled in the ECM benefit shall participate in differing levels of engagement as determined by both the Member and ECM Provider through the development of the Member's ICP. At minimum, Partnership expects that the ECM provider attempts and/or makes successful engagement with the Member once a month via in-person, telehealth, telephonic or televideo where appropriate.
7. Through the delivery of ECM both the ECM provider and/or Member's Lead Care Manager shall use culturally and linguistically appropriate methods of communication with the Member.
8. Partnership shall recruit ECM Providers that have diverse care management staff reflecting the populations they serve.

D. MEMBER IDENTIFICATION & AUTHORIZATION OF ECM SERVICES

1. In accordance with Partnership's Population Health Management Program and activities, Partnership proactively screens, stratifies, segments and assigns risk tiers for Partnership's Membership population using Partnership's proprietary Risk Score Model and additional Member demographic, utilization, and social data. Through this process, Partnership identifies and prioritizes those Members who present with the highest needs and risks and directs them to appropriate interventions and services; including the Enhanced Care Management benefit. See policy MCND 9001 Population Health Management Strategy & Program Description.
2. Partnership will also proactively analyze data and/or information received directly from DHCS, counties, providers, members and/or others to identify additional Members eligible for the ECM benefit. Sources may include, but are not limited to:
   a. Enrollment data
   b. Utilization/claims data including
      1) Encounter data
      2) Pharmacy data
      3) TAR clinical data (ex: Minimum Data Set Survey data from LTCs, CBAS Individualized Plan of Care, etc.)
      4) Laboratory data, as available
   c. Screening or assessment data (ex: Health Risk Assessment for Seniors or Persons with Disabilities (SPD), etc.)
   d. Clinical information on physical and/or behavioral health
   e. SMH/SUD data, as available Risk stratification information for children in Partnership's Whole Child Model (WCM) program
   f. Information about social determinants of health, including standardized assessment tools and/or current ICD codes
   g. Regional Center data feeds
   h. Results from any available Adverse Childhood Experience (ACE) screening
   i. Other cross-sector data and information, including housing, social services, foster care, criminal justice history, school absentee or truancy and other information relevant to the ECM Populations

of Focus (e.g., Homeless Management Information System (HMIS), available data from the education system, etc.).
   j. Plan Data Feed from DHCS
   k. 1915c waiver wait lists
   l. Claims, laboratory, request for services and/or encounters shall be used to internally identify Members who are pregnant or postpartum and meet other ECM Population of Focus criteria.
   m. Other data and/or risk stratification reports
3. Partnership shall compile a monthly report of potentially eligible ECM Members based upon Partnership's available data and analysis.
   a. The list of Members on this report shall be prioritized; with the Members believed to have the immediate needs and in need of outreach and engagement listed first.
   b. This prioritized report shall be shared and assigned to the appropriate ECM provider(s) so that outreach and engagement with Members can be initiated.
4. In addition to using available data, Partnership encourages direct referrals for Members to access ECM services. Information on directly referring Members to ECM, along with Partnership's ECM referral form can be found on Partnership's website as well as information in the Partnership Member/provider newsletter. In addition, Partnership shares information about how to refer Members for ECM services at community partner meetings, provider roundtables and/or community events.
5. Direct referrals for ECM can come from a multitude of sources, including but not limited to:
   a. Providers, ECM providers, and/or community-based organizations via phone, mail, or fax.
   b. Members and/or their family Member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s) via phone, mail, or Partnership Member portal.
   c. Partnership Care Coordination Department
   d. Internal Partnership Department (ex: Claims, Utilization Management, Pharmacy, Member Services, Population Health Management, etc.)
   e. County partners (ex: Health and Human Services, Behavioral Health, Public Health, Social Services, Child Welfare, Continuums of Care, etc.)
   f. Hospitals, including CCS Specialty Care Centers
   g. Probation and/or parole departments
   h. Nursing Homes / Skilled Nursing Facilities
   i. Home Health Agencies
   j. Community Based Adult Services (CBAS) providers
   k. Home and Community Based Waiver Providers
   l. Area Agencies on Aging
   m. Centers for Independent Living
   n. Regional Centers
   o. Schools
   p. Local Foster Care Offices
   q. First 5
   r. Community Based Organizations
   s. Local Perinatal Programs
   t. Community Supports Providers
   u. Correctional facilities, prisons, jails, youth/juvenile facilitates
6. Upon receipt of a direct ECM referral, Partnership's designated staff shall conduct an initial screening for ECM services, and assign Members who may qualify for ECM to an in-network ECM provider for a Comprehensive Assessment and ICP.
   a. For Members who meet the initial screening criteria, Partnership's designated staff shall:
      1) Inform the Member and/or their AR of the Member's referral assignment via

telephone, mail and/or Member portal when appropriate, and

2) Electronically inform the ECM provider of the referral assignment in the electronic systems denoted below in section VI.H.

7. Partnership will require specific ECM referral information from entities in accordance with DHCS ECM referral standards and form template guidance.
   a. Partnership will acknowledge receipt of the ECM referral.
   b. Partnership will notify the individual or entity if there are errors that must be corrected before submission.
8. Partnership will track and monitor all referrals, to ensure complete and necessary information is shared securely and efficiently.
9. Partnership will maintain timely data on referral status and intervene in support of individual referrals to improve Member connections to services.
10. Partnership will collect data on a monthly basis from service provider.
~~8.~~11. For Members who do not meet initial screening criteria, Partnership's Care Coordination Department shall offer other available case management and/or care coordination services (e.g. Complex Case Management, etc.) For Members who qualify for the ECM benefit, Partnership requires that a Treatment Authorization Request (TAR) be submitted to Partnership for review and approval of ECM services. See Partnership policies MCUP3041 - Treatment Authorization Request (TAR) Review Process and ~~MCUP3143~~ MCAP7001 Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS).

E. ECM PROVIDER ASSIGNMENT
1. The Member's assigned ECM provider must meet the following standards:
   a. Must be experienced in serving the ECM Population(s) of Focus they will serve. For Members with long-term services and supports (LTSS) needs, the Lead Care Manager will be experienced and/or have received training in person-centered planning as required by federal law.
   b. Have experience and expertise with the services they provide.
   c. Comply with all applicable state and federal laws and regulations and all ECM program requirements.
   d. Have the capacity to provide culturally appropriate and timely in-person care management activities in accordance with Exhibit A, Attachment 6, Provision 13, Ethnic and Cultural Composition.
2. Members will be assigned to their approved ECM provider after taking into account their known preferences, previous provider relationships, and/or health needs.
   a. If the Member's assigned Primary Care Provider (PCP) is a contracted ECM Provider, Partnership shall assign the Member to the PCP as the ECM Provider, unless the Member has expressed a different preference or Partnership identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
   b. If a Member receives services from a Specialty Mental Health Plan for severe emotional disturbance (SED), substance use disorder (SUD), and/or serious mental health (SMH) and the Member's behavioral health Provider is a contracted ECM Provider, Partnership shall assign that Member to that behavioral health Provider as the ECM Provider, unless the Member has expressed a different preference or Partnership identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
   c. For Members enrolled in Partnership's Whole Child Model for CCS, Partnership shall assign that Member to a CCS Case Manager affiliated with a contracted ECM provider for ECM services, unless the Member or family has expressed a different preference or Partnership identifies a more appropriate ECM Provider given the Member's individual needs and health conditions. For more information on case management and care coordination services provided

under the Whole Child Model for CCS, see Partnership Policy MCCP2024.

3. Members can request to change their assigned ECM provider by contacting Partnership's Care Coordination department via phone, mail or Partnership's Member Portal. Upon receipt of a Member's request for reassignment, Partnership's Care Coordination department shall contact the Member to acknowledge the request, and to work collaboratively with the Member for reassignment to a new ECM provider within 30 days of the request date.
4. Partnership will ensure that ECM provider communication of a Member's assignment to designated ECM provider occurs within ten (10) business days of authorization. Partnership shall communicate the Member's assignment using the information platform described in section VI. H.
5. Partnership will document the Member's ECM Lead Care Manager in its internal electronic platform and systems.
6. As contracted network providers, both ECM providers and PCPs alike can work with Partnership's Provider Relations Department representatives to provide feedback regarding ECM referrals or concerns they may have about ECM Member assignments.

F. DISCONTINUATION OF ECM

1. The ECM provider shall notify Partnership, and the interdisciplinary care team, when a Member discontinues ECM services. Examples of discontinuation include:
   a. The Member has graduated and is no longer in need of intensive case management or care coordination services. Graduation criteria for ECM shall include:
      1) The Member has met all identified goals on their ICP addressing any needs for their medical, behavioral health, dental, long-term supports, or community referral needs as indicated. (e.g. connection to primary/specialty care, appropriate utilization of health care services, connection to mental health, connection to dental care, connection to Community Based Adult Services (CBAS) or In-Home Support Services (IHSS), referrals and linkages to Community Supports, etc.).
      2) The Member has demonstrated an ability to self-manage their health. (e.g., able to make their own appointments, understands warning signs or triggers for their medical and/or mental health conditions and can implement strategies to prevent acute exacerbations, ability to manage their medications or treatment regimens, verbalizes an understanding of who to call if new health problems arise, has obtained all necessary durable medical equipment (DME), etc.).
      3) The Member is connected to appropriate community service(s) and/or Community Supports to address their short-term and long-term needs (e.g., housing, meal delivery, transportation, disease management programs/classes, support groups, etc.).
   b. The Member expresses that they no longer wish to receive ECM
   c. The Member is unresponsive or unwilling to engage in ECM outreach & engagement attempts by the ECM provider
   d. The Member, who was previous enrolled in ECM, no longer responds to the ECM provider's attempts to contact, locate or engage the Member
   e. The Member is deceased
   f. The Member loses Partnership Medi-Cal eligibility
   g. The Member moves out of Partnership's service area
   h. The Member becomes incarcerated for more than 30 days
   i. After attempts to reassign the Lead Care Manager or remedy ECM service delivery, the ECM provider can no longer provide services. (ex: patient behavior, unsafe environment, etc.)

j. The Member is transitioned to an alternative care management or care coordination program/services that can better meet the Member's goals, preferences and care needs.
   1) In order to prevent gaps in care or duplication of ECM services, ECM providers are to plan and coordinate to transfer a Member's care needs within 30 days to an alternative care management or care coordination provider. Examples of such providers/programs include, but are not limited to:
      a) Hospice
      b) Partnership's Intensive Outpatient Palliative Care Program
      c) Long-Term Dialysis
   2) When appropriate, the ECM provider and care team are to coordinate services and transition the Member to a lower level or alternative care management program based on the Member's needs, goals, preferences and progress on ICP, including but not limited to Partnership's Complex Case Management Program.

2. Upon discontinuation of ECM, Partnership shall:
   a. Notify the ECM provider
   b. Issue a Notice of Action (NOA) to the Member regarding discontinuation of ECM services. The notification will serve to inform the Member of their rights per DHCS, including their right to appeal the decision as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals and APL 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates. For more information, see policy MCUP3037 Appeals of Utilization Management / Pharmacy Decisions.

G. CONTINUITY OF CARE
1. Beginning January 1, 2022 for Members who are in process or currently enrolled in a Whole Person Care Pilot program, who are identified by the WPC Lead Entity as belonging to an ECM Population of Focus, Partnership will automatically authorize ECM services for six (6) months pursuant to DHCS implementation schedule.
   a. Transitioning Members must be assessed within six (6) months of their initial authorization, or other timeframes provided by DHCS, to determine most appropriate level of care management services and ECM benefit eligibility per the criteria as outlined above. ECM providers shall:
      1) Complete a comprehensive assessment, ICP and submit to Partnership a Treatment Authorization Request (TAR) pursuant to Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process for continued ECM services.
      2) Transition Members who no longer meet the criteria for ECM services as outlined in section VI.F. Discontinuation of ECM.
      3) Notify Partnership of transitioning Members who have been discharged as outlined in section VI.F. above.
   b. Partnership shall utilize existing data exchange platforms described in section VI.H. to coordinate with WPC Lead Entities to ensure a smooth transition and warm hand-off for mutual Members entering into or being discharged from the ECM benefit.
   c. Both the WPC Lead Entity and Partnership shall work collaboratively to inform Members via written notice of the transition to the ECM benefit pursuant to DHCS' guidance.
2. Partnership shall attempt to contract with each WPC Lead Entity as an ECM provider to provide Members with ongoing care coordination and continuity of care in WPC Pilot Counties.
   a. Partnership shall submit to DHCS for prior approval any requests for exceptions to the WPC contracting requirement. Permissible exceptions to contracting are:

1) There is a justified quality of care concern with the ECM Provider(s)
2) Partnership and ECM Provider(s) are unable to agree on contracted rates
3) ECM Provider(s) is/are unwilling to contract
4) ECM Provider(s) is/are unresponsive to multiple attempts to contract
5) ECM Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by the Contractor; and/or
6) For ECM Provider(s) without a state-level pathway to Medi-Cal enrollment, ECM Provider(s) is/are unable to comply with the Partnership processes for vetting qualifications and experience

b. For transitioning Members for whom Partnership is not able to enter into a contract with the WPC Lead Entity, Partnership shall authorize ECM services with an in-network ECM provider.

3. Members transitioning to Partnership from another managed care plan and /or fee-for-service Medi-Cal who are currently enrolled in ECM, shall automatically be authorized for ECM services. For these Members:
   a. Partnership shall use available utilization data to proactively identify any new Members who are in receipt of ECM within the previous 6 months of their assignment to Partnership, and initiate continued ECM authorization.
   b. Newly assigned Partnership Members or their AR may contact Partnership directly to request continued ECM benefits and Partnership shall expedite this request.
   c. If a pre-existing relationship has been established and the ECM provider is part of Partnership's ECM network or agrees to a letter of agreement until an agreement is reached, Partnership will assign the Member to their existing ECM provider to ensure the Member's relationship is not disrupted.
   d. Partnership shall contact and work with the Member's previous health plan and/or ECM provider to obtain access to the Member's ICP and ensure services are connected appropriately.
   e. ECM services shall be authorized for up to six (6) months. At which time, the Member shall be reassessed for services in accordance to the policy criteria shared above in sections VI. A, B, and F.

H. DATA SHARING TO SUPPORT ECM
1. Partnership has an Information Technology (IT) and data analytic infrastructure to support the delivery of the ECM benefit. Key features of Partnership's systems include, but are not limited to:
   a. Systems and agreements with agencies that support the information captured for ECM Member identification as outlined in section VI.D.
   b. Secure data sharing between, Partnership, ECM provider, the Member, and other providers in support of ECM.
   c. The ability to receive, process, and send encounters from ECM providers to DHCS.
   d. The ability to receive and process supplemental reports from ECM providers.
2. ECM providers shall use the "Point Click Care" module of the cloud-based Point Click Care Platform (see III. B) in the delivery of ECM services. This platform shall allow Partnership and ECM providers to:
   a. Share real-time information between ECM Members' care teams and providers.
   b. Serve as a mechanism for Partnership and ECM providers to share ECM Member assignment files (e.g. targeted engagement lists, referrals, discontinuation or disenrollment from ECM services, etc.)
   c. Track Emergency Department and Inpatient Hospital Admissions as they are occurring.
   d. Perform and run periodic reports of performance on certain quality measures and/or metrics.
3. Partnership will use defined Federal and State standards, specifications, code sets, and terminologies

when sharing physical, behavioral, social, and administrative data with ECM Providers and with DHCS, to the extent practicable.

I. ECM PROVIDER NETWORK DEVELOPMENT
   1. Partnership will contract with providers that meet DHCS' and Partnership requirements
   2. Partnership will collaborate with other Managed Care Plans (MCP) in the applicable county to identify qualified ECM providers with which to contract.
   3. Partnership will make every effort to contract and build a sufficient network of ECM providers
   4. Partnership will collaborate with other MCPs in the county/counties in which it operates to achieve mandatory overlap of the provider network

J. ECM PROVIDER OVERSIGHT & QUALITY MONITORING
   1. Partnership will perform oversight of ECM providers, holding them accountable to all ECM requirements contained in the DHCS Contract amendment and DHCS APL 21-012: Enhanced Care Management Requirements.
      a. Partnership will perform quarterly audits, or more frequently as needed, to evaluate ECM provider performance and compliance to ensure State, Federal, and contractual requirements are met. At a minimum, the following shall be reviewed:
         1) ECM Files:
            a) Visit documentation showing minimum number of visits
            b) Delivery of the Core Services components of ECM
            c) Release of Information (ROI)
         2) ECM provider's policies and procedures as they relate to the delivery of ECM, including but not limited to:
            a) Internal policies
            b) Job descriptions
            c) Training Materials
            d) Organizational charts
            e) Model of Care for Justice Involved providers that includes:
               i. Provisions for a "warm handoff" between ECM providers within the correctional facility and those who will provide ECM services upon release at least 2 weeks prior to date of expected release.
               ii. Ensuring the ECM provider meets the Member within 1-2 days of release wherever possible
               iii. A second follow up ECM appointment occurs within 1 week of release.
               iv. The ECM provider leverages the reentry plan that was developed in the pre-release period as the post-release care management plan.
         3) Quality and monitoring reports to guide improvement across the network
            a) Point Click Care reports
            b) Partnership internal monitoring reports & dashboards
            c) Member experience surveys
            d) Referral patterns
            e) ECM Provider Capacity Reports
      b. Partnership has developed its ECM contracts using the DHCS ECM Provider Standard Terms and Conditions and incorporated all of its ECM provider requirements, including all monitoring and reporting expectations and criteria.
   2. Partnership shall support ECM Provider peer sharing meetings to report on activities at a frequency of every two (2) months for new sites, during the first six (6) months of services, and at a frequency of every six (6) months for existing sites or at a frequency deemed appropriate for support as monitored by Partnership.
      a. Topics shall include, but not be limited to: billing, authorizations, best practices for

operational efficiencies, successful strategies to improve outreach and engagement efforts, case management and care coordination approaches for complex populations, health equity, ECM policy updates, etc.

3. ECM providers shall conduct Member experience surveys of enrolled Members at least once annually and share a summary of this survey with Partnership.
4. Over time, Partnership shall review key performance indicators of ECM providers and ECM benefit to provide benefit monitoring and oversight as well as address quality standards and to identify areas of improvement. Examples include, but are not limited to:
   a. ECM Member-level outcomes related to medical cost, utilization and/or health status'
   b. ECM referral sources and patterns
   c. ECM provider key performance indicators, including but not limited to: Member capacity, successful outreach attempts, # of FTEs providing ECM, etc.
   d. Results of ECM Member surveys
5. Partnership will inform PCPs, Members, family Member(s) guardian, caregiver, and/or other authorized support person(s) and community partners about the ECM benefit through routine Member communication pathways, including but not limited to:
   a. Partnership Member Handbook
   b. Partnership Website
   c. Required DHCS notices
   d. Webinars
   e. Member/Provider newsletters

J. HEALTH EQUITY FOR ENHANCED CARE MANAGEMENT (ECM)
1. Health Equity is a priority for DHCS and Partnership. Partnership shall ensure that ECM services are delivered in a culturally relevant, person-centered manner by:
   a. Encouraging ECM providers to hire and train care management staff with experience and expertise in serving the unique Population of Focus' under ECM.
   b. Screen potential ECM providers through Partnership's ECM Readiness Assessment and contracting process
   c. Include Health Equity measures as part of Partnership's oversight and quality monitoring of ECM, such as disparities in engagement, disparities in access and/or patterns of utilization of ECM services for the health plan.

K. ECM SUBCONTRACTOR DELEGATION
1. Partnership may allow an ECM provider to subcontract with other entities to administer ECM services under the following conditions:
   a. The ECM provider maintains the responsibility for oversight and compliance of all of its subcontractors for the delivery of ECM as set forth in this policy and in DHCS APL 21-012. Examples of compliance include, but are not limited to:
      1) Ensure the subcontractor meets the DHCS required provider experience thresholds for the delivery of ECM for the Population(s) of Focus.
      2) Ensure the subcontractor has appropriate staffing ratios and capacities.
      3) Partnership shall provide oversight and monitoring of the ECM provider's ability to perform delegation of the ECM benefit.
      4) Maintain current contracts and make available to Partnership any subcontractor agreements upon DHCS request. Such agreements will contain minimum required information specified by DHCS, including the method and amount of compensation, Population(s) of Focus served, service area, case ratios and ECM capacity.
   b. Partnership will ensure the agreement between ECM delegated entity and

subcontractor mirrors the requirements outlined in the DHCS Contract and the ECM provider Standard Terms and Conditions, as applicable to the subcontractor.

c. Partnership will make every effort to collaborate with its ECM provider delegated entities and subcontractors on the best approach to streamline the ECM experience and minimize the divergence for ECM Members and providers.

2. Partnership will hold ECM entities and subcontractors to the same ECM provider requirements.
3. Partnership shall maintain appropriate structures and mechanisms to ensure delegation oversight, including pre-delegation evaluation as applicable, no less than annual review of delegation agreement/grid, monitoring of performance data, and oversight auditing of delegated functions. Partnership's delegation oversight is designed to effectively review, evaluate, and verify satisfactory performance and compliance with regulatory and accreditation standards.

L. DHCS ECM OVERSIGHT

1. Partnership will submit the following data and reports to DHCS to support DHCS' oversight of ECM:
   a. Encounter data using national standard specifications and code sets defined by DHCS.
      1) Partnership is responsible for submitting all encounter data to DHCS for ECM services to its Members, regardless of the number of levels of delegation and/or sub-delegation between Partnership and the ECM provider.
      2) In the event the ECM provider is unable to submit the ECM encounters to Partnership using the national standard specifications and codes set by DHCS, Partnership will be responsible for converting the ECM provider's data information before DHCS submission.
   b. Supplemental reporting on a schedule and in the DHCS specified format.
2. Partnership will track and report to DHCS in a DHCS specified format, information about outreach efforts related to potential ECM Members.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment 5 Utilization Management and Attachment 6, Provision 13, Ethnic and Cultural Composition
B. DHCS All Plan Letter (APL)23-032 Enhanced Care Management Requirements (12/22/2023 *supersedes APL 21-012*)
C. DHCS All Plan Letter (APL) 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (*revised* 08/31/2022~~08/31/2021~~)
D. DHCS All Plan Letter (APL) 22-013 Provider Credentialing / Recredentialing and Screening / Enrollment (~~07/19/22~~*revised* 01/02/2025 *supersedes APL 19-004*).
E. Title 42 Code of Federal Regulations (CFR) Section 438.208(c).
F. Title 42 Code of Federal Regulations (CFR) Section 441.301(c).
G. DHCS ECM Policy Guide (August 2024)
H. DHCS ECM Referral Standards and Form Templates (August 2024)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: -MCCP2032: 10/12/22; 11/08/23; 11/13/24; MCAP7002: 09/10/25

Policy/Procedure Number: MCAP7002 *(previously MCCP2032)*			**Lead Department: Health Services** Business Unit: Enhanced Health Services
Policy/Procedure Title: CalAIM Enhanced Care Management (ECM)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/09/2022 **Effective Date:** 01/01/2022 vs. DHCS		**Next Review Date: 11/13/202509/09/2026** **Last Review Date: 11/13/202409/10/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

PREVIOUSLY APPLIED TO:

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

Enhanced Care Management (ECM) Care Plan Guide

Patient Information			
First Name:	Last Name:		DOB:
Gender:	Preferred Pronouns:	Primary Language:	

Address Information			
Street:			
City:	State:	Zip Code:	County:
Mailing Address Same as Home Address?		Yes	No
Street:		PO Box:	
City:	State:	Zip Code:	County:

Contact Information	
Email:	
Phone #:	

Other Contacts		
Family/Caregiver	Name:	May we contact if needed?
Email:		Phone #:
Community Team	Name:	May we contact if needed?
Email:		Phone #:
Program Representative	Name:	May we contact if needed?
Email:		Phone #:

Insurance Information		
Medi-Cal ID:		
Primary Insurance	Plan:	Group #:
Policy #:	Member ID:	
Secondary Insurance	Plan:	Group #:
Policy #:	Member ID:	

Acuity	How does the member feel they manage their health?
__ Low Risk __ High Risk	__ Poor __ Moderate __ Good

Social Factors of Health	
If the member has any changes, check the box and fill out only the changes:	
Education:	Employment Status:
Income Status:	Food Security:
Housing Stability:	Transportation:
Support Networks:	
Additional Notes:	

ECM Criteria		
Populations of Focus *(Check all that apply)*		
Adult	Adults experiencing homelessness.	
	Adults at risk for hospital or emergency department (ED) stays that could be avoided.	
	Adults with Serious Mental Health (SMH) and/or Substance Use Disorder (SUD) needs.	
	Adults living in the community who are at risk of needing long-term care services.	
	Adults moving from a nursing home to the community.	
	Adults that are pregnant and postpartum and/or facing unfair circumstances with birth, because of differences in race and ethnic background.	
	Adults moving from prison to the community.	
Child	Children experiencing homelessness.	
	Children at risk for hospital or emergency department (ED) stays that could be avoided.	
	Children with Serious Mental Health (SMH) and/or Substance Use Disorder (SUD) needs.	
	Children enrolled in California Children's Services (CCS) or CCS Whole Child Model with extra needs.	
	Involved in Child Welfare.	
	Minors that are pregnant and postpartum and/or facing unfair circumstances with birth, because of differences in race and ethnic background.	
	Children moving from a juvenile facility to the community.	

Enhanced Care Management (ECM) Care Plan Guide

Physical Health	
Active Medical Problems (chronic conditions, fall risk, speech, etc.)	**Past Medical History**

***Blood Pressure:**		***A1C (Blood Glucose) Levels:**	
For members 18+ years old; if over 140 / 90, please refer to Primary Care Provider (PCP) for advice		**Members who have diabetes or take antipsychotic medication**	
Date:	___ Systolic / ___ Diastolic	Date:	___ A1C%

Dental Health	
Active Dental Problems/Concerns	
Dentist Name:	Last Visit Date:
Dental Office:	Next Visit Date:

Mental Health History		
***If PHQ-2 Test Score is 3 or more, PHQ-9 Test is required. Scores of 10 or more require follow-up.**		
Date:	*PHQ-2 Score	*PHQ-9 Score
If the member is taking antidepressants or in psychotherapy, please give more information: (For example: takes medication as instructed; improvements in mental health after therapy)		

Substance Use Disorder Screening	
Alcohol Use	**Drug Use**
How often:	How often: Drug type:
*AUDIT-C Score	*DAST-10 Score
If you have any additional information, please share:	

Enhanced Care Management (ECM) Care Plan Guide

Hospitalizations	
# of hospital visits in the last 6 months:	# of emergency room visits in the last 6 months:

Durable Medical Equipment Currently In Use (Select All That Apply)		
___Hospital Bed	___Oxygen	**Additional Equipment Used:**
___Wheelchair	___Walker	

Doctor Visits	
# of PCP visits in the last 6 months:	Last Visit Date:
Doctor's Name:	Doctor's Office:
# of specialist visits in the last 6 months:	Last Visit Date:
Specialist's Name:	Specialist's Office:

Medication List	What is the medication for?

Allergies

Long-Term Support Services			
	Community Based Adult Services (CBAS)		In-Home Support Services (IHSS)
	Home Health Agency (under a provider's care in a home setting)		Multi-purpose Senior Services Program (MSSP)
	Hospice Care		Palliative Care (Medical care for serious illness)
	Other:		
Additional Notes:			

Advanced Care				
Discussed Advanced Care Planning		Yes		No
Surrogate Decision Maker (person who makes medical decisions for a patient)		Has One		Does Not Want One
Advance Directive (document of medical		Has One		Does Not Want One
Additional Notes:				

Enhanced Care Management (ECM) Care Plan Guide

Goals	
Goal:	
Action:	
Obstacles:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Action:	
Obstacles:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Action:	
Obstacles:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Action:	
Obstacles:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met

Referrals Needed

Additional Recommendations

ECM Staff Member Name: _____ Date: _____

ECM Staff Member Signature: _____ Date: _____

Clinician Signature: _____ Title: _____ Date: _____

ENHANCED CARE MANAGEMENT (ECM) SERVICES

Authorization for Use, Exchange, and/or Disclosure
of My Confidential Health Care and Personal Information

PURPOSE

Health care providers, health payers, and social services agencies have joined together to provide **Enhanced Care Management (ECM) services** to help promote your health and well-being. To allow Partnership HealthPlan of California ("**Partnership**") and/or other entities to share your health care and other personal information with each other to help provide you with these ECM services, you must give your authorization first. By filling out this form, you are authorizing the use and release of your health care and other personal information by the following entities participating in ECM ("**ECM Entities**"): health care providers such as hospitals, physicians, and pharmacies; Partnership and other managed care plans that administer Medi-Cal benefits and pay for services you receive under Medi-Cal; community-based organizations that must comply with health care privacy laws; school-based providers such as nurses, social workers, and counselors; the California Departments of Health Care Services, Public Health, Social Services, and Developmental Services; and county agencies including, but not limited to, mental health plans; and providers and case managers at correctional facilities, but only for the purposes set forth below. Your authorization will permit ECM Entities to use and release your health care and other personal information for the following purposes ("**Purposes**"): (a) to provide you with, refer you to, or help you receive comprehensive care management services, including coordinating health and health-related care services and case management ("**Services**") to meet your needs; (b) to identify, support, coordinate, improve and arrange payment for Services that may be provided to you; and (c) to help Partnership provide better care through evaluation, reporting, and population health management. The information may be shared in a secure electronic format, in writing, or verbally to coordinate Services for you.

Member Information

First Name:	Last Name:
Address:	
Phone Number: ( )	Date of Birth:
Member ID/CIN:	

I authorize and ask that **Partnership HealthPlan of California** and **participating ECM Entities** named in **Attachment A** to use and share any of my health care or other personal information with each other for the purpose stated in this Authorization.

Choose ONE of the following options:

INITIAL HERE	**Consent for communication by ECM Program:** By putting my initials here, I am allowing ALL of the ECM Entities listed in **Attachment A** to use and share my health care and other personal information about my medical history, physical and mental condition, and receipt of social services, and to communicate with each other in order to provide ECM Services. The types of health and other confidential information that I am authorizing to be shared between ECM Entities include: (a) Protected health information ("**PHI**"), including information regarding my health

	care, medical history, lab test results, and current or future conditions and treatment; (b) Mental health information, including current and past diagnoses and treatments of my mental health conditions, excluding psychotherapy notes which are only shared if I sign a separate consent form; (c) Individualized Education Program information and other information about social services provided in school; (d) Medi-Cal eligibility/enrollment information, which includes income and certain other demographic and geographic information pertaining to my eligibility for Services and benefits; (e) Housing/homelessness information, including my housing status, history, and supports; and (f) Limited criminal justice information, including booking data, dates and location of incarceration, and supervision status. My consent does not apply to my criminal history, charges, and immigration status.
INITIAL HERE	**Decline to participate in ECM:** I understand that the ECM program allows ECM Entities to be in contact with each other to coordinate my care. I decline to participate in the ECM program. I can ask to participate in case management programs for which I am eligible.

Further, by putting my initials below, I specifically authorize the release of the following information (this information will NOT be released unless you specifically authorize it)

INITIAL HERE	Mental health information, including diagnosis, treatment plan, and provider name. This does not include psychotherapy notes, which are only shared if I sign a separate consent form.
INITIAL HERE	HIV Test Results (Health & Safety Code § 120980 (g))

Substance Use Disorder Information

Substance use disorder ("**SUD**") records are protected by federal confidentiality rules (42 CFR Part 2). The federal rules do not allow any further release of information that finds a patient as having or having had a substance use disorder either by reference to publicly available information, or through proof of such identification by another person unless further release is permitted by the written consent of the person whose information is being given or as otherwise permitted by 42 CFR Part 2. The federal rules restrict any use of the information to investigate or prosecute, with regard to a crime, any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. By filling out this section, you are authorizing ECM Entities to use and release the following SUD information for the Purposes described in this form: your current and past drug or alcohol use diagnoses, medications, treatment, lab tests, trauma history, facility discharges, and any other SUD information about you that comes from a substance/alcohol use disorder provider subject to federal SUD confidentiality regulations (42 C.F.R. Part 2). SUD records (or information therein) that are used or disclosed for treatment, payment, or health care operations by certain ECM Entities, including health care providers, health plans and other third-party payors, may be redisclosed as permitted in the federal HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you. Your SUD counseling notes will not be shared unless you sign a separate consent form.

INITIAL HERE	Initial here to allow the ECM Entities in **Attachment A** to use and share your SUD information as described above, excluding SUD counseling notes.

Expiration of Form

Choose ONE of the following two options:

INITIAL HERE	**Standard expiration:** This authorization will expire 1 year from today's date; OR
INITIAL HERE	**Expiration:** This authorization will expire on:_____. This date may not be less than 6 months (to participate in the ECM program), but may be more than 1 year from today's date.

I understand that:

- I can revoke this Authorization at any time by calling Partnership at (800) 863-4115 or by sending a signed revocation request to:

  Partnership HealthPlan of California
  Attn: Enhanced Health Services
  4665 Business Center Drive
  Fairfield, CA 94534
- A revocation is effective when received, but may not apply to information already shared, based on my prior consent to use or release information.
- I can choose to not sign this form and doing so will not affect my treatment or care, my eligibility for or ability to receive Services, or the payment for Services. However, my ability to participate in the ECM program may be affected by not signing this Authorization.
- Even if I do not sign this form, under federal and state privacy laws, some of the ECM Entities may share my confidential information for treatment, payment, and other purposes, but providers subject to federal substance use confidentiality laws generally may not share my substance use disorder information without my consent (42 CFR Part 2).
- The information I authorize for use or release may be re-shared by ECM Entities, but only in compliance with this Authorization and applicable law.
- I can get a copy of the health information that is being shared.
- I have the right to ask for a copy of this form and one will be sent to me.
- I may obtain a list of all ECM Entities to which my information has been disclosed, including those entities identified in **Attachment A**, by contacting Partnership.
- If I voluntarily include my phone number above, I consent to the receipt of texts or calls to communicate with me about my consent choices and how my health and other confidential information may be shared (standard message and data rates may apply).
- Each of the above rights extend to any representative I authorize under applicable law.

[*signature on next page*]

Signature of Member

If you are signing this Authorization on your own behalf, fill out the first line. If you are signing on behalf of someone else, fill out the second line. If you are signing on behalf of a minor aged 12-17, the minor should fill out the first line and you should fill out the second line.

Beneficiary's Name	Beneficiary's Signature	Date (mm/dd/yyyy)
Representative's Name	Representative's Signature	Date (mm/dd/yyyy)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPQP1048</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Reporting Communicable Diseases</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/17/2009</td><td colspan="4">Next Review Date: ~~09/11/2025~~09/10/2026
Last Review Date: ~~09/11/2024~~09/10/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~09/11/2024~~09/10/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCCP2035 – Local Health Department (LHD) Coordination

~~A.~~B. MPUP3047 – Tuberculosis Related Treatment~~N/A~~

II. IMPACTED DEPTS:

A. Health Services~~N/A~~

III. DEFINITIONS:

A. N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To specify reporting requirements for communicable diseases mandated by California state law (California Code of Regulations, Title 17, § 2500).

VI. POLICY / PROCEDURE:

A. Requirement

1. California state law requires that health care providers report diseases of public health importance to the local public health department. *Health care provider* is defined as "a physician or surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist" (CCR, Title 17, § 2500, (a)(15)).
2. A list of reportable diseases, reporting timeframes, and reporting method are available from the California Department of Public Health website at: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/ReportableDiseases.pdf

B. Where to Report

1. California Local Health Department (LHD) Contact Information for Health Care Providers/Labs To Report Communicable Diseases and Submit Confidential Morbidity Report (CMR) forms can be accessed at https://www.cdph.ca.gov/Programs/CCLHO/Pages/LHD-Communicable-Disease-Contact-List.aspx#

Policy/Procedure Number: MPQP1048			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Reporting Communicable Diseases			☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/17/2009		**Next Review Date:** ~~09/11/2025~~08/10/2026 **Last Review Date:** ~~09/11/2024~~09/10/2025	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒**Partnership Advantage**

VII. REFERENCES:

A. Title 17 of the California Code of Regulations (CCR) § 2500 Reporting to the Local Health Authority
B. California Department of Public Health CCLHO Health Officer Directory ~~April 19, 2024~~July 9, 2025
C. California Department of Public Health Local Health Department (LHD) Communicable Disease Contact List Jan. 27, 2025

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
05/19/10; 10/17/12; 10/16/13; 10/15/14; 10/21/15; 10/19/16; 09/20/17; *09/12/18; 09/11/19; 09/09/20; 09/08/21; 09/14/22; 09/13/23; 09/11/24; 09/10/25

Partnership Advantage (effective Jan. 1, 2027)
N/A

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Healthy-Kids - MPQP1048 (Healthy Kids program ended 12/01/2016)
05/19/10; 10/17/12; 10/16/13; 10/15/14: 10/21/15; 10/19/16 to 12/01/16

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCUP3053 (previously UP100353)				**Lead Department: Health Services**	
Policy/Procedure Title: Acute Inpatient Administrative Days				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 06/20/2001			**Next Review Date:** ~~08/14/2025~~N/A **Last Review Date:** 08/14/2024		
Applies to:	☒ **Medi-Cal**			☐ **Employees**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **P&C**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				~~**Approval Archive**~~ **Date:** ~~08/14/2024~~09/10/2025	

ARCHIVED 09/10/2025 - Refer to MCUG3024 Inpatient UM

I. RELATED POLICIES:
MCUG3024 - Inpatient Utilization Management

II. IMPACTED DEPTS:
A. Health Services,
B. Member Services
C. Claims

III. DEFINITIONS:
Acute administrative days - are those days approved at an acute inpatient facility, which provide a higher level of medical care than currently needed by the Member or when Members are awaiting placement in a transitional care setting such as a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Acute Rehabilitation Unit (ARU) or a Long Term Acute Care (LTAC) facility

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To define the circumstances under which Partnership HealthPlan of California (Partnership) authorizes administrative days for inpatient hospitals when awaiting placement for a lower level of care.

VI. POLICY / PROCEDURE:
A. A Partnership Member may be approved for administrative days when, after review of information from the attending physician and the medical record, it is the professional judgment of the Partnership Chief Medical Officer or physician designee that the Member's care no longer meets acute inpatient criteria, but does require lower level inpatient care such as long-term acute care (LTAC) or subacute care.
B. A Partnership Member may be approved for acute inpatient administrative days when, after review of information from the attending physician and the medical record, it is the professional judgment of the Partnership Chief Medical Officer or physician designee that the medical and nursing care required is at a level of care available in SNFs, ICFs, LTACs or ARUs in the community, but placement is not available at the present time
C. If the Member is pending placement at a level of care that is not Partnership's responsibility, administrative days do not apply. Examples include, but are not limited to, Members awaiting placement at a mental health facility, Members awaiting evaluation on a psychiatric hold, Members who are the responsibility of the criminal justice system or Members being discharged home or to a board and care

facility.

D. As soon as it is identified that the Member will need placement, the acute inpatient facility must contact potential placement facilities within a 60 mile radius or further if needed. Outreach should be made frequently, as often as necessary to attempt to place any particular Member.
   1. The outreach made can cover more than one Member being placed provided that:
      a. The acute inpatient facility staff document in each Member record the attempted placement call/outreach effort.
      b. The post-acute facility can meet the special needs of a particular Member.
   2. The acute inpatient facility must continue placement efforts until placement occurs. The acute inpatient facility may be required to submit its documentation to the Partnership Nurse Coordinator.

VII. REFERENCES:
Medi-Cal Provider Manual/ Guidelines

VIII. DISTRIBUTION:
A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:
Medi-Cal
05/15/02; 05/21/03; 10/20/04; 10/19/05; 10/17/07; 10/15/08; 05/18/11; 09/17/14; 01/21/15; 01/20/16; 01/18/17; *02/14/18; 02/13/19; 02/12/20; 02/10/21; 06/09/21; 06/08/22; 08/09/23; 08/14/24; ARCHIVED 09/10/2025

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

ARCHIVED 09/10/2025 - Refer to MCUG3024 Inpatient UM

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCUP3114			**Lead Department:** Health Services **Business Unit**: Utilization Management	
Policy/Procedure Title: Physical, Occupational and Speech Therapies			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 06/20/2012		**Next Review Date:** ~~08/14/2025~~09/10/2026 **Last Review Date:** ~~08/14/2024~~09/10/2025		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~08/14/2024~~09/10/2025	

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCCP2024 – Whole Child Model for California Children's Services (CCS)
~~C. MPCP2002 – California Children's Services~~
~~D.~~C. MCUP3125 – Gender Dysphoria/ Surgical Treatment
~~E.~~D. MP~~C~~UG3011 – Criteria for Home Health Services
~~F.~~E. MCUP3113 – Telehealth Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.

~~A.~~B. Medical Necessity: Medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

~~B.~~C. Occupational Therapy (OT) provides task-oriented therapeutic activities and exercises designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease or injury; or to help an individual relearn daily living skills or compensatory techniques to improve the level of independence in the activities of daily living.

~~C.~~D. Physical Therapy (PT) is a service with an established theoretical and scientific base and widespread clinical applications in the restoration and promotion of optimal physical function. Physical therapists diagnose and manage movement dysfunction and enhance physical and functional abilities.

~~D.~~E. Physical and Occupational therapy services are designed to:

1. Assess the existence or extent of a medical condition;
2. Assess the impact of a medical condition, injury or surgery upon function and role performance;
3. Restore deterioration in physical function and physical performance of activities of daily living from previous function, due to medical condition, injury, or surgery.
4. Treat physical limitations or physical dysfunctions in physical activities or activities of daily living, due to a medical condition, surgery or procedure.
5. Restore deterioration in cognitive skills that impact the ability to perform activities of daily living from previous function, due to medical condition, injury or surgery and treat sensory dysfunctions

due to a medical condition, injury or surgery that impact oral/pharyngeal intake or lead to bodily damage.

~~E.~~F. Speech Therapy (ST): The treatment of speech, swallowing and communication disorders. The approach used depends on the disorder. It may include physical exercises to strengthen the muscles used in speech and swallowing (oral-motor work), speech drills to improve clarity, or sound production practice to improve articulation.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the treatment authorization process for physical, occupational and speech therapies in the outpatient setting.

VI. POLICY / PROCEDURE:

A. Criteria for Remote PT, OT, and ST:
PT, OT, and ST services may be provided virtually, if the service provided does not require in-person or manual examination, manipulation or therapeutic techniques (see CMS and DHCS policies and Partnership policy MCUP3113 Telehealth Services).

B. General Guidelines for Authorization of PT, OT and ST.

1. No Referral Authorization Form (RAF) is required for PT, OT, or ST services, but services must be ordered through a written prescription of a licensed physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, or Nurse Practitioner).

~~1.~~2. For all Members, n~~N~~o TAR or RAF is required for the initial evaluation.

C. Services That Do NOT Require a TAR

~~2.~~1. Partnership does *not* require Treatment Authorization Requests (TARs) from contracted providers for PT, OT, or ST for ~~the following circumstances~~:

a. Members age 21 and over: No TAR required for up to 12 visits for a specific diagnosis (limit one visit per day) in a rolling 12-month period of time.

1) A TAR will be required for services in excess of 12 visits for a specific diagnosis.

~~C.~~D. Services That Require a TAR

1. After an initial evaluation, Partnership *requires* a TAR for PT, OT, or ST services for the following circumstances:
   a. Members under age 21
   b. Non-contracted Providers
   c. Home Health Services~~:~~ (A TAR is required for all ages for all PT, OT, or ST services provided through a home health agency. Refer to policy MP~~C~~UG3011 Criteria for Home Health Services.)
2. Submission Guidelines When a TAR is Required
   a. Partnership M~~m~~embers can be referred by a physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, or Nurse Practitioner) for one consultation visit through written prescription of licensed practitioners acting within the scope of their practice. As noted above, no TAR or RAF is required for the initial consultation/ evaluation.

~~b.a. No TAR or RAF is required for the initial evaluation.~~

~~c.~~b. Following the initial evaluation, the service provider must submit a TAR for the requested services. The TAR should document, at a minimum, the following information:

1) Medical diagnosis necessitating the service with a summary of medical condition
2) Related medical conditions
3) Functional limitations
4) Dates and length of treatment
5) Therapeutic goals of treatment and current functional status of the patient with respect to these goals
6) Dates of planned progress review
7) Specific services to be rendered (e.g. evaluation, treatment, modalities)

~~d.~~c. Partnership authorizes ancillary services on a case by case basis, provided that medical necessity has been demonstrated in the submitted documentation.

~~e.~~d. The Nurse Coordinators/ Utilization Management (UM) staff review each TAR and consult with the referring physician or ancillary provider as needed to determine the medical necessity of the requested services. If the Nurse Coordinator is unable to approve the requested service based upon information available, the case is submitted to one of Partnership's reviewing physicians for consideration. Determination that a requested service is not medically necessary may only be rendered by a physician.

1) Occupational and physical therapy may be considered medically necessary when:
   a) There is a reasonable expectation, determined by a physical or occupational therapist and the attending physician, that in a predictable period of time the therapy will achieve measurable improvement in the patient's mobility or activities of daily living.
   b) Measurable reversal of deterioration from previous levels of cognitive or communication functions.
   c) The services are used to assess the existence or extent of impairment due to a medical condition.
   d) A "reasonable expectation" referenced above shall be based upon evidence based medicine. A reasonable expectation shall take into consideration the patient's mental alertness to participate and benefit from the therapy process.
   e) Any episode of physical or occupational therapy is not medically necessary and will not be approved when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.
2) Speech Therapy services for M~~m~~embers age 21 or over may be considered medically necessary based upon the receipt of appropriate medical documentation demonstrating that the M~~m~~ember and services meet the following criteria:
   a) Speech Pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.
   b) Appropriate adult candidates for speech therapy must be able to participate in and/or benefit from the therapy process, have adequate attention span, cooperation and endurance to participate, and demonstrate behavior conductive to engaging in the process.
   c) Speech therapy as conversational therapy/ voice training should be considered prior to any pitch changing surgery for transgender or gender nonconforming beneficiaries as discussed in policy MCUP3125 Gender Dysphoria/Surgical Treatment.
   d) Speech therapy services are reviewed in accordance with clinical guidelines when considered medically necessary only when there is reasonable expectation that they will achieve significant, measurable improvement in the M~~m~~ember's communication, cognition or swallowing in a reasonable and predictable period of time as determined by the treating therapist and referring provider.
   e) A "reasonable expectation" referenced above shall be based upon evidence based

medicine. A reasonable expectation shall take into consideration the patient's mental alertness to participate in and benefit from the therapy process.

f) A course of speech therapy shall be determined to be no longer medically necessary when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.

3) The following are examples of conditions where therapy may be considered medically necessary based upon the receipt of appropriate medical documentation:
   a) Musculoskeletal Pathology or Dysfunction, including limitations in joint range of motion and/or mobility, deterioration from previous function of muscle strength and/or decreased endurance, soft tissue dysfunction, alterations in postural control and alignment.
   b) Neuromuscular Pathology or Dysfunction, including deterioration from previous function of gross and/or fine motor coordination, alterations in tone- increased or decreased, deterioration from previous function of motor planning skills, deterioration from previous function of balance, loss of selective motor control, decrease in bilateral integration.
   c) Neurocognitive Pathology or Dysfunction, including sensory dysfunctions regarding food textures and oral tactile defensiveness when impacting overall health; deterioration from previous function in cognitive, self-care or adaptive skills.
   d) Pathology or Dysfunction of the Vascular System, including primary or secondary lymphedema, edema and venous stasis.
   e) Pathology or Injury to Skin, including burns and/or sores following injury or surgery, open wounds.
   f) Assessments of Impairment Related to Medical Condition, including appropriate assessments as part of a multidisciplinary or interdisciplinary team of motor skills disorders and physical functions; appropriate individual assessments of post therapy functions and periodic review of appropriate maintenance activities for the patient and family
   g) Design of Maintenance Activities, including physical exercise, drills, techniques that a patient performs outside of therapy or after any therapy has concluded.
4) The following services are generally not considered "medically" necessary or are not covered:
   a) Recreational therapy
   b) Activities that provide diversion or general motivation
   c) Exercise programs for healthy individuals, including development and delivery of exercise programs; assisted walking
   d) Programs for communication/cognitive deficits from developmental disorders - where deficits do not impact overall health
   e) Maintenance physical or occupational therapy to preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of the treatment plan have been achieved and when no further functional progress is apparent or expected to occur. Maintenance does not require the skills of a qualified provider of physical or occupational therapy services. The patient is responsible for practicing learned drills, techniques and exercises to preserve his or her present level of function and prevent regression of that function. Maintenance includes ongoing supervision of independent exercise programs, supervision/ observation of activities of daily living, and supervision of independent transfer activities.
      i. For Mmembers residing in a skilled nursing facility, the facility must provide

maintenance therapy that is included in the room and board fee and not separately reimbursable.

~~f.~~e. If therapy is required beyond the visits initially approved, a new TAR must be submitted.

~~g.~~f. The approval of continuation of therapy will be based on documentation of measurable improvement in the patient's condition in a reasonable and predictable period of time, based on the written care plan and the clinical judgment of the treating physical or occupational therapist with the patient's referring physician. Regular evaluation of the patient is required to determine that continuation of therapy is medically appropriate. The medical need for continuation must be documented on the TAR submitted to Partnership.

1) Continued therapy will not be approved once a M~~m~~ember has met established treatment goals, or has stabilized and is not expected to continue to make significant gains, based on the written care plan and the clinical judgment of the treating PT or OT in conjunction with the patient's referring physician.

3. Speech Therapy Related to Hearing Loss for Members Under 21 Years of Age:
   a. Partnership Members who have a California Children's Services (CCS)-eligible condition are enrolled in the Whole Child Model (WCM) program. The WCM program integrates CCS program-covered services with Members' regular Medi-Cal benefits to provide seamless care for children and youth.
      1) Partnership covers t~~T~~he medical condition of hearing loss ~~is covered~~ for hearing tests, evaluations by audiologists, and medical evaluations by head and neck surgeons and physicians in other clinical specialties.
      ~~1)~~2) Under the WCM program, Partnership also covers ~~However,~~ speech and language therapy for hearing impaired children who have hearing aids or need to use sign language, but do not have physical impairment of the articulators.~~,~~ For these conditions, ~~is the responsibility of California Children's Services (CCS) and~~ the M~~m~~ember should be referred to CCS ~~California Children's Services (CCS)~~ in the county of residence ~~or the state where applicable,~~ to determine program eligibility. Once CCS program eligibility is established, all medically necessary covered services, including case management and authorization of services, for CCS-eligible conditions will ~~either~~ be provided by ~~State CCS or by~~ Partnership under the ~~Whole Child Model~~WCM program ~~in participating counties~~. See policy ~~ies MPCP2002 California Children's Services and~~ MCCP2024 Whole Child Model for California Children's Services (CCS)[1].
   b. Speech Pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.
   c. A M~~m~~ember may receive services through the Local Educational Agency (LEA) but is not required to do so prior to receiving therapy benefits under Partnership. If a M~~m~~ember is receiving medically necessary services through the LEA, Partnership will coordinate with the LEA to provide additional services to the extent determined to be medically necessary. For example, if it is determined that the M~~m~~ember medically requires speech therapy three times per week, and he/she receives speech services by the LEA one time per week, Partnership will approve the additional two visits per week if criteria is met.

VII. REFERENCES:

[1] ~~In Partnership's service area, 14 counties participate in the Whole Child Model program (Del Norte, Humboldt, Lake, Lassen, Marin, Modoc, Mendocino, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo). As of January 1, 2024, the following 10 counties in Partnership's service area are participants in the State's CCS program and are not participants in Partnership's Whole Child Model program: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba.~~

A. Social Security Act Section 1905(r)
B. Medi-Cal Provider Manual/ Guidelines: Physical Therapy (*phys*); Occupational Therapy *(occu)*; Speech Therapy *(speech)*; Medicine: Telehealth (*medne tele*), Home Health Agencies *(home hlth)*
C. California Children's Services (CCS) Medical Eligibility
~~C.~~D. Full-Year Continuing Appropriations and Extensions Act, 2025

VIII. DISTRIBUTION:
A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 01/20/16; 11/16/16; 11/15/17; *02/13/19; 03/11/20; 06/10/20; 01/13/21; 02/09/22; 02/08/23; 03/13/24; 08/14/24; 09/10/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3133</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Wheelchair Mobility, Seating and Positional Components</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 11/18/2015</td><td colspan="4">Next Review Date: ~~08/14/2025~~09/10/2026
Last Review Date: ~~08/14/2024~~09/10/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIAL~~SING~~</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~08/14/2024~~09/10/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3013 – Durable Medical Equipment (DME) Authorization
C. MCCP2024 – Whole Child Model for California Children's Services (CCS)

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Claims
D. Member Services

III. DEFINITIONS:

A. **Activities of Daily Living (ADL):** The activity of dressing/bathing, eating, ambulating (walking), toileting and hygiene.
B. **Custom Rehabilitation Equipment:** Any item, piece of equipment or product system, whether modified or customized, that is used to increase, maintain or improve functional capabilities with respect to mobility and reduce anatomical degradation and complications of individuals with disabilities. Custom rehabilitation equipment includes, but is not limited to, non-standard manual wheelchairs, power wheelchairs and seating systems, power scooters that are specially configured, ordered, and measured based upon patient height, weight and disability, specialized wheelchair electronics and cushions, custom bath equipment, standards, gait trainers and specialized strollers.
C. **Durable Medical Equipment (DME):** Devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a physician, physician assistant, or advanced practice registered nurse (which includes nurse practitioner, nurse anesthetist, nurse midwife, and clinical nurse specialist)in the treatment of a specific medical condition and which have all of the following characteristics:
   1. Can withstand repeated use
   2. Is used to serve a medical purpose
   3. Is not useful to an individual in the absence of an illness, injury, functional impairment or congenital anomaly; and
   4. Is appropriate for use in or out of a patient's home.
D. **Instrumental Activities of Daily Living (IADL):** Activities that allow an individual to live independently in a community and include shopping, housekeeping, accounting, food preparation, taking medications as prescribed, use of a telephone or other form of communication, and accessing transportation within one's community.

E. **Licensed Practitioners:** Clinical professionals furnishing medical care, or any other type or remedial care recognized under State law within their scope of practice as defined by State Law.

F. **Medical Necessity:** For the purposes of this policy, a wheelchair is considered medically necessary if the beneficiary's medical condition and mobility limitation are such that without the use of a wheelchair, the beneficiary's ability to perform one or more mobility related Activities of Daily Living or Instrumental Activities of Daily Living, in or out of the home, including access to the community, is impaired and the beneficiary is not ambulatory or functionally ambulatory without static supports such as a cane, crutches or walker.

G. **Power Mobility Device (PMD):** Base codes include both integral frame and modular construction type power wheelchairs (PWCs) and power operated vehicles (POVs).

H. **Power Operated Vehicle (POV):** Chair-like battery power fed mobility device for people with difficulty walking due to illness or disability, with integrated seating system, tiller steering, and four-wheel non-highway construction.

I. **Power Wheelchair (PWC):** Chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated seating system, electronic steering, and four or more wheel non-highway construction.

J. **Qualified Healthcare Professional (QHP):** Licensed physical, occupational, or speech therapists with competence in analyzing the needs of consumers with disabilities, assisting in the selection of appropriate assistive technology for the consumer's needs, and training in the use of the selected device(s). Specialty certification is required for professionals working in seating, positioning and mobility.

K. **Qualified Rehabilitation Technical Professional (QRTP):** Individuals typically certified as Assistive Technology Professionals who are employed by the vendor providing assistive technology devices to ~~PHC~~Partnership M~~m~~embers. They may have an additional certification of a Certified Rehabilitation Specialist. The QRTP is responsible for ensuring the equipment provided meets the technical needs of the patient.

L. **SPC:** Seating and provisional components

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the policy and processes for review of wheelchairs (manual and electric powered) and Power Operated Vehicles (POV) in accordance with the Department of Health Care Services All Plan Letter (APL) 15-018 Criteria For Coverage of Wheelchairs and Applicable Seating and Positioning Component issued July 9, 2015 as well as the California Children's Services (CCS) Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) issued August 8, 2003 and CCS N.L. 09-0514 Powered Mobility Devices (PMD) issued May 29, 2014.

VI. POLICY / PROCEDURE:

A. An authorization request for rental or purchase of a manual or powered mobility device (wheelchair, POV) requires a written request/prescription from a licensed professional and will be reviewed as follows:

1. Upon receipt of the Treatment Authorization Request (TAR) for custom rehabilitation equipment (as per III.B.) and/or powered mobility devices (as per III.G.), Partnership HealthPlan of California (~~PHC~~Partnership) will arrange for an assessment by an independent Qualified Healthcare Professional (QHP) who is not employed by or paid by a mobility device vendor. The purpose of the assessment is to evaluate the appropriateness of the request, document medical necessity for the

mobility device, and identify the type of equipment best suited to meet the Mmember's specific needs. The assessment must be performed in the setting where the Mmember will use the mobility device. The independent QHP's written summary of findings and recommendations is required to be submitted to PHCPartnership before a determination decision can be made for the mobility device authorization request. PHCPartnership does not offer incentives or compensation to independent consultants or health plan staff to deny medically appropriate services requested by Mmembers or providers.

2. A prescription for a wheelchair will not be denied on the grounds that it is for use only outside the home.
3. A TAR is required for all wheelchair requests when PHCPartnership is the secondary payer to Medicare.
4. The following sequential questions offer clinical guidance for the ordering of an appropriate device to meet the medical need of treating and restoring the beneficiary's ability to perform one or more mobility related ADLs or IADLs. These guiding principles will be used by PHCPartnership in making a benefit coverage determination.
   a. Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more ADLs or IADLs? A mobility limitation is one that:
      1) Prevents the beneficiary from accomplishing the ADLs or IADLs entirely, or,
      2) Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in ADLs or IADLs, or
      3) Prevents the beneficiary from completing the ADLs or IADLs within a reasonable time frame
   b. Are there other conditions that limit the beneficiary's ability to participate in ADLs or IADLs?
      1) Some examples are impairment of cognition or judgment and/or vision.
      2) For these beneficiaries, the provision of a wheelchair and seating and provisional components (SPC) might not enable them to participate in ADLs or IADLs if the comorbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with wheelchair and SPC.
   c. If these other limitations exist, can they be ameliorated or compensated such that the additional provision of wheelchair and SPC will be reasonably expected to improve the beneficiary's ability to perform or obtain assistance to participate in ADLs or IADLs?
      1) If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of wheelchair and SPC coverage if it results in the beneficiary continuing to have a limitation.
      2) It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of wheelchair and SPC.
   d. Does the beneficiary demonstrate the capability and the willingness to consistently operate the wheelchair and SPC safely and independently?
      1) Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
      2) A history of unsafe behavior may be considered.
      3) Additional information may be requested from the memberMember's treating medical providers.
   e. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane, crutches or walker?

1) The cane, crutches or walker should be appropriately fitted to the beneficiary for this evaluation.
2) Assess the beneficiary's ability to safely use a cane, crutches or walker.

f. Does the beneficiary's typical environment support the use of wheelchair and SPC?
1) Determine whether the beneficiary's environment will support the use of medically necessary types of wheel chair and SPC.
2) Keep in mind such factors as physical layout, surfaces, and obstacles, which may render wheelchair and SPC unusable.

g. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair to participate in ADLs or IADLs during a typical day? The manual wheelchair should be optimally configured (SPC), wheelbase, device weight, and other appropriate accessories) for this determination.
1) Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
2) A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. light-weight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.
3) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
4) Assess the beneficiary's ability and willingness to safely and effectively use a manual wheelchair.

h. Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?
1) A covered POV is a 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation without additional SPC. Three-wheeled devices are not covered.
2) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a POV.
3) Assess the beneficiary's ability to safely use a POV/scooter.

i. Are the additional features provided by a power wheelchair or powered SPC needed to allow the beneficiary to participate in one or more ADLs or IADLs?
1) The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
2) The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
3) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a power wheelchair.
4) Assess the beneficiary's ability to safely and independently use a power wheelchair and powered SPC.

4. When a manual or powered mobility device authorization is approved, it is the vendor's responsibility to have a Qualified Rehabilitation Technical Professional (QRTP) ensure the equipment provided meets the technical needs of the M~~m~~ember. Any customized additions or added features that are not specifically covered under the approved authorization will require submission of another request (for a "custom wheelchair or device") to authorize these additions. Failure on the part of the vendor to do so before building and delivering the customized device could result in denial of requests for payment for the additional features.

B. Medical Necessity
1. Manual wheelchairs are medically necessary when:
a. Criteria 1), 2), 3), 4) and 5) below are met; and

b. Criterion 6) or 7) is met, and
c. Criteria is met for specific devices listed below.
   1) The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more ADLs or IADLs, and
   2) The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane, crutches or walker, and
   3) The manual wheelchair supplied to the beneficiary for use in or out of the home and community settings provides adequate access to these settings (e.g., between rooms, in and out of the home, transportation, over surfaces and a secure storage space), and
   4) Use of a manual wheelchair will improve the beneficiary's ability to participate in ADLs or IADLs.
   5) The beneficiary has expressed a willingness to use the manual wheelchair that is provided, and
   6) The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
   7) A standard wheelchair may be medically necessary
      a) When the beneficiary is able to self-propel the wheelchair, or
      b) Propel with assistance
   8) A standard hemi-wheelchair may be medically necessary
      a) For disarticulation of one or both lower extremities, or
      b) Requires a lower seat height because of short stature, or
      c) To enable the beneficiary to place his/her feet on the ground for propulsion
   9) A lightweight wheelchair may be medically necessary
      a) When a beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel, or
      b) For a beneficiary with marginal propulsion skills.
   10) A high strength lightweight wheelchair may be medically necessary when
      a) The beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel while engaging in frequent ADLs or IADLs that cannot be performed in a standard or lightweight wheelchair, or
      b) The beneficiary requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair
   11) An ultra-lightweight multi-adjustable wheelchair may be medically necessary when
      a) The beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel while engaging in frequent ADLs or IADLs that cannot be performed in a standard, lightweight or high strength lightweight wheelchairs, and
      b) The beneficiary's medical condition and the position of the push rim in relation to the beneficiary's arms and hands is integral to the ability to self-propel the wheelchair effectively, and
      c) The beneficiary has demonstrated the cognitive and physical ability to independently and functionally self-propel the wheelchair, or
      d) The beneficiary's medical condition requires multi-adjustable features or dimensions that are not available in a less costly wheelchair (e.g., pediatric size and growth options)
   12) A heavy duty wheelchair is medically necessary when

a) The beneficiary weighs more than 250 pounds, as documented in clinical notes within the past 12 months, or
b) The beneficiary has severe spasticity, or
c) Body measurements cannot be accommodated by standard sized wheelchairs.

13) An extra heavy duty wheelchair is medically necessary when
a) The beneficiary weighs more than 300 pounds, as documented in clinical notes within the past 12 months, or
b) Body measurements cannot be accommodated by a heavy duty wheelchair

14) Manual tilt-in-space wheelchairs are medically necessary when
a) The beneficiary is dependent for transfers, and
b) The beneficiary has a plan of care that addresses the medical need for frequent positioning changes (e.g., for pressure reduction or poor/absent trunk control) that do not always include a tilt position.

15) Pediatric sized folding adjustable wheelchairs with seating systems are covered as primary or back-up wheeled mobility when
a) The beneficiary meets the criteria for wheeled mobility, and
b) The wheelchair is an appropriate size for the beneficiary, and
c) The beneficiary meets the criteria for recline and positioning options, and
d) The wheelchair provides growth capability in width and length

2. Powered Mobility Devices are medically necessary when:
a. Criteria 1), 2), and 3) below are met, and
b. Criteria is met for specific devices listed below.

1) The beneficiary has a mobility limitation that impairs his or her ability to participate in one or more ADL or IADLs, and
2) The beneficiary's mobility limitation cannot be safely resolved by the use of an appropriately fitted cane, crutches or walker, and
3) The beneficiary does not have upper extremity function to self-propel an optimally-configured manual wheelchair to perform ADLs or IADLs during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function. An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.

A four wheeled Power Operated Vehicle (POV) is covered if all of the basic coverage criteria 1) - 3) have been met and if criteria 4) - 9) are also met.

4) The beneficiary is able to:
a) Safely transfer to and from a POV, and
b) Operate the tiller steering system, and
c) Maintain postural stability and position in standard POV seating while operating the POV without the use of any additional positioning aids

5) The beneficiary's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in or out of the home, and
6) The beneficiary's home provides adequate access between rooms, in and out of the home, maneuvering space, over surfaces and a secure storage space for the operation of the POV that is provided, and
7) The beneficiary's weight, as documented in clinical notes within the past 12 months, is less than or equal to the weight capacity of the POV that is provided, and

8) Use of a POV will significantly improve the beneficiary's ability to participate in ADLs or IADLs, and
9) The beneficiary has expressed willingness to use a POV

A Power Wheelchair (PWC) is covered if all of the basic coverage criteria 1) – 3) have been met and

a) The beneficiary does not meet coverage criterion 4), 5), or 6) above for a POV; and
b) Criteria 10) – 13) below are met; and
c) Any coverage criteria pertaining to the specific wheelchair grouping (see below) are met.

10) The beneficiary has the mental and physical capabilities to safely and independently operate the power wheelchair that is provided, and
11) The beneficiary's typical environment (in or out of the home) provides adequate access between rooms, maneuvering space, over surfaces and a secure storage space for the operation of the power wheelchair that is provided, and
12) The beneficiary has expressed willingness to use a power wheelchair.

Power Wheelchairs are segmented into the following groupings:

13) A Group 1 PWC (K0813-K0816) or a Group 2 (K0820-K0829) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and the wheelchair is appropriate for the beneficiary's weight.
14) Group 2 Single Power Option PWC (K0835 – K0840) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if Criterion a) or b) below is met;
    a) The beneficiary requires a drive control interface other than a hand or chin- operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control), or
    b) The beneficiary meets coverage criteria for a power tilt or a power recline seating system and the system is being used on the wheelchair
15) A Group 2 Multiple Power Option PWC (K0841-K0843) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if Criterion a) or b) below is met;
    a) The beneficiary meets coverage criteria for a power tilt and recline seating system and the system is being used on the wheelchair, or
    b) The beneficiary uses a ventilator which is mounted on the wheelchair.
16) A Group 3 PWC with no power options (K0848-K0855) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if the beneficiary's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.
17) A Group 3 PWC with Single Power Option (K0856-K0860) or with Multiple Power Options (K0861-K0864) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:
    a) The Group 3 criteria [17)] are met, and
    b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.
18) A Group 4 PWC with no power options (K0868-K0871) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:
    a) The Group 3 criteria [17)] are met, and
    b) The minimum range, top end speed, obstacle climb or dynamic stability incline that is medically necessary for the beneficiary engaging in frequent ADLs or IADLs cannot be performed in a Group 3 PWC.
19) A Group 4 PWC with Single Power Option (K0877-K0880) or with Multiple Power

Options (K0884-K0886) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:
   a) The Group 4 criteria [19)] are met, and
   b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.

20) A Group 5 (Pediatric) PWC with Single Power Option (K0890) or with Multiple Power Options (K0891) is covered if the coverage criteria [1) – 3), 10) - 13)] for a PWC are met; and
   a) The beneficiary is expected to grow in height, and
   b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.

21) A push-rim activated power assist device (E0986) for a manual wheelchair is covered if the coverage criteria [1) – 3), 10) - 13)] for a PWC are met, and:
   a) The beneficiary has been self-propelling in a manual wheelchair for at least one year, and
   b) The beneficiary has a non-progressive disease, and
   c) The beneficiary has successfully completed a two-month trial period (reimbursable with prior approval as a rental).

22) SPC may be included with new wheelchair or billed separately under the following conditions:
   a) Refer to the SPC Coverage Criteria for information concerning coverage of general use, skin protection, positioning, powered and custom made components.
   b) A POV or PWC with Captain's Chair seating is not appropriate for a beneficiary who needs a separate SPC
   c) If a beneficiary needs a seat and/or back cushion but does not meet coverage criteria for a skin protection and/or positioning cushion, it is appropriate to provide a Captain's Chair seat (if the code exists) rather than a sling/solid seat/back and a separate general use seat and/or back cushion.
   d) A general use seat and/or back cushion provided with a PWC with a sling/solid seat/back will be considered equivalent to a power wheelchair with Captain's Chair and will be coded and priced accordingly, if that code exists.

23) If a beneficiary's weight, as documented in clinical notes within the past 12 months, combined with the weight of seating and positioning accessories can be accommodated by wheelchair with a lower weight capacity than the wheelchair that is requested or provided, approval or payment will be based on the appropriate HCPCS code that meets the medical need.

24) A power mobility device (PMD) will be denied as not medically necessary if the underlying condition is reversible and the length of need is less than 3 months (e.g., following lower extremity surgery which limits ambulation).

3. Backup manual wheelchairs are medically necessary when
   a. The beneficiary meets the criteria for a powered mobility device, and
   b. The beneficiary meets the criteria for the rented or purchased back-up manual wheelchair, and
   c. The beneficiary is unable to complete ADLs or IADLs without a backup manual wheelchair, and
   d. The backup wheelchair accommodates the SPC on the primary wheelchair.

C. Wheelchairs are NOT covered when:
   1. Not medically necessary
   2. Not used by the beneficiary
   3. Used as a convenience item
   4. Used to replace private or public transportation such as an automobile, bus or taxi

5. Not generally used primarily for health care and are not regularly and primarily used by persons who do not have a specific medical need for them
6. Used in a facility that is expected to provide such items to the beneficiary
7. Used in a skilled nursing facility, unless the beneficiary demonstrates the need for a custom wheelchair under Title 22 of the Code of Regulation section 51321(h)
8. Not prescribed by a licensed practitioner, or, in the case of a custom wheelchair, by a licensed practitioner after evaluation by a QHP.

D. Seating and Positioning Component Coverage Criteria
SPC are covered when criteria 1. 2. and 3., at least one of 4. – 9., and 10. – 19. (if applicable) are met:
1. The beneficiary has met the criteria for wheelchair, and
2. The SPC meets the quality standards and coding definitions specified in the APL 15-018. The Medicaid program reserves the right to review any and all coding assignments by vendors and the Medicare Pricing, Data Analysis and Coding (MPDAC) web site based on submitted and published product specifications and other relevant information.
3. The primary and back-up wheelchair bases accommodate the SPC.
4. A general use seat cushion and a general use back cushion are covered when 1., 2. and 3. are met.
5. A skin protection seat cushion or decubitus wheelchair pad is covered when 1., 2. and 3. are met and that beneficiary has one of the following:
   a. A current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; or
   b. Absent or impaired sensation in the area of contact with the seating surface due to but not limited to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post-polio paralysis traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease; or
   c. Inability to carry out a functional weight shift due to one of, but not limited to, the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn, cell diseases including amyotrophic lateral sclerosis, post-polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease; or
   d. Confined to their wheelchair for more than four (4) continuous hours on a daily basis
   e. A well-documented history (as well as current status) of malnutrition.
6. A positioning seat cushion or positioning back cushion, is covered when 1., 2. and 3. are met and the beneficiary has one of the following:
   a. Significant postural asymmetries that are due to but not limited to one of the diagnoses listed in criterion "5." above; or
   b. One of the following diagnoses: monoplegia of the lower limb or hemiplegia due to stroke, traumatic brain injury, or other etiology, muscular dystrophy, torsion dystonias, spinocerebellar disease.
7. A positioning accessory is covered when criteria 1., 2., 3. and 6. are met and specifically:
   a. A headrest or headrest extension (sling support for the head) is covered when the recipient has a covered manual tilt-in space, manual semi or fully reclining back, or power tilt and/or recline power seating system or needs additional head support. The code for a headrest includes any type of cushioned headrest, fixed, removable or non-removable hardware.
   b. An upper extremity support system (UESS) is covered when the medical need for positioning in a wheelchair cannot be met with less costly alternatives such as any combination of a safety belt, pelvic strap, harness, prompts, armrest modifications, recline, tilt in space or other existing or

potential seating or wheelchair features. UESS dimensions should not exceed the positioning length of the forearms (e.g., 12-15"). UESS and related accessories are not covered when used solely for activities of daily living.

c. UESS padding and positioning blocks are covered in addition to a UESS when there is a medical need for stabilization of the UESS due to strong spasticity or exaggerated muscle activity.

d. Foot-Ankle Padded Positioning Straps (e.g., "ankle huggers") are covered when there is a medical need for stabilization of the foot and ankle due to strong spasticity or exaggerated muscle activity, and positioning in the wheelchair cannot be met with less costly alternatives, such as any combination of heel loop/holders and or toe/loop/holders, with or without ankle straps.

8. A combination skin protection and positioning seat cushion is covered when 1., 2., 3., 5. and 6. are met, i.e., the criteria for both a skin protection seat cushion and a positioning seat cushion are met.
9. A custom fabricated seat cushion is covered if the criteria for 8. are met and there is a comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a vendor or manufacturer), which clearly explains why a standard seating system is not sufficient to meet the beneficiary's seating and positioning needs. (If a custom fabricated seat and back are integrated into a one-piece cushion, code using the custom seat plus the custom back codes.)
10. If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual recipient, the cushion must be billed as a customized cushion, not custom fabricated.
11. The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, which is an integral part of the cushion.
12. Payment for all wheelchair seats, backs and accessory codes includes fixed, removable and/or quick-release mounting hardware if hardware is applicable to the item.
13. The swing away, multi-positioning or removable mounting hardware upgrade code may only be billed in addition to the codes for a headrest, lateral trunk, hip supports, medial thigh supports, calf supports, abductors/pommels, and foot supports when medically justified. It must not be billed in addition to the codes for shoulder harness/straps or chest straps, wheelchair seat cushions or back cushions, or with PWCs with swing away, fixed or retractable joysticks.
14. A manual tilt in space option is covered when:
    a. Criteria 1. – 3. above are met, and
    b. The beneficiary is dependent for transfers, and
    c. The beneficiary has a plan of care that addresses the medical need for frequent positioning changes (e.g., for pressure reduction or poor/absent trunk control) that do not always include a tilt position.
15. A power tilt in space option for a PWC is covered when:
    a. Criteria 1. – 3. and 14. above are met, and
    b. The beneficiary has the mental and physical capabilities to safely and independently operate the power tilt in space that is provided.
16. A manual recline option is covered when:
    a. Criteria 1. – 3. above are met, and
    b. The beneficiary has a plan of care that requires a recline position to complete ADLs or IADLs, and
    c. The beneficiary has positioning needs that cannot be met by upright or fixed angle chair, or
    d. The beneficiary's postural control requires a recline feature.
17. A power recline option for a PWC is covered when:
    a. Criteria 1. – 3. and 16. above are met, and
    b. The beneficiary has a plan of care that requires a recline position to complete ADLs or IADLs,

and

c. The beneficiary has the mental and physical capabilities to safely and independently operate the power recline feature that is provided.

18. A combination manual tilt in space and recline option is covered when criteria 14. and 16. are met and if provided alone will not meet the seating and positioning needs.
19. A combination power tilt in space and recline option is covered when criteria 15. and 17. are met and if provided alone will not meet the seating and positioning needs.

E. Portable Ramps
1. For ~~PHC~~Partnership's policy on portable ramps, please see policy MCUP3013 DME Authorization section VI.G.9.

F. Loaner Rental During Repair
1. Back-up or loaner rental power wheelchairs are not a Medi-Cal covered benefit.
   a. On a case by cases basis, up to a one-month rental of a wheelchair may be considered medically necessary (with maximum of one-month renewal with justification) if a ~~member~~Member-owned wheelchair requires an extended repair. Payment for the rental is based on the type of replacement device that is provided. Requests for loaner powered mobility device rentals will require documentation of medical necessity to be reviewed by the Chief Medical Officer or Physician Designee.

VII. REFERENCES:

A. Title 22, CCR Sections 52260, 51321
B. Medi-Cal Provider Manual/ Guidelines: Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines (*dura wheel guide*) and Bill for Wheelchairs and Wheelchair Accessories (*dura bil wheel*)
C. Department of Health Care Services (DHCS) All-Plan Letter (APL) 15-018 Criteria For Coverage of Wheelchairs and Applicable Seating and Positioning Components (07/09/2015)
D. CCS Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) (08/08/2003)
E. CCS Numbered Letter (N.L.) 09-0514 Powered Mobility Devices (PMD) (05/29/2014)
F. Senate Bill No.717 Complex Needs Patient Act, California Legislature 2021-2022 Regular Session, Amended in Senate May 20, 2021. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB717

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Department Directors
B. ~~PHC~~Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 08/17/16; 08/16/17; *09/12/18; 11/13/19; 11/11/20; 11/10/21; 05/11/22; 06/14/23; 08/14/24; 09/10/2025

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

MCUP3083 - Wheelchair and Power Operated Vehicle Authorization was archived 11/18/2015

Policy/Procedure Number: MCUP3133		**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Wheelchair Mobility, Seating and Positional Components		☒ **External Policy** ☐ **Internal Policy**
Original Date: 11/18/2015	**Next Review Date: 08/14/202509/10/2026** **Last Review Date: 08/14/202409/10/2025**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

Original Date: 04/16/2008
Revision Dates: 07/15/09; 05/18/11

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by ~~PHC~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.

~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCUP3141			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Delegation of Inpatient Utilization Management			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 06/09/2021		**Next Review Date:** ~~08/14/2025~~09/10/2026 **Last Review Date:** ~~08/14/2024~~09/10/2025		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIAL~~ING~~**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*		**Approval Date:** ~~08/14/2024~~09/10/2025		

I. RELATED POLICIES:

A. MCUG3024 - Inpatient Utilization Management
B. MCUP3041 - Treatment Authorization Request (TAR) Review Process
C. MP~~C~~UP3014 - Emergency Services
D. MP~~C~~UP3039 - Direct Members
E. MCUP3037 - Appeals of Utilization Management/Pharmacy Decisions
F. CGA024 - Medi-Cal Member Grievance System
G. CMP36 - Delegation Oversight and Monitoring
H. CMP02 - Risk Assessment, Audits and Monitoring
I. CMP38 - Escalation and Corrective Action
J. ADM47 - Administrative and Financial Sanctions

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Finance
D. Regulatory Affairs/Compliance

III. DEFINITIONS:

A. Adverse Benefit Determination (ABD) - The definition of an Adverse Benefit Determination encompasses all previously existing elements of an "Action" as defined under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability. An ABD is defined to mean any of the following actions taken by a Managed Care Plan (i.e. Partnership HealthPlan of California):
   1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
   2. The reduction, suspension, or termination of a previously authorized service.
   3. The denial, in whole or in part, of payment for a service.
   4. The failure to provide services in a timely manner.
   5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
   6. The denial of the Member's request to obtain services outside the network.
   7. The denial of a Member's request to dispute financial liability.

B. Assigned Risk: In accordance with the Division of Financial Responsibility (DOFR), a determination made by Partnership HealthPlan of California (Partnership) concerning which entity, Partnership or the

Delegated Entity, will be financially responsible for the inpatient hospital services rendered to the Member under the capitation agreement and applied in accordance with the written understanding between Partnership and the Delegated Entity.

C. Capitated Hospital Admission: Admission of an assigned Member to a capitated hospital within a Delegated Entity's contracted network.

D. Capitation: Refers to a form of reimbursement between Partnership and the Delegated Entity of a fixed amount per member per month.

E. Delegated Entity(ies): The hospital that has assumed certain financial responsibilities including Utilization Management (UM), and who has entered into a capitated contractual arrangement with Partnership to perform inpatient services specifically related to fulfilling Partnership's obligations to the Department of Health Care Services (DHCS) under the terms of the DHCS/Medi-Cal contract or those duties Partnership would otherwise perform as defined by the National Committee for Quality Assurance (NCQA).

F. Delegation Oversight: The process whereby Partnership monitors a Delegated Entity's delegated activities to ensure their compliance with statutes, regulations, policies and contractual obligations, including the Delegation Agreement and/or NCQA standards and DHCS requirements.

G. Delegation Agreement: A written agreement between Partnership and the Delegated Entity that defines the obligations and responsibilities of the Delegated Entity.

H. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status is based on the Member's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see PHC network providers and/or certified Medi-Cal providers willing to bill PHC for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.

I. Division of Financial Responsibility (DOFR): DOFR shall be defined as the written understanding between Partnership and the Delegated Entity regarding Assigned Risk.

J. Emergency Medical Condition: Per DHCS County Organized Health System (COHS) contract Exhibit A, Attachment 1 Definitions, a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in one or more of the following:
   1. Placing the health of the individual (or, the case of a pregnant member, the health of the Member or Member's unborn child) in serious jeopardy
   2. Serious impairment to bodily functions
   3. Serious dysfunction of any bodily organ or part, or
   4. Death

~~K. InterQual® Criteria: Nationally recognized medical criteria guidelines, developed and approved by appropriate board certified specialists. InterQual® Criteria are used to assist in making a determination of medical necessity for services proposed or rendered to a Partnership Member.~~

~~L.~~K. Out-of-Area Admission (OOA): An inpatient hospital admission that occurs at a facility that is not in the Delegated Entity's service area as defined by the contractual agreement between Partnership and the Delegated Entity.

~~M.~~L. Utilization Management (UM): The process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and facilities.

IV. ATTACHMENTS:

A. N/A

Policy/Procedure Number: MCUP3141		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Delegation of Inpatient Utilization Management		☒ External Policy ☐ Internal Policy	
Original Date: 06/09/2021		**Next Review Date: 08/14/202509/10/2026** **Last Review Date: 08/14/202409/10/2025**	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

V. PURPOSE:

To define processes, procedures and respective responsibilities that apply when Partnership HealthPlan of California (Partnership) delegates inpatient utilization management functions to hospitals.

VI. POLICY / PROCEDURE:

A. Delegated Entity(ies):
   1. Adventist Health (*Clear Lake, Howard Memorial, Mendocino Coast, St. Helena and Ukiah Valley*)
   2. MarinHealth Medical Center
   3. NorthBay Medical Center/ VacaValley Hospital
   4. Providence (aka St. Joseph Health) Queen of the Valley Medical Center

B. Preauthorization Process for Elective Admissions to the Delegated Entity
   1. Partnership performs prior authorization review to determine if the proposed services meet medical necessity criteria. Partnership notifies the requesting provider of the determination in writing.

C. Preauthorization Process for Elective Admissions outside of the Delegated Entity's Contracted Service Area
   1. Partnership receives the Provider's request and forwards it to the Delegated Entity's UM Designee for their review within one (1) business day of receipt.
   2. ~~The~~ Delegated ~~Entity~~ Entities ~~is~~ are responsible for reviewing authorization requests according to the terms of their DOFR agreement and in accordance with policy MCUP3041 Treatment Authorization Request (TAR) Review Process. ~~-~~This may include, but is not limited to, the following actions:
      a. Reviewing the medical necessity of the requested elective services
         1) The Delegated Entity's Medical Director, or physician designee, must review ~~any~~ cases ~~in which~~ where medical necessity is in question, ~~(based on the nurse reviewer's assessment),~~ utilizing nationally recognized ~~inpatient medical~~ criteria approved by Partnership.
         ~~1)~~ For any
         2) ~~In a~~ denial or modification of medical necessity (adverse benefit determination), the Provider must be ~~Delegated Entity will notify~~ notified ~~the requesting provider~~ in writing or electronically within ~~(using the appropriate NCQA/DHCS approved letter template) at the time of the decision, but no later than~~ 24 hours ~~from the date~~ of the decision, using an NCQA/DHCS-approved letter template. ~~The Delegated Entity shall send~~ A~~a~~ copy of the notification ~~letter~~ must be sent to Partnership, which will mail the notification to the Member. The ~~letter~~ notice must include the medical rationale for the ~~denial or modified~~ determination. ~~Partnership will mail the notification to the Member on behalf of the Delegated Entity.~~
      b. Determining if the elective procedure(s) can be provided (and redirected) within the Delegated Entity's network or whether they will allow the Member to receive services out ~~-~~of ~~-~~network.
      c. Complying with the following ~~NCQA~~ DHCS review and timeliness standards:
         1) Rendering a decision within five (5) business days from receipt of a ~~standard~~ preauthorization request; or
         2) 72 hours from receipt of an urgent request

D. Concurrent Review at Delegated Hospitals
   1. Admission: The Delegated Entity notifies Partnership of any admission to their hospital within one (1) business day.
      a. Admission notification may be made using Partnership's secure Online Services (OLS) Portal https://provider.partnershiphp.org/UI/Login.aspx or by submission of a patient demographic "face sheet" via fax to (707) 863- 4118.
      b. Upon submission, a Treatment Authorization Request (TAR) number is generated in Partnership's electronic system.

2. The Delegated Entity is responsible for concurrent review throughout the inpatient stay.
3. Discharge
    a. The Delegated Entity must complete the final review and determination of the request.~~notify Partnership of the Member's discharge within one (1) business day and provide the following information:~~
    ~~1) Discharge Date~~
    ~~2) Dates of service with specified level of care approved or denied (e.g. Med/Surg, ICU, etc.)~~
    ~~b. Once all authorization information is completed, Partnership forwards the UM review determination electronically to the provider of service.~~
        1) Delegated Entities ~~who are accessing~~utilizing Partnership's electronic system ~~may~~ must populate the discharge information directly into the system to generate the determination correspondence ~~status print of~~ for the UM review ~~determination~~.
        2) Delegated Entities not ~~using~~ utilizing Partnership's electronic system must generate the determination correspondence for the UM review and notify Partnership by phone or fax to update the status in Partnership's system. ~~and then Partnership will generate the status print of the UM review determination.~~ A copy of the correspondence must also be received by Partnership.

E. Emergency Admissions at Hospitals Outside of the Delegated Entity's Contracted Service Area
1. When Partnership is notified that a capitated Member has been admitted emergently to an out-of-area hospital, Partnership notifies the Delegated Entity of the Member's admission within one (1) business day.
2. The case is assigned to a Partnership Concurrent Review Nurse to perform an initial clinical review.
3. Partnership performs concurrent review during the hospital stay or until the Delegated Entity is determined to be financially responsible for the hospital stay. This occurs when Partnership's Chief Medical Officer, or physician designee, determines that the Member is medically stable for transfer to the Delegated Entity's hospital. Upon determination, the Delegated Entity is notified and becomes financially responsible for the continued hospital stay on the next calendar day or in accordance with their contractual agreement with Partnership.
4. The Delegated Entity may choose to allow continued hospitalization at the current hospital or make arrangements to repatriate the Member to their hospital; however, the financial risk remains with the Delegated Entity. The Delegated Entity must ~~verbally~~ notify Partnership's Nurse Coordinator of the decision, with the outcome documented in Partnership's electronic system.
5. In the event the out-of-area hospital fails to notify Partnership in a timely manner (that is after the Member becomes medically stable for transfer to the Delegated Entity's hospital), Partnership's Chief Medical Officer, or physician designee, reviews the clinical documentation and determines the date of medical stability. Partnership then notifies the Delegated Entity of the effective date of the determination.
    a. If Partnership and the Delegated Entity do not agree on the effective date of the Delegated Entity's financial responsibility, both parties agree to negotiate in good faith to resolve the issue or as defined by the contractual arrangement between Partnership and the Delegated Entity.

F. Other Services/Considerations
1. Provider Education
    a. Although Partnership will assist the Delegated Entity with Partnership network resources, it is the Delegated Entity's responsibility to keep their network physicians and/or staff informed of the services that are available within the Delegated Entity's network.
    b. Collaborating with network providers increases the opportunity to keep referrals within the network.
2. Referrals
    a. If a Partnership Member is referred by their Primary Care Provider (who is linked with the

Delegated Entity) to an out-of-area specialist for ongoing specialty care and as a result, the Member is hospitalized on either an elective or an emergency basis in an out-of-area hospital by the out-of-area specialist, Partnership will assign the financial risk to the Delegated Entity at the time of the hospital admission.

3. If a Member is transported by ambulance from the Delegated Entity's hospital to an out-of-area hospital because the service is not routinely provided by the Delegated Entity's hospital, the Delegated Entity maintains the financial responsibility.
4. In the event that an emergency occurs in the Delegated Entity's service area, but the Member is transported to an out-of-area hospital, the financial responsibility remains with the Delegated Entity.
5. If the Delegated Entity's hospital emergency department is on diversion status (unable to accept patients) and the Member is transported to another hospital, the financial responsibility remains with the Delegated Entity.

G. Member Removal from Capitation
1. Certain Partnership Members may be removed from capitation status based on special service needs e.g. Member's medical condition, prime insurance, demographics or administrative eligibility status.
2. In order for Partnership to consider a Member's removal from capitation, the Delegated Entity must securely submit a request with supporting clinical documentation and a detailed description of the circumstances that necessitate removal. Reference should be made to Partnership's policy MPUP3039 Direct Members to determine under what Direct Member status category the request for removal from capitation status is being made and that specific status should be indicated in the letter of request. Requests may be addressed to the Senior Director of ~~Health Services~~Care Management and the Associate Director, UM Regulations at Partnership.
3. The Member will remain under the Delegate's capitation agreement pending written outcome of the review determination.
4. The request and clinical documentation will be reviewed by a Partnership Medical Director and the requesting Delegate will be notified of the determination in writing.
5. If it is determined by Partnership's Medical Director that the Member should be placed in a Direct Member status, the effective date of the Direct Member status will be at the discretion of the ~~date the decision was made by the~~ Medical Director, based on each Member's individual circumstances and reviewed on a case-by-case basis.

H. Provider/Member Appeals and Member Complaints/Grievances
1. Partnership assumes responsibility for processing all Provider and Member appeals, complaints and grievances on behalf of the delegated entities.
2. Delegated Entities must comply with the Appeal/Complaint/Grievance processes by providing all written relevant clinical documentation, review determination rationale and any other available documents pertinent to the subject of the dispute in accordance with regulatory requirements.
3. If the Appeal/ Complaint/ Grievance review results in the overturning of the Delegated Entity's previous determination, the Delegated Entity must abide by Partnership's determination and remains financially responsible for the disputed services.

I. Regulatory Compliance and Oversight
1. Delegated Entities are required to meet UM standards as set forth ~~by the National Committee for Quality Assurance (~~NCQA~~)~~ and ~~the California Department of Health Care Services (~~DHCS~~)~~.
2. Delegated Entities must comply with all oversight activities, which may include, but not be limited to, the following:
   a. Monthly reporting of all inpatient acute admissions to the Delegated Entity's network hospitals. (If the Delegated Entity is using Partnership's electronic system, this report can be generated by Partnership.)
   b. Participation in a Compliance audit at least annually to include (at a minimum) Partnership review of the Delegated Entity's UM policies, procedures, and ~~Member medical record~~

~~reviews~~decisions.

3. Delegated Entity agrees to comply with all requirements set forth in the Delegation Agreement.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment III Section 2.3 Utilization Management Program and Exhibit A, Attachment 1, Definitions

B. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 20254) UM Standards

~~B.~~C. DHCS All Plan Letter (APL) 21-011 *Revised* Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2022

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 06/08/22; 08/09/23; 08/14/24; 09/10/25

PREVIOUSLY APPLIED TO:

Medi-Cal (UP100333; MCUP3033: 01/10/1995 to 06/09/2021)

01/10/95; 10/10/97 (name change only); 12/15/99; 03/22/00 by Commission; 12/20/00; 09/19/01; 10/16/02; 06/16/04; 09/21/05; 10/19/05, 10/18/06; 10/17/07; 10/15/08; 11/18/09; 05/18/11; 02/20/13; 01/21/15; 01/20/16; 01/18/17; *02/14/18; 02/13/19; 08/12/20; ARCHIVED 06/09/2021

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPUP3006 (previously UP100306)				**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Appropriate Service and Coverage Policy				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 06/21/2000			**Next Review Date:** ~~08/14/2025~~09/10/2026 **Last Review Date:** ~~08/14/2024~~09/10/2025		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIAL~~SING~~**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~08/14/2024~~09/10/2025	

I. RELATED POLICIES:

A. MPQP1002 – Quality/ Utilization Advisory Committee
B. CMP36 – Delegation Oversight and Monitoring
~~B.~~C. MPBP8003 – Mental Health Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The purpose of this policy is to define the method by which Partnership Health Plan of California (Partnership) facilitates the delivery of appropriate care, and to identify mechanisms to detect and correct potential under and over-utilization of services.

VI. POLICY / PROCEDURE:

A. Over/Under Utilization Workgroup Composition & Function
1. The Over/Under Utilization Workgroup (O/U UW) meets on a regular basis and at least three (3) times per year.
2. The Workgroup is composed of, but not limited to, the Chief Medical Officer, the Director of Quality and Performance Improvement, the Chief Health Services Officer, the Health Equity Officer, the Utilization Management Director and Associate Director(s), the Manager of Health Analytics, representatives from the Behavioral Health team, ~~,~~the Quality Improvement team, the Provider Relations Department, and the Claims Department.
3. The purpose of the O/U UW is to monitor utilization data for the organization as a whole to detect potential under and over-utilization.
   a. The committee monitors data across practices and provider sites for primary care providers (PCPs), substance use treatment providers, and high-volume specialists.
   b. The O/U UW analyzes the data collected and recommends appropriate interventions whenever it identifies under or over-utilization.

~~a.~~c. The O/U UW reports all analysis to the Internal Quality Improvement Committee (IQI) and then to the Quality/ Utilization Advisory Committee (Q/UAC).

B. Quality/Utilization Advisory Committee Role
   1. The Q/UAC reviews the analysis and recommendations from the O/U UW and implements appropriate interventions whenever it identifies possible under or over-utilization. The Q/UAC directs the O/U UW to measure whether the interventions have been effective at an appropriate interval and then implement strategies to achieve appropriate utilization.

C. Monitoring
   1. Partnership routinely monitors, tracks and analyzes both non-behavioral and behavioral health services as well as substance use treatment services.
   2. The O/U UW may monitor several additional types of data when looking for potential under- or over-utilization problems. It may monitor the following:
      a. HEDIS® measures
      b. Physician practice profiles from Utilization Management (UM) data
      c. Data from Member complaints and PCP change requests
      d. Information on referrals to specialists
      e. Data on inpatient days and discharges
      f. Pharmacy utilization
      g. Data on outpatient visits
      h. Emergency Room visits
      i. Admission and length of stay in acute rehabilitation units
      j. Compliance with Preventive Care Guidelines are routinely assessed by practice site to detect over and under-utilization
      k. Top 10 diagnoses for inpatient, outpatient and the Emergency Department settings
      l. Top 25 Members based on utilization and/or cost
      m. Selected procedures performed by high volume specialists are monitored and compared to other organization's rates or national data to detect under or over-utilization.
      n. Services performed by substance use treatment providers are monitored to detect over-use, under-use, and misuse of services.
      o. The workgroup monitors the accuracy, timeliness, and completeness of data submitted by providers to Partnership.

D. Access to All Covered Services
   1. Unless prohibited by law, Partnership or its subcontractor will arrange for the timely referral and coordination of any Covered Services to which Partnership or its subcontractor has religious or ethical objections to perform or otherwise support and will arrange, coordinate and ensure provision of services.
   2. Providers who are unwilling to perform, provide or otherwise support a covered service are obligated to notify Partnership's Care Coordination or Behavioral Health Department (as applicable). Once notified, a Partnership Case Manager or Behavioral Health Access Guide (as applicable) will assist the Member in obtaining timely access to the covered service.

E. Triage and Referral for Behavioral Health and Substance Use Disorder Services
   1. Partnership monitors ~~the~~ triage and referral protocols ~~for its delegated behavioral health care provider~~ to ensure ~~assure~~ that they are appropriately implemented, monitored and ~~professionally~~ managed. Protocols utilized ~~by delegates must be~~are based on sound clinical evidence and ~~be~~ accepted industry practice. They must define the level of urgency and appropriateness of the care setting.
   2. Triage and referral decisions not requiring clinical judgment are made by staff with relevant knowledge, skills and professional experience.

3. Triage and referral decisions requiring clinical judgment are made by a licensed behavioral health care practitioner with appropriate qualified experience.
4. Supervision of triage and referral staff is by a licensed behavioral health care practitioner with a minimum of a master's degree and five years of post-master's clinical experience.
5. Oversight of triage and referral decisions is by a licensed psychiatrist or an appropriately licensed doctoral level psychologist experienced in clinical risk management.

F. Decisions Made on Medical Appropriateness
1. On an annual basis, Partnership distributes a statement to all its practitioners, providers, members and employees alerting them to the need for special concern about the risks of under-utilization. It requires employees who make utilization-related decisions and those who supervise them to sign a statement which affirms that UM decision making is based only on appropriateness of care and service. Furthermore, Partnership does not reward practitioners, or other individuals conducting utilization reviews, for issuing denials of coverage. There are no financial incentives for UM decision makers to deny care; and Partnership does not encourage decisions which would result in under-utilization, but rather, bases decisions solely on the appropriateness of care or service and the existence of coverage.

G. Delegation Oversight and Monitoring
1. Partnership delegates the network management ~~administration~~ of ~~certain mental~~behavioral health services providers to a managed behavioral health organization.
2. A formal agreement is maintained and inclusive of all delegated functions.
3. Oversight/Regular monitoring activities include, but are not limited to, an audit conducted no less than annually.
4. Results from the annual delegation oversight audit shall be presented to Partnership's Delegation Oversight Review Sub-Committee (DORS) for review and approval and reviewed by the Chief Medical Officer (CMO) or physician designee.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) contract, Exhibit A, Attachment III, 2.3.3
B. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 20254)
UM 1 Program Structure Element A Written Program Description Factors 3 and 4 Involvement of a Designated Senior Level Physician and a Designated Behavioral Healthcare Practitioner;
Front Matter: Policies and Procedures –Section 2
C. DHCS Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Q/UAC members
C. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

Partnership Advantage (Program effective date January 1, 2027)
09/10/25

Medi-Cal
05/16/01; 05/15/02; 10/16/02; 10/20/04; 10/19/05; 10/18/06; 08/20/08; 06/17/09; 07/21/10; 10/01/10; 05/16/12; 08/20/14; 06/17/15; 04/20/16; 04/19/17; *06/13/18; 04/10/19; 11/13/19; 09/09/20; 08/11/21;

08/10/22; 08/09/23; 08/14/24; 09/10/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
Healthy Kids - MPUP3006 (Healthy Kids program ended 12/01/2016)
10/18/06; 08/20/08; 06/17/09; 07/21/10; 10/01/10; 05/16/12; 08/20/14; 06/17/15; 04/20/16 to 12/01/2016

PartnershipAdvantage:
PA UM302 - 06/21/2006 to 08/20/2014
MPUP3006 – 08/20/2014 to 01/01/2015

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MP~~C~~UP3042 (previously MCUP3042, UP100342)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Technology Assessment</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/14/1999</td><td colspan="4">Next Review Date: ~~08/14/2025~~09/10/2026
Last Review Date: ~~08/14/2024~~09/10/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIAL~~S~~ING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~08/14/2024~~09/10/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MPRP4001 – Pharmacy and Therapeutics (P&T) Committee
C. MPQP1003 – Physician Advisory Committee (PAC)
D. MPQP1002 – Quality/Utilization Advisory Committee
E. MP~~C~~UP3138 – External Independent Medical Review

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Biomarker Test: A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment.

B. Partnership Advantage: Effective January 1, 2027, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

~~B.~~C. The following definitions apply to entirely new technologies or new applications of existing technologies

INTERVENTION	Lab or animal studies completed	Human studies completed	FDA or regulatory approval	Medic~~-C~~are benefit	State Medi-Cal benefit	Partnership benefit
Experimental (preclinical trials)	No	No	No	No	No	No
Cont'd below						

Policy/Procedure Number: MPCUP3042 (previously MCUP3042, UP100342)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Technology Assessment		☒ External Policy ☐ Internal Policy	
Original Date: 04/14/1999		**Next Review Date:** ~~08/14/2024~~09/10/2026 **Last Review Date:** ~~08/14/2024~~09/10/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

INTERVENTION	Lab or animal studies completed	Human studies completed	FDA or regulatory approval	Medic~~-C~~are benefit	State Medi-Cal benefit	Partnership benefit
Cont'd **Investigational (clinical trials in progress)**	Yes	No	No	No	No	If all 6 criteria are met
New technology (clinical trial results available)	Yes	Yes	Yes or No	No	No	Case-by case review *OR* Consider addition as a Partnership benefit
New benefit	Yes	Yes	Yes	Yes	Yes	Yes

IV. ATTACHMENTS:

A. Review of New Medical Technology Form

V. PURPOSE:

To define the process utilized by Partnership HealthPlan of California (Partnership) to evaluate new technologies/investigational services and interventions, including medical and behavioral health procedures, pharmaceuticals and devices as well as changes in the application of existing technologies or adding new benefits for Members.

VI. POLICY / PROCEDURE:

A. Investigational Interventions:

1. Partnership Medi-Cal Members:
   a. Department of Health Care Services (DHCS) policy (Title 22, California Code of Regulations [CCR] Section 51303(h) for approval of investigational services (interventions) states that all six of the following criteria must be fully met:
      1) Conventional therapy will not adequately treat the intended patient's condition.
      2) Conventional therapy will not prevent progressive disability or premature death.
      3) The provider of the proposed service has a record of safety and success with the investigational service that is equivalent or superior to that of other providers.
      4) The investigational service is the lowest cost item or service that meets the patient's medical needs and is less costly than all conventional alternatives.
      5) The service is not being performed as part of research study protocol.
      6) There is a reasonable expectation that the investigational service will significantly prolong the intended patient's life and will maintain or restore a range of physical and social function suited to the activities of daily living.
2. Partnership Advantage Enrollees:
   a. Centers for Medicare & Medicaid Services (CMS) National Coverage Determination (NCD) policy 310.1 for Routine Costs in Clinical Trials states the following:
      1) Covered Services:
         a) Items or services that are typically provided absent a clinical trial (e.g. conventional care)

b) Items or services required solely for the provision of the investigational item or service (e.g. administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; AND

c) Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service - in particular, for the diagnosis or treatment of complications.

2) Non-covered Items and Services:

a) The investigational item or service itself, unless otherwise covered outside of the clinical trial

b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan)

~~a)~~c) Items and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial

3. Investigational interventions will not be authorized in the inpatient setting if there is no indication for acute care treatment.
4. After collection of all materials necessary to evaluate whether these criteria are met, the Chief Medical Officer (CMO) or Physician Designee will review the request. If all criteria are judged to be met, the investigational service will be approved.
5. If criteria are not met, the case may be sent for independent medical review by a relevant specialist in the area of the intervention. If, in the opinion of the specialist, criteria have been met, the procedure will be approved.

B. Coverage for Cancer Clinical Trials

1. Partnership follows state and federal guidelines as follows:
   a. Partnership Medi-Cal Members: DHCS guidelines
   b. Partnership Advantage Enrollees: CMS guidelines including NCD policy 310.1 for Routine Costs in Clinical Trials ~~and Noridian Jurisdiction E Medicare Part B Clinical Trials~~.
2. Partnership covers routine patient care costs for eligible Members and Enrollees who are in any one of the four clinical trial phases as long as the following are met:
   a. The treating physician recommends participation in the trial
   b. Participation in the trial MUST have meaningful potential to benefit the Member
   c. The trial must NOT exclusively be to test toxicity, but must have a therapeutic intent
   d. Trial will NOT occur in the inpatient setting if there is no indication for acute care treatment
3. Trials that qualify for approval include:
   a. Those involving a drug exempt under federal regulation from a new drug application OR
   b. The cancer clinical trial is approved by one of the following:
      1) The National Institute of Health
      2) The Food and Drug Administration (FDA) in the form of an investigational new drug application,
      3) The United States Department of Defense
      4) The United States Department of Veterans Affairs
4. Per Health and Safety Code (HSC) § 1370.6, Partnership does not limit, prohibit, or modify a Member's rights to cancer biomarker testing as part of an approved clinical trial and no prior authorization is required for either of the following*:
   a. Biomarker testing for a Member with advanced or metastatic stage 3 or 4 cancer
   b. Biomarker testing for cancer progression or recurrence in a Member with advanced or metastatic stage 3 or 4 cancer

   **If the biomarker test is not associated with an FDA-approved cancer therapy for advanced or*

metastatic stage 3 or 4 cancer, Partnership may still require prior authorization for such testing.

C. New technologies physician request and authorization process
   1. Case-by-case review: If Partnership receives a physician's request to provide benefits of a new intervention for a specific Member the process is as follows:
      a. A Treatment Authorization Request (TAR) must be submitted to Partnership describing the intervention and containing medical justification for its use. Pertinent patient medical records must be included.
      b. The CMO or Physician Designee will ask the provider for background information including copies of clinical studies regarding the intervention. Partnership staff will perform a literature search for peer reviewed studies or recommendations from professional societies regarding the use, efficacy, and safety of the proposed service. In addition, Partnership will consider determinations of regulatory authorities (e.g. ~~Centers for Medicare and Medicaid Services [~~CMS~~]~~ or ~~US Food and Drug Administration [~~FDA~~]~~) concerning the intervention.
      c. The CMO or Physician Designee may request input from a relevant specialist prior to presenting the request to the various committees such as the Pharmacy & Therapeutics (P&T) Committee or Physician Advisory Committee (PAC). This specialist must have expertise in the technology under review.
      d. All behavioral health technologies will include input from an appropriate behavioral health specialist.
      e. When clinically indicated, a case may be sent for external review to a contracted independent medical review organization. (See policy MPCUG3138 External Independent Medical Review.)
      f. Based on input from the Utilization Management Department, P&T Committee, PAC or relevant specialist, the CMO or Physician Designee renders a determination.
      g. All records concerning the review are retained by Partnership's Health Services department.
      h. Determination criteria used by the relevant specialist(s), P&T Committee, PAC, and the CMO or Physician Designee must include all six criteria specified in VI.A.1. a. – f. above when reviewers consider the following:
         1) Sufficient objective information regarding the safety, efficacy, and indications for the intervention which support its use.
         2) The proposed intervention is likely to lead to a better outcome than conventional interventions currently available.
         3) The provider has a record of safety and success with the proposed service which is equivalent or superior to that of other providers of the intervention.
         4) The practitioner proposing to provide the intervention is willing to accept the payment rate offered by Partnership.
         5) The intervention is not provided as part of a research study protocol.
      i. Evaluations of new and existing medications are managed by the process described in the Pharmacy & Therapeutics (P&T) Committee policy MPRP4001.

D. Addition of a new benefit:
   1. A request to add a new Partnership benefit may be submitted by a provider, Member or Partnership staff. In such instance the following steps occur:
      a. The request is sent to the CMO or Physician Designee, which includes a statement explaining why the requested service should be added as a Partnership benefit, identification of the Partnership Member to benefit from the service, and all pertinent supporting clinical information. The Chief Health Services Officer will also review the request and offer feedback.
      b. Partnership will perform a literature search regarding the use, efficacy and safety of the intervention and may also use the services of an external technology assessment organization such as ECRI Institute or others. As needed, materials collected relating to the request may be

forwarded by the CMO or Physician Designee to an appropriate relevant specialist (or to an ad hoc physician committee) to review the material and to advise Partnership regarding the use of the new technology. The reviewer or review committee is asked to recommend whether the intervention be added as a Partnership benefit and to delineate criteria used to evaluate the use of the new technology. The CMO may also opt to bring the proposal to the Quality/Utilization Advisory Committee (QUAC) or PAC for feedback on the proposal.

c. Partnership also has an operational workgroup for review of potential new benefits called the Benefit Review and Evaluation Workgroup (BREW). BREW is comprised of the Chief Medical Officer, the Chief Health Services Officer, the Chief Operating Officer and representatives from these departments: Regulatory Affairs, Provider Relations, Member Services, Finance, Claims, and Information Technology. BREW investigates and considers the medical, financial and operational issues surrounding proposed benefit changes. BREW findings are summarized and presented to the Partnership Executive Committee which will determine next steps. All medical criteria changes follow the process described in VI.D.1.a. and b. above. The Executive Committee may refer a recommendation to the Board (Partnership Commission) for addition of a new benefit class. The Executive Committee may also request input from the Physician Advisory Committee (PAC) prior to rendering a decision. The Executive Committee may approve coverage of single CPT codes ("minor changes") that it deems are within the general scope of medical services generally covered by Partnership. The Executive Committee will also determine operational changes required such as information technology (IT) and claims configuration and/or financial considerations such as recommending Medi-Cal coverage of new technologies to the California Department of Health Care Services (DHCS).

2. Notification of New Benefit Addition: Once approved by the PAC and the Board (Partnership Commission) as applicable, information regarding the new benefit may be disseminated as necessary in the following manner:
   a. Primary Care Providers (PCPs) and relevant specialists are notified electronically by "Important Provider Notice (IPN)."
   b. Internal notification is sent to Partnership department leadership so that policies and procedures may be created and information gathered to inform utilization management determinations, benefit interpretations, care coordination decisions, and the design of health educational materials.
   c. Partnership Members are notified of benefit additions via the Member Newsletter, updates to the Member Handbooks and the Partnership website.

VII. REFERENCES:

A. Title 22, California Code of Regulations (CCR) Section 51303
B. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: An Overview (*chemo an over*)
C. DHCS All Plan Letter (APL) 22-010 Cancer Biomarker Testing (06/22/2022)
D. Health and Safety Code (HSC) § 1370.6
~~D.~~E. ECRI (founded as Emergency Care Research Institute) https://home.ecri.org/
F. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2025~~4~~) UM 10 Evaluation of New Technology Elements A & B
G. Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Section 310.1 Clinical Trials: Routine Costs in Clinical Trials. Implementation date 05/27/2024 or any subsequent updates published by CMS.
~~E.~~H. Noridian Jurisdiction E Medicare Part B Clinical Trials guidance. Last updated 07/09/2025.

VIII. DISTRIBUTION:

A. Partnership Department Directors

~~B.~~ Partnership Provider Manual
~~C.~~B. ~~Health Services Department Heads and Staff~~

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 06/21/00; 12/19/01; 10/16/02, 10/20/04; 10/19/05; 10/18/06; 10/17/07; 05/21/08; 07/15/09; 05/18/11; 02/20/13: 01/20/16; 10/19/16; 10/18/17; *06/13/18; 08/14/19; 08/12/20; 08/11/21; 08/10/22; 08/09/23; 08/14/24; (MPUP3042) 09/10/25

*Through 2017, dates reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

REVIEW OF NEW MEDICAL TECHNOLOGY FORM

Member Name: _____ **Date:** _____

Member ID# _____ **DOB** _____

Review Type ☐ **Reactive** ☐ **Proactive**

Requesting Practitioner: _____ **Phone #**_____

Proposed Treating Practitioner: _____

Proposed Procedure / Treatment / Medication: _____

_____

_____

Facility: _____ **Phone #** _____

Professional Cost: _____

Anticipated LOS: _____ **Facility Cost:** _____

1. **How long has treating practitioner been performing this procedure or treatment?**

   _____

2. **How many cases has he/she performed in the last two years?**

   _____

3. **Estimated Costs:**

Professional	**$**_____
Facility	**$**_____
Other	**$**_____
Total Estimated Cost:	**$**_____

4. **Is privileging or certification required to perform this procedure?**

   ☐ **Yes** ☐ **No**

REVIEW OF NEW MEDICAL TECHNOLOGY FORM

5. Outcomes Review:

- **Mortality during global period?** _____
- **Mortality during 1 year out?** _____
- **Mortality during 5 years out?** _____
- **Other known complications / risks, actual and anticipated?**

_____

_____

_____

6. List other available treatment modalities:

_____

_____

_____

7. Medicare approved? _____

8. FDA approved? _____

9. Hayes Directory review? _____

10. Literature Search? _____

11. Review by Network Practitioners:

Name	Specialty
_____	_____
_____	_____
_____	_____

REVIEW OF NEW MEDICAL TECHNOLOGY FORM

_____ _____

12. Medical Director Review: _____

_____

_____

13. Other comments: _____

_____

_____

14. Send for External Review? **Yes**_____ **No**_____

15. Cover? **Yes**_____ **No**_____

16. Notify Benefits Coordination? **Yes**_____ **No**_____

17. Date Member notification sent _____

18. Date Provider notification sent _____

_____ _____

~~PHC~~ Partnership Medical Director **Date**

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MP~~C~~UP3138 (previously MCUP3138)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: External Independent Medical Review</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 06/13/2018</td><td colspan="3">Next Review Date: ~~08/14/2025~~09/10/2026
Last Review Date: ~~08/14/2024~~09/10/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS~~IN G~~</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~08/14/2024~~09/10/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MP~~C~~UP3042 – Technology Assessment
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
D. MCRP4068 – Medical Benefit Medication TAR Policy

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Independent Medical Review process: Process in which an expert independent medical professional is selected to review a specific health service request and provide a fair and objective opinion based on his/her designated specialty.
B. Independent Medical Review Organization (IMRO): A third-party medical review resource which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence.
C. Independent Review Entity (IRE): Specific to Partnership Advantage Members, an IRE refers to an independent organization contracted by the Centers for Medicare & Medicaid Services (CMS) to review Medicare Advantage (Part C) or Prescription Drug (Part D) plan decisions in the second level of appeal.
D. Life Threatening: Defined as a disease or condition where the likelihood of death is high unless the course of the disease is interrupted OR diseases or conditions with potentially fatal outcomes where the end point of the clinical intervention is survival.
~~C.~~E. Partnership Advantage: Effective January 1, 2027, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.
~~D.~~F. Seriously Debilitating: Defined as diseases or conditions causing major irreversible morbidity.

Policy/Procedure Number: MP~~C~~UP3138 (previously MCUP3138)			**Lead Department: Health Services** **Business Unit:** Utilization Management
Policy/Procedure Title: External Independent Medical Review			☒**External Policy** ☐**Internal Policy**
Original Date: 06/13/2018		**Next Review Date: 08/14/2025** **Last Review Date: 08/14/2024**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the process used by Partnership HealthPlan of California (Partnership) to provide a comprehensive and fair evaluation of health service requests. The external independent medical review process may be applied in circumstances for which nationally recognized evidenced-based criteria or Partnership medical policy does not provide ample guidance or where the Chief Medical Officer (CMO) or Physician Designee desires an additional opinion from an actively practicing board certified physician of like or similar specialty.

VI. POLICY / PROCEDURE:

A. Partnership contracts with ~~an~~ Independent Medical Review Organizations (IMROs) to ensure qualified case-matched independent specialists are available to review health service requests as expeditiously as possible in deference to the Member's health condition. In addition to ~~the~~ an IMRO, Partnership may also use qualified case-matched independent specialists to review on a case by case basis. An IMRO or qualified case-matched independent specialist may be used at the discretion of CMO or Physician Designee for circumstances including, but not limited to the following:
   1. Assessment of health treatment efficacy and/or scope of application
   2. Service requests deemed Experimental or Investigational
   3. In the instance of an appeal (Note: For Partnership Advantage Members, the designated IRE would be used as described in III.C. above)
   4. Denial of an Experimental or Investigational therapy when a Member has a life threatening or seriously debilitating condition.
   5. Denial, modification or delay of health care services based in whole or part on the determination that the service requested is not medically necessary. The Member's contracted treating physician must certify that the condition has not responded to standard therapies AND must make written recommendation that another drug, device, procedure or therapy would be MORE beneficial than those that are standard.
   6. Existing technology/pharmacology used differently

B. With the exception of Experimental or Investigational Therapy, determinations to deny, delay or modify health care services based on a benefit exclusion, are not eligible for an independent medical review under this policy.

C. Partnership does not reward practitioners or other individuals for issuing denials of coverage. There are no financial incentives for Utilization Management (UM) decision makers to deny care, and Partnership does not encourage decisions which would result in underutilization, but rather bases decisions solely on the appropriateness of care or service and the existence of coverage.

D. The IMRO conducting the independent medical review is contracted directly by Partnership. The cost of the independent medical review is the responsibility of the health plan. The Member or Provider requesting an independent medical review on the Member's behalf shall NOT be charged an application or processing fee.

E. Process for Referral to Independent Medical Review
   1. Partnership's CMO or Physician Designee will work with the Utilization Management (UM) Department to assemble and submit all necessary information to the contracted IMRO, IRE, or qualified case-matched independent specialist.
   2. The UM staff will submit a completed file for review by the Independent Medical Reviewer which will include, but is not limited to:
      a. Internal patient identifier for the purpose of the review
      b. Requested service/procedure to include specific CPT/HCPCS code(s)

c. Member diagnosis (Using current ICD Code sets)
d. All information provided relevant to the service requested
e. All information submitted by the practitioner in support of the requested service
f. Pertinent medical history
g. Treatment or clinical data
h. Date response needed
i. Specific questions concerning treatment requiring clarification

3. The UM staff maintain contact with the IMRO and ensure timely resolution of the submitted case.
4. Upon receipt of the independent review, Partnership's CMO or Physician Designee will determine coverage of the requested service.
5. After the coverage decision has been reached and all parties notified, Partnership's CMO or Physician Designee will submit a copy of the case, including the final resolution, to UM department staff.
6. UM department staff uploads a summary of the case and all supporting documentation into the UM Department documentation system as an attachment to the Member's Treatment Authorization Request (TAR) file for which the review was completed.
7. UM staff maintain tracking/monitoring of all cases submitted to the IMRO.
8. IMRO information is available to the Partnership Quality/Utilization Advisory Committee (Q/UAC) upon request.
9. The CMO or Physician Designee is responsible for ensuring the timely processing and final resolution of the requested service. When independent medical review is sought, it must also occur in this time frame.

F. Time Frames
1. Standard Review: The IMRO shall review all relevant information and make a written determination within five (5) business days of receipt of the request in order to allow for timely resolution of non-urgent requests.
2. Expedited Review:
   a. An expedited independent medical review is initiated under the following conditions:
      1) The CMO or Physician Designee, or treating physician determines there is an imminent and serious threat to the health of the Member including, but not limited to, severe pain, the potential loss of life, limb or major bodily function, and or the immediate and serious deterioration of the health of the Member.
      2) The Member's physician has determined that the proposed therapy would be significantly less effective if not promptly initiated.
   b. The IMRO shall make their determination within 24 hours of the receipt of the request and provide supporting documentation to allow for a timely ~~appeal resolution~~ review within seventy-two (72) hours of date of receipt at Partnership. Partnership may extend the IMRO's determination deadline for an additional 24 hours in extraordinary circumstances or for good cause, which is in the best interest of the Member and still allows for a timely review or appeal resolution within seventy-two (72) hours of date of receipt.
3. Retrospective Review: In the case of a retrospective review, the IMRO shall review all relevant information and make a written determination within five (5) to seven (7) business days of receipt of the request to allow for timely ~~appeal~~ review decision within 30 business days of the date of receipt at Partnership.
4. In all cases, Partnership will provide the Member and the Member's treating practitioner with the analysis and determination as well as a description of the qualifications of the medical professionals who reviewed the case. As part of the grievance process, Partnership provides a Member with a written determination to uphold a denial, delay or modification based on either medical necessity or the experimental or investigational nature of the request, and advises the Member of appeal rights

and process.

VII. REFERENCES:

A. California Health and Safety Code, Division 2, Chapter 2.2 Health Care Service Plans, Article 5.55 Appeals Seeking Independent Medical Reviews -Section 1374.30 - .36
B. Title 28~~,~~ California Code of Regulations (CCR), Division 1, Chapter 2, Article 8 Section 1300.70.4 and 1300.74.30
C. In compliance with the California Department of Health Care Services (DHCS) contract
D. Title 22 California Code of Regulations (CCR)
E. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2025~~4~~) UM 4 Appropriate Professionals Element F and UM 10 Evaluation of New Technology Elements A & B
~~E.~~F. Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (11/18/2024)

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer, Chief Medical Officer or Physician Designee

X. REVISION DATES:

08/14/19; 08/12/20; 08/11/21; 08/10/22; 08/09/23; 08/14/24; (MPUP3138) 09/10/25

PREVIOUSLY APPLIED TO:

N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MP301			**Lead Department: Member Services**	
Policy/Procedure Title: -Assisting Providers with Missed Appointments			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 01/22/1999		**Next Review Date:** 09/10/2026~~09/11/2025~~ **Last Review Date:** 09/10/2025~~09/11/2024~~		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: Robert Moore, MD, MPH, MBA			**Approval Date:** 09/10/2025~~09/11/2024~~	

I. RELATED POLICES:

A. MP316 – Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior

II. IMPACTED DEPTS:

A. Provider Relations

III. DEFINITIONS:

A. N/A

IV. ATTACHMENTS:

A. Missed Appointments Notification Form #29

V. PURPOSE:

To preserve the provider/patient relationship, assist providers with patient compliance and educate the member about the importance of keeping scheduled appointments.

VI. POLICY / PROCEDURE:

Members who miss two (2) or more consecutive appointments within the previous three (3) month period are contacted by Partnership staff, upon request of the member's provider. If the request is initiated by a specialist, the specialist is expected to notify the member's PCP of the missed appointments.

A. Requesting Partnership's intervention
   1. Providers complete and fax the Missed Appointment Notification Form (Attachment A) to the Partnership's Member Services (MS) department.

B. Processing the Missed Appointment Notification Form
   1. Designated MS staff informs the member of the importance of keeping scheduled appointments and possible discharge from the practice as outlined below:
      a. MS staff attempts to contact the member by phone or sends letter #66A to determine if the member has had any barriers to care, if they are in treatment or have any scheduled tests. The member is advised of the importance of keeping their appointments, if they continue to miss appointments, the ~~PCP~~ provider can request to discharge the member from their practice.
      b. When a medical condition(s) ~~are~~ is identified, the case is referred to the Care Coordination (CC) department.
      c. The MS staff completes the "Partnership Use Only" section of the Missed Appointment Notification Form (Attachment A) and faxes it back to the provider's office.

d. All actions are noted in the member's record and completed within five (5) business days.

VII. REFERENCES:

A. N/A

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director of Member Services & Grievance.

X. REVISION DATES:

Medi-Cal
01/22/99; 01/10/01; 01/16/03; 07/22/03; 08/10/04; 08/10/05; 06/16/06; 12/09/08; 02/01/10; 04/21/10; 03/12/13; 01/30/15; 04/12/16; 03/15/17; *05/09/18; 08/14/19; 08/12/20; 08/11/21; 09/14/22; 09/13/23; 09/11/24; 09/11/25

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Healthy Kids
11/01/2005 to 12/31/2016

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Missed Appointment Notification Form

Providers fax this form to Partnership's Member Services Department (707) 863-4415 attention: Enrollment Unit

Patient Name:	Date of Birth (MM/DD/YYYY):
Parent/Guardian Name (if applicable):	Phone Number:
Primary Diagnosis:	Partnership ID# (on the Partnership ID Card):
Dates of missed appointments within the last 3 months:	Dates of the last kept appointments:
If your request is from a specialist, PCP office has been notified of missed appointments ☐ Yes ☐ No	
Was the patient notified or reminded of appointment date and time: ☐ Yes ☐ No When was the patient notified or reminded of the last scheduled appointment? _____ (date) How was the patient notified/reminded of the last scheduled appointment? ☐ at the physician's office ☐ over the phone ☐ by mail ☐ by email	
List interventions done when member missed appointments:	
What was the member's response to your interventions?	
Name of Provider:	
<u>Person completing form</u> Name: Date form was completed:	Phone: Fax:

Partnership USE ONLY
Member was contacted by phone on (date):
Letter was sent to member on (date):
Reasons for missing appointments:
Comments:

Form #29

Care Coordination Referral: _____
CC: Provider Relations: _____

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MP316</td><td colspan="3">Lead Department: Member Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 7/27/1994</td><td colspan="4">Next Review Date: 09/10/2026~~09/11/2025~~
Last Review Date: 09/10/2025~~09/11/2024~~</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒~~☐~~ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 09/10/2025~~09/11/2024~~</td></tr>
</table>

I. RELATED POLICIES:

A. MP301 – Assisting Providers with Missed Appointments
B. MP312 – Processing PCP/MH Selections and Transfers Requests

II. IMPACTED DEPTS:

A. Provider Relations
B. Care Coordination

III. DEFINITIONS:

A. Provider Request to Discharge: A provider's request to discharge a member from his/her practice.
B. Re-assignment: A member is transferred to the care of another Primary Care Provider or Direct Member category, if applicable.
C. Member Type U: For the purpose of this policy, members are defined as "Type U Members" if they have been discharged for reasons other than fraud, sexual comments, and threats of violence and/or violent behavior.
D. Member Type V: For the purpose of this policy, members are defined as "Type V Members" if they have been discharged for fraud, sexual comments, and threats of violence and/or violent behavior. Threats of violence includes menacing body language, sexual advances, and/or verbal threats of physical violence.
E. Medical Home: The provider identified as the member's medical home or PCP is responsible for managing the member's primary care needs.
F. ~~W&R –~~Wellness & Recovery (W&R) ~~Program~~: Partnership's regional Drug Medi-Cal Organized Delivery System waivered program in seven counties within Partnership's service area.

IV. ATTACHMENTS:

A. Form #6 (Provider Request for Discharge/Assistance with Inappropriate Behavior)
B. Letter #MS10a (Member Services Notifies PCP of Decision)
C. Letter #MS10c (Assistance with Inappropriate Behavior at Provider's Office)
D. Letter #MS10b (Notification of PCP Discharge Request Approved)

V. PURPOSE:

To define~~clarify~~ the criteria~~circumstances~~ in which a medical provider may discharge a Partnership member from his/her practice and the process of member and provider notification. ~~Additional clarification of questions about this process are directed to the Partnership's Provider Relations (PR)~~ ~~department~~

Policy/Procedure Number: MP316			Lead Department: Member Services
Policy/Procedure Title: Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior			☒ **External Policy** ☐ **Internal Policy**
Original Date: 7/27/1994		**Next Review Date: 09/10/2026~~09/11/2025~~** **Last Review Date: 09/10/2025~~0911/2024~~**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒~~☐~~ **Partnership Advantage**

VI. POLICY / PROCEDURE:

A. Assistance with Inappropriate Behavior

Prior to requesting discharge, providers may request assistance from Partnership when a member~~patient~~ and/or member's~~patient~~ representative displays verbally abusive and/or disruptive behavior in a provider's office.

1. Examples of inappropriate behavior:
   a. Yelling and/or screaming
   b. Ethnic slurs or foul language
   c. Physical or verbal threats of violence
   d. Sexual comments, innuendoes or advances
2. Provider requests Partnership assistance:
   a. C~~The provider c~~ompletes Partnership's Form #6 titled "Provider Request for Discharge/Assistance with Inappropriate Behavior" (Attachment A) ~~for each member included in the request~~ and ~~documentations the nature of the inappropriate behavior and~~ faxes it to ~~the~~ Partnership's Member Services Department.
   ~~a.~~b. Member Services reviews and:
      1) Sends ~~Complete requests - The member is sent~~ letter #10c (Attachment C) to the member and ~~and~~ the provider is copied.
      2) Incomplete forms are referred to ~~requests -~~ Partnership's Provider Relation's department and are pended for five (5) business days.
         a) If information is not received within five (5) business days, the request is denied, and the provider is notified.
   c. Provider Relations contacts the provider to request information to ~~documentation to~~ complete the request.
      ~~The request is pended for five (5) business days. If the information is not received within the five (5) business days the request is denied and the provider is notified.~~

B. Discharge Requests

1. Partnership's best effort is used to provide members the opportunity to be cared for by medical providers with whom a collaborative provider/patient relationship can be developed. Because the relationship is personal in nature, circumstances may arise under which the relationship between a member and a provider becomes non-collaborative. Medical providers are permitted to request that a member be discharged from his/her practice in certain circumstances, but it is the sole responsibility of Partnership to determine if the request meets Partnership's discharge criteria. Providers are expected to have procedures in place that provide guidance to practitioners and staff when dealing with challenging patients.

C. Discharge Criteria

1. Using the written documentation provided by the provider and the discharge criteria listed below, appropriate Partnership staff determines if the request for discharge meets Partnership's discharge criteria. Designated MS staff consults the Care Coordination (CC) designee, Partnership Chief Medical Officer (CMO) or designee as needed.
2. The following behaviors are generally considered appropriate criteria for discharge:
   a. Fraudulently receiving benefits under a health plan contract.
   b. Fraudulently receiving and/or altering prescriptions, theft of prescription pads, or photocopying prescriptions.
   c. Physically or sexually abusive behavior exhibited to the provider or office personnel.
   d. Threatening behavior exhibited in the course of needing or receiving care.
   e. Credible threat of the member's intent to initiate or pursue legal action (not including a state hearing) against the provider and/or their associates.

f. Refusal by the member to follow recommended medical treatment where the provider believes there is no alternative treatment, and that refusal will severely endanger the health of the member. This situation cannot be improved by repeated attempts by Partnership's CC designee to intervene, and in the judgment of the CMO or designee, a change in provider would clearly benefit the member's health status.

g. A determination by Partnership's CC designee and the CMO or designee that deterioration in the provider/patient relationship has occurred to the point where continuation might result in adverse consequences to the member's health or to the safety of the provider or provider's staff.

h. ~~Documented evidence that the member had been discharged from the practice site before the member became Partnership eligible.~~ If a member has been previously discharged from a practice, it is the responsibility of the practice to notify Partnership within sixty (60) days of the member's initial assignment. Documented evidence that the member had been discharged from the practice site before the member became Partnership eligible is required. Exceptions to the sixty (60) day period can be made on a case-by-case basis. ~~The provider's capitation payment is~~

i. Disruptive or verbally inappropriate behavior to the provider, office staff, or other patients if counseling and corrective action by the provider has been ineffective. For assistance with inappropriate behavior, refer to section VI.A. Assistance with Inappropriate Behavior.

j. Three (3) or more missed appointments within the previous six (6) month period or four (4) or more missed appointments within the previous twelve (12) month period, if the provider has made a good faith effort to correct the member's behavior. Good faith effort is defined as at least one verbal and one written warning or at least two written warnings. All verbal and/or written warnings must inform the member that continued missed appointments will result in discharge. Provider offices must provide documentation of the verbal warning and one written warning or two (2) or more written warnings. The verbal and/or written warnings must be within the specified timeframes of the missed appointments.
   1) Exceptions: Missed appointments due to an inpatient hospital stay or appointments cancelled 24 hours in advance are not considered missed appointments for the purpose of this policy.

k. If the provider has multiple locations and/or practices, the provider must specify on the Discharge Request Form if the discharge applies to all locations and/or practices or specific locations and/or practices.

D. Requesting Discharge Process

1. The provider must notify Partnership's MS department in writing to request a member discharge. The provider must provide complete documentation outlining the nature of the problem, including Form #6 titled "Provider Request for Discharge/Assistance with Inappropriate Behavior" (Attachment A) for each member included in the discharge request. The request must indicate if the member is or is not in active care for an acute medical condition and/or if the member has diagnostic testing or surgeries scheduled. If additional information is needed from the provider, the MS department will request the additional information through Partnership's PR department.
2. By the end of the second business day from the date of receipt, the designated MS staff documents the date the discharge request was received using the DE Remark Code.
   When the provider does not provide the required supporting documentation, MS requests assistance from PR to request the additional information from the provider. The request is pended for five (5) business days. If the information is not received within five (5) business days, the request is denied.

E. Provider Notification of Decisions

1. MS sends letter #MS10a (Attachment B) to notify providers of the discharge decision.
2. The provider can call the MS department at (800) 863-4155 to check the status of a request. ~~Direct extensions are not provided.~~

F. Approved Requests
   1. Member Type V - Discharged for fraud, sexual comments, threatening and/or violent behavior.
      a. The copy of the provider's discharge submission and documentation is sent to the CC designee.
      b. The CC designee determines if the relationship between the provider and member can be repaired. If the relationship cannot be repaired, CC designee assists the member in selecting a new medical home or PCP. If the CC designee and/or the member needs more time to select a new medical home or PCP, the member is placed in a limited Direct Member status for a minimum of thirty (30) to a maximum of sixty (60) days. During this time, the member can be seen by any Medi-Cal provider willing to see the member and bill Partnership. If at the end of the limited period, the member has not informed Partnership of their new medical home or PCP, Partnership assigns the member to the next closest open PCP.
   2. Member Type U - Discharged for reasons other than fraud, sexual comment, threats of violence and/or violent behavior.
      a. Members are placed in a limited Direct Member status for a minimum of thirty (30) days to a maximum of sixty (60) days.
      b. Referrals are sent to CC if the Provider Request for Discharge/Assistance with Inappropriate Behavior form, (Attachment A) indicates any current treatments and/or if the member has any open Treatment Authorizations Requests/Referral Authorization Forms.
   3. Member notifications – Letter #MS10b (Attachment D) is sent to the member within ten (10) business days from the date the request was received. The letter explains the reason for the discharge and the effective date of the new medical home or PCP. The letter advises the member how to choose a new medical home or PCP, to contact MS department if they need assistance or have questions and, if applicable, how to receive care during the Direct Member period. Enclosures include, Nond ~~D~~iscrimination and Language Assistance notices.

G. Transition of Care
   1. If the member has diagnostic testing, specialty referrals and/or surgeries scheduled for conditions that could adversely affect the member's health if delayed, designated MS Staff requests that the CC department work with the member and appropriate providers to ensure that needed medical care is provided. The member may be assigned to Direct Member status, depending on the timing of the discharge.
   2. If the member is medically unstable, the PCP will continue to provide care to the member until Partnership is able to change the member's PCP for a period not to exceed two (2) months.

H. Process Approved Request to block system relinking, auto assignment and alert member facing departments
   1. To prevent discharged members from relinking or auto assignment, blocks and alerts are added to the appropriate membership systems.

I. Discharge of Direct ~~-~~Members and W&R "only" members
   1. A provider can terminate care of a Direct Member or W&R "only" members, when the provider/patient relationship becomes non-collaborative, by notifying the member in writing that they will no longer be able to provide care for that member. If the member is unstable, the provider should care for the member until the member selects another provider, and the provider provides emergency care for at least 30 days.
   2. Primary Care Providers should notify Partnership of their intent to discharge a Direct Member from their practice so that Partnership can document the reason for discharge and assist with transition of care, as described above in section VI.G Transition of Care.

J. Discharge Requests from Specialists and W&R Providers
   1. A specialist provider or W&R provider can cease providing care for any member when the provider/patient relationship becomes non-collaborative. In these cases, the specialist physician or W&R provider must notify both the PCP and the patient that they will no longer provide care to the

patient. The PCP should refer the member to another specialist for treatment, if specialist care is still necessary.

2. In all cases, the provider discharging a member should assist with continuity of care by transferring appropriate medical records to the new provider.

K. Request for Grievance
1. Members may request a grievance.

L. Reporting Violent and/or Fraudulent Behavior
1. Providers are encouraged to report violent and/or fraudulent behavior to the appropriate authorities.
2. MS notifies Partnership's Regulatory Affairs and Compliance department of suspected fraudulent behavior.

VII. REFERENCES:

A. N/A

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director of Member Services & Grievance

X. REVISION DATES:

Medi-Cal
04/27/95; 10/13/99; 06/20/01; 08/15/01; 06/19/02 (Hlth Srvcs Policy); 06/18/03 (Mbr Srvcs Policy); 03/05/04; 05/19/04;11/17/04; 11/16/05; 03/07/08; 08/12/08; 01/21/09; 08/19/09; 12/16/09; 03/23/10; 05/11/11; 01/07/2014; 07/14/14; 11/08/17; 02/13/19; 05/13/20; 08/11/21; 09/14/22; 09/13/23; 09/11/24; 09/10/25

Partnership Advantage (effective Jan. 1, 2027)
N/A

PREVIOUSLY APPLIED TO: Partnership*Advantage*: MP316 – 01/01/2007 to 01/01/2015; Healthy Kids: MP 316 12/01/2005 to 12/31/2016

Provider Request for Discharge/Assistance with Inappropriate Behavior

Section 1 - What would you like Partnership to do?

☐ Would you like Partnership to reach out to the member to counsel them on improving their behavior?
☐ Do you want to request that the member be disenrolled from your office(s)? **Must attached required documentation**.

Section 2 - Member Information: Partnership ID (CIN) #_____

Name: _____ DOB: _____ Phone #_____

Section 3 - Member Care Information:

1. Is the member in treatment for an active medical condition? ☐ No ☐ Yes - attach description of medical condition
2. Are there any diagnostic testing or surgeries scheduled? ☐ No ☐ Yes - attach list of scheduled procedures and any active TARs and/or RAFs. Please include TAR & RAF #s:
   _____

Section 4 - Provider Submitting Request:

1. PCP/Med Grp Name: _____ PCP/Group's Partnership PCP#: _____
   Does discharge apply to all facilities and/or locations affiliated with the group? ☐ Yes ☐ No
   If yes, list all the Partnership providers or locations that apply:

2. Have you already communicated with the member regarding your concerns? ☐ Yes ☐ No ☐ N/A If yes, what did you advise the member:
   _____

3. Who do we contact if we have questions regarding the member's care or the reason for disenrollment:

   Print Name: _____ Phone # _____

4. Who and where do we fax our decision to:

   Print Name: _____ Phone # _____ Fax#: _____

Section 5 - Reason for your request:

Please check all applicable boxes. **If you are requesting to disenroll the patient, attach documentation outlined in the policy**. If the action of the member is not specified in the policy, provide documentation outlining the incident or reason for request.

☐ Missed appointments ☐ Disruptive/verbally inappropriate behavior ☐ Suspected fraud
☐ Failure to obtain/maintain a collaborative relationship ☐ Non-Compliance/refusal to follow treatment plan.*
☐ Inappropriate sexual comments or advances
☐ Threats of violence and/or violent behavior; has behavior been reported to police? ☐ Yes ☐ No If "No" please explain why:
_____
☐ Other: _____

Note: *All requests for discharge for non-compliance are reviewed by a Partnership Medical Director. Presence of a Substance Abuse Disorder alone is not sufficient grounds for discharge. Please refer to specialty care or address treatment as necessary.*

Signature of Provider: _____ Date: _____

Print name of Provider: _____

Section 6 - Fax to (707) 420-7580 attention Partnership's **Enrollment Unit:**
Partnership has ten (10) business days to process your request from the date received. Forms that are incomplete or missing the required documentation may be denied.

******************************PARTNERSHIP INTERNAL USE***********************************

Member #: _____

DECISION:

☐ Pended Sent to Dept./Name: _____ Date sent: _____ Due back by: _____

☐ Approved Effective: _____ New Assignment: _____ Date approved:

☐ Request Denied Reason: _____ Date denied: _____

Referral to Case Management: ☐ Yes; date: _____ ☐ No

Letter #_____; Date notice sent to provider: _____

Letter #_____; Date notice sent to member: _____

☐ Call Center/Amisys entries completed on date: _____

COMMENTS:

MS _____

CC _____

PR _____

Member Services Director Signature: _____ Date: _____

PARTNERSHIP HEALTHPLAN of CALIFORNIA

4665 Business Center Drive
Fairfield, California 94534

Letter 10a
Member Services Notifies PCP of Decision

<DATE>

FAX: **<Fax #>**
<Provider Office>
<Provider's Address>
<Provider's City, State and Zip>

Re: Request to discharge: **<mbr>** ~~**PHC**~~ **Partnership ID #**

Dear **<Name>**:

Partnership HealthPlan of California ~~(PHC)~~ has received your request to discharge the above member. The documentation submitted by your office has been reviewed by ~~PHC~~Partnership. Based on the discharge guidelines outlined in Partnership~~PHC~~'s Policy MP 316, your request has been:

☐ Approved. The member will be transferred from your practice, effective **<Date>**.

☐ Denied. It was determined that your request did not meet the discharge guidelines outlined in ~~PHC's~~ Partnership's Policy MP 316. You must continue providing services to this member.

☐ Denied. It was determined that your request did not meet the discharge guidelines outlined in Partnership~~PHC~~'s Policy MP 316. However, the member has requested to be transferred to another primary care provider. The effective date of the transfer is **<Date>**.

☐ Denied. Not enough information has been provided to approve your request. Please provide additional information that specifically details your reason for requesting the discharge and resubmit your disenrollment request. See enclosed Provider Discharge Tool to help determine the type of documentation needed. At this time, you must continue to provide services to this member.

☐ Other:

☐ Special message or instructions

If you have questions or concerns regarding this discharge request or if you would like to appeal this decision, please contact your Provider Relations Representative at **(707) 863-4100**.

Thank you for the excellent care you provide to our members and your continued support of PHC.

Sincerely,
Provider Relations Department
Partnership HealthPlan of California

4665 Business Center Drive
Fairfield, California 94534

Letter 10C
Assistance with Inappropriate Behavior at Provider's Office

<date>

<Member Name>
<Member's Address>
<Member's City, State Zip>

Re: <Member's Name only if minor>

Dear <Member Name or Parent/Legal Guardian>:

This letter is to let you know that Partnership ~~HealthPlan of California~~ was told by <PCP's name and/or name of office>; that <members' name> <enter behavior or reason provider is requesting assistance> <if requesting inappropriate behavior; **add:** may have been inappropriate during a recent medical visit>.

There may be times when something happens at the provider's office that you may not like. It is best to try to solve the issue calmly. Future behavior that is not proper at the provider's office could end in you being let go from their practice.

If you are not able to solve problems at your provider's office, call us for help at **(800) 863-4155**.

Visit the Partnership's website at PartnershipHP.org to use the Member Portal. You can look at the Member Handbook, Provider Directory and read your Rights and Responsibilities on the Member Portal.

We are here to help you. Call us at **(800) 863-4155,** Monday - Friday, 8 a.m. to 5 p.m. if you have any questions or concerns. TDD users can call the California Relay Service at **(800) 735-2929** or call **711**.

You can call the Department of Health Care Services Managed Care Ombudsman's office at **(888) 452-8609**, Monday - Friday from 8 a.m. to 5 p.m., if you have any questions or a complaint about your health care. They can help you with these types of issues.

This notice does not change your Partnership benefits or keep you from getting the care you need.

Sincerely,

Member Services Department

Enclosures: Nondiscrimination and Language Assistance Notice, Member Rights and Responsibilities

4665 Business Center Drive
Fairfield, California 94534

Letter 10b
Notification of PCP Discharge Request Approved

<DATE>

<Member's Name>
<Member's Address>
<Member's City, State and Zip>

Re: Provider Discharge

Dear <Member Name or Parent/Legal Guardian>

<Current PCP> {insert if provider is requesting discharge from multiple sites} <and all affiliated sites> has asked that **<name of discharged member>** be removed from their care. Partnership ~~HealthPlan of California~~ has approved this request.

Below is/are the reason(s) that you have been removed from your primary care (main) doctor:

- ☐ You missed 3 or more appointments within 6 months.
- ☐ You used unkind or upsetting words.
- ☐ You were abusive.
- ☐ You will not follow medical treatment even when another treatment was not an option or was not the right treatment for your needs which could put your health at risk.
- ☐ You no longer get along with the doctor and/or staff.
- ☐ You falsely got and/or changed your medicine(s).
- ☐ You were removed from care by a specialist (doctors who treat certain types of health care problems)
- ☐ Other:

{Insert appropriate paragraph and remove all paragraphs not applicable}

[Member needs to pick a PCP or medical home]
To give you time to pick a new doctor, you have from **<date>** to **<date>** to choose a new doctor. During this time, you may see any Medi-Cal doctor willing to bill Partnership. This is called Direct Member Status.

Please pick a new doctor and let us know who you picked by **<date>.** If you do not pick a new doctor by this date, Partnership will choose one for you.

To pick a new doctor, you can look at our Provider Directory on our website at PartnershipHP.org. Pick a doctor that says they are taking new patients. You can tell us the doctor you picked by changing your doctor using our Member Portal on our website. You can also tell us by calling Member Services at

(800) 863-4155.

[Member has Other Health Coverage (OHC)]
Our records show you have other health coverage. Generally, that means your other health coverage is billed first for your care and Partnership is billed last. Because you have other health coverage and Medi-Cal, you have Direct Member status. This means you can be seen by any Medi-Cal doctor that takes your other health coverage and is willing to bill Partnership for services.

[Members with Medicare Part B]
You have Medicare Part B and Medi-Cal, which means you can be seen by any doctor who takes both Medicare and Medi-Cal. The doctor must agree to see you and bill Medicare and Partnership for covered services. Medicare is billed first and Partnership is billed last. This is called Direct Member Status.

[Out of the service area or approved for continuity of care or any other direct member status]
You qualify for Direct Member status, which means you can be seen by any Medi-Cal doctor that is willing to bill Partnership for services.

[Insert in addition to any of the above paragraph's anytime a member is Native American]
As a Native American, you have the right to get health care services at any Indian Health Service clinic. You have the right to pick an Indian Health Service clinic or a non-Indian Health Service clinic for your primary care (main doctor).

[Member is already assigned to a new PCP]
Because you have already changed your doctor, you do not need to pick a new doctor. You can continue to see the doctor that you have selected.

If you need help picking a new doctor, you can look at our Provider Directory on our website at PartnershipHP.org. If you are in the middle of care and need help or have any questions, please call us at **(800) 863-4155**. We are here to help you Monday – Friday, 8 a.m. to 5 p.m. TTY/TTD users can all the California Relay Service at **(800) 735-2929** or call **711**.

You can call the Department of Health Care Services Managed Care Ombudsman's office at **(888) 452-8609**, Monday – Friday from 8 a.m. to 5 p.m., if you have any questions or a complaint about your health care.

This notice does not change your Partnership benefits or keep you from getting the care you need.

Sincerely,

Member Services Department

4665 Business Center Drive
Fairfield, California 94534

Partnership HealthPlan of California

Enclosures: Nondiscrimination and Language Assistance Notice, Members Rights and Responsibilities Statement

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPNET101</td><td colspan="3">Lead Department: Network Services
Business Unit: Compliance</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Wellness and Recovery Access Standards and Monitoring</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 08/12/20</td><td colspan="4">Next Review Date: ~~08/15/2025~~06/10/2026 09/10/2026
Last Review Date: ~~08/14/2024~~06/11/2025 09/10/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="3">☒ Medi-Cal</td><td>☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="3">☐ P & T</td><td>☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~08/14/2024~~09/10/2025</td></tr>
</table>

I. RELATED POLICIES:
A. MPNET100 – Access Standards and Monitoring

II. IMPACTED DEPTS:
A. Member Services
B. Provider Relations
C. Health Services
D. Finance
~~Compliance~~
E. Behavioral Health

III. DEFINITIONS:
A. Rural Counties: Counties with a population density of <50 people per square mile (according to current Department of Health Care Services (DHCS) standards), includes Del Norte, Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Trinity counties.
B. Suburban or Small Counties: Counties with a population density of 51 to 200 people per square mile (according to current DHCS standards), includes Lake, Napa, and Yolo counties.
C. Urban or Medium Counties: Counties with a population density of 201 to 600 people per square mile (according to current DHCS standards), includes Marin, Solano, and Sonoma counties.
D. Triage or Screening: The assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, for the purpose of determining the urgency of the member's need for care.

IV. ATTACHMENTS:
N/A

V. PURPOSE:
To define access standards for substance use disorder treatment through the Partnership HealthPlan of California (Partnership) Wellness and Recovery Program.

VI. POLICY / PROCEDURE:
Partnership is committed to ensuring that its members have the availability of and accessibility to providers to meet their health care needs. Partnership has established standards for the numbers and types of clinicians and facilities, as well as for their geographic distribution, appointment accessibility and office and telephone

availability. Partnership monitors provider availability and accessibility on an annual basis.

A. Access to Providers
   1. Established ~~measureable~~measurable standards for the geographic distribution of each type of wellness and recovery program.

GEOGRAPHIC DISTRIBUTION OF WELLNESS AND RECOVERY PROVIDERS		
Practitioner Type	**Standard: Geographic Distribution**	**Performance Goal**
Outpatient Services	• Rural Counties: 60 miles or 90 minutes from the beneficiary's residence • Small Counties: 60 miles or 90 minutes from the beneficiary's residence • Medium Counties: 30 miles or 60 minutes from the beneficiary's residence • Large Counties: 15 miles or 30 minutes from the beneficiary's residence	≥ 80%
Opioid Treatment Programs	• Programs Rural Counties: 60 miles or 90 minutes from the beneficiary's residence • Small Counties: 45 miles or 75 minutes from the beneficiary's residence • Medium Counties: 30 miles or 60 minutes from the beneficiary's residence • Large Counties: 15 miles or 30 minutes from the beneficiary's residence	≥ 80%

   2. Established ~~measureable~~measurable standards for timely access of each type of wellness and recovery program.

TIMELY ACCESS STANDARD		
Provider Type	**Standard**	**Performance Goal**
Outpatient Services	Within 10 business days from request to appointment	≥ 80%
Opioid Treatment	Within 3 business days from request to appointment	≥ 80%

B. Communication
   1. Partnership communicates access standards to:
      a. Members through newsletters, Evidence of Coverage (EOC) and other education materials. Provider directories are also available to members online or upon request.
      b. Providers through the Provider Manual, provider newsletter and/or bulletins, initial provider training and during monthly provider training sessions.

VII. REFERENCES:

A. Master Agreement between Partnership and Wellness and Recovery Counties BHIN (Behavioral Health Information Notice) 21-023 2021 Federal Network Certification Requirements for County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS). (May 24, 2021)

VIII. DISTRIBUTION:

Policy/Procedure Number: MPNET101 (previously MPQP1023/QP100123)			**Lead Department:** Network Services Business Unit**: Compliance**
Policy/Procedure Title: Wellness and Recovery Access Standards and Monitoring			☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/12/20		**Next Review Date:** ~~08/15/2025~~06/10/2026~~09/10/2026~~ **Last Review Date:** ~~08/14/2024~~06/11/2025~~09/10/2025~~	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒**Partnership Advantage**

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:
~~Senior~~ Director, Network Services~~Provider Relations~~

X. REVISION DATES:
Medi-Cal
-08/11/2021, 08/10/2022, 08/09/2023, 08/14/2024, 09/10/25~~06/11/25~~

Partnership Advantage (effective Jan. 1, 2027)
N/A

PREVIOUSLY APPLIED TO:
N/A

this page left blank

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Aug. 20, 2025 Quality/Utilization Advisory Committee IQ/UAC) meeting.
It is recommended that you look over the changes to each and note any questions or comments you may have to help keep a progressive meeting agenda.

Policy Number & Name	**Page #**	**Summary of Revisions** (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
Policy Owner: Health Equity – *Mohamed Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)*			
MCED6001 – Quality Improvement and Health Equity Transformation Program (QIHEPT) Program Description	231 – 285 *CLEAN copy begins on p. 259*	This policy is updated to fulfill DHCS-Related corrective action plans and Community Reinvestment Requirements All Plan Letter (APL) 25-004. Updated clear designation of QIHETP leadership/committee roles, to ensure programs are fully implemented and maintained. For each identified role, the qualifications of staff presently fulfilling each role is detailed in an appendix to the Quality Improvement Program Description being presented today. The definition of the Community Reinvestment Management program is updated and a note added to explain the funding requirements per APL 25-004. Also, it is updated to clarify relationship between Partnership HealthPlan and Local Health Jurisdictions (LHJ) and Behavioral Health Teams. Finally, the update clarifies community engagement requirements and reinvestment plan timelines. Community – Access – Respect – Engagement Services (CARES)training coverage is explained. Access to staff for members and practitioners seeking information about the utilization management process and the authorization of care is explained. Linguistic services are provided by Partnership to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries as well as eligible members with sensory impairment for population groups as determined by contract.	Health Services
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Director UM Regulations*			
MCUG3024 – Inpatient Utilization Management	287 – 307 *CLEAN copy begins on p. 299*	This policy has been updated to include information regarding acute inpatient administrative days that was previously located in policy, MCUP3053, which is now archived. Additionally, a new Attachment document has been added to this policy to describe the information required for a post-discharge appeal for Inpatient Admissions. **Section I:** Policy numbers were updated and two Related Policies were added: F. MCUG3038 - Review Guidelines for Member Placement in LTC Facilities G. MCAP7003 - CalAIM Community Supports (CS) **Section III.A.** Definition was added for Acute Inpatient Administrative Days.	Health Services Claims Config Member Services Provider Relations Provider Contracting

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		Section III.E. Definition of Inpatient Admission locations was expanded to include Subacute Care Facilities. Also, each type of location was defined. **Section IV.** Attachment A was added: "Provider Dispute Resolution (PDR) Request: Post Discharge Appeal for Inpatient Admission." **Section VI.B.** This section on Criteria was simplified and the reader was referred instead to further information in policy MPUP3139 Criteria and Guidelines for Utilization Management. **Section VI.E.5.j.** Paragraph was added regarding Peer to Peer request requirements for inpatient admissions. **Section VI.E.5.k.** Paragraph was added regarding requirements for post-discharge provider dispute request for inpatient admission. **Section VI.G.** This new policy section was added to incorporate the information regarding Acute Inpatient Administrative Days that was previously located in policy MCUP3053, which is now archived. **Section VI.H.** This section regarding Inpatient Psychiatric Admissions was updated to clarify that acute inpatient administrative days do not apply when a Partnership Medi-Cal Member is pending evaluation on a psychiatric hold or awaiting placement at a mental health facility. Specialty mental health services are not a Partnership responsibility **Section VI.I.2**. Language was added in the Case Review Conference section to specify that these meetings now often include facility care management staff (e.g. case managers, discharge planners). **Section VI.K.** This section on Communication Services was simplified and the reader was referred instead to further information in policy MCUP3064 Communication Services. **Section VI.L.** This section on Delegation Oversight and Monitoring was simplified and the reader was referred instead to further information in policy MCUP3141 Delegation of Inpatient Utilization Management.	

QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHETP) PROGRAM DESCRIPTION

MCED6001

September 2025

Origination Date: 11/08/2023 Effective Date: 03/03/2024
Physician Advisory Committee (PAC) Approved: 11/12/24; 09/10/25

TABLE OF CONTENTS

Program Purpose and Goals 1
Program Objectives 2
Authority and Responsibility 3
Program Staff 3
Committees 5
Quality and Performance Improvement Collaboration 98
NCQA Accreditation Program Management 109
Data Sources 1110
Culturally & Linguistically Appropriate Services (CLAS) 1817
Quality Improvement and Health Equity Annual Work Plan 1918
Annual Program Evaluation 2019
Non-Discrimination Statement 2221
References 2423
~~Program Purpose and Goals ..... 1~~
~~Program Objectives ..... 2~~
~~Program Staff ..... 3~~
~~Committees ..... 5~~
~~Quality and Performance Improvement Collaboration ..... 8~~
~~NCQA Accreditation Program Management ..... 9~~
~~Data Sources ..... 10~~
~~For any subcontractors' and downstream subcontractors' QI and Health Equity activities, QIHEC will review report findings and actions on a quarterly basis during each QIHEC meeting. A summation of the results will be evaluated in the annual program evaluation. ..... 13~~
~~Community Reinvestment Management ..... 13~~
~~Culturally & Linguistically Appropriate Services (CLAS) ..... 17~~
~~Quality Improvement and Health Equity Annual Work Plan ..... 18~~
~~Annual Program Evaluation ..... 19~~
~~Non-Discrimination Statement ..... 21~~
~~References ..... 23~~

PROGRAM PURPOSE AND GOALS

Partnership HealthPlan of California (Partnership) is a County Organized Health System (COHS) contracted by the State of California to provide Medi-Cal beneficiaries with a health care delivery system to meet their medical needs.

The mission of Partnership HealthPlan of California is "To help our Members, and the Communities we serve, be healthy." Our vision is to be "the most highly regarded health plan in California." Partnership believes in fostering strong partnerships with members, providers, and community leaders to collectively improve health outcomes; focusing on continuous quality improvement in every aspect of the organization and in collaboration with our partners; and promoting diversity by accepting, respecting, and valuing individual differences and capitalizing on the diverse backgrounds and experiences of our members, community partners, and staff.

Partnership's defining focus is ensuring the highest quality of care, positive health outcomes, and timely access to care for all diverse members (i.e., Quality, Access, and Equity). Therefore, Partnership has developed program descriptions and policies to describe the structures needed to promote health equity. Specifically, Partnership has implemented the Partnership Quality Improvement and Health Equity Transformation Program (QIHETP).

The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system to address improvements in the quality of care delivered by all of its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to members. The Partnership QIHETP serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare services
- Ensure that healthcare service is delivered at the appropriate time and in an equitable manner

The Partnership QIHETP provides a reliable and credible mechanism to review, monitor, evaluate, recommend, and implement actions that acknowledge health equity.

The Partnership QIHETP serves as an organized framework to:

- Review and develop equity-focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services by engaging with a member and family-centric approach
- Review activities and identify opportunities to improve health equity throughout Partnership with oversight and participation of the governing Board of Commissioners and the Quality Improvement and Health Equity Committee (QIHEC)
- Promote participation from a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers for QIHETP development and performance reviews
- Review health equity-related training activities and validate that the trainings review the impact of structural and institutional racism and health inequities on members, staff, network providers, subcontractors, and downstream subcontractors per Department of Health Care Services (DHCS) published All Plan Letters (APLs) regarding diversity, equity and inclusion (DEI) training.

PROGRAM OBJECTIVES

The Partnership QIHETP serves to ensure that appropriate, high quality cost-effective utilization of health care resources is available to all members while being cognizant of health care disparities and inequities. This is accomplished through the systematic and consistent application of management processes based on current health equity review literature and expert opinion when needed. The scope of the QIHETP includes the quality of clinical care and services for all members receiving Medi-Cal healthcare services from Partnership. The monitoring and evaluation of clinical issues reflects the population served by Partnership without regard to social drivers of health (SDOH), age group, disease category, or risk status. In alignment with other Partnership departments, the QIHETP encompasses all aspects of medical and behavioral healthcare including:

- Identifying and addressing racial/ethnic and other disparities in health care delivery or outcomes
- Identifying overuse, misuse, and underuse of health care services and prescription medications
- Evaluating clinical quality of physical health care
- Evaluating clinical quality of behavioral health care focusing on prevention, recovery, resiliency, and rehabilitation
- Identifying and addressing equitable access or quality issues related to behavioral health services through delegated contracts
- Ensuring access to primary and specialty health care providers and services
- Ensuring availability and regular engagement with primary care providers (PCPs)
- Evaluating continuity and care coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent provider-patient relationships
- Evaluating member experience with respect to clinical quality, access, and availability and culturally and linguistically competent health care and services, and continuity and care coordination
- Promoting cultural and linguistic competence of Partnership staff and network practice sites and providers

The QIHETP program accomplishes these goals by:

- Systematically monitoring and evaluating services and care provided by conducting quantitative and qualitative data collection. Using this data and various statistical analyses, Partnership will make data-driven decisions
- Identifying, evaluating, and reducing health disparities utilizing internal reports, reflecting utilization management, quality improvement, member satisfaction (Consumer Assessment of Healthcare Providers and Systems [CAHPS®]), care coordination, grievance and appeals, and population health activities to ensure services are provided equitably.
- Actively conducting systematic searches for tertiary and primary medical literature to ensure decisions are based upon up-to-date evidence in the health equity discipline
- Actively pursuing opportunities for improvement in areas that are relevant and important to Partnership members' health
- Implementing strong and sustainable interventions when opportunities for improvement are identified for addressing a health disparity

AUTHORITY AND RESPONSIBILITY

Board of Commissioners

The Board of Commissioners on Medical Care (the Commission) promotes, supports, and has ultimate accountability, authority, and responsibility for a comprehensive and integrated Quality Improvement and Performance Improvement (QI/PI) programs. The Commission is ultimately accountable for the quality of care and services provided to members. The Commission has delegated direct supervision, coordination, and oversight of the QI/PI program to the Physician Advisory Committee (PAC), which serves as the main Quality Improvement committee. PAC is supported by two other quality committees – the Quality and Utilization Advisory Committee (Q/UAC) and the Internal Quality Improvement Committee (IQI), which are described in more detail below. The county Boards of Supervisors for each geographic area appoints members of the Commission, which include representation from the community: consumers, businesses, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health departments. The Commission meets six times per year.

The purpose of the Commission is to arrange for the provision of health care services to qualifying individuals, as well as other purposes set forth in the enabling ordinances established by the respective counties.

Key Roles

The following leadership roles carry authority and responsibility to ensure the QIHETP Program is fully implemented and maintained. The qualifications of staff presently fulfilling these roles are detailed in Appendix D (included with QI Trilogy submission) which includes documented evidence corresponding to that collected annually on behalf of DHCS. Given the personal details included, this appendix is not posted publicly.

PROGRAM STAFF

Chief Medical Officer

The Chief Medical Officer (CMO), with the assistance of the members of PAC, Q/UAC, and IQI, as well as the other medical directors of Partnership, is responsible for providing professional judgment regarding matters of quality of care, peer review, clinical, and medical procedures. The CMO is the chair of IQI and Q/UAC and has significant involvement in all QI/PI, Pharmacy, and Health Services activities as well as providing oversight to these programs on a day-to-day basis. The CMO is a Medical Doctor (MD) or Doctor of Osteopathy (DO) with an unrestricted license in the State of California.

Chief Health Services Officer

The Chief Health Services Officer (CHSO) works closely with leaders in Utilization Management to provide accountability for delegates to meet necessary National committee for Quality Assurance (NCQA) accreditation requirements and provide strategic leadership and guidance in the review and revision of provider contracts to ensure QI reporting requirements and value-based program contingencies are met. The CHSO also has purview over the Care Coordination, Utilization Management, Enhanced Health Services, Behavioral Health and Health Equity departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The CHSO's level of involvement fulfills the need for executive

support and accountability for improvements with data quality~~, coordination~~, and coordination of activities between QI and these departments. Collaborates with the Chief Medical Officer and members of PAC, Q/UAC, and IQI in matters involving quality of care, clinical, and medical procedures.

Director of Health Equity (Health Equity Officer)
The Director of Health Equity serves as the Health Equity Officer (HEO) for Partnership. In collaboration with Partnership leaders, the Director of Health Equity leads the development and implementation of strategies that advance health equity across our network ~~,~~diversity, equity, and inclusion across the organization. This role drives systemic change to enhance representation and cultivates programs that foster a culture of belonging. This role provides oversight, strategic direction, and support for improving quality measure performance and member experience in specified cultural, linguistic, economic, educational, ~~etc~~etc. groups in our community and workforce. In collaboration with the CMO, oversees the Quality Improvement and Health Equity Transformation Program (QIHETP) program operations and assists in the development and coordination of QIHETP policies and procedures. This role also leads the development and management of the diversity, equity, and inclusion and gender-affirming care training programs.

Medical Director for Quality
Assists CMO by providing physician support for varying activities within the QI/PI department, including Performance Improvement, Member Safety, Peer Review, and the Quality Incentive Programs, as well as assists with utilization management review activities. This role also serves as management oversight for the Member Safety teams within the QI/PI department.

Senior Director of Quality and Performance Improvement
This role works collaboratively with the CMO to define strategy, develop programs and services, and to evaluate the effectiveness of the QI/PI Program. Together with the QI management team, including the Medical Director for Quality, provides oversight of Facility Site Reviews, investigation of potential quality issues, compliance with NCQA standards, Healthcare Effectiveness and Data Information Set (HEDIS®) and other performance measure data collection and performance reporting, value-based payment programs (QIPs), performance improvement initiatives and programs, external and internal QI training, provider education on the QIPs and HEDIS®, grant application and grant management. This role works to foster greater cross collaboration of QI staff and strategic involvement of other departments to support the execution of tactics defined and maintained under Partnership's 5-Star Quality Strategy.

Director of Population Health Management
The Director of Population Health Management works collaboratively with leaders across the organization, to execute the organization's Population Health Management strategy. This role provides oversight, strategic direction, and support for related initiatives, including those essential to improving quality measure performance and member experience. This role offers guidance and ensures alignment with health care policies, financing, accreditation requirements, and regulations to drive optimal health outcomes for members.

Behavioral Health Clinical Director
The Behavioral Health Clinical Director holds an MD/DO, PhD or PsyD credential. With the assistance of the Behavioral Health team, this individual is responsible for providing professional judgment regarding matters of quality of care, peer review, and clinical policies and procedures through oversight

of Partnership activities in the areas of mental health and substance use disorder services as provided by Partnership's delegated behavioral health providers.

Administrative Assistant
Under the direction of the Health Equity Officer (HEO) or other designated leadership, provides administrative support to the Health Equity Officer Director and/or other QIHETP Leadership. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

- Tracks project deliverables and resources using appropriate internal tools to ensure deadlines are met
- Coordinates the QIHEC meetings

Project Coordinator I

Oversees timelines and deliverables for department projects. Provides routine and ad hoc reporting for key Population Health activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Supports ongoing audit readiness activities by maintaining structures around audit deliverables, meeting minutes, and the file retrieval system.

- Uploads and maintains policy documents in PowerDMS

COMMITTEES

Board of Commissioners
The Board of Commissioners on Medical Care (the Commission) promotes, supports, and has ultimate accountability, authority and responsibility for a comprehensive and integrated QIHETP program. The Commission is ultimately accountable for the efficient management of healthcare resources and services provided to members. The Commission has delegated direct supervision coordination, and oversight of the QIHETP program to the Q/UAC which reports to the PAC, the committee with overall responsibility for the program. Members of the Commission are appointed by the county Boards of Supervisors for each geographic service area and include representation from the community, consumers, business, physicians, providers, hospitals, community clinics, HMOs, local government, and county health departments. The Commission meets six times a year.

Quality/Utilization Advisory Committee (Q/UAC)
The Q/UAC is responsible to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing systematic evaluation and monitoring process that facilitates continuous quality improvement. Q/UAC voting membership includes consumer representative(s) and external providers who are contracted primary care providers (PCPs) and board certified specialists in the areas of internal medicine, family medicine, pediatrics, OB/GYN, neonatology, behavioral health, and representatives from other high volume specialties. The Partnership Chief Medical Officer (CMO) (chair of the committee), Clinical Director of Behavioral Health, Health Equity Officer, Medical Director for Quality, Associate and Regional Medical Directors and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, Care Coordination, Population Health, Health Equity, Pharmacy, and Grievance departments attend the Q/UAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The

committee meets monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to the PAC and at least quarterly to the Commission. The Q/UAC provides guidance and direction to the QIHEC by functioning as the expert reviewing panel as follows:

- Reviewing, making recommendations to, and approving the *QIHETP Program Description* annually
- Analyzing summary data and making recommendations for action
- Reviewing action plans for quality improvements of QIHETP activities and providing ongoing monitoring and evaluation

Quality Improvement and Health Equity Committee (QIHEC)

Partnership's QIHEC is overseen by the Quality/Utilization Advisory Committee (Q/UAC) and the Physicians Advisory Committee (PAC), which subsequently reports to our governing Board of Commissioners. The QIHEC analyzes and evaluates the results of Health Equity-related Quality Improvement activities. Specifically, QIHEC will conduct an annual review of the results of key health equity-related data to provide plan-wide recommendations (e.g.,, generate policy recommendations) to address health-equity performance deficiencies. The QIHEC ensures appropriate assessment of interventions, measurement, and follow-up of identified performance deficiencies. The QIHEC responsibilities include the following:

- Analyze and evaluate the results of clinical quality performance measures related to Health Plan Ratings (HPR), as specified by NCQA Health Equity Accreditation (HEA) standards, as mandated by DHCS, or due to poor performance trending on the DHCS Managed Care Accountability Set (MCAS) (with stratification by race/ethnicity and language):
  - Assigned Health Effectiveness Data & Information Set (HEDIS®) Measures
  - Consumer Assessment of Healthcare Providers and Systems [CAHPS®]
- Analyze utilization data (types of services, denials, deferrals, modifications) with stratification by race/ethnicity and language
- Analyze utilization data of language services and experience with language services with stratification by language.
- Analyze and evaluate the results of member satisfaction surveys, Grievance and Appeal surveys, and care coordination-based surveys with stratification by race/ethnicity and language
- Analyze and evaluate the strategy and work plans presented by internal committees to ensure that clinical quality performance measures (with stratification by race/ethnicity and language) and member satisfaction are evaluated and attended to in prospective work plans
- Analyze and evaluate feedback from member representative committees (e.g., Community~~nsumer~~ Advisory Committee, Family Advisory Committee)
- Recommend Managed Care Plan (MCP)-related interventions (e.g., education, programs, etc.) for various departments to address key clinical quality performance deficiencies (e.g., HEDIS, CAHPS, etc.) per the scope of work of managed care plans.

Partnership's QIHEC membership will consist of the following key members, who subsequently will report directly to Q/UAC:

- Chief Medical Officer or CMO Designee (e.g., Medical Director)
- Health Equity Officer
- Chief Operating Officer
- Internal Leadership from following departments: Health Analytics, QI/PI, Provider Relations, Utilization Management, Member Services, Care Coordination, and Population Health

In addition, the Partnership's QIHEC membership will be composed of representatives from our Providers, health plan subcontractors, and health plan downstream subcontractors, who provide health care services to members affected by health disparities, members who are considered to have Limited English Proficiency (LEP), members with children with special health care needs (CSHCN), members who are considered to be Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions. Example entities from which representatives will be drawn include, but are not limited to, hospitals, clinics, county partners, physicians, subcontractors, downstream subcontractors, network

providers, and Partnership members. The QIHEC meeting minutes, findings and recommendations will be reported directly to the Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC), and Partnership's Board of Commissioners. Also the QIHEC will report findings to our various other internal committees (e.g., CAC, FAC, etc). Partnership's Confidentiality Policy (CMP-10) provides guidance to ensure avoidance of conflict of interest among committee members and ensure that member confidentiality is maintained throughout QIHEC-related meetings.

Population Health Needs Assessment (PNA) Committee
The Population Health Needs Assessment Committee (PNA) is an internal committee and serves as a multi-departmental body whose goal is to support the advancement, growth, and execution of population health and health equity interventions at Partnership. The committee consists of Partnership staff representing member, community, regional, and provider-facing departments; it also incorporates representatives from Human Resources, Regulatory Affairs, IT, and Health Analytics. The committee meets every other month to align interdepartmental efforts promoting health equity through member and systemic interventions outlined in the relevant Needs Assessment (PNA) Action Plans. The PNA Committee activities and recommendations will be shared with the, Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), QIHEC, Physician Advisory Committee (PAC) and Partnership's Board of Commissioners..

Family Advisory Committee (FAC)
The Family Advisory Committee (FAC) is a member advisory group to the CEO and staff of Partnership. The FAC provides a forum for parents, guardians and caregivers of children with California Children Services (CCS) conditions to discuss common issues of interest and importance, to create a supportive and informative networking environment and to advocate for members by ensuring that Partnership is responsive to the diversity of health care needs for all members. Minutes from FAC meetings are reviewed by the Pediatric Quality Committee (PQC). The FAC membership is comprised of representatives from throughout Partnership's geographic service areas who advocate for CCS-eligible children of diverse cultures, ethnicities, genders, ages and disabilities. Meetings are held at least four (4) times per year with the option for additional meetings as needed

Community Advisory Committee (CAC)
The Community Advisory Committee (CAC) is composed of Partnership health care consumers who represent the diversity and geographic areas of Partnership's membership including hard-to-reach populations. The CAC is a liaison group between members and Partnership, advocating for members by ensuring that the health plan is responsive to the health care and information needs of all members. The CAC meets quarterly, reviews and makes recommendations regarding Member Services' quality improvement activities, provides feedback on quality and health equity initiatives, and serves in the capacity of a focus group. A CAC member(s) serve(s) on the Partnership Board to provide member input and report back to the CAC.

QUALITY AND PERFORMANCE IMPROVEMENT COLLABORATION

The Health Equity department works collaboratively with the Quality and Performance Improvement (QI/PI) department to enhance the care provided to our members through venues such as the Internal Quality Improvement Committee (IQI), the Quality/ Utilization Advisory Committee (Q/UAC) and daily QIHETP activities.

In the committee environment, the Health Equity department takes an analytical, evaluative and strategic look at predetermined metrics to evaluate and offer recommendations which further enhance the QIHETP program. Data is reviewed and discussed annually during the IQI and Q/UAC meetings. The Q/UAC provides guidance and direction to the QIHETP program by coordinating major activities and by functioning as the expert panel when needed. Collaboration includes but is not limited to:

- Reviewing, making recommendations to, and approving the *QIHETP Program Description* annually
- Analyzing summary data and making recommendations for action
- Reviewing the recommendations of QI's Performance Improvement Teams to develop QIHETP improvement action plans specific to clinical quality measure performance with on-going monitoring and evaluation. The QI/PI department is often the lead for many improvement efforts, particularly those that are mandated or due to poor performance on the Managed Care Accountability Set (MCAS), which is the set of measures that DHCS selects for annual reporting by Medi-Cal managed care health plans. This can include mandated improvement efforts to meet disparity reduction targets for specific populations and/or measures as identified by DHCS. The QI/PI department also takes the lead on mandated Performance Improvement Projects (PIPs) that are assigned by DHCS. PIPs are led by the QI/PI program based on criteria defined by DHCS and overseen by the California External Quality Review Organization (EQRO), and include at least annual status reports to DHCS
    - Recommending improvements to enhance health equity language in Partnership policies and protocol according to QIHETP standards

For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the Health Equity department supports ongoing quality improvement efforts in the identification of potential quality or equity of care issues, improvement of HEDIS quality measures in context with social drivers of health. For member-facing improvement efforts, CAC and other member focus groups are often consulted.

NCQA Accreditation Program Management

Partnership strives to improve the health status of members and their care experience to become one of the highest quality health plans in California. NCQA Health Plan Accreditation supports Partnership's vision, mission, and strategic goals byproviding a rigorous and comprehensive framework for essential quality improvement, operational excellence, and measurement of clinical performance (HEDIS) and member experience (CAHPS).

Per the 2024 DHCS contract, all managed care plans (MCPs), including Partnership, are mandated to achieve both NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation (HEA) by Jan. 1, 2026. Partnership successfully achieved HPA reaccreditation on Dec. 18, 2023.. In order to maintain NCQA Health Plan Accreditation, Partnership was required to report annual results starting in June 2022. Partnership earned a Health Plan Rating (HPR) of 3.5 stars in June 2023 based on HEDIS/CAHPS performance from MY 2022/RY 2023. NCQA released Partnership's current HPR of 3.5 stars in September 2024.

Partnership's defining focus is ensuring the highest quality of care, positive health outcomes, and timely access to care for all diverse members (i.e., Quality, Access, and Equity). NCQA Health Equity Accreditation (HEA) complements Partnership's overall mission by encouraging managed care organizations to establish a foundation of health equity work. Specifically, the HEA encourages the focus on building an internal culture that complements external health equity work with our population health management department; collecting relevant data that provides insight on how to ensure appropriate representation in language services and providers; identifying and categorizing inequities to guide future population health-based interventions

Partnership will be submitting first survey documentation, to obtain the NCQA Health Equity Accreditation (HEA), by June 2025.

DATA SOURCES

DHCS Bold Goals

To have a context of Health Equity and align internal quality and health equity efforts with DHCS, Partnership will review the DHCS's Health Disparities Report and Bold Goals of 2025. Currently, The Bold Goals of 2025 are as follows:

- Close racial/ethnic disparities in well child visits by 50%
- Close racial/ethnic disparities in immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow up for mental health and substance use disorder by 50%

Partnership uses several methods to identify and evaluate member needs, and strategize how to address such needs by reducing health disparities.

Step 1: Sample Selection to Evaluate Disparities
Partnership initially utilized Measurement Year 2023 (MY 2023) MCAS final sample measures (n=186 to 167,450 members) to evaluate each of the clinical measures of focus. The rates for each measure are comprised of the members included in each measure's audit for Partnership's Health Plan Accreditation Plan-wide summary of performance report. The random member sample that was generated for each hybrid measure and full member denominator along with member race/ethnicity demographic information, was provided by Partnership's HEDIS vendor, Inovalon. Inovalon has been classified as a direct data source.

Step 2: Statistical Analysis to Identify Key Disparities
After receiving the data from Inovalon, members from Partnership's Health Analytics team conducted various statistical analyses. The Chi-Square and Fisher's Exact statistical tests were utilized, based upon sample size, to determine if there were significant differences for the various categorical measure outcomes.

When analyzing disparities based upon race/ethnicity, Partnership conducted various statistical analyses using the White group as the key comparator group. When analyzing disparities based upon language, Partnership conducted various statistical analyses using the English language group as the key comparator group. Finally, when analyzing disparities based upon gender, Partnership conducted various statistical analyses using the Male gender identity group as the key comparator group. A statistically significant difference was classified as a p value less than 0.05 when comparing the categorical outcomes of one group versus the key comparator group, respectively (i.e., White, English-speaking, Male). These comparators were identified based upon various literature suggesting that such groups, respectively, have had significantly more political, economic, and/or social advantages within the United States (Malat et al., 2018). Data, that were excluded from the evaluation, were findings from patients who reported "Unknown" in race, language, and gender identity.

Step 3: Analysis of Measures
Partnership also reviewed the performance of each race/gender identity/linguistic group in comparison

to the MCAS benchmarks to assess not only how each group performed statistically in comparison to the White/Male/English speaking group, but also in comparison to the national Medicaid benchmarks. In MY 2023, DHCS is holding managed care plans (MCPs) accountable and imposing sanctions on selected Hybrid and Administrative measures performing below the minimum performance level (MPL) (50th national Medicaid percentile) by reporting region, and as a result, Partnership thought it valuable to assess how each group is performing in comparison to that benchmark to assess whether group performance could also have an impact on accountable measures.

Step 4: Prioritization of Disparities

The HEO, CMO, and members of the QI/PI team reviewed the information supplied about health disparities and draft a preliminary report of disparity metrics to prioritize based upon clinical measure stratification, statistical or clinical findings, size of the disparity, strength of evidence, feasibility, and return of investment. An established baseline will be developed for each group to follow for the next 3 to 5 years to evaluate long-term impact. The team will identify the key disparity priorities per region and per population of key racial/ethnic, gender, or linguistic groups.

Step 5: Distribution of Disparity Data for Community Feedback

The preliminary report will be shared with relevant internal committees (e.g., CAC, FAC etc), corresponding providers, health plan subcontractors, and health plan downstream subcontractors, via their corresponding QIHEC representative or newsletter. The goal will be to solicit feedback to ensure we have identified disparities that may not have been captured during our internal data analysis and identify strategies to address the disparities in respective communities. The Health Equity department will review internally submitted community needs assessment information to increase the likelihood of receiving credible information from community leaders and CAC/FAC/QIHEC members. Also, the Health Equity department will review feedback from members, parents, and/or caregivers to ensure that the community is given an opportunity to engage in the development of quality improvement and health equity activities and suggest interventions that will likely work in their respective communities. The advisory feedback will be transcribed and shared with the Health Equity department.

The Health Equity department will review the solicited findings from QIHEC, CAC, FAC, providers, health plan subcontractors, and health plan downstream subcontractors and share the results to the QIHEC for final approval of the key Partnership health equity priorities to share with the overall organization to serve as guidance for various departments and activities (e.g. PNA, QIP, etc.).

Step 6: Distribution of Disparity Data into Department Activities

Quality Improvement

For internal QI/PI related activities, the Health Equity department, in collaboration with the QI/PI team, will ensure that HEDIS/CAHPS–associated disparities (e.g. racial, ethnic, linguistic, disability, SOGI, etc.) are specifically being addressed in QI/PI programs (e.g., value-based payment programs, provider improvement plans, Corrective Action Plans (CAPS) etc.). Specifically, the QIHETP and QI/PI teams will review the internal value based payment programs (e.g., primary care provider quality improvement program (PCP QIP), hospital quality improvement program, (HQIP) etc.) and performance improvement projects to assess whether adjustments need to be made to ensure the projects can address HEDIS/ CAHPS –associated disparities. For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the Health Equity department supports ongoing QI/PI efforts in the identification of potential quality or equity of

care issues, improvement of HEDIS quality measures in context with social determinants of health. The QIHETP and QI/PI teams will collaborate to develop QIHETP improvement action plans specific to clinical quality measure performance with on-going monitoring and evaluation. Finally, the QIHETP and QI/PI teams will share data with NCQA team members to validate that disparity reduction goals/targets are compliant with NCQA HEA standards.

The QIHEC will review, among other reports, the updated QI/PI Program Evaluation to ensure that one or more HEDIS/CAHPS-associated racial disparity, HEDIS/CAHPS-associated linguistic disparity, or a mandated disparity reduction target for specific populations and/or measures as identified by DHCS has been addressed in response to findings from Partnership's annual QI Work Plan.

Population Health
For internal population-health specific activities, the QIHETP and Population Health teams will collaborate to generate a finalized report to help refine the various population health reports and analyses. (The PHM Strategy provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population served in the program. Specifically, teams will review tertiary and primary medical literature and health indices, review findings from other managed care organizations, collaborate with community key opinion leaders or subject matter experts, and survey members of the CAC and FAC to find credible interventions that can be executed by a managed care organization based upon the synthesized findings of the preliminary report. The QIHETP and Population Health and Health Equity teams will review and assess corresponding social drivers of health metrics. t. Social determinants or drivers of health have been classified as conditions in various environments that affect health and overall quality-of-life outcomes

The QIHEC will review, among other reports, relevant Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) information, Population Health and Cultural and Linguistics (C&L)-associated work plans to ensure that one or more HEDIS-associated racial/ethnic disparity(ies), and one or more HEDIS-associated disparity(ies) related to one additional category of stratification (e.g., disability, geographical representation, etc.) is addressed based on the findings from the assessed reports. The QIHEC will also review reports regarding the utilization of language services, individual experience with language services, staff experience with language services, and member experience with language services during health care encounters to ensure that one or more interventions is identified and incorporated into work plan(s) to address one or more culturally and linguistically appropriate services (CLAS) disparity or HEDIS-associated linguistic disparity. The QIHEC will review these elements to ensure they correlate appropriately with Partnership's annual QI Work Plan.

Human Resources
For internal Human Resources (HR) related activities, the Health Equity ~~department~~department, in collaboration with the HR department, will review submitted data for annual DEI-related training for employees, network providers, etc. to ensure review of completion. Specifically, the QIHETP and HR team will review the annual training on culturally and linguistically appropriate practices to ensure they are teaching principles to reduce bias and promote inclusion. Also, QIHETP and HR team will review the annual training to validate that it meets all the criteria to be considered appropriate per any related APL set forth by DHCS. The QIHETP and HR team will also review internal recruiting and hiring processes to ensure they support diversity in staff leadership, committees, and governance bodies. Also, the Health Equity department will conduct an annual survey of the DEI satisfaction from staff,

leadership, governance bodies, and committees and solicit recommendations to improve the DEI or cultural humility of each.

The QIHEC will review, among other reports, the annual results of such DEI surveys to ensure that Partnership has acted on at least one opportunity identified to improve DEI for at least one group (staff, leadership, committees, or governance bodies). Also, the QIHEC will review annual employee demographic data to ensure that our internal recruiting and hiring process continues to support diversity in staff leadership, committees, and governance bodies.

For grievance and appeals-related activities, the Health Equity department, in collaboration with leadership from the Population Health and Grievance and Appeals departments, will review for any patterns of disparities in reported grievances. The QIHEC will review, among other reports, the updated PNA, Cultural and Linguistics (C&L) Program Description and Work Plan, and/or Grievance and Appeals-associated Work Plans to ensure that one or more CAHPS-associated racial disparity(ies) or CAHPS-associated linguistic disparity(ies) is addressed with a Work Plan action item.

Miscellaneous Contributors
For any subcontractors' and downstream subcontractors' QI and Health Equity activities, QIHEC will review report findings and actions on a quarterly basis during each QIHEC meeting. A summation of the results will be evaluated in the annual program evaluation.

Community Reinvestment Management

The Health Equity department will work with the Finances, Population Health, Behavioral Health, Project Management Operations departments to ensure the health plan reinvests a minimum level of our net income into our local communities. Community reinvestment planning will start in calendar year 2025, with community reinvestment activities starting in 2026 and follow a 3 year cycle to align with other DHCS-related initiatives (Community Health Assessment, Behavioral Health Transformation, etc.)

Partnership's Health Equity Officer and Health Equity team, will lead the management of the community reinvestment planning process to ensure all community reinvestment plans align with overall health equity needs and priorities. Also, the health equity team will ensure that the health plan and qualifying subcontractors' activities are based upon engagement with the community and community-identified priorities, with investments in health quality improvement and equity outcomes.

Data
Every 3 years, Partnership will review the following to make a preliminary assessment of community reinvestment landscape in our counties:

- PNA
- CHA/CHIP for each corresponding county
- Behavioral Health Transformation~~HT~~ assessment for each county
- Health Equity Grand Analysis per QIHETP workplan

Funding Requirements
Partnership and qualifying subcontractors will define the base Community Reinvestment as the minimum level of net income that, if with positive net income, is required to invest into initiatives that serve the communities in which the Partnership operates, starting with net income based on Calendar year (CY) 2024 Contract Revenues for Community Reinvestment activities initiated in CY 2026.

- Partnership, since in multiple counties, will calculate the Base Community Reinvestment funding obligations with the following allocation methodology:
  - 5% of Base Community Reinvestment Funds equally across counties in which Partnership operates + 95% of Base Community reinvestment Funds in Proportion to Medi-Cal membership by county
- Partnership will allocate the base community reinvestment funds = (5% of the Partnership's or Qualifying Subcontractors annual net income that is less than or equal to 7.5% of Medi-Cal Contract Revenues/Subcontractor agreement for the year**)** + (7.5% of the Partnership's or Qualifying Subcontractor's annual net income that is greater than 7.5% of Medi-Cal Contract Revenues/subcontractor agreement for the year)
- The approved net income from Partnership will invest into initiatives in counties that do not meet minimum quality measure performance thresholds for the applicable year
- Partnership receives an Enforcement Tier 2 or Tier 3 assignment for the applicable calendar year for any county, it will reinvest at minimum an additional 7.5% of their annual net income into Community Reinvestment initiatives
  - ** For any county in which the Partnership is assigned to Enforcement Tier 2 or Tier 3, it will allocate 100% of our Quality Achievement Community Reinvestment funds toward investments in the "Cultivating Improved Health" category per the discretion of the corresponding public health and behavioral health officers
- Partnership will notify our Qualifying Subcontractors of their minimum Community Reinvestment funding obligations, and any corrections to such obligations, within 7 calendar days of notice from DHCS?
- Partnership and its Qualifying Subcontractors as applicable, will initiate investments in Community Reinvestment activities by no later than the close of the CY in which DHCS approves the initial Community Reinvestment Plan for the applicable investment period, and that Community Reinvestment funding obligations for each three-year investment period will be spent on specific activities included in the initial Community Reinvestment Plan by the end of the three-year period

Community Reinvestment Spending Categories (Inclusion/Exclusion Criteria)
Partnership's investments will be targeted toward reducing existing health disparities and/or promoting health outcomes for Medi-Cal populations through investments primarily focused on upstream causes of poor health such as housing instability, food insecurity, poverty, barriers to access to health and social services, and environments that negatively impact health.

Reinvestment spending may fall into at least one of the following categories but will be specific to each county's needs

- Cultivating Neighborhoods and Built Environment.
- Cultivating a Health Care Workforce.
- Cultivating Well-Being for Priority Populations.
- Cultivating Local Communities
- Cultivating Improved Health

Reinvestment spending may NOT fall into any of the following categories, regardless of the needs of the counties:

- Partnership Contract or Services carved out of the contract but covered under Medi-Cal (e.g. Pharmacy Benefit)
- Health care services inclusive of activities that improve health care quality or within the scope of Medi-Cal benefits or state-funded services
- Administrative activities of Partnership Health Plan (e.g. Employment, Meeting Scheduling, etc.)
- Administrative activities related to community reinvestment planning, implementation
- Member incentives or Grants
- Contract Activities

Local Health Jurisdiction (LHJ) and Behavioral Health Transformation ~~(LHJ/BHT)~~ Engagement
Partnership will engage with the community to ensure alignment with community reinvestment principles. Specifically, Partnership will engage at least quarterly meetings with corresponding public health and behavioral health officers in collaboration with the Population Health team to ensure alignment with community health assessment activities. Also, this will be implemented to ensure that local health jurisdiction and county behavioral health are included in community reinvestment planning and decision-making processes. Each reinvestment plan will solicit attestation from public health and county health directors to confirm that the investment strategy is generally agreeable to the LHJ and County Behavioral Health Department and aligns with community needs identified in the CHA / CHIP.

Community Engagement
Partnership will engage with the community to ensure alignment with community reinvestment principles. Specifically, Partnership will annually consult with our Community Advisory Committees (CACs), Quality/Utilization Advisory Committee (Q/UAC), and Quality Improvement and Health Equity Committee (QIHEC) to solicit Community Reinvestment recommendations. Also, Partnership may intermittently solicit feedback and insight from Members, community residents, community-based organizations, tribal organizations, providers, and other external stakeholders to ensure that Community Reinvestment decisions are rooted in the needs of the community.

Health Plan Engagement
Partnership will engage and coordinate with Kaiser Permanente to align investment planning processes and maximize the collective impact of our corresponding funds.

Initial Community Reinvestment Plan
Every three-year investment period, Partnership will detail the composite set of proposed community reinvestment activities including (but not limited to):

- A detailed description of the anticipated Community Reinvestment activities and their related use category or categories.
- A description of how activities are directly informed by community need identified through the LHJ CHA process.
- If applicable, identification of the LHJ CHIP activity that each Community Reinvestment activity matches.
- If applicable, a description of community needs identified through the Behavioral Health Transformation~~HT~~ community planning process that the Community Reinvestment activity

addresses.

- ~~community planning process that the Community Reinvestment activity addresses.~~
- Anticipated benefits of Community Reinvestment activities (in alignment with criteria described in the "Guiding Principles" and "Community Reinvestment Categories" sections above).
- A description of the approach taken to engage the CAC in the Community Reinvestment planning process, including a summary of the CAC recommendations.
- A description of the approach taken to engage other interested stakeholders in the Community Reinvestment planning process, if any, and identification of those stakeholders.
- A description of any investments recommended by CACs not included in the Community Reinvestment Plan.
- A summary of input provided by Chief Health Equity Officers, and the QIHEC if applicable.
- The expected dollar amount allocated for each Community Reinvestment activity, based on the overall funding obligation for the applicable CY.
- The expected populations that will benefit from or participate in each Community Reinvestment activity.
- A description of how the impact of Community Reinvestment activities will be measured and evaluated.
- A signed attestation from local Public Health and County Behavioral Health Directors.

Subsequent Community Reinvestment Plan Submissions

Each subsequent community reinvestment plan within the investment period will indicate the allocation of additional investments for each activity documented in the initial community reinvestment plan for funding obligations resulting from positive net income for the applicable year. Every future three-year investment period, Partnership will detail the composite set of proposed community reinvestment activities including (but not limited to):

- The expected dollar amount allocated for each Community Reinvestment activity in the initial Community Reinvestment Plan approved by DHCS based on funding obligations for the applicable CY.
- A signed attestation from local Public Health and County Behavioral Health Directors.

Communication

The DHCS-approved Community Reinvestment Plan will be posted on the websites and use DHCS-recommended use templates. Also, Partnership will post a Community Reinvestment Report on our website, using templates included in APL 24-016 in Q2 CY 2030 and every three years thereafter.

CULTURALLY & LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

Partnership is committed to delivering Culturally and Linguistically Appropriate Services (CLAS) to all eligible beneficiaries. Partnership's Health Education team regularly assesses and documents member cultural and linguistic needs in the C&L Program Description to determine whether covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. The Health Education team also ensures that all culturally and linguistics services are provided in an appropriate manner through the C&L Program Description.

The Population Health department is responsible for the operation and implementation of the C&L Program Description and associated work plan. Additionally, key internal committees with community members (e.g., CAC, QIHEC, FAC) provide feedback on the development and implementation of culturally and linguistically accessible services.

Partnership monitors and evaluates the effectiveness of cultural and linguistic services by reviewing and responding to: CAHPS, member grievances and appeals, reports of utilization of interpreter services by language, provider assessments, and facility site reviews.

QUALITY IMPROVEMENT AND HEALTH EQUITY ANNUAL WORK PLAN

The QI and Health Equity Annual Work Plan will be used to strategize, prioritize, and track progress on equity-related initiatives throughout the year. Specifically, the QI and Health Equity Annual Work Plan will provide a comprehensive assessment of the QI and Health Equity activities, undertaken by Partnership, to evaluate effectiveness of Health Equity-related QI interventions.

The QI and Health Equity Annual Work Plan describes population-based Health Equity measured objectives, timelines, and accountable Partnership employees for each activity. It includes progress updates on planned activities and objectives for achieving internal measures of equity in context of clinical care, safety of clinical care, quality of service, and member experience. Forms for providing status updates are sent to staff one month in advance of the semi-annual and annual update deadlines to be completed by work plan contributors. Finally, the Work Plan will be reviewed annually by Q/UAC and approved by PAC and the Board of Commissioners.

The QI and Health Equity Annual Work Plan will also evaluate delegated subcontractors' and downstream fully delegated subcontractors' performance measure results and evaluate actions to mitigate any identified deficiencies.

ANNUAL PROGRAM EVALUATION

The overall effectiveness of the Quality Improvement and Health Equity Transformation Program is annually evaluated and approved at Q/UAC, PAC, and the Commission. The annual QIHETP Program Evaluation includes:

- Clinical Quality of Physical and Behavioral Health
  - Annual assessment of key HEDIS MCAS measures with stratification to race/ethnicity, primary language, gender identify, and/or age
- Member Experience
  - Annual assessment of key CAHPS measures with stratification to race/ethnicity and primary language
  - Analysis of CAC findings and strategy to increase member listening session-like activities
- Access and Engagement of Providers, Community – Access – Respect – Engagement – Service (CARES) Training provided by Partnership, which includes core trainings that cover diversity, equity and inclusion (DEI) and transgender, gender diverse, intersex (TGI) competency.
  - Review submitted data of annual CARES training (sensitivity, diversity, communication skills, and cultural competency training) for staff via internal human resources department
  - Review submitted data of transgender, gender diverse, intersex (TGI) cultural competency training program completion for staff via internal human resources department
  - Review submitted data of CARES training (sensitivity, diversity, communication skills, and cultural competency training) for network providers from the provider relations department per APL 24-016. Per internal Credential and Re-credential decision making process policy, a negative response on a provider attestation regarding completion of training, on credentialing criteria for practitioners, will trigger a file review
- Continuity and Coordination Across Settings and all levels of care
  - Analysis and evaluation of interventions to address both over- and under-utilizations of services and interventions
- Health Equity Promotion in Quality Improvement and Population Health
  - Analysis and evaluation of equity-related programs, initiatives and QI-related work as well as the overall effectiveness of the QI/PI program and of its progress toward influencing network-wide safe clinicalpractices
  - Analysis of county and region specific population needs assessment data
  - Analysis of community partnerships with local health departments, community based organizations, nonprofit organizations, etc.
- Community Reinvestment Plan
  - Community Reinvestment Plan for each investment period
    - DHCS calculated minimum community reinvestment funding obligations required
    - Composite set of proposed community reinvestment activities by county served and expected dollar amount allocated for each community reinvestment activity
    - Description of approach taken to engage with CAC and QIHEC
    - Measurement, analysis and evaluation of community reinvestment programs initiatives (e.g. qualitative description of benefits to Members)
  - Community Reinvestment Analysis
    - The actual dollar amount spent on each Community Reinvestment activity by county.
    - Description of each Community Reinvestment activity by category and county.

    - Description of how each Community Reinvestment activity aligns with DHCS' Guiding Principles.
    - Description of how each Community Reinvestment activity aligns with designated Reinvestment categories
    - Outcomes from Community Reinvestment activities, including any preliminary data and qualitative description of benefits to Members and the communities in which they reside
    - Signed letters from the CAC with descriptions of the degree to which Partnership engaged with CAC members in planning efforts and clarification on how their feedback was integrated with reinvestment activities.
- Regional Quality and Health Equity Team Compositions
    - Names and Roles of Partnership Team Members per region for quality and health equity
    - Identity of key network providers, county behavioral health plans, local health departments, community-based organizations, local government agencies, First 5 programs, etc. per disparity priority
- Administrative
    - The annual QI and Health Equity Work Plan goals and associated deliverables are informed by the QIHEC. If there are opportunities for improvement identified in the evaluation of prior year initiatives and work conducted to support the goals of the quality improvement program, these opportunities are translated into goals with actionable deliverables for the next year's work plan. The results in the annual QI and Health Equity Program Evaluation, particularly those tied to the need to revisit allocated resources, for committees, standing programs and other related activity are assessed and if changes are deemed necessary, they are reflected in the program in the subsequent year.
    - Strategy of sharing annual program evaluation with various subcontractors, downstream subcontractors, and network providers
    - Analysis of actions taken to address any recommendations in the annual external quality review technical report
    - Analysis of annual reports of any subcontractors' and downstream subcontractors' performance of delegated health equity activities. Each subcontractor's health equity officer/liaison will be required to submit an annual performance report to Partnership
    - NCQA Health Equity Accreditation Status
    - Annual Summary of QIHEC activities

The following are separate evaluations and not included in the QI and Health Equity Annual Work Plan Evaluation:

- Evaluation of cultural and linguistic competency work plan activities
- Evaluation of Utilization Management and Care Coordination activities
- Evaluation of Member grievance and appeals

Preparation for the Annual Program Evaluation involves participation by all QIHETP leadership including but not limited to:

- Chief Medical Officer
- Chief Health Services Officer
- Health Equity Officer
- Senior Director of Quality and Performance Improvement

The QI and Health Equity Plan will be made available on the Partnership website on an annual basis

NON-DISCRIMINATION STATEMENT

Partnership complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

Partnership will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available. Also, Partnership will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

Partnership provides access to staff for members and practitioners seeking information about the UM process and the authorization of care in the following ways:

- Calls from members are triaged through Member Services staff who are accessible to practitioners and members to discuss UM issues during normal working hours when the health plan is in operation (Monday - Friday 8 a.m. - 5 p.m.).
- After normal business hours, Members and Providers may contact the Partnership voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
- After normal business hours, members may contact the advice nurse line at (866) 778-8873 for assistance with clinical concerns.
- Practitioners, both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
    - Partnership has a dedicated after-hours phone number local (707) 430-4808 or toll free (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's Chief Medical Director or physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a member whose emergency medical condition is stabilized.
- Partnership UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
- Partnership maintains a toll free number (800) 863-4155 that is available to both members and practitioners.
- Members can view information about Partnership's language assistance services and disability services in the Member Handbook which is made available to members upon enrollment and is always viewable online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf

Additionally, Partnership provides annual written notice to Members about our language assistance services and disability services (e.g., TTY for hearing impaired) in our Member Newsletter.

Linguistic services are provided by Partnership to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries as well as eligible members with sensory impairment for population groups as determined by contract. These services include the following:

No Cost Linguistic Services

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
- Written information and materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated by qualified translators into threshold languages for Partnership Members according to regulatory timeframes, and into other languages or alternative formats upon request. Alternative material formats include audio, large print and electronically for members with hearing and/or visual disabilities. Braille versions are available for members with visual disabilities. Auxiliary aids are also available upon request. Please refer to MCND9002 Cultural and Linguistic Program Description for more information. The organization may continue to provide translated materials in other languages represented by the population at the discretion of Partnership, such as when the materials were previously translated or when translation may address Health Equity concerns.
- Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735-2929 or 711]

Partnership regularly assesses and documents member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization. (See policy MCND9002 *Cultural and Linguistic Program Description*)

REFERENCES

1. Department of Health Care Services (DHCS) standards

	08/20/25

Robert Moore, MD, MPH, MBA *Date Approved*
Quality/Utilization Advisory Committee Chairperson

	09/10/25

Angela Brennan, DO *Date Approved*
Physician Advisory Committee Chairperson

	10/22/25

Kim Tangermann *Date Approved*
Board of Commissioners Chairperson

this page left blank

QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHETP) PROGRAM DESCRIPTION

MCED6001

September 2025

Origination Date: 11/08/2023 Effective Date: 03/03/2024
Physician Advisory Committee (PAC) Approved: 11/12/24; 09/10/25

TABLE OF CONTENTS

Program Purpose and Goals 1
Program Objectives 2
Authority and Responsibility 3
Program Staff 3
Committees 5
Quality and Performance Improvement Collaboration 9
NCQA Accreditation Program Management 10
Data Sources 11
Culturally & Linguistically Appropriate Services (CLAS) 18
Quality Improvement and Health Equity Annual Work Plan 19
Annual Program Evaluation 20
Non-Discrimination Statement 22
References 24

PROGRAM PURPOSE AND GOALS

Partnership HealthPlan of California (Partnership) is a County Organized Health System (COHS) contracted by the State of California to provide Medi-Cal beneficiaries with a health care delivery system to meet their medical needs.

The mission of Partnership HealthPlan of California is "To help our Members, and the Communities we serve, be healthy." Our vision is to be "the most highly regarded health plan in California." Partnership believes in fostering strong partnerships with members, providers, and community leaders to collectively improve health outcomes; focusing on continuous quality improvement in every aspect of the organization and in collaboration with our partners; and promoting diversity by accepting, respecting, and valuing individual differences and capitalizing on the diverse backgrounds and experiences of our members, community partners, and staff.

Partnership's defining focus is ensuring the highest quality of care, positive health outcomes, and timely access to care for all diverse members (i.e., Quality, Access, and Equity). Therefore, Partnership has developed program descriptions and policies to describe the structures needed to promote health equity. Specifically, Partnership has implemented the Partnership Quality Improvement and Health Equity Transformation Program (QIHETP).

The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system to address improvements in the quality of care delivered by all of its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to members. The Partnership QIHETP serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare services
- Ensure that healthcare service is delivered at the appropriate time and in an equitable manner

The Partnership QIHETP provides a reliable and credible mechanism to review, monitor, evaluate, recommend, and implement actions that acknowledge health equity.

The Partnership QIHETP serves as an organized framework to:

- Review and develop equity-focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services by engaging with a member and family-centric approach
- Review activities and identify opportunities to improve health equity throughout Partnership with oversight and participation of the governing Board of Commissioners and the Quality Improvement and Health Equity Committee (QIHEC)
- Promote participation from a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers for QIHETP development and performance reviews
- Review health equity-related training activities and validate that the trainings review the impact of structural and institutional racism and health inequities on members, staff, network providers, subcontractors, and downstream subcontractors per Department of Health Care Services (DHCS) published All Plan Letters (APLs) regarding diversity, equity and inclusion (DEI) training.

PROGRAM OBJECTIVES

The Partnership QIHETP serves to ensure that appropriate, high quality cost-effective utilization of health care resources is available to all members while being cognizant of health care disparities and inequities. This is accomplished through the systematic and consistent application of management processes based on current health equity review literature and expert opinion when needed. The scope of the QIHETP includes the quality of clinical care and services for all members receiving Medi-Cal healthcare services from Partnership. The monitoring and evaluation of clinical issues reflects the population served by Partnership without regard to social drivers of health (SDOH), age group, disease category, or risk status. In alignment with other Partnership departments, the QIHETP encompasses all aspects of medical and behavioral healthcare including:

- Identifying and addressing racial/ethnic and other disparities in health care delivery or outcomes
- Identifying overuse, misuse, and underuse of health care services and prescription medications
- Evaluating clinical quality of physical health care
- Evaluating clinical quality of behavioral health care focusing on prevention, recovery, resiliency, and rehabilitation
- Identifying and addressing equitable access or quality issues related to behavioral health services through delegated contracts
- Ensuring access to primary and specialty health care providers and services
- Ensuring availability and regular engagement with primary care providers (PCPs)
- Evaluating continuity and care coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent provider-patient relationships
- Evaluating member experience with respect to clinical quality, access, and availability and culturally and linguistically competent health care and services, and continuity and care coordination
- Promoting cultural and linguistic competence of Partnership staff and network practice sites and providers

The QIHETP program accomplishes these goals by:

- Systematically monitoring and evaluating services and care provided by conducting quantitative and qualitative data collection. Using this data and various statistical analyses, Partnership will make data-driven decisions
- Identifying, evaluating, and reducing health disparities utilizing internal reports, reflecting utilization management, quality improvement, member satisfaction (Consumer Assessment of Healthcare Providers and Systems [CAHPS®]), care coordination, grievance and appeals, and population health activities to ensure services are provided equitably.
- Actively conducting systematic searches for tertiary and primary medical literature to ensure decisions are based upon up-to-date evidence in the health equity discipline
- Actively pursuing opportunities for improvement in areas that are relevant and important to Partnership members' health
- Implementing strong and sustainable interventions when opportunities for improvement are identified for addressing a health disparity

AUTHORITY AND RESPONSIBILITY

Board of Commissioners

The Board of Commissioners on Medical Care (the Commission) promotes, supports, and has ultimate accountability, authority, and responsibility for a comprehensive and integrated Quality Improvement and Performance Improvement (QI/PI) programs. The Commission is ultimately accountable for the quality of care and services provided to members. The Commission has delegated direct supervision, coordination, and oversight of the QI/PI program to the Physician Advisory Committee (PAC), which serves as the main Quality Improvement committee. PAC is supported by two other quality committees – the Quality and Utilization Advisory Committee (Q/UAC) and the Internal Quality Improvement Committee (IQI), which are described in more detail below. The county Boards of Supervisors for each geographic area appoints members of the Commission, which include representation from the community: consumers, businesses, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health departments. The Commission meets six times per year.

The purpose of the Commission is to arrange for the provision of health care services to qualifying individuals, as well as other purposes set forth in the enabling ordinances established by the respective counties.

Key Roles

The following leadership roles carry authority and responsibility to ensure the QIHETP Program is fully implemented and maintained. The qualifications of staff presently fulfilling these roles are detailed in Appendix D (included with QI Trilogy submission) which includes documented evidence corresponding to that collected annually on behalf of DHCS. Given the personal details included, this appendix is not posted publicly.

PROGRAM STAFF

Chief Medical Officer

The Chief Medical Officer (CMO), with the assistance of the members of PAC, Q/UAC, and IQI, as well as the other medical directors of Partnership, is responsible for providing professional judgment regarding matters of quality of care, peer review, clinical, and medical procedures. The CMO is the chair of IQI and Q/UAC and has significant involvement in all QI/PI, Pharmacy, and Health Services activities as well as providing oversight to these programs on a day-to-day basis. The CMO is a Medical Doctor (MD) or Doctor of Osteopathy (DO) with an unrestricted license in the State of California.

Chief Health Services Officer

The Chief Health Services Officer (CHSO) works closely with leaders in Utilization Management to provide accountability for delegates to meet necessary National committee for Quality Assurance (NCQA) accreditation requirements and provide strategic leadership and guidance in the review and revision of provider contracts to ensure QI reporting requirements and value-based program contingencies are met. The CHSO also has purview over the Care Coordination, Utilization Management, Enhanced Health Services, Behavioral Health and Health Equity departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The CHSO's level of involvement fulfills the need for executive

support and accountability for improvements with data quality, and coordination of activities between QI and these departments. Collaborates with the Chief Medical Officer and members of PAC, Q/UAC, and IQI in matters involving quality of care, clinical, and medical procedures.

Director of Health Equity (Health Equity Officer)
The Director of Health Equity serves as the Health Equity Officer (HEO) for Partnership. In collaboration with Partnership leaders, the Director of Health Equity leads the development and implementation of strategies that advance health equity across our network diversity, equity, and inclusion across the organization. This role drives systemic change to enhance representation and cultivates programs that foster a culture of belonging. This role provides oversight, strategic direction, and support for improving quality measure performance and member experience in specified cultural, linguistic, economic, educational, etc. groups in our community and workforce. In collaboration with the CMO, oversees the Quality Improvement and Health Equity Transformation Program (QIHETP) program operations and assists in the development and coordination of QIHETP policies and procedures. This role also leads the development and management of the diversity, equity, and inclusion and gender-affirming care training programs.

Medical Director for Quality
Assists CMO by providing physician support for varying activities within the QI/PI department, including Performance Improvement, Member Safety, Peer Review, and the Quality Incentive Programs, as well as assists with utilization management review activities. This role also serves as management oversight for the Member Safety teams within the QI/PI department.

Senior Director of Quality and Performance Improvement
This role works collaboratively with the CMO to define strategy, develop programs and services, and to evaluate the effectiveness of the QI/PI Program. Together with the QI management team, including the Medical Director for Quality, provides oversight of Facility Site Reviews, investigation of potential quality issues, compliance with NCQA standards, Healthcare Effectiveness and Data Information Set (HEDIS®) and other performance measure data collection and performance reporting, value-based payment programs (QIPs), performance improvement initiatives and programs, external and internal QI training, provider education on the QIPs and HEDIS®, grant application and grant management. This role works to foster greater cross collaboration of QI staff and strategic involvement of other departments to support the execution of tactics defined and maintained under Partnership's 5-Star Quality Strategy.

Director of Population Health Management
The Director of Population Health Management works collaboratively with leaders across the organization, to execute the organization's Population Health Management strategy. This role provides oversight, strategic direction, and support for related initiatives, including those essential to improving quality measure performance and member experience. This role offers guidance and ensures alignment with health care policies, financing, accreditation requirements, and regulations to drive optimal health outcomes for members.

Behavioral Health Clinical Director
The Behavioral Health Clinical Director holds an MD/DO, PhD or PsyD credential. With the assistance of the Behavioral Health team, this individual is responsible for providing professional judgment regarding matters of quality of care, peer review, and clinical policies and procedures through oversight

of Partnership activities in the areas of mental health and substance use disorder services as provided by Partnership's delegated behavioral health providers.

Administrative Assistant
Under the direction of the Health Equity Officer (HEO) or other designated leadership, provides administrative support to the Health Equity Officer Director and/or other QIHETP Leadership. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

- Tracks project deliverables and resources using appropriate internal tools to ensure deadlines are met
- Coordinates the QIHEC meetings

Project Coordinator I

Oversees timelines and deliverables for department projects. Provides routine and ad hoc reporting for key Population Health activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Supports ongoing audit readiness activities by maintaining structures around audit deliverables, meeting minutes, and the file retrieval system.

- Uploads and maintains policy documents in PowerDMS

COMMITTEES

Board of Commissioners
The Board of Commissioners on Medical Care (the Commission) promotes, supports, and has ultimate accountability, authority and responsibility for a comprehensive and integrated QIHETP program. The Commission is ultimately accountable for the efficient management of healthcare resources and services provided to members. The Commission has delegated direct supervision coordination, and oversight of the QIHETP program to the Q/UAC which reports to the PAC, the committee with overall responsibility for the program. Members of the Commission are appointed by the county Boards of Supervisors for each geographic service area and include representation from the community, consumers, business, physicians, providers, hospitals, community clinics, HMOs, local government, and county health departments. The Commission meets six times a year.

Quality/Utilization Advisory Committee (Q/UAC)
The Q/UAC is responsible to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing systematic evaluation and monitoring process that facilitates continuous quality improvement. Q/UAC voting membership includes consumer representative(s) and external providers who are contracted primary care providers (PCPs) and board certified specialists in the areas of internal medicine, family medicine, pediatrics, OB/GYN, neonatology, behavioral health, and representatives from other high volume specialties. The Partnership Chief Medical Officer (CMO) (chair of the committee), Clinical Director of Behavioral Health, Health Equity Officer, Medical Director for Quality, Associate and Regional Medical Directors and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, Care Coordination, Population Health, Health Equity, Pharmacy, and Grievance departments attend the Q/UAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The

committee meets monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to the PAC and at least quarterly to the Commission. The Q/UAC provides guidance and direction to the QIHEC by functioning as the expert reviewing panel as follows:

- Reviewing, making recommendations to, and approving the *QIHETP Program Description* annually
- Analyzing summary data and making recommendations for action
- Reviewing action plans for quality improvements of QIHETP activities and providing ongoing monitoring and evaluation

Quality Improvement and Health Equity Committee (QIHEC)

Partnership's QIHEC is overseen by the Quality/Utilization Advisory Committee (Q/UAC) and the Physicians Advisory Committee (PAC), which subsequently reports to our governing Board of Commissioners. The QIHEC analyzes and evaluates the results of Health Equity-related Quality Improvement activities. Specifically, QIHEC will conduct an annual review of the results of key health equity-related data to provide plan-wide recommendations (e.g.,, generate policy recommendations) to address health-equity performance deficiencies. The QIHEC ensures appropriate assessment of interventions, measurement, and follow-up of identified performance deficiencies. The QIHEC responsibilities include the following:

- Analyze and evaluate the results of clinical quality performance measures related to Health Plan Ratings (HPR), as specified by NCQA Health Equity Accreditation (HEA) standards, as mandated by DHCS, or due to poor performance trending on the DHCS Managed Care Accountability Set (MCAS) (with stratification by race/ethnicity and language):
  - Assigned Health Effectiveness Data & Information Set (HEDIS®) Measures
  - Consumer Assessment of Healthcare Providers and Systems [CAHPS®]
- Analyze utilization data (types of services, denials, deferrals, modifications) with stratification by race/ethnicity and language
- Analyze utilization data of language services and experience with language services with stratification by language.
- Analyze and evaluate the results of member satisfaction surveys, Grievance and Appeal surveys, and care coordination-based surveys with stratification by race/ethnicity and language
- Analyze and evaluate the strategy and work plans presented by internal committees to ensure that clinical quality performance measures (with stratification by race/ethnicity and language) and member satisfaction are evaluated and attended to in prospective work plans
- Analyze and evaluate feedback from member representative committees (e.g., Community Advisory Committee, Family Advisory Committee)
- Recommend Managed Care Plan (MCP)-related interventions (e.g., education, programs, etc.) for various departments to address key clinical quality performance deficiencies (e.g., HEDIS, CAHPS, etc.) per the scope of work of managed care plans.

Partnership's QIHEC membership will consist of the following key members, who subsequently will report directly to Q/UAC:

- Chief Medical Officer or CMO Designee (e.g., Medical Director)
- Health Equity Officer
- Chief Operating Officer
- Internal Leadership from following departments: Health Analytics, QI/PI, Provider Relations, Utilization Management, Member Services, Care Coordination, and Population Health

In addition, the Partnership's QIHEC membership will be composed of representatives from our Providers, health plan subcontractors, and health plan downstream subcontractors, who provide health care services to members affected by health disparities, members who are considered to have Limited English Proficiency (LEP), members with children with special health care needs (CSHCN), members who are considered to be Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions. Example entities from which representatives will be drawn include, but are not limited to, hospitals, clinics, county partners, physicians, subcontractors, downstream subcontractors, network

providers, and Partnership members. The QIHEC meeting minutes, findings and recommendations will be reported directly to the Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC), and Partnership's Board of Commissioners. Also the QIHEC will report findings to our various other internal committees (e.g., CAC, FAC, etc). Partnership's Confidentiality Policy (CMP-10) provides guidance to ensure avoidance of conflict of interest among committee members and ensure that member confidentiality is maintained throughout QIHEC-related meetings.

Population Health Needs Assessment (PNA) Committee
The Population Health Needs Assessment Committee (PNA) is an internal committee and serves as a multi-departmental body whose goal is to support the advancement, growth, and execution of population health and health equity interventions at Partnership. The committee consists of Partnership staff representing member, community, regional, and provider-facing departments; it also incorporates representatives from Human Resources, Regulatory Affairs, IT, and Health Analytics. The committee meets every other month to align interdepartmental efforts promoting health equity through member and systemic interventions outlined in the relevant Needs Assessment (PNA) Action Plans. The PNA Committee activities and recommendations will be shared with the, Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), QIHEC, Physician Advisory Committee (PAC) and Partnership's Board of Commissioners..

Family Advisory Committee (FAC)
The Family Advisory Committee (FAC) is a member advisory group to the CEO and staff of Partnership. The FAC provides a forum for parents, guardians and caregivers of children with California Children Services (CCS) conditions to discuss common issues of interest and importance, to create a supportive and informative networking environment and to advocate for members by ensuring that Partnership is responsive to the diversity of health care needs for all members. Minutes from FAC meetings are reviewed by the Pediatric Quality Committee (PQC). The FAC membership is comprised of representatives from throughout Partnership's geographic service areas who advocate for CCS-eligible children of diverse cultures, ethnicities, genders, ages and disabilities. Meetings are held at least four (4) times per year with the option for additional meetings as needed

Community Advisory Committee (CAC)
The Community Advisory Committee (CAC) is composed of Partnership health care consumers who represent the diversity and geographic areas of Partnership's membership including hard-to-reach populations. The CAC is a liaison group between members and Partnership, advocating for members by ensuring that the health plan is responsive to the health care and information needs of all members. The CAC meets quarterly, reviews and makes recommendations regarding Member Services' quality improvement activities, provides feedback on quality and health equity initiatives, and serves in the capacity of a focus group. A CAC member(s) serve(s) on the Partnership Board to provide member input and report back to the CAC.

QUALITY AND PERFORMANCE IMPROVEMENT COLLABORATION

The Health Equity department works collaboratively with the Quality and Performance Improvement (QI/PI) department to enhance the care provided to our members through venues such as the Internal Quality Improvement Committee (IQI), the Quality/ Utilization Advisory Committee (Q/UAC) and daily QIHETP activities.

In the committee environment, the Health Equity department takes an analytical, evaluative and strategic look at predetermined metrics to evaluate and offer recommendations which further enhance the QIHETP program. Data is reviewed and discussed annually during the IQI and Q/UAC meetings. The Q/UAC provides guidance and direction to the QIHETP program by coordinating major activities and by functioning as the expert panel when needed. Collaboration includes but is not limited to:

- Reviewing, making recommendations to, and approving the *QIHETP Program Description* annually
- Analyzing summary data and making recommendations for action
- Reviewing the recommendations of QI's Performance Improvement Teams to develop QIHETP improvement action plans specific to clinical quality measure performance with on-going monitoring and evaluation. The QI/PI department is often the lead for many improvement efforts, particularly those that are mandated or due to poor performance on the Managed Care Accountability Set (MCAS), which is the set of measures that DHCS selects for annual reporting by Medi-Cal managed care health plans. This can include mandated improvement efforts to meet disparity reduction targets for specific populations and/or measures as identified by DHCS. The QI/PI department also takes the lead on mandated Performance Improvement Projects (PIPs) that are assigned by DHCS. PIPs are led by the QI/PI program based on criteria defined by DHCS and overseen by the California External Quality Review Organization (EQRO), and include at least annual status reports to DHCS
    - Recommending improvements to enhance health equity language in Partnership policies and protocol according to QIHETP standards

For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the Health Equity department supports ongoing quality improvement efforts in the identification of potential quality or equity of care issues, improvement of HEDIS quality measures in context with social drivers of health. For member-facing improvement efforts, CAC and other member focus groups are often consulted.

NCQA Accreditation Program Management

Partnership strives to improve the health status of members and their care experience to become one of the highest quality health plans in California. NCQA Health Plan Accreditation supports Partnership's vision, mission, and strategic goals byproviding a rigorous and comprehensive framework for essential quality improvement, operational excellence, and measurement of clinical performance (HEDIS) and member experience (CAHPS).

Per the 2024 DHCS contract, all managed care plans (MCPs), including Partnership, are mandated to achieve both NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation (HEA) by Jan. 1, 2026. Partnership successfully achieved HPA reaccreditation on Dec. 18, 2023.. In order to maintain NCQA Health Plan Accreditation, Partnership was required to report annual results starting in June 2022. Partnership earned a Health Plan Rating (HPR) of 3.5 stars in June 2023 based on HEDIS/CAHPS performance from MY 2022/RY 2023. NCQA released Partnership's current HPR of 3.5 stars in September 2024.

Partnership's defining focus is ensuring the highest quality of care, positive health outcomes, and timely access to care for all diverse members (i.e., Quality, Access, and Equity). NCQA Health Equity Accreditation (HEA) complements Partnership's overall mission by encouraging managed care organizations to establish a foundation of health equity work. Specifically, the HEA encourages the focus on building an internal culture that complements external health equity work with our population health management department; collecting relevant data that provides insight on how to ensure appropriate representation in language services and providers; identifying and categorizing inequities to guide future population health-based interventions

Partnership will be submitting first survey documentation, to obtain the NCQA Health Equity Accreditation (HEA), by June 2025.

DATA SOURCES

DHCS Bold Goals

To have a context of Health Equity and align internal quality and health equity efforts with DHCS, Partnership will review the DHCS's Health Disparities Report and Bold Goals of 2025. Currently, The Bold Goals of 2025 are as follows:

- Close racial/ethnic disparities in well child visits by 50%
- Close racial/ethnic disparities in immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow up for mental health and substance use disorder by 50%

Partnership uses several methods to identify and evaluate member needs, and strategize how to address such needs by reducing health disparities.

Step 1: Sample Selection to Evaluate Disparities
Partnership initially utilized Measurement Year 2023 (MY 2023) MCAS final sample measures (n=186 to 167,450 members) to evaluate each of the clinical measures of focus. The rates for each measure are comprised of the members included in each measure's audit for Partnership's Health Plan Accreditation Plan-wide summary of performance report. The random member sample that was generated for each hybrid measure and full member denominator along with member race/ethnicity demographic information, was provided by Partnership's HEDIS vendor, Inovalon. Inovalon has been classified as a direct data source.

Step 2: Statistical Analysis to Identify Key Disparities
After receiving the data from Inovalon, members from Partnership's Health Analytics team conducted various statistical analyses. The Chi-Square and Fisher's Exact statistical tests were utilized, based upon sample size, to determine if there were significant differences for the various categorical measure outcomes.

When analyzing disparities based upon race/ethnicity, Partnership conducted various statistical analyses using the White group as the key comparator group. When analyzing disparities based upon language, Partnership conducted various statistical analyses using the English language group as the key comparator group. Finally, when analyzing disparities based upon gender, Partnership conducted various statistical analyses using the Male gender identity group as the key comparator group. A statistically significant difference was classified as a p value less than 0.05 when comparing the categorical outcomes of one group versus the key comparator group, respectively (i.e., White, English-speaking, Male). These comparators were identified based upon various literature suggesting that such groups, respectively, have had significantly more political, economic, and/or social advantages within the United States (Malat et al., 2018). Data, that were excluded from the evaluation, were findings from patients who reported "Unknown" in race, language, and gender identity.

Step 3: Analysis of Measures
Partnership also reviewed the performance of each race/gender identity/linguistic group in comparison

to the MCAS benchmarks to assess not only how each group performed statistically in comparison to the White/Male/English speaking group, but also in comparison to the national Medicaid benchmarks. In MY 2023, DHCS is holding managed care plans (MCPs) accountable and imposing sanctions on selected Hybrid and Administrative measures performing below the minimum performance level (MPL) (50th national Medicaid percentile) by reporting region, and as a result, Partnership thought it valuable to assess how each group is performing in comparison to that benchmark to assess whether group performance could also have an impact on accountable measures.

Step 4: Prioritization of Disparities

The HEO, CMO, and members of the QI/PI team reviewed the information supplied about health disparities and draft a preliminary report of disparity metrics to prioritize based upon clinical measure stratification, statistical or clinical findings, size of the disparity, strength of evidence, feasibility, and return of investment. An established baseline will be developed for each group to follow for the next 3 to 5 years to evaluate long-term impact. The team will identify the key disparity priorities per region and per population of key racial/ethnic, gender, or linguistic groups.

Step 5: Distribution of Disparity Data for Community Feedback

The preliminary report will be shared with relevant internal committees (e.g., CAC, FAC etc), corresponding providers, health plan subcontractors, and health plan downstream subcontractors, via their corresponding QIHEC representative or newsletter. The goal will be to solicit feedback to ensure we have identified disparities that may not have been captured during our internal data analysis and identify strategies to address the disparities in respective communities. The Health Equity department will review internally submitted community needs assessment information to increase the likelihood of receiving credible information from community leaders and CAC/FAC/QIHEC members. Also, the Health Equity department will review feedback from members, parents, and/or caregivers to ensure that the community is given an opportunity to engage in the development of quality improvement and health equity activities and suggest interventions that will likely work in their respective communities. The advisory feedback will be transcribed and shared with the Health Equity department.

The Health Equity department will review the solicited findings from QIHEC, CAC, FAC, providers, health plan subcontractors, and health plan downstream subcontractors and share the results to the QIHEC for final approval of the key Partnership health equity priorities to share with the overall organization to serve as guidance for various departments and activities (e.g. PNA, QIP, etc.).

Step 6: Distribution of Disparity Data into Department Activities

Quality Improvement

For internal QI/PI related activities, the Health Equity department, in collaboration with the QI/PI team, will ensure that HEDIS/CAHPS–associated disparities (e.g. racial, ethnic, linguistic, disability, SOGI, etc.) are specifically being addressed in QI/PI programs (e.g., value-based payment programs, provider improvement plans, Corrective Action Plans (CAPS) etc.). Specifically, the QIHETP and QI/PI teams will review the internal value based payment programs (e.g., primary care provider quality improvement program (PCP QIP), hospital quality improvement program, (HQIP) etc.) and performance improvement projects to assess whether adjustments need to be made to ensure the projects can address HEDIS/ CAHPS –associated disparities. For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the Health Equity department supports ongoing QI/PI efforts in the identification of potential quality or equity of

care issues, improvement of HEDIS quality measures in context with social determinants of health. The QIHETP and QI/PI teams will collaborate to develop QIHETP improvement action plans specific to clinical quality measure performance with on-going monitoring and evaluation. Finally, the QIHETP and QI/PI teams will share data with NCQA team members to validate that disparity reduction goals/targets are compliant with NCQA HEA standards.

The QIHEC will review, among other reports, the updated QI/PI Program Evaluation to ensure that one or more HEDIS/CAHPS-associated racial disparity, HEDIS/CAHPS-associated linguistic disparity, or a mandated disparity reduction target for specific populations and/or measures as identified by DHCS has been addressed in response to findings from Partnership's annual QI Work Plan.

Population Health
For internal population-health specific activities, the QIHETP and Population Health teams will collaborate to generate a finalized report to help refine the various population health reports and analyses. (The PHM Strategy provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population served in the program. Specifically, teams will review tertiary and primary medical literature and health indices, review findings from other managed care organizations, collaborate with community key opinion leaders or subject matter experts, and survey members of the CAC and FAC to find credible interventions that can be executed by a managed care organization based upon the synthesized findings of the preliminary report. The QIHETP and Population Health and Health Equity teams will review and assess corresponding social drivers of health metrics. t. Social determinants or drivers of health have been classified as conditions in various environments that affect health and overall quality-of-life outcomes

The QIHEC will review, among other reports, relevant Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) information, Population Health and Cultural and Linguistics (C&L)-associated work plans to ensure that one or more HEDIS-associated racial/ethnic disparity(ies), and one or more HEDIS-associated disparity(ies) related to one additional category of stratification (e.g., disability, geographical representation, etc.) is addressed based on the findings from the assessed reports. The QIHEC will also review reports regarding the utilization of language services, individual experience with language services, staff experience with language services, and member experience with language services during health care encounters to ensure that one or more interventions is identified and incorporated into work plan(s) to address one or more culturally and linguistically appropriate services (CLAS) disparity or HEDIS-associated linguistic disparity. The QIHEC will review these elements to ensure they correlate appropriately with Partnership's annual QI Work Plan.

Human Resources
For internal Human Resources (HR) related activities, the Health Equity department, in collaboration with the HR department, will review submitted data for annual DEI-related training for employees, network providers, etc. to ensure review of completion. Specifically, the QIHETP and HR team will review the annual training on culturally and linguistically appropriate practices to ensure they are teaching principles to reduce bias and promote inclusion. Also, QIHETP and HR team will review the annual training to validate that it meets all the criteria to be considered appropriate per any related APL set forth by DHCS. The QIHETP and HR team will also review internal recruiting and hiring processes to ensure they support diversity in staff leadership, committees, and governance bodies. Also, the Health Equity department will conduct an annual survey of the DEI satisfaction from staff, leadership,

governance bodies, and committees and solicit recommendations to improve the DEI or cultural humility of each.

The QIHEC will review, among other reports, the annual results of such DEI surveys to ensure that Partnership has acted on at least one opportunity identified to improve DEI for at least one group (staff, leadership, committees, or governance bodies). Also, the QIHEC will review annual employee demographic data to ensure that our internal recruiting and hiring process continues to support diversity in staff leadership, committees, and governance bodies.

For grievance and appeals-related activities, the Health Equity department, in collaboration with leadership from the Population Health and Grievance and Appeals departments, will review for any patterns of disparities in reported grievances. The QIHEC will review, among other reports, the updated PNA, Cultural and Linguistics (C&L) Program Description and Work Plan, and/or Grievance and Appeals-associated Work Plans to ensure that one or more CAHPS-associated racial disparity(ies) or CAHPS-associated linguistic disparity(ies) is addressed with a Work Plan action item.

Miscellaneous Contributors
For any subcontractors' and downstream subcontractors' QI and Health Equity activities, QIHEC will review report findings and actions on a quarterly basis during each QIHEC meeting. A summation of the results will be evaluated in the annual program evaluation.

Community Reinvestment Management
The Health Equity department will work with the Finances, Population Health, Behavioral Health, Project Management Operations departments to ensure the health plan reinvests a minimum level of our net income into our local communities. Community reinvestment planning will start in calendar year 2025, with community reinvestment activities starting in 2026 and follow a 3 year cycle to align with other DHCS-related initiatives (Community Health Assessment, Behavioral Health Transformation, etc.)

Partnership's Health Equity Officer and Health Equity team, will lead the management of the community reinvestment planning process to ensure all community reinvestment plans align with overall health equity needs and priorities. Also, the health equity team will ensure that the health plan and qualifying subcontractors' activities are based upon engagement with the community and community-identified priorities, with investments in health quality improvement and equity outcomes.

Data
Every 3 years, Partnership will review the following to make a preliminary assessment of community reinvestment landscape in our counties:

- PNA
- CHA/CHIP for each corresponding county
- Behavioral Health Transformation assessment for each county
- Health Equity Grand Analysis per QIHETP workplan

Funding Requirements
Partnership and qualifying subcontractors will define the base Community Reinvestment as the minimum level of net income that, if with positive net income, is required to invest into initiatives that serve the communities in which the Partnership operates, starting with net income based on Calendar year (CY) 2024 Contract Revenues for Community Reinvestment activities initiated in CY 2026.

- Partnership, since in multiple counties, will calculate the Base Community Reinvestment funding obligations with the following allocation methodology:
  - 5% of Base Community Reinvestment Funds equally across counties in which Partnership operates + 95% of Base Community reinvestment Funds in Proportion to Medi-Cal membership by county
- Partnership will allocate the base community reinvestment funds = (5% of the Partnership's or Qualifying Subcontractors annual net income that is less than or equal to 7.5% of Medi-Cal Contract Revenues/Subcontractor agreement for the year**)** + (7.5% of the Partnership's or Qualifying Subcontractor's annual net income that is greater than 7.5% of Medi-Cal Contract Revenues/subcontractor agreement for the year)
- The approved net income from Partnership will invest into initiatives in counties that do not meet minimum quality measure performance thresholds for the applicable year
- Partnership receives an Enforcement Tier 2 or Tier 3 assignment for the applicable calendar year for any county, it will reinvest at minimum an additional 7.5% of their annual net income into Community Reinvestment initiatives
  - ** For any county in which the Partnership is assigned to Enforcement Tier 2 or Tier 3, it will allocate 100% of our Quality Achievement Community Reinvestment funds toward investments in the "Cultivating Improved Health" category per the discretion of the corresponding public health and behavioral health officers
- Partnership will notify our Qualifying Subcontractors of their minimum Community Reinvestment funding obligations, and any corrections to such obligations, within 7 calendar days of notice from DHCS?
- Partnership and its Qualifying Subcontractors as applicable, will initiate investments in Community Reinvestment activities by no later than the close of the CY in which DHCS approves the initial Community Reinvestment Plan for the applicable investment period, and that Community Reinvestment funding obligations for each three-year investment period will be spent on specific activities included in the initial Community Reinvestment Plan by the end of the three-year period

Community Reinvestment Spending Categories (Inclusion/Exclusion Criteria)
Partnership's investments will be targeted toward reducing existing health disparities and/or promoting health outcomes for Medi-Cal populations through investments primarily focused on upstream causes of poor health such as housing instability, food insecurity, poverty, barriers to access to health and social services, and environments that negatively impact health.

Reinvestment spending may fall into at least one of the following categories but will be specific to each county's needs

- Cultivating Neighborhoods and Built Environment.
- Cultivating a Health Care Workforce.
- Cultivating Well-Being for Priority Populations.
- Cultivating Local Communities
- Cultivating Improved Health

Reinvestment spending may NOT fall into any of the following categories, regardless of the needs of the counties:

- Partnership Contract or Services carved out of the contract but covered under Medi-Cal (e.g. Pharmacy Benefit)
- Health care services inclusive of activities that improve health care quality or within the scope of Medi-Cal benefits or state-funded services
- Administrative activities of Partnership Health Plan (e.g. Employment, Meeting Scheduling, etc.)
- Administrative activities related to community reinvestment planning, implementation
- Member incentives or Grants
- Contract Activities

Local Health Jurisdiction (LHJ) and Behavioral Health Transformation Engagement
Partnership will engage with the community to ensure alignment with community reinvestment principles. Specifically, Partnership will engage at least quarterly meetings with corresponding public health and behavioral health officers in collaboration with the Population Health team to ensure alignment with community health assessment activities. Also, this will be implemented to ensure that local health jurisdiction and county behavioral health are included in community reinvestment planning and decision-making processes. Each reinvestment plan will solicit attestation from public health and county health directors to confirm that the investment strategy is generally agreeable to the LHJ and County Behavioral Health Department and aligns with community needs identified in the CHA / CHIP.

Community Engagement
Partnership will engage with the community to ensure alignment with community reinvestment principles. Specifically, Partnership will annually consult with our Community Advisory Committees (CACs), Quality/Utilization Advisory Committee (Q/UAC), and Quality Improvement and Health Equity Committee (QIHEC) to solicit Community Reinvestment recommendations. Also, Partnership may intermittently solicit feedback and insight from Members, community residents, community-based organizations, tribal organizations, providers, and other external stakeholders to ensure that Community Reinvestment decisions are rooted in the needs of the community.

Health Plan Engagement
Partnership will engage and coordinate with Kaiser Permanente to align investment planning processes and maximize the collective impact of our corresponding funds.

Initial Community Reinvestment Plan
Every three-year investment period, Partnership will detail the composite set of proposed community reinvestment activities including (but not limited to):

- A detailed description of the anticipated Community Reinvestment activities and their related use category or categories.
- A description of how activities are directly informed by community need identified through the LHJ CHA process.
- If applicable, identification of the LHJ CHIP activity that each Community Reinvestment activity matches.
- If applicable, a description of community needs identified through the Behavioral Health Transformation community planning process that the Community Reinvestment activity addresses.

- Anticipated benefits of Community Reinvestment activities (in alignment with criteria described in the "Guiding Principles" and "Community Reinvestment Categories" sections above).
- A description of the approach taken to engage the CAC in the Community Reinvestment planning process, including a summary of the CAC recommendations.
- A description of the approach taken to engage other interested stakeholders in the Community Reinvestment planning process, if any, and identification of those stakeholders.
- A description of any investments recommended by CACs not included in the Community Reinvestment Plan.
- A summary of input provided by Chief Health Equity Officers, and the QIHEC if applicable.
- The expected dollar amount allocated for each Community Reinvestment activity, based on the overall funding obligation for the applicable CY.
- The expected populations that will benefit from or participate in each Community Reinvestment activity.
- A description of how the impact of Community Reinvestment activities will be measured and evaluated.
- A signed attestation from local Public Health and County Behavioral Health Directors.

Subsequent Community Reinvestment Plan Submissions

Each subsequent community reinvestment plan within the investment period will indicate the allocation of additional investments for each activity documented in the initial community reinvestment plan for funding obligations resulting from positive net income for the applicable year. Every future three-year investment period, Partnership will detail the composite set of proposed community reinvestment activities including (but not limited to):

- The expected dollar amount allocated for each Community Reinvestment activity in the initial Community Reinvestment Plan approved by DHCS based on funding obligations for the applicable CY.
- A signed attestation from local Public Health and County Behavioral Health Directors.

Communication

The DHCS-approved Community Reinvestment Plan will be posted on the websites and use DHCS-recommended use templates. Also, Partnership will post a Community Reinvestment Report on our website, using templates included in APL 24-016 in Q2 CY 2030 and every three years thereafter.

CULTURALLY & LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

Partnership is committed to delivering Culturally and Linguistically Appropriate Services (CLAS) to all eligible beneficiaries. Partnership's Health Education team regularly assesses and documents member cultural and linguistic needs in the C&L Program Description to determine whether covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. The Health Education team also ensures that all culturally and linguistics services are provided in an appropriate manner through the C&L Program Description.

The Population Health department is responsible for the operation and implementation of the C&L Program Description and associated work plan. Additionally, key internal committees with community members (e.g., CAC, QIHEC, FAC) provide feedback on the development and implementation of culturally and linguistically accessible services.

Partnership monitors and evaluates the effectiveness of cultural and linguistic services by reviewing and responding to: CAHPS, member grievances and appeals, reports of utilization of interpreter services by language, provider assessments, and facility site reviews.

QUALITY IMPROVEMENT AND HEALTH EQUITY ANNUAL WORK PLAN

The QI and Health Equity Annual Work Plan will be used to strategize, prioritize, and track progress on equity-related initiatives throughout the year. Specifically, the QI and Health Equity Annual Work Plan will provide a comprehensive assessment of the QI and Health Equity activities, undertaken by Partnership, to evaluate effectiveness of Health Equity-related QI interventions.

The QI and Health Equity Annual Work Plan describes population-based Health Equity measured objectives, timelines, and accountable Partnership employees for each activity. It includes progress updates on planned activities and objectives for achieving internal measures of equity in context of clinical care, safety of clinical care, quality of service, and member experience. Forms for providing status updates are sent to staff one month in advance of the semi-annual and annual update deadlines to be completed by work plan contributors. Finally, the Work Plan will be reviewed annually by Q/UAC and approved by PAC and the Board of Commissioners.

The QI and Health Equity Annual Work Plan will also evaluate delegated subcontractors' and downstream fully delegated subcontractors' performance measure results and evaluate actions to mitigate any identified deficiencies.

ANNUAL PROGRAM EVALUATION

The overall effectiveness of the Quality Improvement and Health Equity Transformation Program is annually evaluated and approved at Q/UAC, PAC, and the Commission. The annual QIHETP Program Evaluation includes:

- Clinical Quality of Physical and Behavioral Health
  - Annual assessment of key HEDIS MCAS measures with stratification to race/ethnicity, primary language, gender identify, and/or age
- Member Experience
  - Annual assessment of key CAHPS measures with stratification to race/ethnicity and primary language
  - Analysis of CAC findings and strategy to increase member listening session-like activities
- Access and Engagement of Providers, Community – Access – Respect – Engagement – Service (CARES) Training provided by Partnership, which includes core trainings that cover diversity, equity and inclusion (DEI) and transgender, gender diverse, intersex (TGI) competency.
  - Review submitted data of annual CARES training (sensitivity, diversity, communication skills, and cultural competency training) for staff via internal human resources department
  - Review submitted data of transgender, gender diverse, intersex (TGI) cultural competency training program completion for staff via internal human resources department
  - Review submitted data of CARES training (sensitivity, diversity, communication skills, and cultural competency training) for network providers from the provider relations department per APL 24-016. Per internal Credential and Re-credential decision making process policy, a negative response on a provider attestation regarding completion of training, on credentialing criteria for practitioners, will trigger a file review
- Continuity and Coordination Across Settings and all levels of care
  - Analysis and evaluation of interventions to address both over- and under-utilizations of services and interventions
- Health Equity Promotion in Quality Improvement and Population Health
  - Analysis and evaluation of equity-related programs, initiatives and QI-related work as well as the overall effectiveness of the QI/PI program and of its progress toward influencing network-wide safe clinicalpractices
  - Analysis of county and region specific population needs assessment data
  - Analysis of community partnerships with local health departments, community based organizations, nonprofit organizations, etc.
- Community Reinvestment Plan
  - Community Reinvestment Plan for each investment period
    - DHCS calculated minimum community reinvestment funding obligations required
    - Composite set of proposed community reinvestment activities by county served and expected dollar amount allocated for each community reinvestment activity
    - Description of approach taken to engage with CAC and QIHEC
    - Measurement, analysis and evaluation of community reinvestment programs initiatives (e.g. qualitative description of benefits to Members)
  - Community Reinvestment Analysis
    - The actual dollar amount spent on each Community Reinvestment activity by county.
    - Description of each Community Reinvestment activity by category and county.

        - Description of how each Community Reinvestment activity aligns with DHCS' Guiding Principles.
        - Description of how each Community Reinvestment activity aligns with designated Reinvestment categories
        - Outcomes from Community Reinvestment activities, including any preliminary data and qualitative description of benefits to Members and the communities in which they reside
        - Signed letters from the CAC with descriptions of the degree to which Partnership engaged with CAC members in planning efforts and clarification on how their feedback was integrated with reinvestment activities.
- Regional Quality and Health Equity Team Compositions
    - Names and Roles of Partnership Team Members per region for quality and health equity
    - Identity of key network providers, county behavioral health plans, local health departments, community-based organizations, local government agencies, First 5 programs, etc. per disparity priority
- Administrative
    - The annual QI and Health Equity Work Plan goals and associated deliverables are informed by the QIHEC. If there are opportunities for improvement identified in the evaluation of prior year initiatives and work conducted to support the goals of the quality improvement program, these opportunities are translated into goals with actionable deliverables for the next year's work plan. The results in the annual QI and Health Equity Program Evaluation, particularly those tied to the need to revisit allocated resources, for committees, standing programs and other related activity are assessed and if changes are deemed necessary, they are reflected in the program in the subsequent year.
    - Strategy of sharing annual program evaluation with various subcontractors, downstream subcontractors, and network providers
    - Analysis of actions taken to address any recommendations in the annual external quality review technical report
    - Analysis of annual reports of any subcontractors' and downstream subcontractors' performance of delegated health equity activities. Each subcontractor's health equity officer/liaison will be required to submit an annual performance report to Partnership
    - NCQA Health Equity Accreditation Status
    - Annual Summary of QIHEC activities

The following are separate evaluations and not included in the QI and Health Equity Annual Work Plan Evaluation:

- Evaluation of cultural and linguistic competency work plan activities
- Evaluation of Utilization Management and Care Coordination activities
- Evaluation of Member grievance and appeals

Preparation for the Annual Program Evaluation involves participation by all QIHETP leadership including but not limited to:

- Chief Medical Officer
- Chief Health Services Officer
- Health Equity Officer
- Senior Director of Quality and Performance Improvement

The QI and Health Equity Plan will be made available on the Partnership website on an annual basis

NON-DISCRIMINATION STATEMENT

Partnership complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

Partnership will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available. Also, Partnership will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

Partnership provides access to staff for members and practitioners seeking information about the UM process and the authorization of care in the following ways:

- Calls from members are triaged through Member Services staff who are accessible to practitioners and members to discuss UM issues during normal working hours when the health plan is in operation (Monday - Friday 8 a.m. - 5 p.m.).
- After normal business hours, Members and Providers may contact the Partnership voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
- After normal business hours, members may contact the advice nurse line at (866) 778-8873 for assistance with clinical concerns.
- Practitioners, both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
    - Partnership has a dedicated after-hours phone number local (707) 430-4808 or toll free (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's Chief Medical Director or physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a member whose emergency medical condition is stabilized.
- Partnership UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
- Partnership maintains a toll free number (800) 863-4155 that is available to both members and practitioners.
- Members can view information about Partnership's language assistance services and disability services in the Member Handbook which is made available to members upon enrollment and is always viewable online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf

Additionally, Partnership provides annual written notice to Members about our language assistance services and disability services (e.g., TTY for hearing impaired) in our Member Newsletter.

Linguistic services are provided by Partnership to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries as well as eligible members with sensory impairment for population groups as determined by contract. These services include the following:

No Cost Linguistic Services

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
- Written information and materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated by qualified translators into threshold languages for Partnership Members according to regulatory timeframes, and into other languages or alternative formats upon request. Alternative material formats include audio, large print and electronically for members with hearing and/or visual disabilities. Braille versions are available for members with visual disabilities. Auxiliary aids are also available upon request. Please refer to MCND9002 Cultural and Linguistic Program Description for more information. The organization may continue to provide translated materials in other languages represented by the population at the discretion of Partnership, such as when the materials were previously translated or when translation may address Health Equity concerns.
- Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735-2929 or 711]

Partnership regularly assesses and documents member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization. (See policy MCND9002 *Cultural and Linguistic Program Description*)

REFERENCES

1. Department of Health Care Services (DHCS) standards

	08/20/25

Robert Moore, MD, MPH, MBA *Date Approved*
Quality/Utilization Advisory Committee Chairperson

	09/10/25

Angela Brennan, DO *Date Approved*
Physician Advisory Committee Chairperson

	10/22/25

Kim Tangermann *Date Approved*
Board of Commissioners Chairperson

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
GUIDELINE / PROCEDURE

Guideline/Procedure Number: MCUG3024 (previously UG100324)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Guideline/Procedure Title: Inpatient Utilization Management			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/25/1994		**Next Review Date:** ~~09/11/2025~~09/10/2026 **Last Review Date:** ~~09/11/2024~~09/10/2025		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIAL~~S~~ING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~09/11/2024~~09/10/2025	

I. RELATED POLICIES:
A. MCUP3037 - Appeals of Utilization Management/Pharmacy Decisions
B. MCUP3041 - Treatment Authorization Request (TAR) Review Process
C. MP~~C~~UP3139 - Criteria and Guidelines for Utilization Management
D. MCUP3124 - Referral to Specialists (RAF) Policy
E. MCUG3058 - Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
F. MCUG3038 - Review Guidelines for Member Placement in Long Term Care (LTC) Facilities
~~E.~~G. MCAP7003 - CalAIM Community Supports (CS)
~~F.~~H. MPUP3078 - Second Medical Opinion
~~G.~~I. MP~~C~~UP3138 - External Independent Medical Review
~~H.~~J. MPUD3001 - Utilization Management Program Description
~~I.~~K. ~~MCUP3028~~ MPBP8003 - Mental Health Services
~~J.~~L. MCUP3141 - Delegation of Inpatient Utilization Management
~~K.~~M. CMP36 - Delegation Oversight and Monitoring

II. IMPACTED DEPTS:
A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:
A. Acute inpatient administrative days are days approved at an acute inpatient facility, which provides a higher level of medical care than currently needed by the Member, or when a Members ~~are~~is awaiting placement in a transitional care setting, such as a Skilled Nursing Facility (SNF), Subacute Facility, or Intermediate Care Facility (ICF)~~, Acute Rehabilitation Unit (ARU), or a Long Term Acute Care (LTAC) facility~~.
B. Acute inpatient care is defined as that care provided to persons sufficiently ill or disabled who require the following:
   1. Constant availability of medical supervision by the attending physician or other professional medical staff
   2. Constant availability of licensed professional nursing personnel
   3. The availability of other diagnostic or therapeutic services and equipment which are ordinarily immediately available only in a hospital setting to ensure proper medical management
C. Elective as a guideline for admission is defined as planned treatment that can be delayed without risk to permanent health. Also known as a scheduled admission.

D. Emergency Medical Condition as a guideline for admission is defined as:
A condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in:
1. Placing the health of the individual (or, the case of a pregnant Member, the health of the Member or the unborn child) in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part

E. Inpatient admission locations include:
1. Acute Hospitals: These hospitals treat patients with severe or brief illnesses, injuries, or during recovery from surgery. They often have specialized units like ICUs, trauma centers, and emergency departments.
2. Acute Rehabilitation Centers (ARUs): Inpatient facilities that provides intensive rehabilitation services to individuals who need to regain maximum independent function after a physical or cognitive impairment. These centers focus on restoring mobility, self-care, and independent living skills, enabling patients to return home or transition to a lower level of care.
3. Long Term Acute Care (LTAC) Facility: A type of hospital that provides extended, intensive medical care for patients with serious, complex conditions who require a longer recovery period than typically provided in a traditional acute care hospital. These facilities are designed for patients who no longer require the intensive diagnostic procedures of a traditional hospital but still need acute inpatient level of care.
4. Subacute Care Facilities: Facilities with a level of care that is less intensive than acute care, but more intensive than skilled nursing care (e.g. Members who require ventilators, tracheostomies, total parenteral nutrition, tube feeding, complex wound management care, etc.).
~~4.~~5. Skilled Nursing Facility (SNFs): A special facility or part of a hospital that provides medically necessary services provided by nurses, therapists, and/or physicians.
~~5.~~6. Hospice Facility~~y~~: A licensed facility providing care for terminally ill individuals 24 hours per day, 7 days per week, that is focused on comfort and symptom management rather than curative treatment. Medi-Cal hospice providers must be Medicare-certified and enrolled with Medi-Cal.

F. Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

G. Urgent as a guideline for admission is defined as:
1. Patient requires immediate attention for the care and treatment of a physical disorder. An unscheduled admission.
2. Medical situations that require prompt medical attention, but do not endanger the patient's life or risk permanent health if care is not obtained in a reasonable period of time.
3. The immediate treatment of a medical condition that requires prompt medical attention, but where a reasonable lapse of time before medical care is obtained would not endanger life or cause significant impairment.
4. A non-emergency admission that is neither life threatening nor elective, but requires immediate attention for optimal outcome.

H. Utilization Management (UM) is the process of reviewing medical services prior to and during confinement to evaluate the following:
1. Medical necessity - meaning reasonable and necessary service to protect life, prevent significant illness or disability or alleviate severe pain through the diagnosis or treatment of disease, illness or injury
2. Ongoing review of patient response to treatment
3. Appropriate level of care
4. Therapeutic decisions to determine if more effective, efficient avenues are available.
5. Use of Partnership HealthPlan of California (Partnership) contracted providers and facilities

Guideline/Procedure Number: MCUG3024 (previously UG100324)		Lead Department: Health Services Business Unit: Utilization Management
Guideline/Procedure Title: Inpatient Utilization Management		☒ External Policy ☐ Internal Policy
Original Date: 04/25/1994	Next Review Date: 09/11/202509/10/2026 Last Review Date: 09/11/202409/10/2025	
Applies to:	☒ Medi-Cal	☐ Employees

IV. ATTACHMENTS:

A. ~~N/A~~ Provider Dispute Resolution (PDR) Request: Post Discharge Appeal for Inpatient Admission

V. PURPOSE:

To provide guidelines for the Partnership HealthPlan of California's inpatient utilization management activities. These activities are performed by the Utilization Management Department under the direction of the Chief Medical Officer (CMO) or Physician Designee.

VI. GUIDELINE / PROCEDURE:

A. The Objectives of the Utilization Management Program ~~is to~~are as follows:
   1. Reduce unnecessary or inappropriate admissions
   2. Ensure that services are provided in the appropriate setting or manner required for the patient's medical condition - the right care at the right time, in the right setting
   3. Reduce medically unnecessary inpatient days
   4. Identify and report potential quality of care issues
   5. Evaluate the anticipated course of treatment and length of stay for appropriateness and efficiency
   6. Integrate second opinion guidelines when appropriate
   7. Ensure participating providers who are contracted with Partnership are appropriately utilized
   8. Collaborate with facility staff and Member's physician to address, plan, and coordinate needs of the patient prior to discharge, including identification of cases appropriate for referral to an appropriate case management program. The Nurse Coordinator utilizes the historical information provided by the facility in the decision making process as well as InterQual® which is the department's evidenced-based practice tool. Some of the information utilized includes but is not limited to:
      a. Age
      b. Comorbidities
      c. Complications
      d. Progress of treatment
      e. Psychosocial situations
      f. Home environment, when applicable

B. CRITERIA
   1. Acute inpatient cases are reviewed according to guidelines set forth by the California Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), clinical guidelines such as InterQual® and National Comprehensive Cancer Network (NCCN) and other broadly accepted standards of care. Please see policy MPUP3139 Criteria and Guidelines for Utilization Management for further information.

   ~~1. Current InterQual® criteria sets are used as the main review guidelines. Other resources as necessary are used to help in determining review decisions, these include, but are not limited to, Medi-Cal (State of California) guidelines and Partnership internally developed and approved guidelines. Partnership does not reward practitioners or other individuals for issuing denials of coverage. There are no financial incentives for UM decision makers to deny care; and Partnership does not encourage decisions which would result in underutilization, but rather bases decisions solely on the appropriateness of care or service and the existence of coverage.~~

      ~~a.~~ If a request is received for review of services that varies from such guidelines, or for which review criteria have not been developed, the ~~Chief Medical Officer~~ CMO/~~or~~ Physician Designee will use clinical judgment and discussion using a specialty matched board certified specialist as necessary to make a determination based on medical appropriateness.

   2.

   ~~2. Decisions are based on information derived from the following sources:~~

~~a. Clinical records~~
~~b. Medical care personnel~~
~~c.~~a. Utilization management staff will provide the InterQual® information, as well as a patient summary developed from the facility's discharge planning or UM staff (including the applicable policies), for the Medical Director to reference.
~~d.~~b. Information from the a~~A~~ttending physician will also be considered. ~~(~~The attending physician can be the primary care physician, hospitalist, or the specialist physician (or all three as necessary).

3. The needs of individual patients and the characteristics of the local delivery system are taken into account when determining the medical necessity of an inpatient hospitalization.

C. URGENT AND NEWBORN ADMISSION AUTHORIZATION PROCESS
1. Urgent or Emergency Admission
   a. In the case of an urgent or emergent admission, the hospital is required to notify the Health Services Department within 1 business day of the admission.
   b. All declared emergency admissions will be followed by a Nurse Coordinator who will perform the initial review within 72 hours of notification to Partnership. The Nurse Coordinator will then follow concurrent review procedures.
   c. Refer to III.~~E – F~~G. and III.D. above for definitions of urgent and emergency.
2. Newborn Admissions
   a. All initial inpatient newborn care is automatically authorized if care rendered to the mother is approved. The neonate is assigned the same number as the mother if the mother and baby are discharged on the same day. If mother is discharged and the infant remains in the hospital, a new authorization number will be assigned for the baby.
   b. If the newborn is admitted to the intensive care nursery, an authorization number must be assigned at the time of admission to NICU and the appropriate capitated provider, if applicable, notified.

D. ELECTIVE/SCHEDULED ADMISSION AUTHORIZATION PROCESS
1. This type of review requires justification of medical necessity before a patient can be admitted to an acute care facility. It is a process to assure that elective or non-emergency hospitalization is medically necessary and arranged in the appropriate facility. Authorization is required for all elective/scheduled admissions as follows:
   a. Prior authorization should be obtained by the admitting physician as soon as possible but not less than five (5) to ten (10) days prior to the planned admission.
   b. Preadmission authorization is the process in which the Nurse Coordinator evaluates a request for an elective admission to a health care facility. The procedure involves the admitting physician furnishing the pertinent information such as diagnosis, age, indication for admission, and any planned surgical procedure.
   c. If a specialist is planning to admit the Member, a Referral Authorization from the Primary Care Physician is required. (see policy MCUG3024 Referral to Specialists (RAF) Policy)
   d. Preadmission testing will be performed prior to elective admissions.
   e. Early morning admission on the day of a proposed surgical procedure should be utilized. If the patient's problem precludes such utilization, the admitting physician must document the need for a preoperative review and a determination of medical necessity and appropriateness will be included in the prior authorization of the proposed admission. Using established criteria, most confinements can be pre-approved by the Nurse Coordinator. If a less expensive but equally effective care alternative is available and the patient's condition permits, Partnership's ~~Chief Medical Officer or~~CMO/~~-~~Physician Designee will approve treatment at that level of care. If medical necessity is not clear, the request will be escalated to the ~~Chief Medical Officer or~~CMO/~~-~~Physician Designee for review.
   f. It is the admitting facility's responsibility to verify (prior to admission) that the required prior authorization has been completed and approved. The admitting facility is required to notify

Partnership of the actual admission within one business day of the admission, even though the admission has been pre-approved. (In the event that a prior-authorization request is not submitted for an elective procedure, a review for medical necessity is still performed.)

g. The purpose of this process is to arrive at the most cost efficient manner for Partnership HealthPlan's patients to obtain quality care as well as screen patients for medical necessity and appropriateness of admission to an acute care facility.

h. Refer to III.C ~~D~~. above for definition of elective.

E. CONTINUED STAY REVIEW/CONCURRENT REVIEW AUTHORIZATION PROCESS

1. Concurrent review is the process of review for the assessment of ongoing medical necessity and appropriateness of continued hospitalization in an inpatient facility. All hospital admissions are subject to the concurrent review process.
2. All patients in acute or subacute facilities are reviewed concurrently, either ~~on site,~~ telephonically, electronically, or via faxed reviews, for appropriateness of care and use of hospital services in an effort to assure cost efficient delivery of care as well as medical necessity and quality of care.
3. Objectives of Concurrent Review
   a. Evaluate medical necessity
   b. Monitor and ensure the efficient us of health care services
   c. Determine if the hospital setting is consistent with care being rendered
   d. To evaluate the course of treatment and length of stay
   e. To identify and report any potential quality of care issues
   f. To reduce length of stay by proactively working with hospital discharge planners and Case Managers to facilitate timely discharge planning and needed follow up
   g. Identify cases requiring C~~hief Medical Officer or~~ CMO/Physician Designee review and/or intervention
4. ~~Chief Medical Officer or~~CMO/~~-~~Physician Designee referrals include but are not limited to cases:
   a. Which appear to fail to meet criteria
   b. For which medical information provided is insufficient to make a decision
   c. For which a level of care determination may be required
   d. For which physician to physician consultation is deemed necessary, e.g., procedures that may not be considered standard medical practice, questionable procedures/treatment
5. Continued Stay/Concurrent Review Process
   a. Partnership maintains electronic records on all hospital admissions and monitors the Member's care throughout the length of stay using established criteria as defined in Section VI. B, the Nurse Coordinator determines the medical necessity and appropriateness of continued hospitalization.
   b. Partnership will render a decision (approve, modify, defer/pend, deny) within 72 hours of receipt of notification of admission. The Nurse Coordinator will continue to concurrently review the authorization within 24 hours of receipt each time clinical information is received throughout the remainder of the stay.
   c. If continued hospitalization meets InterQual criteria, the next/frequency of review is determined by the Member's acuity level, individual circumstances, and InterQual criteria.
   d. If the stay does not meet the criteria due to lack of documentation/information, further information from the nursing staff/appropriate departments/personnel may be requested.
   e. If, after all available information has been reviewed, and the stay does not appear to meet criteria, the authorization is escalated by the Nurse Coordinator to the ~~Chief Medical Officer or~~CMO/ Physician Designee for review of medical necessity.
   f. The ~~Chief Medical Officer or~~CMO/~~-~~Physician Designee reviews the medical record documentation and makes the decision to approve or deny continued hospitalization within 24 hours (1 calendar day).
   g. If the ~~Chief Medical Officer or~~CMO/~~-~~Physician Designee approves continued stay, the Nurse

Coordinator will continue the concurrent review process.

h. The ~~Chief Medical Officer or~~CMO/~~-~~Physician Designee may contact the attending physician to discuss the case. The result of the review is documented on the appropriate review form and includes the rationale for the decision.

i. If the ~~Chief Medical Officer or~~CMO/~~-~~Physician Designee determines the stay is not medically necessary, the patient's stay is not approved and the Nurse Coordinator verbally notifies the facility that the stay is denied, followed by electronic or written notice of denial within 24 hours from the verbal notification. The ~~Chief Medical Officer or~~CMO/~~-~~Physician Designee signs the denial letter.

j. Attending clinicians of inpatient facilities may request a Peer to Peer ~~of~~for a M~~m~~ember currently admitted to the facility if the determination of the case in concurrent review by the CMO/Physician designee does not meet criteria for medical necessity for the level of care requested, and the stay is not approved.

~~j.~~k. After a member is discharged from the hospital, if a hospital has a disagreement with a denial of medical necessity for a hospital admission, or one or more inpatient days of an admission, the hospital should ~~not request a Peer to Peer but rather~~ submit a provider dispute resolution request. ~~P~~Please see Attachment A for ~~Peer to Peer Request Requirements for Inpatient Admissions~~the information we require to consider.~~.~~

F. INTER-FACILITY TRANSFERS OF MEMBERS

1. Partnership UM staff may facilitate the transfer of a Member from a non-contracted hospital to a contracted hospital. Criteria for consideration of transfer include:
   a. A benefit analysis of care offered for the patient.
   b. The Member is medically stable for transfer.
   c. There is a contracted facility available that can meet the Member's medical needs.
   d. The estimated length of stay at the receiving hospital is greater than three days.
   e. The attending physician at the transferring hospital is agreeable to the transfer and willing to sign the necessary documents.
   f. The attending physician and the hospital staff at the accepting hospital are willing to accept the Member in transfer.
   g. There is agreement of agencies responsible for authorizing services (e.g. California Children's Services [CCS] or the Genetically Handicapped Persons Program [GHPP]).
   h. The consent of the parent or authorized caregiver for children under the age of 21 hospitalized under the CCS program is required prior to the transfer.
   i. In each of the above situations, the utilization management forms and appropriate electronic record screens are documented as applicable.
2. Partnership may coordinate other inter-facility transfers of Members when deemed medically necessary.
3. For further discussion of services for Members capitated to contracted hospitals, please see policy MCUP3141 Delegation of Inpatient Utilization Management.

G. ACUTE INPATIENT ADMINISTRATIVE DAYS

1. A Partnership Member may be approved for acute inpatient administrative days when, after review of information from the attending physician and the medical record, it is the professional judgment of the Partnership CMO/~~ or~~ physician designee that the Member's care no longer meets acute inpatient criteria, and medical and nursing care is required at a lower level of care, but placement is not available at the present time.
2. Inpatient acute facilities must provide documentation to demonstrate that active inquiries are being made to potential facilities for the appropriate level of care as determined by medical necessity. The Member's record must reflect the outreach efforts to achieve placement at a SNF, Subacute facility, or ICF.
3. For Members who require placement for continued management, the acute inpatient facility must initiate inquiries and contact with facilities that are appropriate for the Member's needs.

a. The acute inpatient facility must continue placement efforts until placement occurs.
b. The Member's record must reflect the outreach efforts to achieve placement.
c. Partnership will review documentation of placement efforts on a regular basis for ongoing approval of acute inpatient administrative days.

~~2.~~4. If the Member is pending placement at a level of care that is not Partnership's responsibility, acute inpatient administrative days do not apply. Examples include, but are not limited to, Members who are the responsibility of the criminal justice system or being discharged home or to a board and care facility.

H. INPATIENT PSYCHIATRIC ADMISSIONS

1. For Partnership Medi-Cal Members: Specialty mental health services are not a Partnership covered benefit.
   a. Partnership Medi-Cal Members determined to have moderate to severe mental health conditions which require specialty mental health services are referred to the County ~~Mental~~ Behavioral Health Plan in the Member's county of residence. The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each County Mental Health Plan, consistent with California statutes and regulations.
   b. Acute inpatient administrative days do not apply when the Partnership Medi-Cal Member is pending evaluation on a psychiatric hold or awaiting placement at a mental health facility. Specialty mental health services are not a Partnership responsibility.
2. For further information, see policy ~~MCUP3028~~ MPBP8003 Mental Health Services.

I. CASE REVIEW CONFERENCES

1. Case Review Conferences provide a forum to promote and ensure consistent application of criteria and decision-making between and among Nurse Coordinators and the ~~Chief Medical Officer or~~CMO/ Physician Designee. They are also used as an educational tool for research, discussion of unique and difficult cases, and pertinent, new treatment innovations and pharmaceuticals. The goal is to keep the staff up to date on current medical care.
2. Case Review Conferences occur weekly, at a minimum~~.~~ and often include facility care management staff (e.g. case managers, discharge planners).
3. The meetings are conducted in a private area, either an office or conference room. This serves to encourage frank discussion of cases while protecting and preserving patient confidentiality.
4. The meetings are conducted by the Director of UM or Designee, and attended by the Health Services Nurse Coordinator staff and Managers involved in the in-patient review process, appropriate Care Coordination staff and the ~~Chief Medical Officer or~~CMO/ ~~-~~Physician Designee.
5. Identified cases (e.g. patients with long lengths of stay, typically over seven (7) calendar days from the date of admission are discussed in detail by the team with a focus on creative, innovative solutions and remedies to move patients through the health care continuum in the most efficient manner.
6. Nurse Coordinators are expected to follow the review guidelines outlined in this policy.
7. The objectives of case conferences are to:
   a. Reduce unnecessary or inappropriate admissions and inpatient days.
   b. Ensure that services are provided in the appropriate setting or manner required for the patient's medical condition
   c. Improve the quality of care rendered
   d. Evaluate the anticipated course of treatment and length of stay
   e. Evaluate Members for transfer from non-contracted to contracted hospitals
   f. Ensure participating providers who are contracted with Partnership are appropriately utilized
   g. Address, plan, and coordinate needs of the patient upon discharge, including identification of cases appropriate to case management intervention
   h. Ensure the provision of efficient, quality care and assist in assessing alternative treatments
   i. Provide appropriate support and recommendations to the Inpatient UM Nurse Coordinators

J. PROCESS FOR A PROVIDER TO APPEAL AN ADVERSE BENEFIT DETERMINATION ON BEHALF

OF A MEMBER

1. Refer to Partnership's policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.

K. POST-SERVICE OR RETROSPECTIVE REVIEW

Retrospective review applies the same process and criteria as continued stay/concurrent review, only AFTER the patient has been discharged.

1. Objective
   Retrospective review is used to identify medically unnecessary admissions and bed days that have been incurred.
2. Process
   a. For post-service/retrospective review, Partnership will render a decision (approve, modify, defer/pend, deny) no later than 30 calendar days from the receipt of the request.
   b. When the clinical information is received, the acute care hospitalization is evaluated, day by day, to determine the appropriateness of admission and length of stay given the patient's clinical status and the course of treatment.
   c. Identified problem areas are presented to the ~~Chief Medical Officer or~~CMO/-Physician Designee as with continued stay review/concurrent review.
   d. Electronic or written notification of the decision and how to initiate a routine or expedited appeal if applicable is communicated to the provider within 24 hours of decision, but no later than 30 calendar days from the date of the receipt of the request. Written notification is mailed to the Member within two (2) business days of the decision.

L. COMMUNICATION SERVICES

1. Partnership provides access to staff for Members and practitioners seeking information about the UM process and the authorization of care ~~in the following ways:~~as described in policy MCUP3064 Communication Services.
   ~~a. Calls from Members are triaged through Member service staff who are accessible to practitioners and Members to discuss UM issues during normal working hours when the health plan is in operation (Monday - Friday 8 a.m. – 5 p.m.).~~
   ~~b. Members and Providers may contact the Partnership voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday-Friday are returned on the same business day.~~
   ~~c. After normal business hours, Members may contact the advice nurse line at (866) 778-8873 for clinical concerns.~~
   ~~d. Practitioners, both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.~~
2. Note that Partnership also has a dedicated after-hours local phone number (707) 430-4808 or toll free number (866) 828-2304 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's ~~Chief Medical Director or~~CMO/ physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a Member whose emergency medical condition is stabilized.

M. ~~For information on utilization management procedures (prior authorization requirements, Clinical Protocols and Practice Guidelines) refer to Partnership's Provider Manual, Section 5: Health Services at www.partnershiphp.org. For information on how to submit claims, refer to Partnership's Provider Manual, Section 3: Claims at www.partnershiphp.org.~~

~~Partnership has a toll free number (800) 863-4155 that is available to either Member or practitioners.~~

~~UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. For a list of UM Program Staff and Assigned Responsibilities, please refer to policy MPUD3001 Utilization Management Program Description.~~

~~Members can view information about Partnership's language assistance services and disability services in the Member Handbook which is mailed to Members upon enrollment and is always available online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf~~

~~Additionally, Partnership provides annual written notice to Members about our language assistance services and disability services in our Member Newsletter.~~

~~Linguistic services to discuss UM issues are provided by Partnership to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries for population groups as determined by contract. These no cost linguistic services include the following:~~

~~Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries~~

~~Written informing materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated into threshold languages in accordance with regulatory timeframes and into other languages or alternative formats as indicated in the Member's record or upon request. Material formats include audio, large print and electronically for Members with hearing and/or visual disabilities. Braille versions are available for Members with visual disabilities. The organization may continue to provide translated materials in other languages represented by the population at the discretion of Partnership, such as when the materials were previously translated or when translation may address Health Equity concerns.~~

~~Use of California Relay Services for hearing impaired (TTY/TDD: [800] 735-2929 or 711)~~

~~Partnership regularly assesses and documents Member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization.~~

DELEGATION OVERSIGHT AND MONITORING

1. Partnership delegates UM functions to select contracted hospitals. Please see policy MCUP3141 Delegation of Inpatient Utilization Management.

~~1. For any services delegated, the following procedures apply:~~

~~a. A formal agreement is maintained and inclusive of all delegated functions.~~

~~b. Partnership conducts an audit of delegated entities no less than annually to ensure the delegate is following the appropriate policies and procedures for all UM functions.~~

~~Results from the annual delegation oversight audit shall be presented to Partnership's Delegation Oversight Review Sub-Committee (DORS) for review and approval and reviewed by the CMO or physician designee.~~

VII. REFERENCES:

A. InterQual® criteria
B. Medi-Cal Provider Manual/ Guidelines
C. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2025~~4~~) UM 5 Timeliness

of UM Decisions Elements A and E

D. DHCS All Plan Letter (APL) 21-011 *Revised* Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2022)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

03/23/95; 08/98; 06/21/00; 06/20/01; 09/18/02; 04/16/03; 05/21/03; 10/20/04; 02/16/05; 08/20/08; 11/18/09; 05/18/11; 05/20/15; 08/19/15; 05/18/16; 04/19/17; *08/08/18; 04/10/19; 04/08/20; 04/14/21; 06/09/21; 06/08/22; 08/09/23; 09/11/24; 09/10/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: ~~N/A~~MCUP3053 Acute Inpatient Administrative Days (06/20/2001 – 09/10/2025)

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PROVIDER DISPUTE RESOLUTION (PDR) REQUEST
Post Discharge Appeal for Inpatient Admission

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and NARRATIVE. Use additional pages if needed.
- Provide additional information to support the description of the dispute.
- Do not include a copy of a claim that was previously processed.
- Mail or Fax the completed form to: **Partnership HealthPlan of California**
  Attn: Utilization Management Department
  4665 Business Center Drive
  Fairfield, CA 94534
  Fax: (707) 863-4118

Has A Claim Been Submitted? ☐ **Y** ☐ **N** **If Yes, please submit a Provider Claims Dispute Resolution Request (Link)**
If No, please complete this form

***DISPUTE TYPE:**

☐ **PDR to appeal for Medical Necessity.** Please check this box if you received a Notice of Action denial letter from our Utilization Management (UM) Department and you would like to appeal the denial for medical necessity

☐ Other _____

MEMBER INFORMATION:

***Member Name:**		***Date of Birth:**
***CIN/Mem ID Number:**	**Patient Account Number:**	***TAR Number:**
***Primary Reason for Admission:**		
Date ED Visit Began (If Admitted from ED)**:**	**Observation Dates/Times** (If applicable):	***Date of Member Admission:**
Date of Primary Surgery (if applicable)**:**	***Date of Discharge:**	***Patient Disposition Upon Discharge:**

PROVIDER INFORMATION:

***PROVIDER NPI:**	***PROVIDER TAX ID:**
***PROVIDER NAME:**	
***PROVIDER ADDRESS:**	
***PROVIDER TELEPHONE:**	***PROVIDER FAX:**

APPEAL SUBMISSION INFORMATION:

***NAME OF PERSON SIGNING THIS APPEAL:**	***TITLE**
***TELEPHONE:**	***FAX:**
***NAME OF ASSISTANT HELPING PREPARE THIS APPEAL:**	***TITLE**
***TELEPHONE:**	***FAX:**

PROVIDER DISPUTE RESOLUTION (PDR) REQUEST
Post Discharge Appeal for Inpatient Admission

INSTRUCTIONS:
- Attach any supporting clinical documentation.
- Please only send clinical records that are pertinent for the DOS you are contesting.
- Provide a clear explanation as to why the denial decision should be overturned in the space provided below.

***DESCRIPTION OF DISPUTE**:
- List days on which Partnership denied inpatient status for not meeting criteria for inpatient admission (Note: The date of discharge does not count as a billable/paid date.)
- Of these days, which dates does hospital want to have re-evaluated?
- Please list the name(s) and title(s) of the hospitalist(s) who rounded on the patient on the specified days

***NARRATIVE:**
- Summarize the reasons given by Partnership for lack of meeting criteria for inpatient coverage
- Please give a narrative of the hospitalist's description of circumstances that they feel justify acute inpatient level of care, for each day they wish to contest.

***ATTACHMENTS REQUIRED:**
Please attach, for this hospitalization:
- The Admission and Physical note
- The Discharge summary note
- The hospital progress notes (including notes from consultants and primary rounding hospitalist) and any other supporting evidence for the contested days of care

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
GUIDELINE / PROCEDURE

<table>
<tr><td colspan="4">Guideline/Procedure Number: MCUG3024 (previously UG100324)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Guideline/Procedure Title: Inpatient Utilization Management</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: 09/10/2026
Last Review Date: 09/10/2025</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 09/10/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3037 - Appeals of Utilization Management/Pharmacy Decisions
B. MCUP3041 - Treatment Authorization Request (TAR) Review Process
C. MPUP3139 - Criteria and Guidelines for Utilization Management
D. MCUP3124 - Referral to Specialists (RAF) Policy
E. MCUG3058 - Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
F. MCUG3038 - Review Guidelines for Member Placement in Long Term Care (LTC) Facilities
G. MCAP7003 - CalAIM Community Supports (CS)
H. MPUP3078 - Second Medical Opinion
I. MPUP3138 - External Independent Medical Review
J. MPUD3001 - Utilization Management Program Description
K. MPBP8003 - Mental Health Services
L. MCUP3141 - Delegation of Inpatient Utilization Management
M. CMP36 - Delegation Oversight and Monitoring

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. Acute inpatient administrative days are days approved at an acute inpatient facility, which provides a higher level of medical care than currently needed by the Member, or when a Member is awaiting placement in a transitional care setting, such as a Skilled Nursing Facility (SNF), Subacute Facility, or Intermediate Care Facility (ICF).
B. Acute inpatient care is defined as that care provided to persons sufficiently ill or disabled who require the following:
   1. Constant availability of medical supervision by the attending physician or other professional medical staff
   2. Constant availability of licensed professional nursing personnel
   3. The availability of other diagnostic or therapeutic services and equipment which are ordinarily immediately available only in a hospital setting to ensure proper medical management
C. Elective as a guideline for admission is defined as planned treatment that can be delayed without risk to permanent health. Also known as a scheduled admission.

D. Emergency Medical Condition as a guideline for admission is defined as:
A condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in:
   1. Placing the health of the individual (or, the case of a pregnant Member, the health of the Member or the unborn child) in serious jeopardy
   2. Serious impairment to bodily functions
   3. Serious dysfunction of any bodily organ or part

E. Inpatient admission locations include:
   1. Acute Hospitals: These hospitals treat patients with severe or brief illnesses, injuries, or during recovery from surgery. They often have specialized units like ICUs, trauma centers, and emergency departments.
   2. Acute Rehabilitation Centers (ARUs): Inpatient facilities that provides intensive rehabilitation services to individuals who need to regain maximum independent function after a physical or cognitive impairment. These centers focus on restoring mobility, self-care, and independent living skills, enabling patients to return home or transition to a lower level of care.
   3. Long Term Acute Care (LTAC) Facility: A type of hospital that provides extended, intensive medical care for patients with serious, complex conditions who require a longer recovery period than typically provided in a traditional acute care hospital. These facilities are designed for patients who no longer require the intensive diagnostic procedures of a traditional hospital but still need acute inpatient level of care.
   4. Subacute Care Facilities: Facilities with a level of care that is less intensive than acute care, but more intensive than skilled nursing care (e.g. Members who require ventilators, tracheostomies, total parenteral nutrition, tube feeding, complex wound management care, etc.).
   5. Skilled Nursing Facility (SNFs): A special facility or part of a hospital that provides medically necessary services provided by nurses, therapists, and/or physicians.
   6. Hospice Facility: A licensed facility providing care for terminally ill individuals 24 hours per day, 7 days per week, that is focused on comfort and symptom management rather than curative treatment. Medi-Cal hospice providers must be Medicare-certified and enrolled with Medi-Cal.

F. Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

G. Urgent as a guideline for admission is defined as:
   1. Patient requires immediate attention for the care and treatment of a physical disorder. An unscheduled admission.
   2. Medical situations that require prompt medical attention, but do not endanger the patient's life or risk permanent health if care is not obtained in a reasonable period of time.
   3. The immediate treatment of a medical condition that requires prompt medical attention, but where a reasonable lapse of time before medical care is obtained would not endanger life or cause significant impairment.
   4. A non-emergency admission that is neither life threatening nor elective, but requires immediate attention for optimal outcome.

H. Utilization Management (UM) is the process of reviewing medical services prior to and during confinement to evaluate the following:
   1. Medical necessity - meaning reasonable and necessary service to protect life, prevent significant illness or disability or alleviate severe pain through the diagnosis or treatment of disease, illness or injury
   2. Ongoing review of patient response to treatment
   3. Appropriate level of care
   4. Therapeutic decisions to determine if more effective, efficient avenues are available.
   5. Use of Partnership HealthPlan of California (Partnership) contracted providers and facilities

IV. ATTACHMENTS:

A. Provider Dispute Resolution (PDR) Request: Post Discharge Appeal for Inpatient Admission

V. PURPOSE:

To provide guidelines for the Partnership HealthPlan of California's inpatient utilization management activities. These activities are performed by the Utilization Management Department under the direction of the Chief Medical Officer (CMO) or Physician Designee.

VI. GUIDELINE / PROCEDURE:

A. The Objectives of the Utilization Management Program are as follows:
   1. Reduce unnecessary or inappropriate admissions
   2. Ensure that services are provided in the appropriate setting or manner required for the patient's medical condition - the right care at the right time, in the right setting
   3. Reduce medically unnecessary inpatient days
   4. Identify and report potential quality of care issues
   5. Evaluate the anticipated course of treatment and length of stay for appropriateness and efficiency
   6. Integrate second opinion guidelines when appropriate
   7. Ensure participating providers who are contracted with Partnership are appropriately utilized
   8. Collaborate with facility staff and Member's physician to address, plan, and coordinate needs of the patient prior to discharge, including identification of cases appropriate for referral to an appropriate case management program. The Nurse Coordinator utilizes the historical information provided by the facility in the decision making process as well as InterQual® which is the department's evidenced-based practice tool. Some of the information utilized includes but is not limited to:
      a. Age
      b. Comorbidities
      c. Complications
      d. Progress of treatment
      e. Psychosocial situations
      f. Home environment, when applicable

B. CRITERIA
   1. Acute inpatient cases are reviewed according to guidelines set forth by the California Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), clinical guidelines such as InterQual® and National Comprehensive Cancer Network (NCCN) and other broadly accepted standards of care. Please see policy MPUP3139 Criteria and Guidelines for Utilization Management for further information.
   2. If a request is received for review of services that varies from such guidelines, or for which review criteria have not been developed, the CMO/Physician Designee will use clinical judgment and discussion using a specialty matched board certified specialist as necessary to make a determination based on medical appropriateness.
      a. Utilization management staff will provide the InterQual® information, as well as a patient summary developed from the facility's discharge planning or UM staff (including the applicable policies), for the Medical Director to reference.
      b. Information from the attending physician will also be considered. The attending physician can be the primary care physician, hospitalist, or the specialist physician (or all three as necessary).
   3. The needs of individual patients and the characteristics of the local delivery system are taken into account when determining the medical necessity of an inpatient hospitalization.

C. URGENT AND NEWBORN ADMISSION AUTHORIZATION PROCESS
   1. Urgent or Emergency Admission

a. In the case of an urgent or emergent admission, the hospital is required to notify the Health Services Department within 1 business day of the admission.
b. All declared emergency admissions will be followed by a Nurse Coordinator who will perform the initial review within 72 hours of notification to Partnership. The Nurse Coordinator will then follow concurrent review procedures.
c. Refer to III.G. and III.D. above for definitions of urgent and emergency.

2. Newborn Admissions
   a. All initial inpatient newborn care is automatically authorized if care rendered to the mother is approved. The neonate is assigned the same number as the mother if the mother and baby are discharged on the same day. If mother is discharged and the infant remains in the hospital, a new authorization number will be assigned for the baby.
   b. If the newborn is admitted to the intensive care nursery, an authorization number must be assigned at the time of admission to NICU and the appropriate capitated provider, if applicable, notified.

D. ELECTIVE/SCHEDULED ADMISSION AUTHORIZATION PROCESS
1. This type of review requires justification of medical necessity before a patient can be admitted to an acute care facility. It is a process to assure that elective or non-emergency hospitalization is medically necessary and arranged in the appropriate facility. Authorization is required for all elective/scheduled admissions as follows:
   a. Prior authorization should be obtained by the admitting physician as soon as possible but not less than five (5) to ten (10) days prior to the planned admission.
   b. Preadmission authorization is the process in which the Nurse Coordinator evaluates a request for an elective admission to a health care facility. The procedure involves the admitting physician furnishing the pertinent information such as diagnosis, age, indication for admission, and any planned surgical procedure.
   c. If a specialist is planning to admit the Member, a Referral Authorization from the Primary Care Physician is required. (see policy MCUG3024 Referral to Specialists (RAF) Policy)
   d. Preadmission testing will be performed prior to elective admissions.
   e. Early morning admission on the day of a proposed surgical procedure should be utilized. If the patient's problem precludes such utilization, the admitting physician must document the need for a preoperative review and a determination of medical necessity and appropriateness will be included in the prior authorization of the proposed admission. Using established criteria, most confinements can be pre-approved by the Nurse Coordinator. If a less expensive but equally effective care alternative is available and the patient's condition permits, Partnership's CMO/Physician Designee will approve treatment at that level of care. If medical necessity is not clear, the request will be escalated to the CMO/Physician Designee for review.
   f. It is the admitting facility's responsibility to verify (prior to admission) that the required prior authorization has been completed and approved. The admitting facility is required to notify Partnership of the actual admission within one business day of the admission, even though the admission has been pre-approved. (In the event that a prior-authorization request is not submitted for an elective procedure, a review for medical necessity is still performed.)
   g. The purpose of this process is to arrive at the most cost efficient manner for Partnership HealthPlan's patients to obtain quality care as well as screen patients for medical necessity and appropriateness of admission to an acute care facility.
   h. Refer to III.C. above for definition of elective.

E. CONTINUED STAY REVIEW/CONCURRENT REVIEW AUTHORIZATION PROCESS
1. Concurrent review is the process of review for the assessment of ongoing medical necessity and appropriateness of continued hospitalization in an inpatient facility. All hospital admissions are subject to the concurrent review process.
2. All patients in acute or subacute facilities are reviewed concurrently, either telephonically,

electronically, or via faxed reviews, for appropriateness of care and use of hospital services in an effort to assure cost efficient delivery of care as well as medical necessity and quality of care.

3. Objectives of Concurrent Review
   a. Evaluate medical necessity
   b. Monitor and ensure the efficient us of health care services
   c. Determine if the hospital setting is consistent with care being rendered
   d. To evaluate the course of treatment and length of stay
   e. To identify and report any potential quality of care issues
   f. To reduce length of stay by proactively working with hospital discharge planners and Case Managers to facilitate timely discharge planning and needed follow up
   g. Identify cases requiring CCMO/Physician Designee review and/or intervention
4. CMO/Physician Designee referrals include but are not limited to cases:
   a. Which appear to fail to meet criteria
   b. For which medical information provided is insufficient to make a decision
   c. For which a level of care determination may be required
   d. For which physician to physician consultation is deemed necessary, e.g., procedures that may not be considered standard medical practice, questionable procedures/treatment
5. Continued Stay/Concurrent Review Process
   a. Partnership maintains electronic records on all hospital admissions and monitors the Member's care throughout the length of stay using established criteria as defined in Section VI. B, the Nurse Coordinator determines the medical necessity and appropriateness of continued hospitalization.
   b. Partnership will render a decision (approve, modify, defer/pend, deny) within 72 hours of receipt of notification of admission. The Nurse Coordinator will continue to concurrently review the authorization within 24 hours of receipt each time clinical information is received throughout the remainder of the stay.
   c. If continued hospitalization meets InterQual criteria, the next/frequency of review is determined by the Member's acuity level, individual circumstances, and InterQual criteria.
   d. If the stay does not meet the criteria due to lack of documentation/information, further information from the nursing staff/appropriate departments/personnel may be requested.
   e. If, after all available information has been reviewed, and the stay does not appear to meet criteria, the authorization is escalated by the Nurse Coordinator to the CMO/Physician Designee for review of medical necessity.
   f. The CMO/Physician Designee reviews the medical record documentation and makes the decision to approve or deny continued hospitalization within 24 hours (1 calendar day).
   g. If the CMO/Physician Designee approves continued stay, the Nurse Coordinator will continue the concurrent review process.
   h. The CMO/Physician Designee may contact the attending physician to discuss the case. The result of the review is documented on the appropriate review form and includes the rationale for the decision.
   i. If the CMO/Physician Designee determines the stay is not medically necessary, the patient's stay is not approved and the Nurse Coordinator verbally notifies the facility that the stay is denied, followed by electronic or written notice of denial within 24 hours from the verbal notification. The CMO/Physician Designee signs the denial letter.
   j. Attending clinicians of inpatient facilities may request a Peer to Peer for a Member currently admitted to the facility if the determination of the case in concurrent review by the CMO/Physician designee does not meet criteria for medical necessity for the level of care requested, and the stay is not approved.
   k. After a member is discharged from the hospital, if a hospital has a disagreement with a denial of medical necessity for a hospital admission, or one or more inpatient days of an admission, the hospital should submit a provider dispute resolution request. Please see Attachment A for the

information we require to consider.

F. INTER-FACILITY TRANSFERS OF MEMBERS
   1. Partnership UM staff may facilitate the transfer of a Member from a non-contracted hospital to a contracted hospital. Criteria for consideration of transfer include:
      a. A benefit analysis of care offered for the patient.
      b. The Member is medically stable for transfer.
      c. There is a contracted facility available that can meet the Member's medical needs.
      d. The estimated length of stay at the receiving hospital is greater than three days.
      e. The attending physician at the transferring hospital is agreeable to the transfer and willing to sign the necessary documents.
      f. The attending physician and the hospital staff at the accepting hospital are willing to accept the Member in transfer.
      g. There is agreement of agencies responsible for authorizing services (e.g. California Children's Services [CCS] or the Genetically Handicapped Persons Program [GHPP]).
      h. The consent of the parent or authorized caregiver for children under the age of 21 hospitalized under the CCS program is required prior to the transfer.
      i. In each of the above situations, the utilization management forms and appropriate electronic record screens are documented as applicable.
   2. Partnership may coordinate other inter-facility transfers of Members when deemed medically necessary.
   3. For further discussion of services for Members capitated to contracted hospitals, please see policy MCUP3141 Delegation of Inpatient Utilization Management.

G. ACUTE INPATIENT ADMINISTRATIVE DAYS
   1. A Partnership Member may be approved for acute inpatient administrative days when, after review of information from the attending physician and the medical record, it is the professional judgment of the Partnership CMO/physician designee that the Member's care no longer meets acute inpatient criteria, and medical and nursing care is required at a lower level of care, but placement is not available at the present time.
   2. Inpatient acute facilities must provide documentation to demonstrate that active inquiries are being made to potential facilities for the appropriate level of care as determined by medical necessity. The Member's record must reflect the outreach efforts to achieve placement at a SNF, Subacute facility, or ICF.
   3. For Members who require placement for continued management, the acute inpatient facility must initiate inquiries and contact with facilities that are appropriate for the Member's needs.
      a. The acute inpatient facility must continue placement efforts until placement occurs.
      b. The Member's record must reflect the outreach efforts to achieve placement.
      c. Partnership will review documentation of placement efforts on a regular basis for ongoing approval of acute inpatient administrative days.
   4. If the Member is pending placement at a level of care that is not Partnership's responsibility, acute inpatient administrative days do not apply. Examples include, but are not limited to, Members who are the responsibility of the criminal justice system or being discharged home or to a board and care facility.

H. INPATIENT PSYCHIATRIC ADMISSIONS
   1. For Partnership Medi-Cal Members: Specialty mental health services are not a Partnership covered benefit.
      a. Partnership Medi-Cal Members determined to have moderate to severe mental health conditions which require specialty mental health services are referred to the County Behavioral Health Plan in the Member's county of residence. The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each County Mental Health Plan, consistent with California statutes and regulations.
      b. Acute inpatient administrative days do not apply when the Partnership Medi-Cal Member is pending evaluation on a psychiatric hold or awaiting placement at a mental health facility. Specialty mental

health services are not a Partnership responsibility.

2. For further information, see policy MPBP8003 Mental Health Services.

I. CASE REVIEW CONFERENCES

1. Case Review Conferences provide a forum to promote and ensure consistent application of criteria and decision-making between and among Nurse Coordinators and the CMO/Physician Designee. They are also used as an educational tool for research, discussion of unique and difficult cases, and pertinent, new treatment innovations and pharmaceuticals. The goal is to keep the staff up to date on current medical care.
2. Case Review Conferences occur weekly, at a minimum and often include facility care management staff (e.g. case managers, discharge planners).
3. The meetings are conducted in a private area, either an office or conference room. This serves to encourage frank discussion of cases while protecting and preserving patient confidentiality.
4. The meetings are conducted by the Director of UM or Designee, and attended by the Health Services Nurse Coordinator staff and Managers involved in the in-patient review process, appropriate Care Coordination staff and the CMO/Physician Designee.
5. Identified cases (e.g. patients with long lengths of stay, typically over seven (7) calendar days from the date of admission are discussed in detail by the team with a focus on creative, innovative solutions and remedies to move patients through the health care continuum in the most efficient manner.
6. Nurse Coordinators are expected to follow the review guidelines outlined in this policy.
7. The objectives of case conferences are to:
   a. Reduce unnecessary or inappropriate admissions and inpatient days.
   b. Ensure that services are provided in the appropriate setting or manner required for the patient's medical condition
   c. Improve the quality of care rendered
   d. Evaluate the anticipated course of treatment and length of stay
   e. Evaluate Members for transfer from non-contracted to contracted hospitals
   f. Ensure participating providers who are contracted with Partnership are appropriately utilized
   g. Address, plan, and coordinate needs of the patient upon discharge, including identification of cases appropriate to case management intervention
   h. Ensure the provision of efficient, quality care and assist in assessing alternative treatments
   i. Provide appropriate support and recommendations to the Inpatient UM Nurse Coordinators

J. PROCESS FOR A PROVIDER TO APPEAL AN ADVERSE BENEFIT DETERMINATION ON BEHALF OF A MEMBER

1. Refer to Partnership's policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.

K. POST-SERVICE OR RETROSPECTIVE REVIEW

Retrospective review applies the same process and criteria as continued stay/concurrent review, only AFTER the patient has been discharged.

1. Objective
   Retrospective review is used to identify medically unnecessary admissions and bed days that have been incurred.
2. Process
   a. For post-service/retrospective review, Partnership will render a decision (approve, modify, defer/pend, deny) no later than 30 calendar days from the receipt of the request.
   b. When the clinical information is received, the acute care hospitalization is evaluated, day by day, to determine the appropriateness of admission and length of stay given the patient's clinical status and the course of treatment.
   c. Identified problem areas are presented to the CMO/Physician Designee as with continued stay review/concurrent review.

d. Electronic or written notification of the decision and how to initiate a routine or expedited appeal if applicable is communicated to the provider within 24 hours of decision, but no later than 30 calendar days from the date of the receipt of the request. Written notification is mailed to the Member within two (2) business days of the decision.

L. COMMUNICATION SERVICES
1. Partnership provides access to staff for Members and practitioners seeking information about the UM process and the authorization of care as described in policy MCUP3064 Communication Services.
2. Note that Partnership also has a dedicated after-hours local phone number (707) 430-4808 or toll free number (866) 828-2304 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's CMO/physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a Member whose emergency medical condition is stabilized.

M. DELEGATION OVERSIGHT AND MONITORING
1. Partnership delegates UM functions to select contracted hospitals. Please see policy MCUP3141 Delegation of Inpatient Utilization Management.

VII. REFERENCES:
A. InterQual® criteria
B. Medi-Cal Provider Manual/ Guidelines
C. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2025) UM 5 Timeliness of UM Decisions Elements A and E
D. DHCS All Plan Letter (APL) 21-011 *Revised* Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2022)

VIII. DISTRIBUTION:
A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:
03/23/95; 08/98; 06/21/00; 06/20/01; 09/18/02; 04/16/03; 05/21/03; 10/20/04; 02/16/05; 08/20/08; 11/18/09; 05/18/11; 05/20/15; 08/19/15; 05/18/16; 04/19/17; *08/08/18; 04/10/19; 04/08/20; 04/14/21; 06/09/21; 06/08/22; 08/09/23; 09/11/24; 09/10/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: MCUP3053 Acute Inpatient Administrative Days (06/20/2001 – 09/10/2025)

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes

- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

this page left blank

Healthcare Effectiveness Data and Information Set (HEDIS®)

MY2024 / RY2025 Summary of Performance

Presented by:

Kristine Gual, Director of Quality Measurement

Today's Topics

- MY2024 Changes to Reporting Populations for HEDIS Programs

- DHCS Managed Care Accountability Set (MCAS) Results

  MY2024 MCAS Annual Summary of Performance

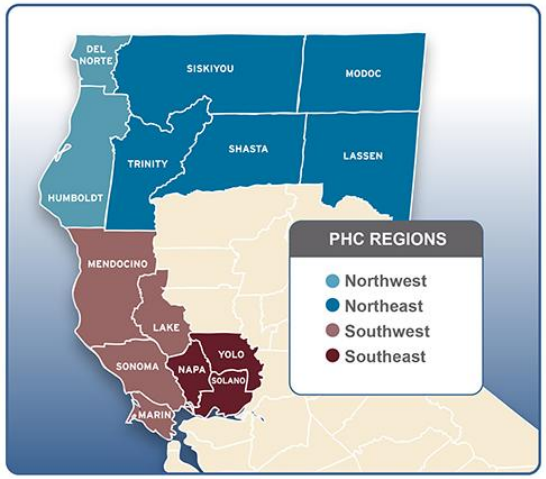
- NCQA Health Plan Accreditation (HPA) - Projected Star Rating

  MY2024 NCQA HPA Annual Summary of Performance

MY2024 HEDIS Project – Changes to Reporting Populations

MY2023 vs. MY2024 Reporting Populations

MY2023



MY2024 **36.7% increase in membership**

Managed Care Accountability Set (MCAS) Reporting	
Northwest	Humboldt, Del Norte
Northeast	Lassen, Modoc, Siskiyou, Trinity, Shasta
Southwest	Sonoma, Marin, Mendocino, Lake
Southeast	Solano, Yolo, Napa
NCQA Health Plan Accreditation (HPA) Reporting	
Plan-Wide	All 14 Legacy Partnership Counties

Population	Description	Purpose
NCQA HEDIS Reporting - DHCS Populations		
Plan Wide	All 24 counties - Plan wide reported rates	DHCS-published HEDIS rates for MCP
County	County level measure rates for each of Partnership's 24 counties	Geographic sanctions and withholds will be applied at DHCS's discretion (applied only to 14 legacy counties in MY2024)
NCQA HEDIS Reporting - HPA Population		
Plan Wide	All 24 counties - Plan wide reported rates	NCQA Star Rating

MY2024 DHCS Managed Care Accountability Set (MCAS) Results

MCAS: Accountable Measures MY2024

Domain	Measure	
Pediatric	W30+6	**Well Child Visits: 0-15 Months****
	W30+2	**Well Child Visits: 15-30 Months****
	WCV	**Child & Adolescent Well Care Visits****
	CIS	**Childhood Immunizations****
	IMA	**Immunizations for Adolescents****
	LSC	Lead Screening in Children
	TFL-CH	Topical Fluoride for Children
	DEV	Developmental Screening in 0-3yrs

Domain	Measure	
Cancer Prevention	BCS-E	Breast Cancer Screening
	CCS	Cervical Cancer Screening
Reproductive	CHL	Chlamydia Screening
	PPC-Pre	**Timeliness of Prenatal Care****
	PPC-Post	**Postpartum Care****
Chronic Disease	GSD	**Hemoglobin A1c Poor Control (>9%)****
	CBP	**Controlling High BP****
	AMR	Asthma Medication Ratio
Behavioral Health	FUA-30	F-Up after ED Visit for Substance Use
	FUM-30	F-Up after ED Visit for Mental Illness

**** Designates a Quality Withhold measure**

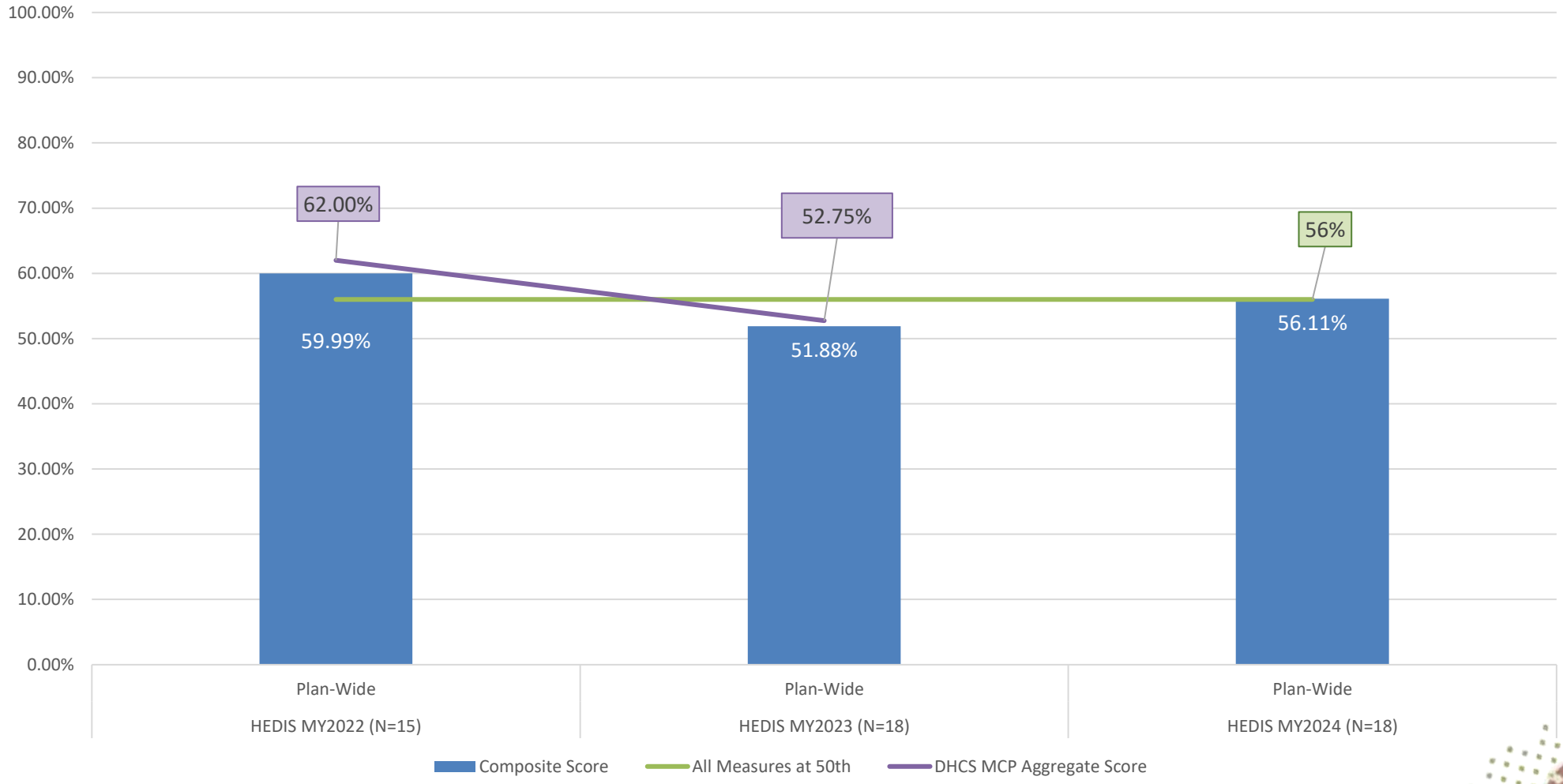
- 18 measures in MY2024
- All 18 measures from MY2023 continue in MY2024
- Accountable measures must meet or exceed the Minimum Performance Level (MPL) (i.e. 50th percentile national Medicaid percentile) or Partnership is subject to enforcement actions

Composite Scoring Methodology

- Partnership receives a composite score from DHCS – **Quality Factor Score.**
- A maximum of 10 points is awarded per measure based on Quality Compass 2024 (i.e. national Medicaid) benchmarks.
- With 18 measures in MY2024, a total of 172 points are possible based on DHCS's scoring system. Our composite score is a **percentage (%)** of 18 measures x 10 points/measure = 180 points.
- Partnership's Composite Score will be **one Plan-Wide score for MY2024**, a transition from four (4) Reporting Unit scores in prior years.

Quality Compass Benchmark	Points Awarded per Measure's Performance
90th	10
82.5th	9
75th	8
62.5th	7
50th – MPL or >50th (CMS)	6
37.5th	5
25th	4
17.5th	3
10th	2
<10th or <50th (CMS)	1

MCAS Composite Scoring & Year-over-Year Trends, Complete MCAS Measure Set



MY2024 Plan-Wide MCAS Performance

HEDIS Plan Wide Performance
Report Year 2025; Measurement Year 2024
Performance Relative to Quality Compass® Medicaid Benchmarks

	Plan Wide Performance	National Medicaid Benchmarks			
Measures	Plan Wide	25TH	50TH	75TH	90TH
Asthma Medication Ratio - Total, 5 to 64 Ratios > 0.50	64.71%	59.47%	66.24%	72.22%	76.65%
***Breast Cancer Screening ECDS - Non-Medicare Total	56.29%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening*	59.12%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status - Combination 10*	28.22%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women - Total	55.58%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure - Non-Medicare Total*	69.59%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV) - Total All Ages	29.65%		35.70%		
Follow-Up After ED Visit for Mental Illness - 30 Days Total	29.01%	46.05%	53.82%	63.06%	73.12%
Follow-Up After ED Visit for Substance Use - 30 Days Total	33.27%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Control for Pts w/ Diabetes - HbA1c Poor Control (>9%)*	32.60%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents - Combination 2*	40.39%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	71.78%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care - Postpartum care*	89.54%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care - Timeliness of Prental Care*	85.40%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	12.40%		19.30%		
Well Care Visits (WCV) - Total	48.83%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	72.22%	65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	67.05%	54.46%	60.38%	64.99%	69.67%

- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MPL** (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

Measure Performance: Plan-Wide Strengths

Plan-Wide: Most Improved Measures

	MY2023 Plan-Wide (Weighted rate)	MY2024 Plan-Wide
Lead Screening in Children (LSC)	25th	75th + 12.66%
Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months (W30-6) **	<10th	75th +24.96%
Well-Child Visits in the First 30 Months of Life - 2+ visits 15-30 months (W30-2) **	37.5th	62.5th +7.67%

**** DHCS Withhold measure**

Benchmark	Pt Value
90th	10
82.5th	9
75th	8
62.5th	7
50th – MPL or >50th (CMS)	6
37.5th	5
25th	4
17.5th	3
10th	2
<10th or <50th (CMS)	1

Measure Performance: Plan-Wide Strengths

Plan-Wide: Newly Above the 50th Percentile

	MY2023 Plan-Wide (Weighted rate)	MY2024 Plan-Wide
Breast Cancer Screening (BCS-E)	37.5th	50th +0.77%
Cervical Cancer Screening (CCS)	37.5th	50th +2.77%
Childhood Immunization Status—Combination 10 only (CIS-10) **	25th	50th +0.97%

**** DHCS Withhold measure**

Benchmark	Pt Value
90th	10
82.5th	9
75th	8
62.5th	7
50th – MPL or >50th (CMS)	6
37.5th	5
25th	4
17.5th	3
10th	2
<10th or <50th (CMS)	1

Measure Performance: Plan-Wide Strengths

Plan-Wide: Sustained High Performing Measures

	MY2023 Plan-Wide (Weighted rate)	MY2024 Plan-Wide	
Controlling High Blood Pressure (CBP) **	50th	75th +6.23%	
Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) **^	62.5th	50th -1.48%	WATCH
Immunizations for Adolescents—Combination 2 (IMA-2) **	50th	62.5th +2.43%	
Prenatal and Postpartum Care: Postpartum Care (PPC-Post) **	90th	90th +4.14%	
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) **	50th	50th -0.78%	WATCH

Benchmark	Pt Value
90th	10
82.5th	9
75th	8
62.5th	7
50th – MPL or >50th (CMS)	6
37.5th	5
25th	4
17.5th	3
10th	2
<10th or <50th (CMS)	1

**** DHCS Withhold measure**
^ Inverse measure, lower rate is better

Measure Performance: Plan-Wide Opportunities

Plan-Wide: Opportunities for Performance Improvement

	MY2023 Plan-Wide (Weighted rate)	MY2024 Plan-Wide
Asthma Medication Ratio (AMR)	37.5th	37.5th +0.70%
Chlamydia Screening in Women (CHL)	50th	37.5th -0.42%
Child and Adolescent Well-Care Visits (WCV) **	37.5th	37.5th +1.42%

**** DHCS Withhold measure**

Benchmark	Pt Value
90th	10
82.5th	9
75th	8
62.5th	7
50th – MPL or >50th (CMS)	6
37.5th	5
25th	4
17.5th	3
10th	2
<10th or <50th (CMS)	1

Measure Performance: Data Completeness Issues

Plan-Wide: Significant Data Completeness Issues Contribute to Poor Performance

	MY2023 Plan-Wide (Weighted rate)	MY2024 Plan-Wide
Developmental Screening in the First Three Years of Life (DEV)	>50th	<50th -0.38%
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA-30)	25th	37.5th +1.25%
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30)	>10th	<10th -2.47%
Topical Fluoride for Children (TFL-CH)	<50th	<50th +12.15%

Benchmark	Pt Value
90th	10
82.5th	9
75th	8
62.5th	7
50th – MPL or >50th (CMS)	6
37.5th	5
25th	4
17.5th	3
10th	2
<10th or <50th (CMS)	1

MY2024 NCQA Health Plan Accreditation Projected Star Rating

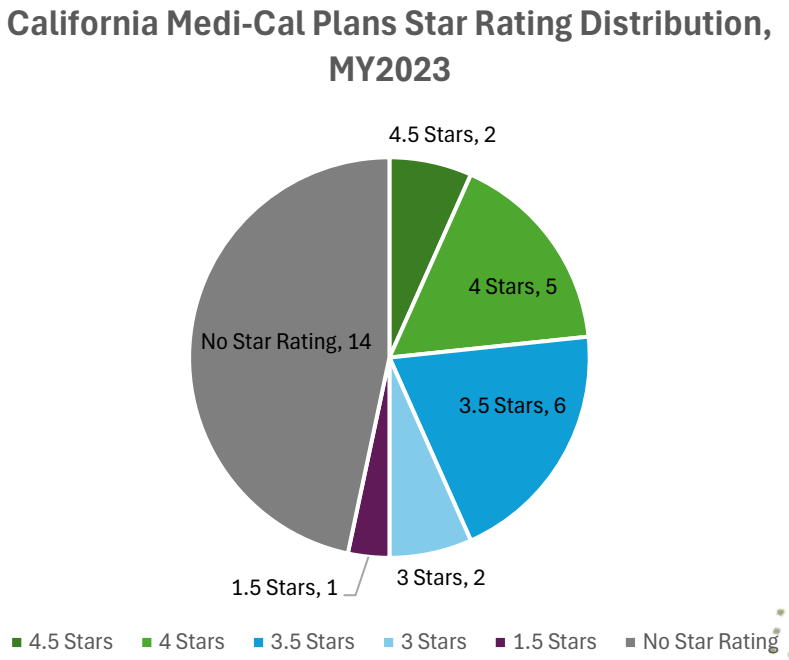
NCQA Health Plan Accreditation (HPA) – Healthplan Rating Methodology

The overall rating is calculated on a 0–5 point scale, to the nearest half point, based on performance in 3 subcategories:

1. **Patient Experience:** CAHPS Survey measures – each year Partnership chooses to submit Child CAHPS or Adult CAHPS Survey

2. **Rates for Clinical Measures:** HEDIS measures designated in 2 domains: 1) Prevention and Population and 2) Treatment

3. **NCQA Health Plan Accreditation:** 0.5 bonus points are added to the overall rating before rounding to the nearest half point and displaying as the final Star rating.



Projected HPR for MY2024

The *projected* HPR rating for MY2024 is **3.5 Stars, using the Child CAHPS Survey**.

	MY2022 – Final Used Child CAHPS	MY2023 – Final Used Adult CAHPS	MY2024 – Projected Used Child CAHPS	MY2024 – Projected If we used Adult CAHPS
Patient Experience (CAHPS)	2.0	1.5	2.5	2.0
Prevention and Population (HEDIS domain)	3.5	3.5	3.5	3.5
Treatment (HEDIS domain)	3.5	3.5	2.5	2.5
Bonus for maintaining Accreditation	0.5	0.5	0.5	0.5
Overall HPR	**3.5**	**3.5**	**3.5**	**3.5**

Questions?

HEDIS Team: hedisteam@partnershiphp.org

MY2024 MCAS Annual Summary of Performance

MY2024 NCQA HPA Annual Summary of Performance

Healthcare Effectiveness Data and Information Set (HEDIS®)

Measurement Year 2024 / Reporting Year 2025

Managed Care Accountability Set (MCAS)
Summary of Performance
August 2025

Table of Contents

NCQA's Notice of Copyright and Disclaimers 4
1.0 Notable Changes to the MY2024 Annual Summary of Performance Report 5
2.0 Plan-Wide MCAS Performance Relative to Quality Compass® Medicaid Benchmarks 10
3.0 MCAS Summary of Performance by Region 11
3.1 MCAS Measures at or Above the High Performance Level (HPL) – 90th Percentile 11
3.2 MCAS Measures below the Minimum Performance Level (MPL) - 50th Percentile 11
4.0 MCAS Summary of Performance by County 12
4.1 MCAS Distribution of Percentile Rankings by County 12
4.2 MCAS Percentile Ranking Change from Prior Year 13
4.2.1 MCAS Percentile Ranking Change MY2023-2024 – Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties 14
4.2.2 MCAS Percentile Ranking Change MY2023-2024 – Fairfield Region: Napa, Solano, Yolo Counties 15
4.2.3 MCAS Percentile Ranking Change MY2023-2024 – Redding Region: Lassen, Modoc, Shasta, Siskiyou, Trinity Counties 16
4.2.4 MCAS Percentile Ranking Change MY2023-2024 – Santa Rosa Region: Marin, Sonoma Counties 17
4.3 MY2024 MCAS Annual Performance by County 18
4.3.1 MCAS Auburn Region: Nevada, Placer, Plumas, Sierra Counties 18
4.3.2 MCAS Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties 19
4.3.3 MCAS Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties 20
4.3.4 MCAS Fairfield Region: Solano, Yolo, and Napa Counties 21
4.3.5 MCAS Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties 22
4.3.6 MCAS Santa Rosa Region: Marin, Sonoma Counties 23
5.0 Overall Health Plan Ranking: DHCS Managed Care Accountability Set (MCAS) 24
6.0 Year-over-year Performance Trends and Initial Assessment of Results 26
6.1 Year-over-year Performance Trends 26
6.2 Plan-Wide Strengths: Measure Performing Above MPL 26
6.3 Plan-Wide Opportunities for Improvement 29
6.3.1 MCAS Measures with Performance Opportunities 29
6.3.2 MCAS Measures with Data Completeness and Measure Limitation Issues 31
6.4 Comparing MY2024 MCAS Results to MY2024 PCP QIP Results 33

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

6.6 Next Steps in Finalizing Assessment of Results 34
7.0 Summary of Measures in the Primary Care Provider Quality Improvement Program (PCP QIP) 34
8.0 Measurement Year 2024 Managed Care Accountability Site (MCAS) Measurement Set Descriptions-Accountable Measures 36
9.0 Quality Improvement Initiatives - HEDIS Score Improvement 40
9.2 Chronic Disease Measure Activities 40
9.3 Behavioral Health Measure Activities 41
9.4 Pediatric Medicine Measure Activities 43
9.5 Women's Health and Perinatal Care Measure Activities 44

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

NCQA's Notice of Copyright and Disclaimers

The source for certain health plan measure rates and benchmark (averages and percentiles) data ("the Data") is Quality Compass® [2024] and is used with the permission of the National Committee for Quality Assurance ("NCQA"). Any analysis, interpretation or conclusion based on the Data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation or conclusion. Quality Compass is a registered trademark of NCQA.

The Data comprises audited performance rates and associated benchmarks for Healthcare Effectiveness Data and Information Set measures ("HEDIS®") and HEDIS CAHPS® survey measure results. HEDIS measures and specifications were developed by and are owned by NCQA. HEDIS measures and specifications are not clinical guidelines and do not establish standards of medical care. NCQA makes no representations, warranties or endorsement about the quality of any organization or clinician who uses or reports performance measures, or any data or rates calculated using HEDIS measures and specifications, and NCQA has no liability to anyone who relies on such measures or specifications.

NCQA holds a copyright in Quality Compass and the Data, or NCQA has obtained the necessary rights in the Data, and may rescind or alter the Data at any time. The Data may not be modified by anyone other than NCQA. Anyone desiring to use or reproduce the Data without modification for an internal, noncommercial purpose may do so without obtaining approval from NCQA. All other uses, including a commercial use and/or external reproduction, distribution or publication, must be approved by NCQA and are subject to a license at the discretion of NCQA. © [2024] National Committee for Quality Assurance, all rights reserved.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

1.0 Notable Changes to the MY2024 Annual Summary of Performance Report

MY2024 continued to host two required separate audits:

- DHCS / MCAS required reporting: Health Service Advisory Group (HSAG) Auditor (this report's focus)
- NCQA HEDIS Health Plan Accreditation / HPA: Advent Advisory Auditor

Partnership HEDIS Reporting Populations – MY2024

In MY2024, Partnership observed an increase in overall membership by approximately 36.7%, to 906,964 assigned members in December 2024. The changes in membership reflect the addition of 10 new counties to the Partnership network, as well as the departure of members assigned to Kaiser sites, who moved to Kaiser as their Medi-Cal Managed Care Plan.

- Incoming counties added approximately 316,000 members to Partnership.
- Approximately 82,000 members assigned to Kaiser departed from Partnership. The decrease in membership primarily impacted Solano, Sonoma, Napa and Yolo Counties.

	Dec 2023	Dec 2024
Total Membership	**663,919**	**906,964**
10 Incoming Counties	**0**	**316,096**
New membership	0	316,096
14 Legacy Counties	**663,919**	**590,868**
Kaiser assigned Partnership members	82,033	0
Non-Kaiser membership	581,886	590,868

The addition of 10 incoming counties to Partnership's network coincides with changes to Partnership's HEDIS Reporting Populations for both DHCS's MCAS measure set and NCQA's Health Plan Accreditation (HPA). Starting in MY2024, Partnership reported one Plan-Wide rate for all 24 counties in its network for the MCAS measure set to its DHCS auditor, HSAG. The Reporting Unit configuration of Partnership regions used until MY2023 (i.e.: Southeast, Southwest, Northeast, and Northwest) has been retired.

The impact of population shifts in Partnership's network impacts HEDIS measure eligible populations differently, depending on each measure's continuous enrollment requirements as defined in the NCQA HEDIS MY2024 Technical Specifications. A subset of measures require continuous enrollment greater than one (1) year for a member to be included in the measure's eligible population, which meant that very few members from incoming counties met the criteria to be included in the measures' plan-wide rates in MY2024. For the MCAS measure set, these measures with very small eligible populations for incoming counties in MY2024 are:

- Asthma Medication Ratio (AMR)
- Breast Cancer Screening, ECDS (BCS-E)
- Well-Child Visits in the First 30 Months of Life (W30)

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

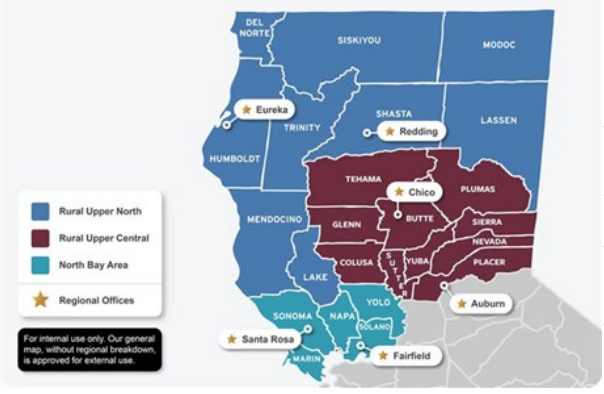
Changes to DHCS Sanctioning Methodology – MY2024

Starting in MY2024, Partnership also reported county-wide rates for all MCAS measures and their respective sub-measures to DHCS directly. DHCS intends to hold all California Managed Care Plans accountable for sanctions for all MCAS Accountable measures that did not reach the 50th percentile benchmark at either the county level or at the level of groups of counties. Details have not been finalized at the time of this report.

Of note, sanctions do not apply to counties newly covered by a Managed Care Plan. For Partnership, this includes the Plan's 14 legacy counties; the 10 incoming counties are not held to performance sanctions in MY2024.

Population	Description	Purpose
NCQA HEDIS Reporting - DHCS Populations		
Plan Wide	All 24 counties - Plan wide reported rates	DHCS-published HEDIS rates for MCP
County	County level measure rates for each of Partnership's 24 counties	Geographic sanctions and withholds will be applied at DHCS's discretion (applied only to 14 legacy counties in MY2024)
NCQA HEDIS Reporting - HPA Population		
Plan Wide	All 24 counties - Plan wide reported rates	NCQA Star Rating

Starting in MY2024, DHCS also intends to use its Withhold/Incentives accountability program for Partnership to earn back a percentage of its withheld income from DHCS based on performance of a subset of MCAS measures and two (2) CAHPS measures. The Withhold accountability program measures MCAS measure rates aggregated by DHCS Quality Rating Regions. The Rural Upper Central Rating Region, which is made up of the 10 incoming counties to Partnership in 2024, is excluded from the Withhold/Incentives accountability program for MY2024. An illustration of Partnership's network organized by DHCS Quality Rating Regions is shown below.



DHCS Quality Rating Region	Counties
North Bay	Marin, Napa, Sonoma, Solano, Yolo
Rural Upper North	Del Norte, Humboldt, Lassen, Lake, Mendocino, Modoc, Shasta, Siskiyou, Trinity
Rural Upper Central	Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

Changes to NCQA HEDIS Measures – MY2024

NCQA released changes to two existing clinical measures used in DHCS MCAS for MY2024:

- The former Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) measure was revised to Glycemic Status Assessment for Patients with Diabetes (GSD).
- Colorectal Cancer Screening (COL-E) using ECDS methodology replaced Colorectal Cancer Screening (COL), which was an administrative measure.

Partnership's Efforts to Improve Data Quality – MY2024

Partnership was able to use a number of new supplemental data sources in the MY2024 HEDIS Annual project.

Electronic Clinical Data Systems (ECDS) Vendor Pilot: Partnership piloted the use of Datalink, an NCQA Certified Data Aggregator software, in MY2024, and received auditor approval to include records from two (2) EMR vendors (eClinical Works and Nextgen) in the MY2024 HEDIS Project. Records from six (6) practices within Partnership's provider network were included in the MY2024 HEDIS Annual Project. The analysis shows promising results from the Datalink pilot:

- The MCAS (Report Only) measure set includes seven (7) Depression Screening measures. Datalink was the sole source of data for six (6) of the seven (7) Depression Screening measures.
- Five (5) of the seven (7) Depression Screening measures exceeded the 50th percentile as a result of the inclusion of Datalink data.
- Datalink also made a positive impact on administrative rates for MCAS Accountable measures, including Controlling Blood Pressure (CBP) and Glycemic Status Assessment for Patients with Diabetes (GSD).

Medical Record Review for Well-Child Visits in the First 30 Months of Life (W30) Pilot:
Partnership has historically scored below the 50th percentile on both W30 measures, though the rates for the W15 measure (Well Child Visits Birth – 15 Months) within the Primary Care Provided Quality Incentive Program (PCP QIP) have been above the 50th percentile since MY2022. The QI department devoted time and resources to researching root causes for the discrepancy between HEDIS and QIP rates in 2024 and identified numerous points of failure for newborn visits to be counted towards the HEDIS rate using administrative data. The major issue identified was a temporary member ID number that could not automatically be matched to the child's final permanent membership ID.

As a result of this analysis, the HEDIS team piloted a supplemental Medical Record Review of the entire W30 measure eligible population in early 2025, which was accepted as a supplemental data source by HSAG's auditor. The supplemental Medical Record Review made a dramatic impact on the rates for both W30 submeasures, and both W30 submeasure rates scored above the 50th percentile for MY2024.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

Sacramento Valley MedShare (SVMS): SVMS is a Health Information Exchange used by practices and health systems throughout Northern California. In MY2024, Partnership received auditor approval to use Immunization, Lab, and Measurement (i.e.: blood pressure readings) records towards the HEDIS Annual Project, which had a significant impact on several MCAS measures in MY2024. In previous years not all three record categories were approved for use in the HEDIS Annual Project.

Root cause analysis of fluoride varnish coding: Partnership worked with DHCS in 2024-2025 to better understand how it receives fluoride varnish claims and encounters that can be counted towards the Topical Fluoride for Children (TFL-CH) MCAS measure, most of which are billed to Denti-Cal from Federally Qualified Health Center (FQHC), Rural Health Center (RHC), and Tribal Health Dental Centers and then sent to Partnership. As a result, Partnership was able to identify dental visits completed by FQHC, RHC, and Tribal Health Dental Centers and receive approval from HSAG's auditor to include in the MY2024 HEDIS Annual Project. Unfortunately, the dental visit data for the FQHC, RHC, and Tribal Health Dental Centers that Partnership receives from DHCS does not include procedure codes for dental fluoride varnish applications; only diagnosis codes for fluoride varnish are included. In 2025 Partnership is actively working with Dental Centers throughout its network to expand the use of dental fluoride varnish diagnosis coding to help with next year's MY2025 HEDIS audit.

HEDIS Annual Project Outcomes

Partnership successfully launched our HEDIS® MY2024/RY2025 data collection and reporting audits incorporating all changes as noted above.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

DHCS MCAS Accountable Measures

In MY2024/RY2025 HEDIS® Annual Final Reporting, DHCS announced that it is planning to hold managed care plans (MCPs) accountable and imposing financial sanctions on 18 selected Hybrid and Administrative measures performing below the minimum performance level (MPL - 50th national Medicaid percentile). In prior years, the final list of sanctionable measures was changed just before sanctions were announced, so the final number of sanctionable measures may change late in 2025.

Results of an additional 20 MCAS measures were reported but were not part of the accountability measure set in MY2024 ("reporting only measures"). The full list of MY2024 MCAS measures can be found on the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Documents/Managed-Care-Accountability-Set-Reporting-Year-2025.pdf

The same 18 MCAS accountable measures from MY2023 continued into MY2024, although two of the MY2023 measures (FUA and FUM) were removed from being accountable for MY2023 sanctions after the annual analysis was complete, due to data incompleteness transmitted from DHCS to Managed Care Plans.

Much of the measure performance analysis that follows is based on the performance of the 18 accountable MCAS measures per NCQA Quality Compass 2024 Benchmarks, developed on MY2023 performance.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

2.0 Plan-Wide MCAS Performance Relative to Quality Compass® Medicaid Benchmarks

- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MPL** (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

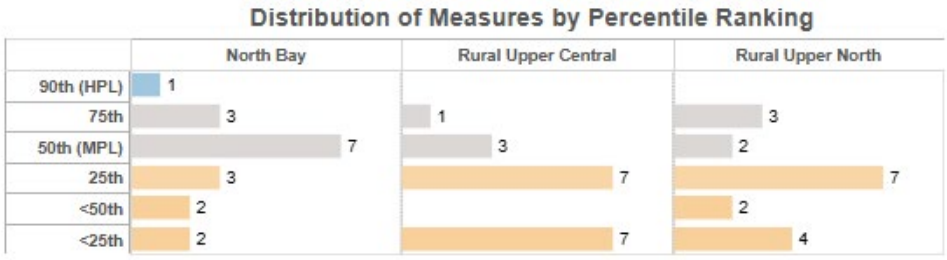
	Plan Wide Performance	National Medicaid Benchmarks			
Measures	**Plan Wide**	**25TH**	**50TH**	**75TH**	**90TH**
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	64.71%	59.47%	66.24%	72.22%	76.65%
Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	56.29%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS) - *	59.12%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	28.22%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	55.58%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	69.59%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	29.65%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	29.01%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	33.27%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	32.60%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	40.39%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC) - *	71.78%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	89.54%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	85.40%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	12.40%		19.30%		
Well Care Visits (WCV) - Total	48.83%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	72.22%	65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	67.05%	54.46%	60.38%	64.99%	69.67%

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

3.0 MCAS Summary of Performance by Region

Regional Distribution of Measures by Percentile Ranking



● Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)

● Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

3.1 MCAS Measures at or Above the High Performance Level (HPL) – 90th Percentile

Measures	North Bay
Prenatal and Postpartum Care (PPC) - Postpartum care*	●

3.2 MCAS Measures below the Minimum Performance Level (MPL) - 50th Percentile

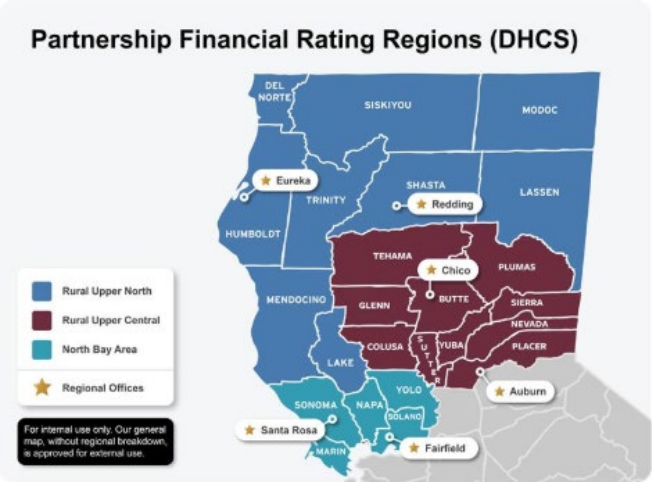
Measures	North Bay	Rural Upper Central	Rural Upper North
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50		●	●
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total		●	●
Cervical Cancer Screening (CCS)*		●	●
Childhood Immunization Status (CIS) - Combination 10*		●	●
Chlamydia Screening in Women (CHL) - Total		●	●
Controlling High Blood Pressure (CBP) - Non-Medicare Total*		●	●
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	●		●
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total	●	●	●
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	●	●	●
**Hemoglobin A1c Poor Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)*	●	●	
Immunizations for Adolescents (IMA) - Combination 2*		●	●
Prenatal and Postpartum Care (PPC) - Timeliness of Prental Care*	●	●	●
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	●		●
Well Care Visits (WCV) - Total	●	●	●
^Well Child 30 (W30) - Well child visits for age15-30 months		●	
^Well Child 30 (W30) - Well child visits in the first 15 months		●	

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

4.0 MCAS Summary of Performance by County

4.1 MCAS Distribution of Percentile Rankings by County



DHCS_ Financial_ Rating_Region	County	<25th	<50th(DEV and TFL-CH only)	25th	50th (MPL)	75th	90th (HPL)
North Bay	MARIN	1	1	3	5	2	6
	NAPA	4	2	2	2	1	7
	SOLANO	4	2	4	3	3	2
	SONOMA	1	2	4	5	3	3
	YOLO	4		4	7	3	
Rural Upper Central	BUTTE	10	2	3	2		1
	COLUSA	5		3	5		4
	GLENN	2	1	4	5	3	1
	NEVADA	7	1	2	2	2	2
	PLACER	6		3	5	1	
	PLUMAS	9	2	2		2	1
	SIERRA	8	2				1
	SUTTER	2		3	7	1	2
	TEHAMA	9	2	4		2	1
	YUBA	3		5	6		1
Rural Upper North	DEL NORTE	8	2	5	2	1	
	HUMBOLDT	3	1	4	2	5	3
	LAKE	6	2	4	2	2	2
	LASSEN	8	2	2	5	1	
	MENDOCINO	2	2	6	3	3	2
	MODOC	8	2	5		2	1
	SHASTA	9	2	2	3	2	
	SISKIYOU	6	2	7	1	1	1
	TRINITY	9	2	5		2	

- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MPL** (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

NOTE: The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. Performance below the 50th percentile is indicated by the <50th column in the graph.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

4.2 MCAS Percentile Ranking Change from Prior Year

Where measures remained in the MCAS in MY2024, the next set of tables show that Partnership observed a number of measures within the fourteen (14) legacy counties that declined or improved in percentile ranking relative to prior year. The NCQA Quality Compass 2024 Benchmarks, which were developed based on MY2023 performance, result in the percentile rankings below.

At the County level, a comparison of county-level performance between MY2023 and MY2024 in Partnership's 14 legacy counties shows:

- 67 county-level measures, or 26.59% of 252 county-level measures, improved in performance and moved to a higher benchmark in MY2024.
- 126 county-level measures, or 50.39% of 252 county-level measures, stayed at their same benchmark as MY2023 in MY2024.
- 58 county-level measures, or 23.02% of 252 county-level measures, declined in performance and moved to a lower benchmark in MY2024.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

4.2.1 MCAS Percentile Ranking Change MY2023-2024 – Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

	DEL NORTE		HUMBOLDT		LAKE		MENDOCINO	
Measure	**MY2023**	**MY2024**	**MY2023**	**MY2024**	**MY2023**	**MY2024**	**MY2023**	**MY2024**
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	<25th	25th	25th	25th	<25th	<25th	25th	25th
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	<25th	<25th	25th	25th	25th	25th	25th	50th
Cervical Cancer Screening (CCS)*	<25th	<25th	50th	75th	<25th	25th	<25th	75th
Childhood Immunization Status (CIS) - Combination 10*	<25th	<25th	<25th	<25th	25th	<25th	<25th	25th
Chlamydia Screening in Women (CHL) - Total	<25th	<25th	25th	25th	25th	25th	25th	25th
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	<25th	<25th	50th	75th	50th	<25th	75th	25th
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	<50th	<50th	<50th	50th	<50th	<50th	<50th	<50th
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	<25th	25th	25th	75th	25th	<25th	25th	25th
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	75th	25th	75th	90th	50th	<25th	50th	50th
Immunizations for Adolescents (IMA) - Combination 2*	<25th	50th	50th	50th	50th	75th	25th	<25th
Lead Screening in Children (LSC)*	25th	<25th	50th	90th	<25th	50th	75th	75th
Prenatal and Postpartum Care (PPC) - Postpartum care*	<25th	25th	90th	90th	25th	90th	90th	90th
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	25th	<25th	<25th	<25th	90th	50th	90th	50th
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th
Child and Adolescent Well Care Visits (WCV) - Total	25th	25th	50th	25th	25th	25th	25th	25th
^Well Child 30 (W30) - Well child visits for age15-30 months	<25th	50th	25th	75th	<25th	75th	50th	75th
^Well Child 30 (W30) - Well child visits in the first 15 months	<25th	75th	<25th	75th	<25th	90th	25th	90th

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

4.2.2 MCAS Percentile Ranking Change MY2023-2024 – Fairfield Region: Napa, Solano, Yolo Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

	NAPA		SOLANO		YOLO	
Measure	**MY2023**	**MY2024**	**MY2023**	**MY2024**	**MY2023**	**MY2024**
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	90th	90th	50th	25th	50th	50th
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	90th	90th	75th	50th	75th	75th
Cervical Cancer Screening (CCS)*	90th	90th	25th	75th	50th	25th
Childhood Immunization Status (CIS) - Combination 10*	90th	90th	75th	75th	75th	50th
Chlamydia Screening in Women (CHL) - Total	25th	<25th	50th	50th	25th	25th
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	50th	25th	75th	50th	25th	25th
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	<50th	<50th	50th	<50th	50th	50th
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	<25th	<25th	<25th	<25th	<25th	<25th
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	25th	<25th	25th	25th	<25th	<25th
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	90th	50th	50th	<25th	90th	25th
Immunizations for Adolescents (IMA) - Combination 2*	90th	90th	90th	90th	75th	75th
Lead Screening in Children (LSC)*	50th	90th	25th	75th	50th	50th
Prenatal and Postpartum Care (PPC) - Postpartum care*	90th	90th	90th	90th	90th	50th
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	90th	<25th	50th	25th	90th	<25th
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	<50th	<50th	<50th	<50th	<50th	50th
Well Care Visits (WCV) - Total	75th	50th	<25th	<25th	50th	50th
^Well Child 30 (W30) - Well child visits for age15-30 months	75th	75th	<25th	<25th	75th	75th
^Well Child 30 (W30) - Well child visits in the first 15 months	<25th	25th	<25th	25th	<25th	<25th

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

4.2.3 MCAS Percentile Ranking Change MY2023-2024 – Redding Region: Lassen, Modoc, Shasta, Siskiyou, Trinity Counties

Tehama County is excluded from the Redding Region table, since the County joined Partnership in 2024.

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

	LASSEN		MODOC		SHASTA		SISKIYOU		TRINITY	
Measure	**MY2023**	**MY2024**	**MY2023**	**MY2024**	**MY2023**	**MY2024**	**MY2023**	**MY2024**	**MY2023**	**MY2024**
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	<25th	<25th	<25th	25th	<25th	<25th	<25th	25th	<25th	<25th
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	<25th	<25th	<25th	25th	25th	50th	25th	25th	<25th	25th
Cervical Cancer Screening (CCS)*	<25th	25th	<25th	<25th	<25th	25th	25th	<25th	<25th	25th
Childhood Immunization Status (CIS) - Combination 10*	<25th	<25th	<25th	<25th	<25th	<25th	<25th	25th	<25th	<25th
Chlamydia Screening in Women (CHL) - Total	<25th	<25th	<25th	<25th	25th	25th	<25th	<25th	<25th	<25th
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	25th	50th	<25th	<25th	25th	<25th	90th	50th	50th	<25th
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	<25th	<25th	25th	75th	75th	75th	25th	25th	50th	25th
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	75th	50th	90th	75th	25th	50th	25th	90th	75th	75th
Immunizations for Adolescents (IMA) - Combination 2*	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
Lead Screening in Children (LSC)*	<25th	75th	50th	90th	25th	50th	<25th	25th	50th	75th
Prenatal and Postpartum Care (PPC) - Postpartum care*	75th	25th	90th	25th	50th	<25th	50th	75th	50th	<25th
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	25th	50th	90th	25th	25th	<25th	90th	<25th	50th	<25th
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th
Well Care Visits (WCV) - Total	<25th	<25th	<25th	25th	<25th	<25th	<25th	25th	25th	25th
^Well Child 30 (W30) - Well child visits for age15-30 months	<25th	50th	25th	<25th	<25th	<25th	<25th	25th	<25th	<25th
^Well Child 30 (W30) - Well child visits in the first 15 months	<25th	50th	<25th	<25th	<25th	75th	<25th	<25th	<25th	25th

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

4.2.4 MCAS Percentile Ranking Change MY2023-2024 – Santa Rosa Region: Marin, Sonoma Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

	MARIN		SONOMA	
Measure	**MY2023**	**MY2024**	**MY2023**	**MY2024**
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	50th	25th	75th	50th
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	75th	75th	75th	50th
Cervical Cancer Screening (CCS)*	90th	75th	90th	75th
Childhood Immunization Status (CIS) - Combination 10*	75th	50th	75th	50th
Chlamydia Screening in Women (CHL) - Total	90th	90th	25th	25th
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	75th	50th	50th	75th
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	50th	50th	50th	<50th
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	<25th	<25th	<25th	<25th
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	25th	25th	25th	25th
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	75th	25th	75th	90th
Immunizations for Adolescents (IMA) - Combination 2*	75th	90th	90th	75th
Lead Screening in Children (LSC)*	90th	90th	<25th	25th
Prenatal and Postpartum Care (PPC) - Postpartum care*	90th	90th	90th	90th
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	50th	50th	90th	25th
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	<50th	<50th	<50th	<50th
Well Care Visits (WCV) - Total	75th	50th	50th	50th
^Well Child 30 (W30) - Well child visits for age15-30 months	75th	90th	25th	50th
^Well Child 30 (W30) - Well child visits in the first 15 months	<25th	90th	<25th	90th

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

4.3 MY2024 MCAS Annual Performance by County

4.3.1 MCAS Auburn Region: Nevada, Placer, Plumas, Sierra Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

Measures	Partnership Region - Auburn				National Medicaid Benchmarks			
	NEVADA	PLACER	PLUMAS	SIERRA	25TH	50TH	75th	90th
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50			100.00%		59.47%	66.24%		
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	66.67%	0.00%		0.00%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS)*	40.21%	39.39%	32.63%	43.43%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	15.22%	21.67%	12.50%		22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	48.06%	60.67%	23.26%	27.27%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	56.00%	53.00%	34.00%		59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	39.51%	44.12%	0.00%	0.00%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	36.81%	23.45%	25.00%	0.00%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	38.31%	34.08%	32.69%	100.00%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	34.00%	36.00%	73.00%		40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	17.54%	36.00%	0.00%	0.00%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	76.09%	65.00%	75.00%		53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	83.84%	84.00%	77.78%	25.00%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	82.83%	68.00%	88.89%	75.00%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	7.38%	20.20%	5.44%	5.45%		19.30%		
Well Care Visits (WCV) - Total	42.02%	47.93%	28.19%	30.90%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	100.00%		33.33%		65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months					54.46%	60.38%	64.99%	69.67%

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.* ***Blank cells indicate an Eligible Population of 0 members within a County for the measure.***

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

4.3.2 MCAS Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties

- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MPL** (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

	Partnership Region - Chico					National Medicaid Benchmarks			
Measures	BUTTE	COLUSA	GLENN	SUTTER	YUBA	25TH	50TH	75th	90th
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	66.67%		100.00%			59.47%	66.24%	72.22%	76.65%
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	26.32%	20.00%	0.00%	0.00%	100.00%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS)*	46.94%	60.61%	50.51%	54.08%	42.00%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	15.00%	21.88%	27.78%	37.84%	23.19%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	55.64%	53.02%	51.47%	57.24%	57.89%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	66.00%	64.00%	71.00%	67.68%	61.00%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	10.10%	40.68%	36.17%	57.22%	56.33%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	20.40%	33.33%	28.57%	26.09%	24.72%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	34.49%	26.92%	34.78%	29.85%	30.13%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	43.00%	32.00%	33.00%	36.00%	43.00%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	22.00%	60.00%	37.93%	39.51%	37.14%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	53.00%	87.50%	77.78%	83.78%	63.77%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	90.00%	92.94%	85.00%	90.00%	81.82%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	82.00%	74.12%	83.00%	87.00%	87.88%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	18.62%	28.95%	9.77%	39.49%	28.17%		19.30%		
Well Care Visits (WCV) - Total	41.84%	55.53%	53.91%	55.93%	47.65%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	50.00%	100.00%				65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	0.00%	0.00%				54.46%	60.38%	64.99%	69.67%

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.* ***Blank cells indicate an Eligible Population of 0 members within a County for the measure.***

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

4.3.3 MCAS Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

	Partnership Region - Eureka				National Medicaid Benchmarks			
Measures	DEL NORTE	HUMBOLDT	LAKE	MENDOCINO	25TH	50TH	75th	90th
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	60.83%	63.41%	57.84%	62.50%	59.47%	66.24%	72.22%	76.65%
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	46.83%	51.35%	48.55%	56.75%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS)*	49.00%	63.00%	56.25%	62.63%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	6.00%	19.00%	21.00%	25.00%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	47.33%	54.61%	53.93%	52.00%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	58.59%	70.00%	52.00%	63.00%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	27.71%	38.89%	6.03%	8.12%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	27.68%	35.36%	35.75%	30.66%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	27.06%	42.26%	23.51%	30.15%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	35.00%	23.00%	49.00%	31.00%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	36.00%	38.00%	42.00%	28.00%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	53.00%	89.00%	71.00%	79.00%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	79.00%	93.00%	91.00%	92.00%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	78.00%	79.00%	86.00%	86.00%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	0.68%	1.11%	1.69%	3.86%		19.30%		
Well Care Visits (WCV) - Total	49.25%	50.11%	48.82%	47.59%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	71.79%	74.89%	78.92%	75.15%	65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	68.47%	68.89%	79.34%	74.19%	54.46%	60.38%	64.99%	69.67%

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

4.3.4 MCAS Fairfield Region: Solano, Yolo, and Napa Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

Measures	Partnership Region - Fairfield			National Medicaid Benchmarks			
	NAPA	SOLANO	YOLO	25TH	50TH	75th	90th
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	79.82%	65.79%	67.84%	59.47%	66.24%	72.22%	76.65%
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	66.84%	54.14%	60.29%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS)*	70.00%	64.95%	52.53%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	47.00%	38.00%	33.00%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	49.58%	62.14%	51.37%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	63.00%	67.00%	63.00%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	3.77%	33.92%	61.20%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	26.09%	24.53%	26.73%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	26.11%	29.24%	26.46%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	32.00%	41.00%	35.00%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	53.00%	49.00%	46.00%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	84.00%	72.00%	71.00%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	93.00%	89.00%	82.00%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	74.00%	82.00%	65.00%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	13.87%	16.40%	19.73%		19.30%		
Well Care Visits (WCV) - Total	55.43%	43.99%	52.25%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	75.50%	63.84%	73.35%	65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	54.79%	55.26%	49.82%	54.46%	60.38%	64.99%	69.67%

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

4.3.5 MCAS Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

	Partnership Region - Redding						National Medicaid Benchmarks			
Measures	LASSEN	MODOC	SHASTA	SISKIYOU	TEHAMA	TRINITY	25TH	50TH	75th	90th
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	58.70%	63.16%	57.28%	59.62%	0.00%	50.00%	59.47%	66.24%	72.22%	76.65%
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	43.08%	48.52%	54.90%	52.64%	38.46%	49.39%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS)*	50.52%	46.46%	52.53%	49.49%	44.00%	55.79%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	13.00%	9.76%	14.00%	26.00%	16.00%	7.25%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	41.55%	32.89%	52.12%	45.38%	54.34%	34.72%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	66.00%	56.00%	58.00%	67.00%	64.00%	47.00%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	11.91%	27.27%	26.09%	28.95%	32.26%	8.67%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	18.75%	11.76%	35.70%	37.50%	14.81%	12.50%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	25.81%	45.45%	43.80%	32.53%	31.60%	32.56%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	32.00%	29.00%	30.00%	27.00%	41.00%	28.00%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	9.00%	24.00%	23.00%	17.00%	17.54%	20.37%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	76.00%	80.49%	71.00%	55.00%	76.00%	72.46%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	79.76%	77.42%	69.00%	84.00%	80.00%	75.47%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	86.90%	83.87%	71.00%	78.00%	72.00%	67.92%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	3.23%	3.06%	5.05%	1.25%	9.96%	2.39%		19.30%		
Well Care Visits (WCV) - Total	36.95%	48.59%	44.19%	47.51%	46.42%	48.35%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	70.16%	56.10%	65.41%	69.10%	75.00%	61.40%	65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	63.64%	45.83%	65.20%	37.63%	75.00%	59.38%	54.46%	60.38%	64.99%	69.67%

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

4.3.6 MCAS Santa Rosa Region: Marin, Sonoma Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

	Partnership Region - Santa Rosa		National Medicaid Benchmarks			
Measures	MARIN	SONOMA	25TH	50TH	75th	90th
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	61.27%	70.42%	59.47%	66.24%	72.22%	76.65%
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	63.44%	59.17%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS)*	64.00%	66.67%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	34.00%	30.00%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	77.63%	51.89%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	69.00%	70.00%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	48.23%	26.47%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	37.27%	33.66%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	34.63%	31.17%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	37.00%	27.00%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	49.00%	48.00%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	89.00%	54.00%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	98.00%	98.00%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	88.00%	81.00%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	0.55%	6.17%		19.30%		
Well Care Visits (WCV) - Total	56.18%	55.42%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	90.11%	71.03%	65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	86.53%	70.70%	54.46%	60.38%	64.99%	69.67%

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

5.0 Overall Health Plan Ranking: DHCS Managed Care Accountability Set (MCAS)

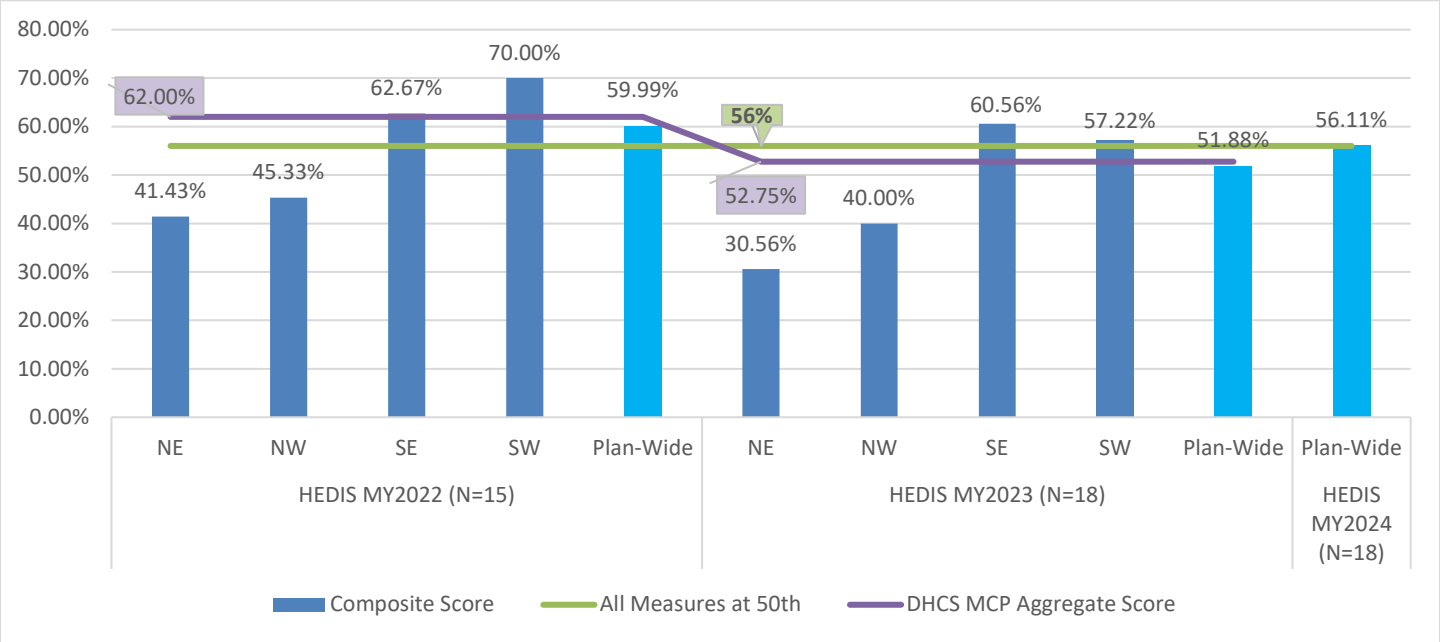
DHCS uses a scoring methodology to determine an aggregated Quality Factor Score (QFS), which ranks health plan performance relative to California Medicaid reporting health plans. Partnership adopts DHCS' scoring methodology to determine Partnership's composite scores year over year. In prior years, Partnership's composite score was calculated for each of the four (4) legacy Reporting Units (Southeast, Southwest, Northeast, and Northwest). In MY2024, since Partnership transitioned to one (1) Plan-Wide Reporting Unit, a single Plan-Wide composite score is calculated.

To calculate the composite score, each measure is given a score from one to ten (1-10) based on performance relative to national benchmarks. A composite score is then calculated by dividing total earned points by total possible points.

The Quality Compass 2024 Benchmarks, which were developed based on national MY2023 performance, are the most currently available benchmarks. These benchmarks were used by Partnership to determine percentile rankings and the following composite scoring year over year analysis. Annually each fall, DHCS releases a dashboard displaying the plan's Quality Factor Scores and associated rankings to other health plans. The results of this ranking will be published upon the release of this information and will be utilized by DHCS to assess mandated improvement activities and any sanctions.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

MY2024 HEDIS® Composite Performance Year over Year Comparison: DHCS Managed Care Accountability Set (MCAS)



Note: MY2024/RY2025: Total Points Earned: 101 Points out of 180 Total Points (18 measures included)

- In MY2024 18 measures were held accountable to the MPL.
- Three (3) measures were added to the MCAS Accountable Measure Set in MY2023: Asthma Medication Ratio (AMR), Developmental Screening for Children (DEV), and Topical Fluoride for Children (TFL-CH).
- MY2022-MY2023 represents DHCS's Quality Factor Scores, which are publicly available and issued in year following the Reporting Year.
- For MY2022-MY2023, Partnership received four (4) Quality Factor Scores from DHCS for each of its legacy Reporting Units. Partnership calculates its Plan-Wide score across all four DHCS MCAS reporting regions by factoring in eligible populations by region, given membership is significantly greater in the Southern region reporting populations than Northern.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

6.0 Year-over-year Performance Trends and Initial Assessment of Results

6.1 Year-over-year Performance Trends

The MY2024 HEDIS® Composite Performance Year-Over-Year Comparison is based on NCQA Quality Compass 2024 (MY2023) Benchmarks. To date, DHCS has only established state-wide MPLs for the two newly accountable CMS Core set measures, Developmental Screening in the First Three Years of Life (DEV) and Topical Fluoride for Children (TFL-CH). Therefore, the maximum points for these two (2) measures is 6 points. All other measures in the MCAS Accountable Measure Set can earn up to 10 points.

Overall, the MY2024 HEDIS® Composite Performance Year over Year Comparison indicates a 4.22% increase in aggregate plan-wide performance from MY2023 to MY2024.

Plan-Wide, Partnership saw the following Year over Year changes in Plan-Wide rates between MY2023 and MY2024:

- 9 of 18 measures improved in performance and moved to a higher benchmark in MY2024.
- 6 of 18 measures stayed at their same benchmark as MY2023 in MY2024.
- 3 of 18 measures declined in performance and moved to a lower benchmark in MY2024.

6.2 Plan-Wide Strengths: Measure Performing Above MPL

Eleven (11) of the 18 measures in the MCAS Accountable set exceeded the Minimum Performance Level in MY2024.

Six (6) measures are newly above the Minimum Performance Level in MY2024, as seen in the Table below.

Table: MCAS Measures Newly Above MPL in MY2024

Measure	MY2023 Plan-Wide Benchmark	MY2024 Plan-Wide Benchmark YOY points gained
Breast Cancer Screening (BCS-E)	37.5th	50th +0.77%
Cervical Cancer Screening (CCS)	37.5th	50th +2.77%
Childhood Immunization Status—Combination 10 only (CIS-10)	25th	50th +0.97%
Lead Screening in Children (LSC)	25th	75th +12.66%
Well-Child Visits in the First 30 Months of Life - 2+ visits 15-30 months (W30-2)	37.5th	62.5th +7.67%
Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months (W30-6)	<10th	75th +24.96%

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

- Breast Cancer Screening (BCS): Partnership achieved a Plan-Wide score above the MPL for the first time in MY2024. These gains are largely attributed to initiatives cited in Section 9, focused on creating greater access through mobile mammography events. This measure continues in the PCP QIP to bring continued PCP focus on utilizing available access to mammography services on an ongoing basis.

  Of note, performance in this measure is expected to drop in MY2025 and in the following few years, as the BCS-E measure lowered the age range for beginning breast cancer screening from age 50 years to 40 years. As this is a national change to the HEDIS measure, an adjustment in the benchmarks for this measure may follow, but some negative impact on performance is anticipated. Because the measure has long continuous enrollment requirements for members to be included in the measure, MY2024's measure included very few members from the incoming 10 counties. Since the incoming counties showed significant data completeness issues in their measure performance, Partnership also anticipates a drop in performance in MY2025 when the full cohort of members are included in the BCS-E measure.

- Cervical Cancer Screening (CCS): In MY2024 Partnership received approval on all of its supplemental data sources, including Health Information Exchange lab data that captures screenings outside the primary care setting. Strong performance in legacy counties counterbalanced data completeness challenges in incoming counties for this measure with a five-year lookback period. As noted in Section 9, Partnership is promoting self-swab testing to members through PCPs, now that this method has received FDA approval and can be counted towards this HEDIS measure in MY2025 and onward.

- Childhood Immunizations (CIS): Partnership met the MPL benchmark Plan-Wide on this measure for the first time in MY2024. The improvement in performance is partially due to a 3% decline in the national percentiles between MY2023 and MY2024. Fairfield and Santa Rosa Region counties had significantly stronger measure performance than Auburn, Chico, Eureka, and Redding Region counties. In review of HEDIS sampled medical records, the second required influenza immunization was observed as the most common missing immunization. In cases where the immunizations were administered, the dates of service were often outside the measurement compliance timeframe. Additionally, high rates of parental refusal continue to be a major factor in measure performance, which even when documented in the record is not a permitted exclusion under the HEDIS measure.

- Lead Screening for Children (LSC): Partnership showed dramatic improvement on the LSC measure, gaining over 12% on its Plan-Wide rate between MY2023-2024. Improvement is related to the inclusion of the measure in the PCP QIP, which allows practices to measure their improvement throughout the measurement year. Partnership spearheaded extensive provider education efforts throughout the provider network as a component of Facility Site Reviews and with dedicated Lead Screening training webinars. The Lead Screening Point of Care (POC) Distribution Program, in which PCP sites could receive a POC device from Partnership for real-time lead screening, made a significant contribution to improved rates for this measure.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

- Well Child Visits in the First 30 Months of Life (W30): As described in Section 1, Partnership addressed the known data completeness issues around the W30 measure by completing a Medical Record Review (MRR) of the entire eligible population for the W30 measure in MY2024. By requesting charts from PCP's and completing a Medical Record Review, Partnership treated the measure as a hybrid measure and received auditor approval to include the W30 MRR as a supplemental data source. As a result, both W30 submeasures improved dramatically in performance, and are now both above the 50th percentile for the first time in MY2024. Partnership intends to continue completing a MRR on the W30 measure in future HEDIS Projects.

Five (5) additional measures have sustained Plan-Wide performance above the MPL since MY2023.

Table: MCAS Measures With Sustained Performance above the MPL MY2023-2024

Measure	MY2023 Plan-Wide Benchmark	MY2024 Plan-Wide Benchmark YOY points gained
Controlling High Blood Pressure (CBP)	50th	75th +6.23%
Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD)	62.5th	50th +1.48%
Immunizations for Adolescents—Combination 2 (IMA-2)	50th	62.5th +2.43%
Prenatal and Postpartum Care: Postpartum Care (PPC-Post)	90th	90th +4.14%
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)	50th	50th -0.78%

- Controlling High Blood Pressure (CBP) and Glycemic Status Assessment for Patients with Diabetes (>9%) (GSD): Both measures benefitted greatly from the approval of all supplemental data sources by Partnership's HEDIS auditor in MY2024. Partnership's Health Information Exchange, Sacramento Valley MedShare (SVMS) is a clearinghouse for lab and measurement data, which helps support the Medical Record Review for this measure. Additionally, Partnership piloted use of an NCQA Data Aggregator, Datalink, in MY2024 – as described in Section 1, Datalink is a promising new source of blood pressure readings and Hemoglobin A1c results. Finally, the increased use of OCHIN Epic within the PCP network means that more practices have the ability to automate the CPTII coding that is required to support these measures.

  Though GSD's Plan-Wide rate improved by 1.48% in MY2024 (as an inverse measure, improvement is reflected as a lower rate), Partnership's drop in percentile for GSD reflects an over 4.5% benchmark movement between MY2023 and MY2024, making a high benchmark harder to obtain.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

- Immunizations for Adolescents (IMA-2): Because some of the vaccinations included in this measure are required for public school enrollment, this is historically a higher performing childhood vaccination measure than Childhood Immunization Series (CIS-10). Encouragingly, MY2024 shows several counties in Rural Upper North and Rural Upper Central regions exceeding the MPL for this measure along with all North Bay Area counties. The predominant causes of low rates are missing or late secondary doses of the HPV immunization series and high rates of parental refusal.

- Timeliness of Prenatal Care (PPC-Pre): Partnership just met the MPL for the Plan-Wide rate for this measure in MY2024. Because of variations in Eligible Populations within regional rates (calculated from county rates, which use a larger random sample of charts from each county than plan-wide rates), none of Partnership's Financial Rating Regions met the 50th percentile for this measure. The HEDIS team observed several performance issues around prenatal visits, including that many members receive their first prenatal visit outside of the measure timeline, and that visits do not include all of the required components of a prenatal visit. Prenatal visits will be a measure of increased focus in MY2025 onwards to reverse declining rates on this measure throughout Partnership's network.

- Postpartum Care (PPC-Post): Postpartum Care visits continue to be a source of strength for Partnership, with sustained performance over the 90th percentile. Interventions to maintain high postpartum care rates are described in Section 9 and include refinements to the Growing Together Program and equity focused programs centered on communities with lower prenatal and postpartum visit rates.

6.3 Plan-Wide Opportunities for Improvement

After analyzing the MY2024 annual results and year over year performance comparisons, measures below the MPL can be categorized across three primary drivers.

1.) Performance – Members qualifying under a measure did not receive the required care per measure specifications and designated timeframes

2.) **Data Completeness** – Data used to generate reported rates has gaps, decreasing confidence that reported rates accurately reflect performance.

3.) Measure Limitations – Measure specifications determine how data is collected through the reporting of rate performance. Measure specifications can detract from a measure's intended purpose. In these cases, specifications can limit accurate representation of performance as well as detection of recent improvements that are in alignment with the measure's purpose and clinical practice.

6.3.1 MCAS Measures with Performance Opportunities

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

Three (3) measures are performance improvement opportunities for Partnership's provider network. These measures have sustained performance below the MPL, and data completeness issues are not the primary driver of low measure rates.

Table: MCAS Measures with Performance Opportunities

Measure	MY2023 Plan-Wide Benchmark	MY2024 Plan-Wide Benchmark YOY points gaine
Asthma Medication Ratio (AMR)	37.5th	37.5th +0.70%
Chlamydia Screening in Women (CHL)	50th	37.5th -0.42%
Child and Adolescent Well-Care Visits (WCV)	37.5th	37.5th +1.42%

- Asthma Medication Ration (AMR): Partnership removed AMR from its PCP QIP at the conclusion of MY2023, given continued year-over-year performance gains in recent years. The HEDIS team reviewed updates to its AMR custom code mapping frequently during the MY2024 Annual Project and requested several custom code mappings from their auditor. In MY2025, Partnership added a Unit of Service (UOS) measure to its PCP QIP, to incentivize practices to host Academic Detailing sessions with Partnership's Pharmacy team. The Pharmacy team reviews pharmacy claims data to improve medication management for asthma and other chronic conditions. The AMR measure is being retired at the end of MY2025, with a new measure of follow up after ED visits for Asthma replacing it.

- Chlamydia Screening in Women (CHL): Chlamydia Screening rates declined Plan-Wide in MY2024, despite the use of all supplemental data sources for the MY2024 HEDIS Annual Project, including Health Information Exchange lab data that captures screenings outside the primary care setting. In MY2025, Partnership added the CHL measure to its PCP QIP, which will allow practices to monitor their performance on this measure.

- Child and Adolescent Well Care Visits (WCV): This measure requires an annual well care visit for children and adolescents between the ages of 3-21. While Plan-Wide performance improved in MY2024, it was not sufficient to meet the MPL benchmark, which increased in MY2024. Given this measure's demand, performance is largely impacted by access constraints. Rates drop significantly for children in older age bands for the WCV measure. When providers face capacity challenges, they prioritize babies and toddlers for visits versus older adolescents. Young adults in the 18-21 years age band are more likely to be reliant on episodic care, live away from family (out

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

of Partnership's coverage area or out of state), and access care in settings such as student health centers, episodic telehealth services, and urgent care centers that are not part of Partnership's PCP network. For these reasons, Partnership has opted to exclude young adults ages 18-21 years from its PCP QIP WCV measure.

6.3.2 MCAS Measures with Data Completeness and Measure Limitation Issues

Finally, four (4) measures have sustained performance below the MPL primarily because of data completeness and measure limitation issues. Partnership has documented and escalated data completeness issues around all four measures directly to DHCS and is engaged in interventions and activities meant to improve the quality and completeness of data.

Table: MCAS Measures with Data Completeness and Measure Limitation Issues

Measure	MY2023 Plan-Wide Benchmark	MY2024 Plan-Wide Benchmark YOY points gained
Developmental Screening in the First Three Years of Life (DEV)	>50th	<50th -0.38%
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA-30)	25th	37.5th +1.25%
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30)	>10th	<10th -2.47%
Topical Fluoride for Children (TFL-CH)	<50th	<50th +12.15%

- Developmental Screening (DEV): Starting in 2019, Partnership's Site Review team incorporated chart audits for this measure into their workflow. The results from these and other chart audits suggest that more screenings are occurring than what this measure's performance reflects. Along with the chart audits, the Site Review team includes counseling of providers performing these screenings to update their coding practices. This resulted in very limited success, due to struggles to gain provider adoption of coding these screenings properly to capture compliance.

  Accurate measurement of this developmental screening is significantly limited by prescriptive coding requirements, and the measure uses a CPT code that does not have standardized coding rules. Partnership was sanctioned for performance below the MPL in MY2023 and is in the process of appealing the sanctions.

  In MY2025, DHCS transitioned the DEV measure from administrative to hybrid, which is recommended by CMS, the measure steward. As a hybrid measure, Partnership will have the

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

opportunity to complete a Medical Record Review on this measure in MY2025, which will help overcome the measure limitations described above.

- Follow-up After Emergency Department (ED) Visit for Mental Illness (FUM-30) or Substance Use (FUA-30): Unlike other state Medicaid systems (which drive national benchmarks), Medi-Cal divides mental health benefits from medical benefits, and then further divides these benefits between managed care plans and "County Mental Health Plans (MHPs)". Benefits for those requiring "Specialty Mental Health Services (SMHS): aka Serious and Persistent Mental Health Services" are the responsibility of the County MHPs, while the benefits for those requiring Non-Specialty Mental Health Services (NSMHS) are the responsibility of Partnership. This complicated dual delivery system limits Partnership's ability to capture, through internal means, all follow-up visits, as it relies on reporting from the state, which currently provides this data on behalf of counties in SMHS cases (where the county is responsible for follow-up visits). MCP's are dependent on DHCS to provide the MHP data, and Partnership has documented significant drops in monthly data provided by DHCS. In MY2023, DHCS declined to sanction any California Managed Care Plan for performance below the MPL on both measures because of data completeness issues.

  To address data completeness issues, Partnership actively pursued data agreements with all of its counties to improve capturing follow-up visits from county mental health providers through SVMS; to date, 22 of 24 counties are contracted with SVMS. Interventions with large PCP organizations are also underway, focused on timely referral processing and/or timely follow-up to ED discharge reporting. Incomplete data is the largest driver, but Measure Limitations and Performance drivers are also contributing to the low reported rates. Partnership also acknowledges there is significant performance improvement potential under both measures, which can be more fully addressed once data is more complete.

- Topical Fluoride for Children (TFL-CH): The largest driver of low rates on this measure is incomplete dental claims data provided by DHCS. This measure can be fulfilled through services provided in either the primary care or dental setting – over 90 percent of dental services for Partnership members are completed in a FQHC, Rural Health Center, or Tribal Health Dental Center. These services, including fluoride varnish applications, are billed to Denti-Cal; Denti-Cal then sends data to DHCS, and DHCS sends data to MCP's in a monthly data feed. DHCS has admitted that their system does not have the capacity to store or exchange the dental codes that indicate fluoride varnish was applied; they are only capable of sending codes indicating a dental service was completed. Partnership was sanctioned for performance below the MPL in MY2023 and is in the process of appealing the sanctions.

  Partnership is closely engaged with DHCS's Data Team around improving the completeness of data around this measure. DHCS's Data Team provided a work-around for their inability to send dental codes, which is to use an ICD-10 code indicating fluoride varnish application with Dental Center claims. Partnership received auditor approval to map the ICD code towards the TFL-CH measure in MY2024, which resulted in a significant year-over-year improvement in rates in MY2024.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

6.4 Comparing MY2024 MCAS Results to MY2024 PCP QIP Results

The clinical measures included in the PCP QIP are designed to reflect HEDIS measure priorities. Most PCP QIP clinical measures have very similar definitions to their HEDIS measure counterparts, and strong performance on PCP QIP measures should be reflected in strong HEDIS measure performance. Differences between PCP QIP and HEDIS measures are designed to improve providers' ability to impact the population in the measure. Some examples include:

- Partnership relaxes the strict continuous enrollment requirements in PCP QIP measures that are present in many HEDIS measures. Several measures (AMR, BCS-E, and W30) require members be continuously enrolled with a MCP for eleven (11) months to be included in the HEDIS measure; Partnership relaxed this requirement so that incoming members could be included in their PCP QIP cohorts.

- Partnership allows PCP's to upload supplemental data for all PCP QIP measures. HEDIS administrative and ECDS measures only allow claims and encounter data, as well as auditor approved supplemental data, to be applied to a HEDIS measure.

Overall, plan-wide performance declined on seven (7) of ten (10) continuous measures on the PCP QIP between MY2023 and MY2024. The primary factor in the decline in PCP QIP performance was the addition of over 100 PCP sites to Partnership in the ten (10) incoming counties in 2024. Incoming PCP's were challenged by data completeness issues described in Section 1, which gave them limited historical data for multi-year measures. Incoming PCP's also experienced significant member assignment mismatches at the beginning of 2024, which limited their ability to impact the members on their panels – this impacted both their PCP QIP scores and their local HEDIS measure rates.

The MY2024 MCAS measure performance trends for North Bay and Rural Upper North Rating Regions (DHCS's Rating Regions for the fourteen (14) legacy counties) were consistent with corresponding MY2024 PCP QIP results for the fourteen (14) legacy counties.

In MY2024, Partnership's HEDIS rates for Well Child Visits Birth – 15 Months (W30-6) was closely aligned with PCP QIP performance on the Well Child First 15 Months (W15) measure, which permits submission of supplemental data – this is thanks to the W30 Medical Record Review described in Section 1.

For reasons noted in Section 6.3.1, the PCP QIP Child and Adolescent Well Care Visits (WCV) measure only includes members 3-17 years of age. This, combined with permitting supplemental medical records not allowed under HEDIS measure Child and Adolescent Well Care Visits (WCV), influenced the higher achievement of 55.48% in PCP QIP plan-wide performance.

With the exception of WCV, all other HEDIS measures that are aligned with PCP QIP measures showed slightly higher plan wide performance in the HEDIS measure than in the plan wide PCP QIP.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

6.6 Next Steps in Finalizing Assessment of Results

- DHCS will finalize Quality Factor Scoring of all managed care plans, based on composite scoring per reporting region, in fall or winter 2025.
- DHCS has not yet announced its final methodology for sanctioning managed care plans for performance below the MPL. Once methodologies are finalized, DHCS will share mandated performance improvement activities and sanctions with plans including Partnership.
- Final assessment of results will be used to adapt quality measure score improvement strategies and tactics in 2025-2026.

7.0 Summary of Measures in the Primary Care Provider Quality Improvement Program (PCP QIP)

The table below provides a summary of Primary Care Provider Quality Improvement Program measures included in the Measures Managed Care Accountability Sets (MCAS) for Medi-Cal Managed Care Plans Measurement Year 2024 | Reporting Year 2025.

HEDIS® Measures	MCAS Accountable/Reporting	MY2023 PCP QIP Measures	MY2024 PCP QIP Measures	QIP Program
Asthma Medication Ration (AMR)*	Accountable	X		PCP QIP – removed from QIP in MY2024
Breast Cancer Screening (BCS-E)*	Accountable	X	X	PCP QIP
Controlling High Blood Pressure (CBP)	Accountable	X	X	PCP QIP
Cervical Cancer Screening (CCS)	Accountable	X	X	PCP QIP
Childhood Immunization Status (CIS) – Combo 10	Accountable	X	X	PCP QIP
Colorectal Cancer Screening (COL-E)	Reporting	X	X	PCP QIP
Eye Exam for Patients with Diabetes (EED)	Reporting	X	X	PCP QIP
Glycemic Status Assessment for Patients with Diabetes—Glycemic Status (>9%), Poor Control (GSD)	Accountable	X	X	PCP QIP QIP uses the inverse of this measure: Good Control, HbA1c Good Control <9%
Immunizations for Adolescents (IMA) – Combo 2	Accountable	X	X	PCP QIP
Lead Screening in Children (LSC)	Accountable	X	X	PCP QIP MY2023: UOS measure MY2024: Clinical
Postpartum Depression Screening (PDS-E)	Reporting	X	X	Perinatal QIP
Prenatal Depression Screening (PND-E)	Reporting	X	X	Perinatal QIP
Prenatal and Postpartum Care (PPC) – Postpartum Care	Reporting	X	X	Perinatal QIP

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

HEDIS® Measures	MCAS Accountable/Reporting	MY2023 PCP QIP Measures	MY2024 PCP QIP Measures	QIP Program
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	Reporting	X	X	Perinatal QIP
Prenatal Immunization Status – combo (PRS-E)	Reporting	X	X	Perinatal QIP
Well-Child Visits in the First 30 Months of Life—0 to 15 Months—Six or More Well-Child Visits (W30-6)	Accountable	X	X	PCP QIP
Child and Adolescent Well-Care Visits (WCV)	Accountable	X	X	PCP QIP

PCP QIP Measurement Set: http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

8.0 Measurement Year 2024 Managed Care Accountability Site (MCAS) Measurement Set Descriptions-Accountable Measures

HEDIS Measure	Measure Indicator	Measure Definition
*Asthma Medication Ratio (AMR)	• Total	• The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
*Breast Cancer Screening (BCS-E)	• Non-Medicare Total	• The percentage of women 52–74 years of age who had a mammogram to screen for breast cancer as of December 31 of the measurement year.
Cervical Cancer Screening (CCS)	• Total	• The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: o Women 21–64 years of age who had cervical cytology performed within the last 3 years o Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years
*Child and Adolescent Well-Care Visits (WCV)	• Total	• The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. • Total. The sum of the age stratifications (ages 3–21) as of December 31 of the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Childhood Immunization Status (CIS)	• Combination 10	• The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.
*Chlamydia Screening in Women (CHL)	• Total	• The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. o Total: The sum of the age stratifications.
Controlling High Blood Pressure (CBP)	• Total	• The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
*Developmental Screening in the First Three Years of Life (DEV_CH)	• Total All Ages	• Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. • This measure is a CMS FFY 2023 Child Core Set Measure, held to the DHCS designated MPL.
*Follow-Up After ED Visit for Mental Illness – 30 days (FUM)	• Total	• The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

HEDIS Measure	Measure Indicator	Measure Definition
*Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)	• Total	• The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
Immunizations for Adolescents (IMA)	• Combination 2	• The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. • Combination 2. Adolescents who have had all three indicators (meningococcal, Tdap and HPV).
Hemoglobin A1c Control for Patients With Diabetes (HBD)	• HbA1c poor control (>9.0%)	• The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the Measure Indicators performed. ○ HbA1c poor control (>9.0%). The most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.
Lead Screening in Children (LSC)	• Total	• The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. • At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday.

HEDIS Measure	Measure Indicator	Measure Definition
Prenatal and Postpartum Care (PPC)	• Timeliness of Prenatal Care • Postpartum Care	• The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. o Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. o Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
*Topical Fluoride for Children (TFL-CH)	• Total ages 1 through 20	• Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year. • This measure is a CMS FFY 2023 Child Core Set Measure, held to the DHCS designated MPL.
*Well-Child Visits in the First 30 Months of Life (W30)	• Well-Child Visits in the First 15 Months • Well-Child Visits for Age 15 Months–30 Months.	• The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: • Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. • Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

**-Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures*

9.0 Quality Improvement Initiatives - HEDIS Score Improvement

Partnership's Quality Improvement organization-wide goals for 2024-2025 focused on four measure domains similar to those defined under the DHCS Managed Care Accountability Set (MCAS) measures:

1. **Chronic Diseases**
2. **Behavioral Health**
3. **Pediatrics**
4. **Women's Health and Perinatal**

The Quality Measure Score Improvement (QMSI) effort continues to better coordinate service and performance across the organization and to raise Partnership's overall performance in quality measures, as defined under DHCS MCAS and NCQA Health Plan Accreditation (HPA). This effort involved team formation under QMSI to encompass all current and potentially future accountable measures by measure family within each workgroup team: Pediatric, Chronic Diseases, Behavioral Health, Women's Health and Perinatal Care. A fifth QMSI Workgroup, Medication Management, was disbanded in July 2024 and its measures were absorbed into the Chronic Disease and Behavioral Health Workgroups. Each workgroup monitored and reviewed all measure performance where data was available, assessed current improvement efforts, identified gaps and initiated new performance improvement activities.

QMSI workgroups consisted of cross-functional teams led by Quality and included representation from across the organization, such as: Care Coordination, Claims, Health Education, Office of the CMO, Pharmacy, Population Health, Provider Relations, Quality and/or regional leadership. The following summaries include what each measure-family QMSI Workgroup Team achieved in 2024-2025.

9.2 Chronic Disease Measure Activities

Colorectal Cancer Screening: Cologuard: In 2023 Partnership conducted a pilot project with Exact Sciences who produces the Cologuard Fit DNA colorectal cancer screening product. During the pilot Partnership observed notable improvements in colorectal cancer screening rates with participating providers. Partnership has turned this effort into an ongoing program and has worked closely with Exact Sciences to spread awareness and access to the bulk ordering program. Partnership has created a resources page on its public website to aggregate lessons learned and details on the bulk ordering process. Exact Sciences has a minimum number of patients required for bulk orders since it is resource intensive for them to do outreach and messaging for patients with an order. Partnership has offered to help facilitate bulk orders for smaller practices who do not have large enough denominators to do bulk orders on their own, with orders going out every few months.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

Academic Detailing Sessions Through Partnership Pharmacy Team: For MY2025 Partnership added a Unit of Service (UOS) measure to the PCP QIP program. The purpose of this new unit of service measure is to incentivize provider organizations to host a two-part academic detailing meeting with Partnership's Pharmacy Team/Medical Director. Pharmacy academic detailing helps clinicians improve medication management, improve quality measure performance, and achieve better clinical outcomes for their patients. The UOS measure applies to practices with at least 1,000 assigned members and requires an initial training as well as a follow-up session to review any changes in prescribing practices following the initial training. Provider practices are offered up to $2,500 to help cover costs to get prescribers out of clinic for education.

Pharmacy academic detailing meetings focused on improving medication management through pharmacy claims analysis within the following disease states:

- CBP: Controlling High Blood Pressure
- HbA1c Good Control
- AMR: Asthma Medication Ratio
- Statin therapy in:
    - Cardiovascular disease
    - Diabetes
- Opioid Disorder Measure (only if providers are interested in opioids and MAT)

9.3 Behavioral Health Measure Activities

Sac Valley MedShare Data Exchange: Partnership HealthPlan of California and SacValley MedShare (SVMS): To improve data sharing capabilities between Behavioral Health Plans (BHPs) and Partnership, the partnership with SacValley MedShare (SVMS) was expanded to include county participation. Over the course of a 12-month collaboration, 22 out of 24 counties signed participation agreements with SVMS, which allowed various levels of data use and sharing to be integrated into county operations.

Key Outcomes and Learnings:

- The collaboration facilitated the provision of medical data, including real-time admissions, discharges, and transfers, from participating hospitals.
- Some counties implemented opt-in procedures for data sharing, which have limited the number of beneficiaries included in the data.
- Substance use disorder data has not yet been included in the exchange due to varying levels of regulatory uncertainty across counties.

DHCS Mandated Non-Clinical PIP: Improving Provider Notifications and Follow-Up for Members with Serious Mental Health Diagnoses: The Department of Health Care Services (DHCS) has mandated a

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

non-clinical Performance Improvement Project (PIP) focused on enhancing the timeliness and consistency of provider notifications for members with Serious Mental Health (SMH) diagnoses following emergency department (ED) visits. The primary goal of this initiative is to improve the percentage of notifications sent to providers within seven days of an ED visit, thereby increasing the likelihood of timely follow-up care for affected members.

In 2024, the QI team at Partnership identified a tool with the potential to significantly improve provider notification processes: PointClickCare. Partnership subscribes to this platform, which serves as a centralized hub for real-time Admission, Discharge, and Transfer (ADT) messages from EDs and hospitals across California. To operationalize this data, Partnership launched a targeted intervention in the Northwest region, routing daily PointClickCare reports to a large provider organization. These reports flag assigned members with recent ED visits for SMH diagnoses. In response, the provider organization is developing integrated clinical and operational workflows across its sites to proactively conduct outreach, schedule appointments, and ensure follow-up care is completed within 30 days of the ED event.

Key Outcomes and Learnings:

- Regular data exchange to promote shared learning, pattern recognition, and continuous quality improvement.
- Real-time data analysis to support agile adjustments and maintain program responsiveness.
- Focused efforts on increasing the rate of timely notifications and achieving compliance with follow-up targets.

<u>DHCS/IHI Behavioral Health Collaborative: Partnership HealthPlan of California and Nevada County:</u>
Beginning June 3, 2024, the Behavioral Health and Quality Improvement departments at Partnership embarked on a 15-month collaborative initiative facilitated by the Department of Health Care Services (DHCS) and the Institute for Healthcare Improvement (IHI). This partnership, in coordination with the Nevada County Department of Behavioral Health, aims to improve Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) measures.

Key Outcomes and Learnings:

- The collaboration has significantly strengthened the working relationship between Partnership and Nevada County, laying the foundation for ongoing partnership and communication.
- Despite ongoing data misalignment between the County and Partnership, the collaborative has initiated efforts to identify data gaps, establish a shared baseline, and apply data-driven strategies to guide targeted quality improvement interventions.
- Piloted standardized screening procedures for Emergency Department bedside.

<u>Community Health Worker (CHW) & Emergency Department: Partnership HealthPlan of California:</u>

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

To bridge the gap between existing Substance Use Navigation (SUN) grants and the implementation of community health workers (CHWs), Partnership offered a grant of up to $100,000 to promote the use of CHWs in emergency departments. A total of 24 hospitals expressed interest, and 17 followed through during the grant year.

Key Outcomes and Learnings:

- Most emergency department EHRs (Electronic Health Records) were not capturing non-clinical interactions, which made it difficult to promote CHW work as a billable service.
- Staffing challenges arose at some hospitals, including engaging HR to create new job descriptions, adding positions late in budget cycles, and dealing with workforce shortages in certain areas.
- Many hospitals felt that longer grant periods would be necessary to fully capture the impact of the new CHW role

9.4 Pediatric Medicine Measure Activities

State-Mandated Performance Improvement Project (PIP) Focused on Early Well-Care in Black/African American Members in Solano County: This PIP's initial intervention addressed delays in Medi-Cal enrollment, which have a significant impact on all families, including African American families. The team launched a six-week phone outreach pilot project in collaboration with NorthBay Health. Upon discharge, NorthBay staff informed Partnership members that they would receive a call from Partnership. NorthBay then emailed Partnership a daily list of members that had been discharged from their Labor and Delivery unit. Partnership staff would then reach out to these members within 72 hours of discharge, educating new parents on Medi-Cal enrollment, newborn PCP selection, well baby visit scheduling, and connection to resources. The pilot had an 81% reach rate and a 51.6% engagement rate, which is significantly higher than similar outreach programs within Partnership.

Increase HPV Vaccine Completion Rates Through 2nd Dose Reminder Mailers: The HPV 2nd Dose Pilot Project identified children under age 13 who are due for their second dose of the HPV vaccine and mailed a reminder notice to their homes to encourage timely completion. This three-month initiative aims to assess whether mailed reminders can improve HPV vaccine series completion rates.

Develop a Plan-Wide Strategy for Well-Child Visits in the First 30 Months of Life – Birth to 15 Months (W30-6): While there have been many unique approaches for improving W30-6, Partnership recognized that the significant efforts were lacking a strategic vision for addressing the complexities that exist in W30-6 and decided to form a W30-6 Plan-Wide Strategy Committee. The purpose of this committee was to develop a concerted approach to understanding the current state and strategically planning for future improvement efforts.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

The committee launched in October 2024 with a cross-functional stakeholder group. The purpose of the committee was to develop and implement a guiding strategy for improving performance of well-baby visits across Partnership's service area:

- Link all improvement efforts and provide a more strategic and streamlined approach
- Ensure thoughtful investment of time and resources
- Raise awareness and increase engagement across all stakeholders, both internal and external

Expand Promotion of Healthy Babies Growing Together Program to Provider Network to Increase W30-6 and CIS-10 Rates: Member incentives are widely known as a best practice for improving member appointment completion rates. Population Health's rebranding of the Growing Together Program (GTP) led to member incentives directly aligning with the CIS-10 and W30+6 MCAS Accountable measures. Improvement advisors, through their engagement with sites, recommended promotion of this program beyond the member population to the provider network.

Improve Data Capture of Topical Fluoride Application: Partnership launched a multi-pronged messaging campaign to providers to evangelize the use of the Z29.3 ICD code to indicate fluoride varnish application in FQHC, RHC, and Tribal Health Dental Centers. Following the messaging campaign, QI coaches and Partnership's new Dental Liaison followed up with practices during coaching calls to see if the codes had been implemented. As of May 2025, Partnership has started receiving claims with the Z29.3 code from providers who were quick to implement the code into their processes. Partnership will continue to monitor claims and work with practices who have not implemented the code.

9.5 Women's Health and Perinatal Care Measure Activities

Improve Breast Cancer Screening by Engaging Mobile Mammography: Partnership's Mobile Mammography program continued as a strategy to increase Breast Cancer Screening performance. Partnership collaborates with Alinea Medical Imaging and providers to host Mobile Mammography events, helping members complete preventive screenings at their primary care provider sites. In FY2024/2025 the program completed 77 mobile mammography event days resulting in 2,162 completed screenings. Mobile Mammography events were held at seven Tribal Health Centers, and Partnership led talking circles on screening importance at three Tribal Health Center's Mobile Mammography events.

Cervical Cancer Screening Self-Swab Pilot: A Cervical Cancer self-swab pilot launched in January 2024 with five strategically selected primary care clinics. The cervical cancer self-swabs were piloted in provider clinics and mobile settings to increase screening access for patients who previously declined clinician-administered exams. Early learning suggests broad provider and patient interest.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

In May 2024, the U.S. Food and Drug Administration approved two HPV self-collect vaginal tests for cervical cancer screening. In March 2025 Quest and LabCorp launched the Roche Molecular Systems, Inc Cobas HPV test for self-collection with a new CPTII code 87626. Instructions on how to complete the self-swab were developed. In the March 2025 release of HEDIS MY 2025 Value Set Directory CPT code 87626 was included in the High-Risk HPV Lab Test Value Set. In May 2025, the CPT code was added to the CCS code set in eReports. Partnership worked closely with Quest and LabCorp to facilitate integration of the self-swab in its network. An HPV Self-Swab Webinar was held April 1, 2025, with 100+ attendees and the webinar is available on Partnership's website.

Perinatal Growing Together Program (Perinatal GTP): This program aims to improve early access to prenatal care and improve timely well-baby care. In FY24/25 the Perinatal GTP made 23,234 contacts across both the Prenatal and Postpartum Growing Together Program campaigns, outreaching to 12,117 unique members. Of the 4,144 unique members outreached for the Prenatal program, 60.4% agreed to participate. Of the 7,973 outreached for the Postpartum program, 58.5% agreed to participate. These members were transitioned into the GTP Postpartum program for targeted conversations post-birth.

Maternal Events: Population Health organized maternal photo shoots and baby showers to build trust and engagement with Black and Hispanic members. These events promoted health education and connected families to local and Partnership resources.

Tribal Perinatal Program (TPP) aims to improve perinatal health outcomes among California Indian communities through a comprehensive approach encompassing training, curriculum development, evaluation, and continuous improvement initiatives. TPP started in April 2024 and has 6 Tribal Health Centers enrolled across 3 cohorts. This program addresses disparities identified in prenatal care and postpartum care for American Indian/Alaskan Native members.

The Solano Perinatal Clinical Collaborative continues for FY24/25. The collaborative focuses on addressing health disparities in prenatal care for African Americans in Solano County. They have identified operational and communication barriers that were impeding access. They developed better systems of care across organizations and improved the standards and methods of patient related and professional communication.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

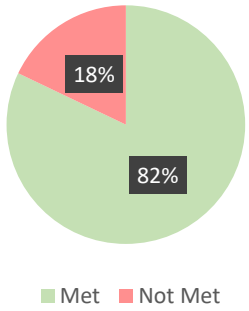
this page left blank

QI TRILOGY PROGRAM

Background: The QI Work Plan is designed to track progress on key QI activities and initiatives throughout the year. Approved by our Board of Directors and quality committees, it includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service and members' experience. The Work Plan is set on a fiscal year (FY) 2024-2025 schedule. This update includes progress on activities included in the FY 2024-2025 QI Work Plan from July 1, 2024 to June 30, 2025.

Results: Of the 67 goals outlined in the QI Work Plan, 55 are "Met"; 12 are "Not Met".

Goal Status July 1, 2024 – June 30, 2025		
Status	**Total Number:**	**%**
Met	55	82.09%
Not Met	12	17.91%



QI Major Milestones and Activities:

- The Dual Eligible Special Needs Plan (D-SNP) Strategy Work Group was formed and met with representatives from across the organization. All Medicare D-SNP measures were reviewed including those in Part C, Part D and Display measures, along with DHCS D-SNP measures for which Partnership will be accountable. Each measure was reviewed to identify measure ownership, data collection and intervention/actions. This information was documented for all measures across the organization. The shared document is available will be used for other projects to identify business needs by department.
- A new Primary Care Provider (PCP) Incentive Program for organizations contracting to serve Partnership Advantage members has been developed and gained executive approval. The approved proposal included program goals and principles, member

and provider eligibility criteria, the measure set, scoring methodology, and payment mechanisms.

- External vendors and internal IT resource capacity were both explored to identify a system solution for performance tracking of the Dual Eligible Special Needs Plan (D-SNP) PCP QIP program. After opting to buy versus build, several external vendors were considered through detailed responses to Partnership's Request for proposal (RFP). A vendor with experience delivering provider-based measure performance solutions was identified as the preferred option and recommended to Partnership's Project Review Board (PRB) in May 2025. The recommendation was accepted and contracting is underway at the close of 24-25.
- A CAHPS D-SNP programmatic work plan and timeline have been developed with framework informed by research into survey methodologies and conversation with other local health plans in California. Ongoing coordination with the identified survey vendor and CAHPS team will help further implementation planning.
- A detailed review of D-SNP requirements was completed by the Member Safety Quality Investigation team. No changes are needed to Partnership's current Peer Review Committee (PRC) policy or to the current Potential Quality Investigation (PQI) process to accommodate D-SNP.
- The Member Safety Quality Investigation team completed UAT testing and upgraded its PQI process tool to Sugar, Version 14. This tool is used to maintain PQI cases end-to-end through the process and for storage.
- The Member Safety Inspections Team piloted a "Quality Management Overview" document that is completed prior to each scheduled site review. Each Overview details recent QI interactions, status check on sites, and updates on HEDIS, QIP, and Performance Improvement programs and initiatives. These details are reviewed with the site's staff during the completion of the Medical Record Review (MRR). Post review surveys of Site Review nurses revealed mixed feedback. Most nurses found sharing this additional quality information beneficial to conducting the site review. A few warm hand offs to the PI and QIP teams also resulted.
- The Inspections Team developed provider training materials to reflect Child Health and Disability Program (CHDP) requirements. The delivery of these training materials is now the responsibility of managed care plans. Training topics include: vision, hearing, fluoride varnish application, anthropometric screenings and information on vaccines for children (VFC). These materials have been distributed to the provider network with issuance of certificates upon staff completion.
- Pharmacy conducted concurrent review of Latent Tuberculosis Infection (LTBI) medication treatments and provided timely provider notification to all identified potential LTBI treatment regimen gaps, which results from late refill, non-adherence, inappropriate prescribing, and/or inappropriate dispensing.
- The Primary Care Provider Quality Incentive Program (PCP QIP) reviewed its existing Data Validation framework to identify areas for improvement, based on

learnings over the past year. The team added a dedicated Non-Clinical Measure Preliminary Period for providers to review and validate their final data before Partnership completes scoring and payment. The team also detailed steps key in the existing eReports clinical validation period and updated the process for verifying HIE connections by provider organization. A designated QIP Workgroup developed provider education materials to inform and influence Member Experience improvement activities. The MY2025 specifications now include a URL resource link within the Patient Experience Unit of Service measure description.

- The Quality Measure Score Improvement (QMSI) initiative successfully engaged five measure-specific workgroups. Each workgroup monitored and reviewed measure performance, as data was available, identified and completed score improvement activities for all stated deliverables by the end of the fiscal year. Highlights include:

  1. Pediatrics
     - Expanded promotion of Healthy Babies Growing Together Program to include Partnership's Provider Network and specific messaging on an expanded $100 member incentive offering for timely completion of childhood immunizations required by HEDIS measure, CIS-10
     - Launched a new Human Papillomavirus (HPV) 2nd Dose Reminder Program Pilot to affect HEDIS immunization measure performance under IMA-2
     - Launched a new provider educational webinar on Developmental Screening in the First Three Years of Life (DEV) in preparation for more focused DEV measure improvement work in the provider network
     - Extended the PCP QIP Unit of Service (UOS) group well care visits' measure to include members eligible under either the Well Child Visits in the First 15 Months (W15) or Well Child Visits for ages 15-30 months (W30) measure
     - Conducted Topical Fluoride for Children (TFL-CH) data investigation to identify and better address known data source gaps in related MCAS measure reporting
     - Completed a Child and Adolescent Well Care Visits (WCV) Disparity Sprint Campaign focused on improving well child visit completion in 4Q 2024 among disparate populations identified by DHCS from MY2022 MCAS Annual HEDIS reporting.
     - Continued work on the DHCS-mandated Performance Improvement Project (PIP) to improve W15 completion rates in African American members in Solano County, while looking for spread opportunities in other areas of Partnership's service region.
  2. Behavioral Health
     - As part of the DHCS-mandated Non-Clinical PIP, implemented a pilot to track and improve the follow up care for patients with mental health (FUM) and substance abuse disorder (FUA) after emergency department (ED) discharge aiming to increase the percentage of PCP notifications for a provider partner's assigned members.

- Executed the DHCS-mandated IHI Behavioral Health Collaborative Project in partnership with Nevada County
- Engaged County Departments of Behavioral Health (DBH) to utilize Sac Valley Med Share Data Exchange for follow-up after mental illness (FUM) data
- Facilitated collaboration amongst several departments, including: Behavior Health, Care Coordination, Population Health, Pharmacy, Health Equity's Tribal Health Liaison, and Quality Improvement. This collaborative group monitored and evaluated interventions aiming to improve FUM and FUA measures scores.
- Increased embedded Community Health Workers (CHWs) in hospital Emergency Departments

3. Management of Chronic Diseases
   - Monitored, evaluated, and improved the use of the Diabetes management program offered by TeleMed2U
   - Implemented a pilot of a comprehensive, service-intensive diabetes management program with Gojii
   - Brought the blood pressure control strategies into alignment with best practices of at least one primary care practice
   - Implemented a retinal eye exam grant to support providers in improving the rate of diabetic members receiving an annual retinal eye exam
   - Implemented improvements to the Cologuard bulk ordering program to better serve a broader group of Primary Care providers
4. Women's Health
   - Facilitated integration of cervical cancer screening HPV Self Swab across our network to affect the corresponding measure (CCS) rate
   - Identified 3 practices in counties with Chlamydia Screening in Women (CHL) rates below the minimum performance level (MPL) and conducted 1 on 1 provider education
   - Promoted incentives for "Increasing Screening Mammogram Capacity" in the Hospital Quality Incentive Program (H-QIP)
   - Elevated promotion of the Growing Together Program's increased incentive to impact postpartum rates
   - Identified counties with race/ethnicity disparities for post-partum visits and supported connection to Enhanced Care Management (ECM) Birth Equity (BE) providers to support members accessing post-partum care
5. Elder Care
   - Identified all D-SNP measures which fall within the QMSI workgroups by work group domain for further focus in D-SNP implementation planning.

- The Performance Improvement (PI) team collaborated with the far northern consortia to bring QI awareness and education to providers serving members in Partnership's Redding and Eureka Regions through several activities and forums.

- Four (4) new Eastern region providers were added to the Joint Leadership Initiative (JLI) series.
- Improvement Academy offered six (6) virtual trainings in 2025 highlighting priority MCAS measures including Pediatric Preventative Care for Ages 0 - 30 Months, Pediatric Preventative Care for Ages 3 - 17 years, Chronic Disease and Colorectal Cancer Screening, Perinatal Care and Chlamydia Screening, Breast and Cervical Cancer Screenings, and Diabetes Control. Improving Member Outcomes webinar attendance ranged from 53 to 90 attendees, with each session representing 28 to 45 unique organizations. Of attendees who completed the post-session evaluations for all six webinars, 99% selected “strongly agree” or “agree” when asked if the webinar was relevant and useful.
- Improvement Academy hosted three (3) ABCs of Quality Improvement in-person trainings with 100% of survey respondents, representing 37 unique provider organizations, reporting being extremely satisfied/satisfied with this course.
- The Healthy Kids Growing Together Program conducted two (2) cohorts focused on contacting any 3 -6 year old who has never had a well-child visit in a set timeframe and offered an incentive to complete a well-child visit within 90 days prior to their 4th, 5th, and 6th birthday. Over 2600 children participated and received member incentives.
- The Primary Care Provider Quality Incentive Program (PCP) QIP Breast Cancer 50th percentile benchmark has been met in the legacy Southeast, Southwest, and Northeast regions. This improvement was largely influenced by 77 Mobile Mammography event days, resulting in 2,162 completed breast cancer screenings.
    - 15 Mobile Mammography event days were held at Tribal Health Centers.
    - 14 Mobile Mammography event days were held at Enhanced Provider Engagement (EPE) provider organizations.

FY24/25 Final Goal Status: Delayed/Terminated

Project or Program	Goal	Status Details	Next Steps
2.g. Partnership Quality Dashboard (PQD)	**Goal #1**: By June 30, 2025, apply annual development updates of the MY2025 HEDIS® Monthly Exploratory Dashboard in accordance with identified stakeholder needs (Contingent on HRP® implementation).	Delayed	Delay due to revised HRP® launch date. Deliverable 4 will be completed in CY Q3 of 2025.

Project or Program	Goal	Status Details	Next Steps
	Goal #2: By June 30, 2025, apply annual development updates of the PCP QIP Provider and Internal View Dashboards in accordance with identified stakeholder needs.		Delay due to revised HRP® launch date. Deliverables 4-5 will be completed following the implementation of HRP®.
2.h. Enterprise Information Management	**Goal #1:** By December 31, 2024, integrate the HRP® version of the HEDIS® monthly project data into the Enterprise Data Warehouse and use this data to create the HRP® version of the HEDIS® PQD modules.	Delayed	Delay due to revised HRP® launch date. Deliverable 3 will be completed following the implementation of HRP®.
3.c. Palliative Care Quality Incentive Program (PC QIP)	**Goal #2:** By June 30, 2025, complete CY 2024 PC QIP evaluation.	Delayed	Payment processing for the Palliative Care QIP 2024 measure period II (July-December) did not begin until March 2025.This goal is on track to be completed, but not until July 2025.
3.e. Enhanced Care Management Quality Incentive Program (ECM QIP)	**Goal #2:** By December 31, 2024, complete CY 2023 ECM QIP evaluation.	Delayed	Due to this program only offering one measure from its inception spanning from 4th quarter CY 2022 to 4th quarter CY 2023, an evaluation of CY 2025 will be completed to provide a robust evaluation of the

Project or Program	Goal	Status Details	Next Steps
			present program's five measures with year over year performance trend analysis. This goal is scheduled to be completed during the 2025-2026 QI Work Plan.
4.b. Missed Opportunities and Member Engagement	**Goal #1:** By June 30, 2025 Incorporate missed opportunity data and feedback from the 23/24 goal and include in the member engagement dashboard currently in development and publish externally for providers to use.	Delayed	Delay due to revised HRP® launch date. Deliverables 2 and 3 will be completed following the implementation of HRP®.
5.b. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Dual Eligible Special Needs Plan (D-SNP)	**Goal #1:** By June 30, 2025, select and contract with a Medicare Dual Eligible Special Needs Plan (D-SNP) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) CMS-approved vendor.	Terminated	A survey vendor has been identified. However, it was determined that contracting with a survey vendor is not required during this fiscal year (24-25) and will be addressed at a later date if or when the need arises.
8.d. Provider Coaching and Engagement	**Goal #2:** By June 30, 2025, the Performance Improvement teams will engage with practices in the 10 incoming counties joining Partnership in 2024. We will engage	Delayed	Due to heightened organization sensitivity to requesting too many meetings with our contracted providers, the Chico regional meeting has been rescheduled to July 2025. Deliverable 2 will

Project or Program	Goal	Status Details	Next Steps
	with practices holding 70% of assigned membership for incoming counties around PCP QIP performance.		be completed during the 25-26 QI Work Plan.
8.e. Expansion of Regional Quality Meetings	**Goal #1:** By June 30, 2025, Partnership will implement regional quality meetings in all six (6) operational regions to offer forums for regional dialogue to address quality improvement opportunities or barriers.	Delayed	Redding, Fairfield, and Eureka regional meetings continue. Santa Rosa, Chico, and Auburn regional offices are currently in planning for Quarterly Quality meetings. Deliverable 2 on track to be completed by end of CY 2025.
14.a. Grand Analysis - Continuity and Coordination of Medical Care (QI3) Report	**Goal #1:** By June 30, 2025, Quality Improvement will complete as much as possible of the annual Continuity and Coordination of Medical Care Grand Analysis (QI3) report, given the complete data sets that are available. (The delay for full document completion past June 30, 2025 is required to allow appropriate analysis of all of the data required for the report, some of which is not anticipated to be available for review by June 30th.)	Terminated	Grand Analysis - Continuity and Coordination of Medical Care (QI3) Report is retired under 2025 HPA standards.
14.a.	**Goal #1:** By June 30, 2025, Behavioral	Terminated	Grand Analysis - Continuity and

Project or Program	Goal	Status Details	Next Steps
Grand Analysis - Continuity and Coordination of Behavioral Health (QI4) Report	Health will complete the annual Continuity and Coordination of Behavioral Health Grand Analysis (QI4).		Coordination of Behavioral Health (QI4) Report is retired under 2025 HPA Standards.

this page left blank

Summary of QI Trilogy Documents

August 2025

Annually, the Quality and Performance Improvement Team updates three documents that reflect past, present, and future work related to quality improvement at Partnership HealthPlan of California (Partnership):

1. Quality Improvement Program Description
2. Quality Improvement Program Evaluation
3. Quality Improvement Work Plan

Each document is a regulatory and NCQA Accreditation requirement. The Quality Improvement Project Management team in partnership with the Senior Director of Quality and Performance Improvement and Director of Quality Management, serves as the QI Trilogy Document Team. The team led the preparation of the documents for review by Partnership's quality committees. These documents will be presented during the quality committees in August and final approval will be sought from the Board of Commissioners in the fall. Along with this review cycle, each document accounts for activities on a fiscal year cycle. These documents will be submitted to the State after Board approval and shared with Partnership members via the website and upon request.

DOCUMENT SUMMARIES:

QI Program Description

The QI Program Description is a summary of the QI program with content including the structure, processes, and intra and interdepartmental work that supports quality improvement efforts at Partnership. The description contains the following components per the NCQA accreditation standards (QI 1A):

- The QI program structure.
- The behavioral healthcare aspects of the program.
- Involvement of a designated physician in the QI program.
- Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program.
- Oversight of QI functions of the organization by the QI Committee.

The Partnership fiscal year 2025-2026 document reflects revisions completed through interdepartmental review and collaboration, particularly in the following areas:

1. Clearer designation of leadership roles carrying authority and responsibility to ensure the program is fully implemented and maintained. For each identified role, the qualifications of staff presently fulfilling each role are detailed in an appendix.
2. Due to the delayed implementation of Partnership Advantage, Partnership's Dual Eligible Special Needs Plan (D-SNP) language was updated to reflect implementation in 2027. Increased programmatic details specific to the D-SNP implementation will be included in the next annual update, including the launch of a dedicated Quality D-SNP Sub-Committee and expansion of the CAHPS® survey administration to include the D-SNP population.

3. Revisions made to a few of Partnership's Value Based Payment Programs, which include the sunsetting of the Specialist Quality Incentive Program and measurement focus in the Enhanced Care Management Quality Incentive Program.
4. Changes in the Site Review team's scope, such as the inclusion of monitoring Mobile/Street medicine and workflow changes due to the sunsetting of DHCS' Comprehensive Perinatal Service Program (CPSP) and launch of Partnership Health Perinatal Service Program.
5. Partnership continues to devote coaching resources designed to align with the priorities and needs of organization performing below the minimum performance level (MPL) to build capacity for quality improvement work.

QI Evaluation

The QI Evaluation is designed to assess performance on work outlined in the QI Program Description and the QI Work Plan. Per NCQA requirements (QI 1C), the evaluation must include the following:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
- Trending of measures of performance in the quality and safety of clinical care and quality of service.
- Evaluation of the overall effectiveness of the QI program and of its progress toward influencing network wide safe clinical practices.

The evaluation includes work directly completed by the Quality and Performance Improvement department and other departmental partners within Partnership. In preparing the 2024-2025 evaluation, the following items were given greater consideration.

1. Continued analysis of the QI program structure and how the roles defined within the QI department and senior leadership/physician roles fulfill it.
2. Enhanced trend analysis and implementation of interventions for measurements related to clinical quality, member safety, and member experience outcomes, reflecting the most recent 12-month period compared to the prior year
3. Continued assessment of barriers in quality improvement with corresponding health plan adaptations to member and provider engagement strategies and tactics
4. Assessment of resources and organization of quality and performance improvement activities to accommodate the growing scope and complexity of quality measurement and reporting under both DHCS and NCQA accreditation. In FY 24-25, of particular focus was the preparation for the implementation of Partnership's Dual Eligible Special Needs Plan (D-SNP), evaluation of achieving at least a 3.5 STAR health plan rating as an NCQA accredited health plan, and preparation for NCQA Health Equity Accreditation requirements.

Summary of QI Trilogy Documents

August 2025

QI Work Plan

The QI Work Plan outlines major activities for the QI Department and organization as a whole that advance quality and performance improvement.

There are four main areas the Work Plan is designed to monitor and increase accountability per the NCQA technical specifications (QI 1B):

- Yearly planned QI activities and objectives for improving:
  - – Quality of clinical care
  - – Safety of clinical care
  - – Quality of service
  - – Members' experience
- Time frame for each activity's completion
- Staff members responsible for each activity
- Monitoring of previously identified issues
- Evaluation of the QI program

The document and requests for semi-annual and annual updates also provide a better accounting of the following:

1. Continued improvement to clearly identify and align Work Plan activities with organizational goals and desired outcomes.
2. Enhancement of document to identify whether a goal is new or continued to better track Monitoring of Previous Conditions, which is an NCQA requirement.

Annually, the process for completing the trilogy documents is assessed for improvement. In developing the 2025-2026 Work Plan, QI leadership worked to proactively identify new and adapted projects and programs based on the closeout of the 2024-2025 Work Plan. This led to greater dialog amongst sponsors, business owners and contributors on lessons learned, which correlates to the accomplishments and challenges cited in the 2024-2025 QI Evaluation. Ultimately, this refined approach aided the work plan change process and led to sound goal setting and deliverable identification in the 2025-2026 Work Plan.

this pag left blank

Quality Improvement Program Evaluation

2024-2025

EVALUATION PERIOD

(JULY 1, 2024 – JUNE 30, 2025)

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Approval of Quality Improvement Program Evaluation

	08/20/2025

Robert Moore, MD, MPH, MBA Date Approved
Quality/Utilization Advisory Committee Chairperson

	09/10/2025

Angela Brennan, DO Date Approved
Physician Advisory Committee Chairperson

	10/22/2025

Kim Tangerman Date Approved
Board of Commission Chairperson

TABLE OF CONTENTS

Quality Improvement Overview and Program Oversight	
Scope of Data and Results Reported in the 2023-2024 Quality Improvement (QI) Program Evaluation	8
Quality Improvement Program Structure	10
Quality Improvement Governance	13
Board of Commissioners	13
Internal Quality Improvement Committee	13
Quality and Utilization Advisory Committee	14
Physician Advisory Committee Oversight of QI Program	15
Quality Incentive Program Advisory Groups	15
Quality Improvement Leadership Engagement & Commitment	16
Chief Executive Officer	16
Chief Operating Officer	17
Chief Medical Officer	17
Chief Health Services Officer	18
Chief Strategy & Government Affairs Officer	18
Quality Improvement Departmental Changes	19
Changes within QI Department	19
Quality Improvement Executive Summary	
Executive Summary	23
2024-2025 QI Work Plan Summary	27
Background	27
2024-2025 QI Major Milestones and Activities	27
FY 24/25 Work Plan Final Goal Status	30
National Committee for Quality Assurance (NCQA) Accreditation	
NCQA Overview	35
NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA) Key Activities	35
Compliance with NCQA Survey Standards	35
NCQA Health Equity Accreditation Initial Survey	36
Preparation for HPA Renewal Survey and HEA Initial Survey	37
CAHPS® and HEDIS® Reporting for Health Plan Accreditation	39
Partners in Quality	40
Key Benefits of Being a Partner in Quality (PIQ) Recognized Organization	40
Preparations for Partnership Advantage D-SNP	
Preparations for Partnership Advantage (D-SNP)	42
Model of Care	42
Integrating Partnership Advantage D-SNP	42
HealthPlan Quality Performance	
Overall Summary	44
Partnership HEDIS Reporting Populations – MY2024	44
Overall HealthPlan Ranking: DHCS Managed Care Accountability Set (MCAS)	45
MY2024 HEDIS® Composite Performance Year Over Year Comparison: DHCS Managed Care Accountability Set (MCAS)	45
DHCS MCAS Accountable Measures	48

NCQA Health Plan Accreditation (HPA) – Health Plan Rating (HPR) Methodology	50
MY2024 HPA Star Rating Results	51
Summary of Measures in the Primary Care Provider Quality Incentive Program (PCP QIP)	52
Quality in Data Governance	
Data Governance, Stewardship, and Analytics Integration	55
Data Governance	55
Data Stewardship	55
Analytics Center of Excellence	56
Partnership Quality Dashboard	57
Summary of FY 23-24 PQD Dashboards	58
Provider Network Quality Improvement Support and Initiatives	
Quality & Performance Improvement Initiatives and Projects	63
Overview	63
Quality Measure Score Improvement	64
Improvement Team Workgroups	64
Chronic Disease	64
Behavioral Health	69
Pediatric Preventive Care	71
Women's Health and Perinatal Care	78
Elder Care	82
New Dashboards in Development	83
Quality Improvement Coaching	83
Enhanced Provider Engagement and Modified PCP QIP	84
Expansion Region Coaching	85
Equity and Practice Transformation	87
Practice Facilitation and Provider Coaching	88
Joint Leadership Initiative	89
Expansion of Regional Quality Meetings	90
QI Technical Assistance in Partnership with Northern Region Consortia	92
Other QI Provider Resources Updates and Changes	92
Quality Improvement Training	93
Improving Measure Outcomes	93
ABCs of Quality Improvement	95
Microlearnings	97
Value Based Pay-for-Performance Programs	97
Primary Care Provider Quality Incentive Program	97
Program Goals	97
MY2023 PCP QIP Program Evaluation Summary	98
Program Performance	98
Provider Experience	98
PCP QIP eReports System	99
Hospital Quality Incentive Program	99
Program Goals	99
Completed Goals	100
Perinatal Quality Incentive Program	102

Program Goals	102
Completed Goals	102
Palliative Care Quality Incentive Program	105
Enhanced Care Management Quality Incentive Program	106
Long-Term Care Quality Incentive Program	106
D-SNP Quality Incentive Program	107
Member Safety and Quality Compliance Activities	
Member Safety and Quality Compliance Activities	110
Potential Quality Issues	110
Assignment of Practitioner Performance and Systems Scores	112
Site Reviews	113
Facility Site Reviews	114
Medical Record Reviews	115
Provider Billing Guide	115
Provider Educational Trainings	116
Improving Blood Lead Screening	116
Physical Accessibility Review Survey	117
Initial Health Appointment	118
Improvement Activities	119
Delegation Oversight	120
Latent TB Infection – 12 Dose Treatment	120
Quality in Member Experience	
Care for Members with Complex Needs and Community Partnerships	123
Care for Members with Complex Needs	123
Complex Case Management	123
Community Resource Web Pages	124
Services and Patient Experience	124
Access to Care	128
Methodology and Notable Findings	129
Member Service Access	130
Opportunities for Improvement	131
Activities to Improve Access	131
CAHPS® Program | Member Experience	132
Evaluation Summary	134
Identification of Opportunities and Priority	137
FY 2023-2024 Summary of Activities and Interventions	140
Lessons Learned	144
Web Based Member Information Assessment	146
Quality In Grand Analyses	
NCQA - Grand Analyses	156
Access and Availability (NET 3) Report	156
Pharmacy & Utilization Management (UM1B) Report: Utilization Management	157
Member Experience (ME 7) Report	158
HE-6 Grand Analysis	159
Evaluation Conclusion	

Evaluation Conclusion	167

Appendices

Appendix A: Pharmacy & Utilization Management (UM1B) Report: Utilization Management
Appendix B: Member Experience (ME 7) Report
Appendix C: HE-6 Grand Analysis
Appendix D: HEDIS® MY2023 / RY2024 Annual Summary of Performance Report (MCAS)
Appendix E: HEDIS® MY2023 / RY2024 Annual Summary of Performance Report (HPA)
Appendix F: 2023-2024 QI Work Plan Summary
Appendix G: 2024 Grievance & Appeals Annual Report

Quality Improvement Overview and Program Oversight

QI TRILOGY

Scope of Data and Results Reported in the 2024-2025 Quality Improvement (QI) Program Evaluation

Partnership HealthPlan of California's (Partnership) Quality and Performance Improvement (QI) program provides a systematic process to monitor the quality of clinical care and health care service delivery to all Partnership members. It includes an organized framework for ongoing review of activities to identify opportunities to improve the quality of health care services provided, promote efficient and effective use of health plan financial resources, and partner with internal and external stakeholders to support performance improvement and to improve health outcomes and advance health equity. The program promotes consistency in application of quality assessment and improvement functions for the full scope of health care services while providing a mechanism to:

- Ensure integration with current community health priorities, standards, and goals that impact the health of the Partnership member population
- Ensure alignment with DHCS' Comprehensive Quality Strategy Report
- Identify and act upon opportunities to improve care and service
- Identify overuse, misuse, and underuse of health care services
- Identify and act on opportunities to improve processes to ensure member safety
- Identify and act on opportunities to address disparities in health access and outcomes
- Address potential or tangible quality issues
- Review data for trends that suggest variations in health care service delivery processes or disparities in care

The QI Program adheres to the following goals to improve the quality and effectiveness of clinical care and service to Partnership members:

- Improve the health of the populations Partnership serves
- Enhance the member care experience
- Support the delivery of high-quality clinical care
- Reduce disparities in health access and outcomes
- Ensure member safety
- Measure and encourage appropriate use of clinical resources
- Strengthen a culture of continuous quality improvement throughout the Partnership network

The QI Program accomplishes these goals by:

- Systematically monitoring and evaluating service and care provided
- Continuously improving data and analytics to validate care outcomes
- Actively pursuing opportunities for improvement in areas that are relevant and important to Partnership members' health
- Implementing strong interventions when opportunities for improvement are identified
- Addressing overall member experience by improving provider access and member awareness of the health plan's role and responsibilities

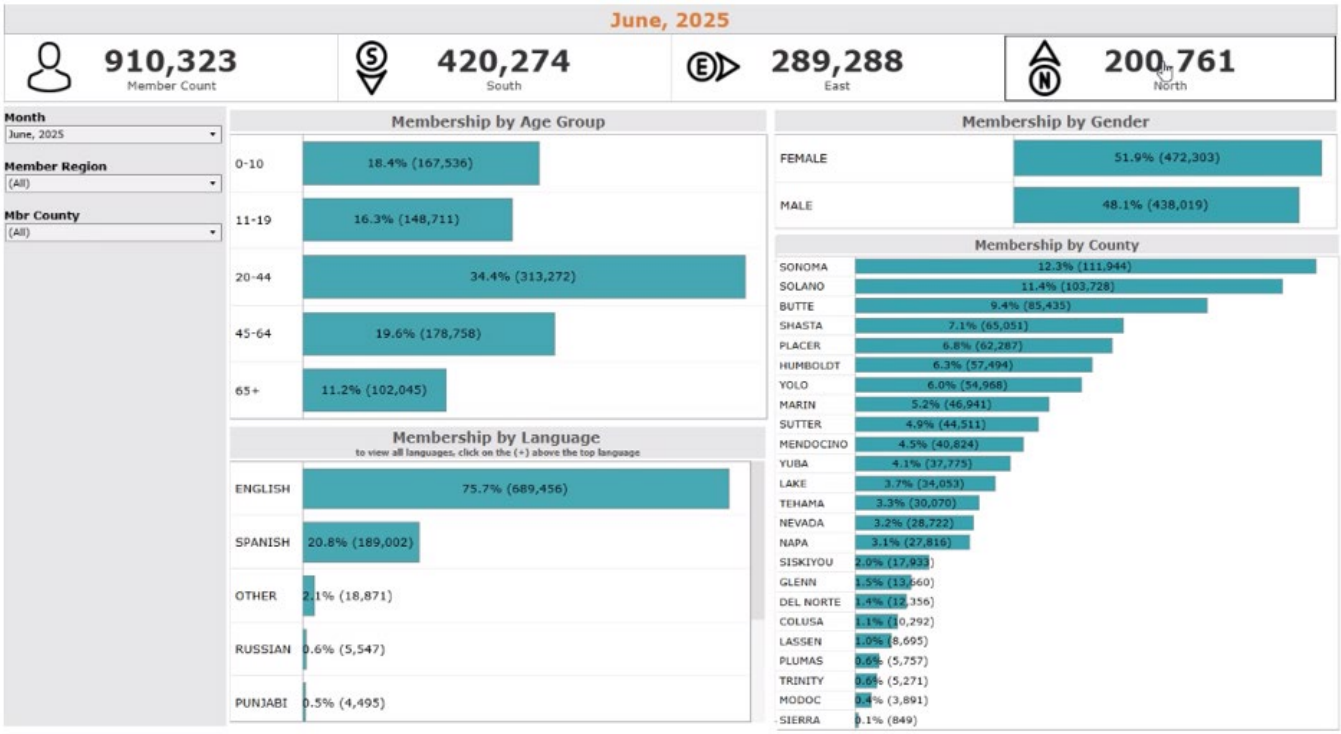
Detailed results of projects, programs, and quality assurance activities regulated by the Department of Health Care Services (DHCS) were presented to the various quality committees throughout the year. This evaluation provides highlights of activities led by or in partnership with the Quality and Performance Improvement department. The evaluation does not include detailed results from the Grievance and Appeals Department, Pharmacy Department, Utilization Management, Care Coordination, or Population Health Departments. Separate evaluations address these functional areas. Additionally, the Quality and Performance Improvement Department partners closely with its Health Equity and Population Health Departments, as defined in Partnership's Quality Improvement and Health Equity Transformation Program (QIHETP) Description. The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system to address improvements in the quality of care delivered by all its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to members. The Quality Improvement and Health Equity Committee (QIHEC) oversees the QIHETP, and the program's overall effectiveness is evaluated in a separate annual evaluation, which complements this overall program evaluation.

The 2024-2025 QI program covers Medi-Cal lines of business across 24 counties: Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo and Yuba. Associated quality improvement initiatives and programs are designed to encourage appropriate care at the right time while being cognizant of resource utilization. Initiatives target areas of under-use, misuse, and overuse in addition to exploring different strategies and payment models for improving access to care and the care of medically complex patients.

The time period of this evaluation is July 1, 2024, to June 30, 2025. This is the first annual QI Program evaluation representing a complete year of experience in counties joining Partnership's service region as part of its most recent geographical expansion, effective January 1, 2024. This expansion included the addition of Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba counties. While these 10-counties have previously been referred to as the East Region, Partnership has since operationally re-organized itself and now designates the expansion counties as part of either the Chico Region or the Auburn Region. Similarly, the legacy counties are now designated operationally across the Fairfield, Santa Rosa, Eureka, and Redding Regions. This shift in regional references reflects the location of Partnership's six Regional Offices and corresponding leadership and staff who are in roles regionally allocated. Similarly, QI staff are aligned by region, where appropriate, to fulfill quality programs and initiatives designated under the overall QI Program. Since Partnership's last evaluation (fiscal year 2023-2024), Partnership's total membership has increased from 900,432 (as of July 1, 2024) to 910,323 (as of June 1, 2025).

Across all 24 counties, 51.9% of Partnership members are female and 48.1% are male. Caucasians represent (37.9%); Hispanic (34.1%); Unknown (13.9%); members who identify as "Other" (4.4%); Black (3.6%); Asian (2.5%); Native American (1.7%); Asian Indian (1.6%); and Native Hawaiian or other Pacific Islander (0.2%). English speakers comprise 75.7%; followed by Spanish (20.8%); Other (2.1%); Russian (0.6%) and Punjabi (0.5%). Members ages 0-10 comprise 18.4%; members ages 11-19 comprise 16.3% of the population; followed by members ages 20-44 (34.4%); members ages 45-64 (19.6%); and 11.2% of Partnership's membership is 65 or older.

Below is a summary of membership by county.



Quality Improvement Program Structure

This section outlines the structure of the Quality Improvement Program, including executive leadership, departmental organization, collaboration mechanisms, and operational capabilities for FY 2024 2025, in accordance with NCQA QI 1 Element C.

To address evolving priorities and increasing operational complexity, the following structural highlights illustrate how the Quality Improvement Program was organized and mobilized throughout FY 2024–2025.

The QI Program operates under the executive leadership of the Chief Medical Officer (CMO) and Senior Director of QI, supported by the leadership team that includes Directors of Quality Management, Quality Measurement, and the Medical Director for Quality. Together this team guided execution of the 5-Star Quality Strategy and objectives outlined in the QI Tactical Plan.

Department managers led teams focused on: Member Safety-Quality Investigations and Clinical Compliance; Accreditation; Quality Measurement; Performance Improvement (PI); Quality Incentive Programs (QIP); and Quality Improvement Programs and Project Management. Within these teams, there are efforts to support data quality and validation in collaboration with IT and Finance – Health Analytics. The department periodically utilizes external consultants to support QI training for provider organizations and internal staff and National Committee for Quality Assurance (NCQA) Accreditation and contract employees for Healthcare Effectiveness Data and Information Set (HEDIS®)-related data collection and reviews.

Programmatic and Operational Highlights

- **Support for Geographical Expansion**: A cross-section of representatives under the QI program continued efforts to ensure regulatory alignment and high-quality services within its expanded provider network for new members gained through the 10-county geographic expansion. These activities included expanding the scope of quality measurement in HEDIS and QIP, proactive provider engagement, onboarding, and strategic support to promote quality program success in the newly integrated counties. This work contributed to sustaining Partnership's regional support overall and resulted in allocating additional resources across QI teams.

- **Expansion and Roles of the Program and Project Management Team**: The Quality Improvement Program and Project Management Team (PPMT) formed in 2023 continued work in FY 24-25, including program activities central to fulfilling DHCS Quality regulatory requirements and NCQA Health Plan Accreditation deliverables. This spectrum also includes transitioning successful pilots from the regional Performance Improvement Teams for further scaling. Then, with continued results, this team leads conversion to sustained program offerings plan wide. They are also the QI Team tasked with providing project management structure, accountability, and urgency to new initiatives and work brought forward by DHCS, internal customers, the provider network, and community partners.

- **Enhanced Regional PI Team Capacity**: In FY 2024-2025, the growth of the PPMT allowed greater focus on regionally driven activities led by the Performance Improvement Teams. This was particularly needed given the geographical expansion coupled with continued focus in legacy counties on driving quality measure score improvement interventions and initiatives, inclusive of new efforts to identify and reduce health disparities within quality measure performance. In early FY 2024–2025, executive leadership restructured regional operations from three to six regions for improved local support. QI's PI teams were realigned accordingly, and a new regional PI Manager role was introduced, along with additional staff positions, to ensure sufficient capacity and alignment with the expanded regional model.

- **Sustained Leadership of QMSI Workgroups**: Performance Improvement Teams continue to lead measure-focused improvement workgroups under the Quality Measure Score Improvement Initiative (QMSI). Each workgroup is responsible for a specified measure domain and has 1-2 designated leaders to facilitate cross-departmental analysis and review of quality measure performance, assess and initiate new interventions to address prioritized care gaps. This year included developing a new QMSI workgroup focused on Elder Care, which represents measures unique to members enrolling in Partnership's forthcoming D-SNP offering.

- **Enhanced Provider Engagement (EPE) and Modified PCP QIP**: In 2024-2025, Partnership continued its EPE and Modified PCP QIP coaching programs focused on providers facing significant infrastructure and workforce challenges, serving members in communities with historical healthcare disparities, and reporting low performance in the PCP QIP. Provider organizations demonstrating improvement transitioned to coaching and collaboration activities that are elective and less prescriptive, while new participants were onboarded based on low performance in priority quality measures.

Cross-Functional Alignment and Special Projects

- **CAHPS / Member Experience Efforts**: In Fiscal Year 2024-2025, CAHPS® / Member Experience goal efforts continued. As a result, implementation of new improvement activities and interventions that targeted workforce development, improved access to care, transportation services, direct-to-member activities, and increased Partnership branding and awareness were the focus and thus supported stronger linkage to Partnership's 5-Star Strategy and the stated objectives of the Engaging Members focus area in the corresponding QI Tactical Plan.

- **NCQA Health Plan Accreditation and Health Equity Accreditation (HEA) Readiness:** In FY 2024-2025, the Accreditation Program maintained Partnership's health plan accreditation and continued work in preparation for NCQA Health Equity Accreditation (HEA). The team led readiness activities across departments and conducted a full mock HEA survey in August 2024, with its first HEA survey scheduled for June 2025.

- **Support for D-SNP Implementation**: In FY 2024-2025, significant progress was made in implementation planning for the future launch of Partnership's Dual Eligible Special Needs Plan (D-SNP), defined as an Exclusively Aligned Enrollment (EAE) model. The Senior Medicare QI Program Manager was fully integrated into the QI Program structure over the course of 2024-2025. Reporting into the Senior Director of QI, this position worked closely with the Medicare Medical Director, Medicare Program Manager, QI leaders, and other Health Services leaders to develop, implement, and sustain the Model of Care and lead organization-wide implementation of Partnership's CMS Medicare STARS Quality strategy, which is crucial to the organization achieving an optimal STARS rating. QI added new resources across QI teams to support implementation planning activities central to the QI Program. QI also facilitated cross-functional collaboration with internal and external stakeholders to prepare for program launch activities, including quality strategy alignment, readiness assessments, and infrastructure planning key to the long-term needs of the QI Program.

- **HRP Implementation**: In fiscal year 2024-2025, QI resources continued supporting the development and testing related to the transition from Partnership's prior core claims processing system, Amisys, to the new core claims processing system, HealthRules Payer® (HRP®). The QI Department remains actively engaged in ongoing work to ensure quality and compliance alignment throughout the system implementation lifecycle and will continue supporting this work through its launch.

Conclusion and Structural Growth

In response to organizational expansion and increasing program complexity, the QI Department added multiple new roles, aligned regional operations, and refined team responsibilities to support sustained quality oversight and performance improvement across all regions. Additional details on personnel changes are provided in the Quality Improvement Departmental Changes section.

Quality Improvement Governance

Partnership HealthPlan of California maintains a comprehensive and well-integrated Quality Improvement (QI) governance structure designed to ensure strong oversight, accountability, and collaboration across all levels of the organization. The QI governance framework brings together diverse specialties and expertise through multiple committees and advisory groups. These committees work in alignment to oversee, monitor, and continuously improve the quality of care and services provided to members.

The organization is satisfied with the number and types of specialties represented across its governance bodies including the Board of Commissioners, Physician Advisory Committee (PAC), Quality and Utilization Advisory Committee (Q/UAC), Internal Quality Improvement (IQI) Committee, and the Quality Incentive Program (QIP) Advisory Groups — each playing a critical role in supporting Partnership's mission and advancing quality initiatives.

Board of Commissioners

The purpose of the Commission is to arrange for the provision of health care services to qualifying individuals, as well as other purposes set forth in the enabling ordinances established by the respective counties. The Commission promotes, supports, and has ultimate accountability, authority, and responsibility for a comprehensive and integrated QI Program. The Commission is ultimately accountable for the quality of care and services provided to members. The Commission has delegated direct supervision, coordination, and oversight of the QI Program to the Physician Advisory Committee (PAC), which serves as the main Quality Improvement committee. PAC is supported by two (2) other quality committees – the Quality and Utilization Advisory Committee (Q/UAC) and the Internal Quality Improvement (IQI) Committee, which are described in more detail below. The county Boards of Supervisors for each geographic area appoints members of the Commission, which include representation from the community, consumers, business, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health departments. The Commission meets six (6) times per year.

Internal Quality Improvement Committee

The Internal Quality Improvement (IQI) Committee is comprised of appropriate Partnership department directors and staff that track progress towards successful completion of quality initiatives, surveys, audits, and accreditation. The IQI Committee under the leadership of the Chief Medical Officer, Medical Director for Quality, and Senior Director for Quality and Performance Improvement, meets 10 times per year, with the option to add additional meetings if needed, and reviews approximately 185 or more external-facing policies owned by the various Health Services department, including QI, and a few non-HS departments (i.e., Credentialing, Network Services, Provider Relations, Member Services, and Grievance & Appeals). IQI also considers QI initiatives spearheaded by Performance Improvement staff ; reviews annual evaluations of the various Quality Incentive Programs (QIPs) and hears annual "Grand Analysis" presented by various Health Services departments. IQI is also the initial committee to receive and provide feedback on the monitoring of Initial Health Assessment trends and actions, site review results, and trends in potential quality of care issues. Multidisciplinary improvement teams may be designated to complete analysis and intervention recommendations for quality improvement issues and activities. The IQI Committee serves to integrate quality activities organization wide. Activities and progress are reported to the Quality and Utilization Advisory Committee (Q/UAC) and then the Physician Advisory Committee (PAC).

The IQI Committee met 10 times during fiscal year 2024-2025. Partnership's IQI Committee agenda remained heavy throughout the year, due to the volume of policy changes related to NCQA Accreditation and DHCS requirements. To date, Partnership addressed all agenda items timely. The IQI Committee membership remained stable, consisting of a multi-departmental team that included the necessary level of leadership across departments impacted by policies and procedures moving through the IQI Committee. The meeting structure included a policy pre-review process and dedicated policy review time during the meeting, both of which ensure there is adequate time for policy discussion. Discussion topics were presented to the committee, and Partnership leveraged these presentations and reports for IQI Committee members to provide input and qualitative feedback. Overall, the IQI Committee structure has been sufficient to provide adequate oversight and support in tracking quality initiatives and providing health plan and/or clinical expertise into policy and procedure review.

Partnership's IQI Committee agenda grew heavier this year, not least because of increasing volume of policy changes related to NCQA Accreditation and DHCS requirements. (For example, the IQI Committee twice this fiscal year considered a new internal Health Equity policy for the purpose of helping to obtain initial NCQA Health Equity Accreditation (HEA) in June 2025.) Volume also increased this fiscal year over last as departments reorganized and existing policies were reassigned from one department to another and new Medi-Cal policies were born. In Health Services, the emerging Enhanced Health Services and Behavioral Health sub-departments or "business units" assumed policies that had previously belonged to Administration, Care Coordination, or Utilization Management. (The expansion of Health Services sub-departments sparked a reformatting of the general policy template. Whereas only the "Lead Department" was once specified, now the "business unit" is as well: e.g., Health Services/Quality Improvement. This innovation makes it easier to ascertain who owns what policy.) Tracking non-HS department policies was made more difficult by the August 2024 Provider Relations split into Provider Relations and Network Services, the latter of which assumed the Credentialing policies. Finally, in the fall of 2024, work began in earnest on policy requirements to meet the needs of the new Dual-Eligible Special Needs Program (D-SNP) "Partnership Advantage," Partnership's Medicare product line that will take effect Jan. 1, 2027, and the volume of policy review at IQI increased accordingly beginning in February 2025. Staff anticipates that the IQI Committee workload will remain heavy in FY 2025-2026 as preparations continue for the coming Medicare product. The policy pool could grow from approximately 185 to well above 200 distinct documents.

Quality and Utilization Advisory Committee

The Quality and Utilization Advisory Committee's (Q/UAC) role is to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. This responsibility includes providing significant input on the QI Program Description, Annual Evaluation, and Work Plan. The committee is required to meet at least 10 times per year, with the option of adding meetings if needed. Present Q/UAC voting membership includes two consumer representatives, one physician currently serving as a county Public Health Officer, and 10 external clinicians whose specialties are internal medicine, family medicine, pediatrics, OB/GYN, neonatology, or behavioral health, among others. The Partnership CMO (chair of the committee), Medical Director for Quality (vice-chair), and leadership from the Health Service departments (i.e. QI, CMO Office, Utilization Management, Care Coordination, Pharmacy, Population Health, Health Equity, Behavioral Health, and Enhanced Health Services) and non-HS departments (e.g., Member Services and Grievance & Appeals) regularly attend Q/UAC meetings. Q/UAC activities and recommendations are reported monthly to PAC and at least quarterly to the Commission.

Q/UAC met 10 times during fiscal year 2024-2025. Partnership's Q/UAC agenda remained heavy due to the volume of policy changes related to maintaining NCQA Accreditation and new DHCS requirements largely associated with California Advancing & Innovating Medi-Cal (Cal-AIM) and other All Plan Letters. Furthermore, Partnership's addition of 10 new counties to its service area, effective January 2024, continued to impact the QI Program at large and Q/UAC discussions particularly.

Committee membership remained steady, and quorum was met each meeting. Partnership was able to address all agenda items timely, although at times, reports on QI initiatives had to move from verbal presentation to directing committee members to refer to written reports in their meeting packets in soliciting feedback. This was a result of accommodating the increased discussion corresponding to the growing policy load. (See Internal Quality Improvement (IQI) Committee above for details.) In Fall 2024, QI staff took an informal straw poll of Q/UAC voters and received no support to increase monthly meeting time from 90 minutes to two hours. This and other remedies, however, may need to be considered in the future. Overall, in 2024-2025, the Q/UAC committee structure was sufficient and provided adequate oversight and support to the Quality Improvement program and sufficient clinical expertise to support informing policy and procedure. Moreover, the medical expertise of Q/UAC's clinicians is deemed sufficient to meet Medicare's requirements, that those whose practices care for the elderly and disabled are involved.

Physician Advisory Committee Oversight Program

Physician Advisory Committee (PAC) and voting membership included external PCPs, board certified high-volume specialists, and advanced practice clinicians such as certified nurse midwives, nurse practitioners, or physician assistants. A voting provider member of the committee chaired PAC. Per Partnership policy, the committee met monthly, at least 10 times during fiscal year 2023-2024. PAC monitored and evaluated all Health Services activities and was directly accountable to the Commission for the oversight of the QI Program. The parameters for membership and meeting frequency were met for the fiscal year 2023-2024, and activities including review and approval of policies and procedures, QI activities, and evaluations of projects and programs were addressed by an appropriate mix of Primary Care and Specialty physician members who attended. Quorum requirements were met for nine of the ten convened meetings. The Partnership CMO, Medical Director for Quality, Clinical Director of Behavioral Health, and leadership from QI, Provider Relations, Utilization Management, Care Coordination, and Pharmacy Departments attended PAC meetings regularly.

Quality Incentive Program Advisory Groups

As detailed later, Partnership has several incentive programs called Quality Incentive Programs (QIPs). QIP Advisory Groups are made up of appropriate Partnership staff and representative provider network staff to ensure ongoing collaboration in Partnership's value-based program offerings. Each year they review and recommend measures for the QIPs in which they participate, with each member of the QIP Advisory Group serving for a two-year time frame. The QIP Team manages the Advisory Group member list and is responsible for inviting new participants at the conclusion of the two-year service period. Advisory Group meetings are held once per quarter throughout a measurement year for most QIPs and less frequently but no less than twice per measurement year for smaller programs.

Physician Advisory Committee (PAC) oversees the QIP Advisory Groups and the QIP Team is responsible for hosting the meeting and creating the Advisory Group meeting agenda in collaboration with the Partnership Chief

Medical Officer. Each QIP Advisory Group formulates recommendations generated by internal QIP Technical Working Groups, in the form of draft measures which are released to their respective provider networks during a "public comment period." Feedback from the public comment period is shared with the QIP Advisory Groups, who assimilate them into a set of measure recommendations that are forwarded to PAC for review and approval. The current committee structure supports the QIPs and allows for valuable feedback from appropriate stakeholders, in a fashion that helps Partnership meet its goals. The QIP Advisory Group includes representation from all Partnership regions, including invitees from smaller organizations to diversify feedback and increase stakeholder buy-in.

Quality Improvement Leadership Engagement & Commitment

Partnership HealthPlan of California's executive leadership team provides essential oversight, accountability, and strategic guidance to support the Quality Improvement (QI) Program. Through active participation in key committees, workgroups, and strategic initiatives, these leaders ensure alignment between organizational priorities and quality goals. Each executive brings unique expertise and plays a distinct role in advancing quality management, supporting NCQA accreditation, meeting regulatory requirements, and driving performance improvement initiatives that enhance member care. The following describes the roles and contributions of executive leaders key to the governance and success of the QI Program.

Chief Executive Officer

The Partnership Chief Executive Officer's (CEO) primary roles in quality management and improvement were four-fold:

- Maintained a working knowledge of clinical and service issues targeted for improvement
- Provided organizational leadership and direction
- Participated in prioritization and organizational oversight of quality improvement activities
- Ensured availability of resources necessary to implement the approved QI Program

The CEO is a member of the Internal Quality Improvement (IQI) Committee and is a standing attendee and presenter at the Physician Advisory Committee (PAC). Along with other members of the Executive Team, the CEO further supports the QI Program through participation in the NCQA Steering Committee and Executive Quality Measure Score Improvement meetings. The Executive Team provides oversight, accountability and support for NCQA, HEDIS®, and related quality improvement initiatives.

In recognition of the need to better engage provider executive leadership at practice sites primarily responsible for driving quality measure performance, the CEO and CMO (or their senior leadership designees) meet with the executive and senior leadership of our largest primary care provider sites. One (1) to three (3) meetings are held annually with each of the participating provider organizations. These meetings have been an effective engagement strategy over the past several years and will continue in the next FY. The CEO was also a member of the Board Quality Advisory Group and partnered with the CMO in the consideration of topics and areas to gain further insights and recommendations from Board members who are also leaders at some of our largest participating network provider sites. The CEO's level of involvement in quality improvement activities was appropriate to ensure executive level accountability in support of the department and organizational wide goals and responsibilities.

Chief Operating Officer

The Chief Operating Officer (COO) provides strategic leadership and guidance in all health plan operations. The COO has purview over the Member Services, Claims, Configuration, Grievance and Appeals, Transportation, Provider Relations, Contracting, Network Services, and the Regional Leadership departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The COO is a regular attendee and ad hoc member of PAC and an engaged participant at NCQA Steering Committee and Executive Quality Measure Score Improvement meetings. The COO's level of involvement fulfilled the need for executive support and accountability for operations key to successful quality improvement interventions, initiatives, and related organization wide goals and responsibilities.

Chief Medical Officer

The Chief Medical Officer (CMO), with the assistance of the members of the PAC, Q/UAC, and IQI Committees, is responsible for providing professional judgment regarding matters of quality of care, peer review, clinical services, and medical procedures. The CMO is the chair of the IQI Committee and Q/UAC and has significant involvement in all QI, Pharmacy, Population Health Management, and Health Services activities. The CMO facilitates the Board Quality Advisory Group and presents a report on quality at each Board of Commissioners meeting.

The CMO and the QI Program senior leadership team provide oversight for QI programs on a day-to-day basis. The team is comprised of:

- Associate Medical Directors - Assists CMO with utilization management review, review of appeal decisions, and review of Potential Quality Issues (PQI). The level of involvement of the associate medical directors was sufficient for reconciliation of PQIs via the peer review process.
- Medical Director for Quality - Assists CMO by providing physician support for varying activities within the Department, including Performance Improvement, Member Safety, Peer Review, and the Quality Improvement Programs, as well as assisted with utilization management review activities. This role also has management oversight of the Member Safety Teams within the Quality Department. The time allocated and scope of responsibilities of the Medical Director for Quality is set appropriately to meet the evolving needs of the QI Department.
- Regional Medical Directors - Works closely with respective counties on quality improvement activities including: liaison to physician leaders, serve as medical leadership at community meetings, support process improvement activities, author/ edit provider and member QI newsletter articles, drive improvements on adult and child quality measures and foster further collaboration and engagement with providers through regional meetings.
- Medical Director of Medicare Services – This new role was added in 2023-2024 to assure physician leadership in preparations for implementing the Medicare Dual Special Needs Plan (D-SNP). This medical director works closely with the CMO and Quality Department to develop policy, strategy, and tactical activities with Medicare leads designated in other departments across the organization. As D-SNP is implemented, this role will provide medical leadership for Partnership's Medicare activities, including utilization management, quality, care coordination, pharmacy, grievances, and compliance activities. Also assists CMO, as requested, in supporting broader needs to oversee appropriateness and quality of care delivered through Partnership and for the cost-effective utilization of services.

- Chief Health Services Officer - Reports to the CEO but works in close collaboration with the CMO and QI Program senior leadership. Responsible for the day-to-day implementation of Partnership's Utilization Management, Care Coordination and Health Equity Programs. This position has the authority to make decisions on coverage not relating to medical necessity. This role serves as a standing Member of PAC, Q/UAC and the Peer Review Committee and provides oversight, guidance, and evaluations of ongoing UM activities and programs under their oversight.
- Senior Director of Quality and Performance Improvement - Works collaboratively with the CMO to define strategy, develop programs and services, and evaluate the effectiveness of the QI Program. Together with the QI management team, including the Medical Director for Quality, provides oversight of Facility Site Reviews, investigation of potential quality issues, compliance with NCQA standards, HEDIS® and other performance measure data collection and performance reporting, value based payment programs (QIPs), performance improvement initiatives and programs, external and internal QI training, provider education on the QIPs and HEDIS®, grant application and grant management. This role works to foster greater cross collaboration of QI staff and strategic involvement of other departments to support the execution of tactics defined and maintained under Partnership's 5-Star Quality Strategy.

The number of associated Health Services staff and level of involvement of the CMO was appropriate for meeting the objectives of the Quality Improvement Program.

Chief Health Services Officer

The Chief Health Services Officer (CHSO) works closely with leaders in Utilization Management to provide accountability for delegates to meet necessary NCQA accreditation requirements and provide strategic leadership and guidance in the review and revision of provider contracts to ensure QI reporting requirements and value-based program contingencies are met. The CHSO also has purview over the Care Coordination, Utilization Management, Enhanced Health Services, Behavioral Health, and Health Equity Departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The CHSO's level of involvement fulfills the need for executive support and accountability for improvements with data quality, and coordination of activities between QI and these departments. Collaborates with the Chief Medical Officer and members of PAC, Q/UAC, and IQI in matters involving quality of care, clinical, and medical procedures.

Chief Strategy & Government Affairs Officer

The Chief Strategy and Government Affairs Officer (CSGAO) reports to the Chief Executive Officer and is a peer to the other executive team members. The CSGAO leads the overall strategic direction of the HealthPlan in consultation with the CEO and Governing Board.

This position is responsible for the operations and executive management of Regulatory Affairs and Compliance (RAC); Communications, Legal, and Project Management/Operational Excellence (PMO) departments. This executive leader is also overseeing the organizational implementation of the Partnership Advantage (D-SNP) product line.

Quality Improvement Departmental Changes

The structure of the QI Department, including committee structure (inclusive of leadership and practitioner participation), position changes, staff and team roles and responsibilities, are periodically assessed. The results of these assessments can lead to major operational and structural changes to the department or related QI functions. Consideration is given to new state directives, local and national events, general business needs, staff growth and development and fiscal responsibility when making a determination on whether to make structural or operational changes.

Based on the considerations noted above and the evaluation and assessment of the 2023-2024 QI Program, the following changes were made during fiscal year 2024-2025:

Changes within QI Department

Key personnel changes and Program restructuring in fiscal year 2024-2025:**Member Safety**

- Two Project Coordinator Is were added to the Member Safety-Inspections team to address logistics and site review scheduling associated with increasing DHCS regulatory requirements integrated in the site review process. These requirements include: oversight of Comprehensive Perinatal Services Programs (CPSP), supporting CPSP-like services, and absorbing Child Health and Disability Prevention (CHDP) provider training responsibilities. The Inspections team is also working to prepare provider sites in Partnership's recent 10-county expansion region for increased site review requirements before their next periodic review. This has led to these newer staff arranging focused trainings, led by certified site review nurses, in the expansion counties on DHCS Site Review Tool changes to ensure providers are prepared for the significant changes in Medical Record Review and CAP requirements. Simultaneously, the Inspections team is relied upon to maintain an expanded periodic site review schedule post-geographic expansion.
- A new role was created and added to the Inspections team: Quality Training Specialist and Dental Liaison. This position is responsible for maintaining and delivering provider education, required previously of the counties, under the Child Health and Disability Prevention (CHDP) Program. In anticipation of the sunset of the CHDP Program, Partnership has re-branded its newly implemented program as CHILD (Comprehensive Health Interventions for Lifelong Development) trainings. This role also serves providers as Partnership's designated Dental Liaison. As Dental Liaison, this position is responsible for collaborating with providers, internal departments, and other stakeholders to identify process improvements and other improvement activities for enhancing the quality of dental and oral health care our members received. This position maintains current knowledge of related benefit changes from DHCS and standards of care to help improve member health status and quality outcomes while establishing a positive provider experience and rapport.

Quality Improvement Program and Project Management Team (PPMT)

- Two Project Manager Is were added to support new and expanding program and project management needs within the overall QI Program. This includes adapting QI programs for D-SNP integration, scaling successful measure improvement pilots transitioning from the Performance Improvement teams, expanding established performance improvement programs and scaling initiatives into Partnership's expansion region, supporting county partners focused on quality measure performance improvement under DHCS required Community Health Assessments and Community Health Improvement Plans, and assuring timely completion of increasing deliverables under DHCS' Equity and Practice Transformation Program.

Performance Improvement

- Over the last two years, as Partnership prepared for and completed its 10-county geographic expansion, QI leadership opted to add new Performance Improvement (PI) staff, namely Improvement Advisors and improvement-focused Project Managers, versus adding a new regional PI Manager. The Northern Region PI Team integrated Tehama County into their workloads, while the Southern Region PI Team integrated the remaining nine new counties. The NR PI and SR PI Teams worked closely together over 2023-2024 and the first half of 2024-2025 to provide boots on the ground support to the provider network, with emphasis in primary care. In early 2024-2025, the executive leadership of Partnership opted to re-structure Partnership's regional operations from 3 to 6 regions for improved local coverage and impact in all its counties. Similarly, the CMO and Senior Director of QI worked to align QI's regionally designated PI teams. A new regional PI Manager role was added, and the existing NR and SR PI teams were re-structured to reflect the new regional structure. This resulted in the former NR PI Team being allocated to the Redding and Eureka Regions which include: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity, Del Norte, Humboldt, Lake, and Mendocino counties. The former SR PI Team was allocated to the Fairfield and Santa Rosa Regions which include: Marin, Napa, Solano, Sonoma, and Yolo. The new regional PI Manager and team were allocated to the Chico and Auburn Regions which include: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, and Yuba. This resulted in several changes within PI including role and reporting changes for existing staff and the addition of new staff and leaders. In addition to the new regional PI Manager role, a new Project Coordinator II position and another Improvement Advisor position were added to ensure adequate capacity in PI across all regions.

HEDIS

- QI added a new role, the Director of Quality Measurement in 4Q 2024. For several years, QI had a designated Associate Director of Quality Measurement to fulfill a role like this one. Due to the departure of this leader in 2021 and budget limitations, the Medical Director for Quality added the HEDIS team to his oversight responsibilities in 2022. Given increasing risks of sanctions and quality withholds, increasing complexity in the HEDIS projects, and expanding measure sets, additional leadership focus was needed in HEDIS. Simultaneously, this addition permitted the Medical Director for Quality to focus his leadership, clinical expertise and strengths in directing QI's Member Safety teams, supporting grievances, and increasing needs (due to impending medical director retirements) in credentialing. The Director of Quality Measurement is responsible for establishing data sources that are integrated and validated for optimal clinical quality measurement and reporting across both Medicaid/Medi-Cal and Medicare D-SNP product lines. This includes directing analyses of quality outcomes and reporting required per DHCS MCAS, NCQA HPA, DHCS D-SNPs, and CMS Medicare Stars. This position provides the primary strategic and management/supervisory support for the current Manager of Quality Measurement, the HEDIS projects and HEDIS team. This leader is key in identifying and driving strategies with IT, Health Analytics, and others in QI for enhancing data quality central to quality measurement that informs Performance Improvement priorities, namely ongoing quality measure score improvement activities. This position was filled by the former SR PI Manager, who has the analytical qualifications and related work experience to step into this new role. Her Partnership experience as a PI leader positions her very well in driving strategies essential to improving measure outcomes.
- Another QI Analyst was added to the HEDIS team due to the increasing workload brought forward with the 2024 Geographic Expansion, effective on Measurement Year (MY) 2024 HEDIS reporting. This position supports an estimated increase of 200k members to our current HEDIS eligible population in both DHCS MCAS and NCQA HPA Annual projects. This role is also key to assuring successful Primary Source Verification (PSV) of Electronic Clinical Data Systems (ECDS) sourced data through our NCQA-certified Data Aggregator as well as supplemental data from regional HIEs and other non-standard data sources.

- The HEDIS team also added another Program Coordinator II to support the growth of the HEDIS eligible population and the additional county-level oversampling required to support ongoing DHCS Quality Reporting. Both increase the team's non-clinical, medical records management workload substantially.
- Lastly, a Program Manager I was added to the HEDIS team focused on preparing for the D-SNP HEDIS projects. This role serves as the team's point of contact to collect the D-SNP Reporting requirements, understand and identify the new data sources that will be needed to capture the data, and create business requirements to integrate into existing systems key to fulfilling regulatory-based measure reporting requirements and inform Partnership's STAR strategy.

Quality Improvement Executive Summary

QI TRILOGY

Executive Summary

Partnership has identified three (3) strategic priorities in its 2024-2027 Strategic Plan – 1) Champion Local Partnerships, Provide Statewide Leadership, 2) Be a Catalyst for Health Equity and Quality and 3) Extend Our Reach, Transform Our Role.

Partnership's Quality Improvement (QI) Program was successful over the course of fiscal year 2024-2025 in achieving its quality improvement goals and commitments. The structure of the QI Program and its associated work planning process included ongoing monitoring of planned objectives and activities dedicated to improving quality of clinical care, safety of clinical care, quality of service and members' experience.

Key accomplishments and highlighted learnings, further detailed in this annual QI Evaluation, include:

- The NCQA Accreditation Program Management Team worked with business owners across Partnership to maintain compliance with all assigned and current NCQA Health Plan Accreditation (HPA) Standards and Guidelines. Confidence in maintaining compliance was primarily achieved through applicable departments' participation in quarterly file review audits and scheduled Mock File Reviews in the spring of 2025. All Business Owners addressed resulting findings and recommendations shared by Partnership's external NCQA Consultant. The HPA Report schedule was also fulfilled, with timely analysis reports deemed compliant by the NCQA Consultant.
- Business owners across the organization also continued working with the NCQA Program Management Team in achieving NCQA Health Equity Accreditation survey readiness. The 2024-2025 HEA goal aimed at readiness of all assigned HEA Standards and Guidelines for Initial Survey, scheduled for June 17, 2025. Confidence in readiness was achieved through the completion of a full scope HEA Mock Survey in August 2024 and the subsequent completion of all resulting corrective actions. Business owners also on confirming documented processes are in compliance with all evidence and analysis reports submitted timely for NCQA Consultant review. At the close of 2024-2025, an overall compliance rate of 100% is estimated.
- In FY 2024-2025, significant progress was made in implementation planning for the future launch of Partnership Advantage, a Dual Eligible Special Needs Plan (D-SNP) which is defined as an Exclusively Aligned Enrollment (EAE) model. QI worked closely with the Medicare Medical Director, Medicare Program Manager, and other Health Services leaders to develop, implement, and sustain its Model of Care. QI also led organization-wide implementation of Partnership's CMS Medicare STARS Quality strategy. QI added new resources across QI teams to support implementation planning activities central to the QI Program. QI also facilitated cross-functional collaboration with internal and external stakeholders to prepare for program launch activities, including quality strategy alignment, readiness assessments, and infrastructure planning key to the long-term needs of the QI Program.
- Partnership achieved an NCQA Health Plan Rating (HPR) of 3.5 in September 2024, reflecting Measurement Year 2023 health plan performance. NCQA assessed Partnership as a 3.5 Star accredited health plan, considered a slightly better than average rating on the five-point scale used nationally. The HPR methodology used by NCQA represents a composite metric of health plan performance under HPA HEDIS® measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey measures. As such, Partnership's QI Program has adapted in recent years to incorporate greater focus on improving both the quality measures defined by the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS), NCQA HPA, and CAHPS® surveys, as each are used to assess the quality of healthcare provided to our members. Partnership continues to evaluate its QI Program under its 5-Star Quality Strategy (last updated in February 2020) and corresponding tactical plan, which is updated quarterly. This framework is reflected in detailed goals and

deliverables within Partnership's annual QI Work Plan. This approach has aided Partnership in demonstrating continued organizational focus on improving HEDIS® and CAHPS® scores over 2024-2025, which will continue as a multi-year effort and focus across the health plan. At the close of 2024-2025, Partnership estimates its HPR will be maintained as a 3.5 Star rating, given recently submitted HEDIS® and CAHPS® rates for Measurement Year 2024. The final HPR is pending NCQA assessment and reporting in September 2025.

- In 2024, DHCS implemented several new contract deliverables for managed care plans, emphasizing enhanced quality, access, accountability, and health equity. These contracts introduced requirements such as improved integration of physical and mental health services, culturally competent care, and mandates for plans to reinvest a portion of their profits into community health initiatives. At the same time, DHCS revised its sanctions methodology to assess annual MCAS performance at the county-level (vs regional or plan-wide level), while in parallel constructing its new Quality Withhold and Incentive Program, effective on MY2024 MCAS and CAHPS results. These new accountability deliverables and revised assessment criteria represent increasing pressure to optimize quality measure performance. In 2024-2025, Partnership continued its focus on corresponding priority quality measures and initiatives to meet these state goals and minimize financial sanctions and withholds that may impact how we serve our communities in the future. In addition to maintaining focus on driving quality measure score improvement through a variety of performance improvement initiatives and quality incentive programs, we also worked to enhance data completeness in reporting quality measure performance. Our goals are to enhance data completeness to better represent the actual care and services being delivered to our members that is increasingly not reflected in the reported quality measure performance rates. First, a new leadership role was inserted in the QI Program, the Director of Quality Measurement. This role oversees the HEDIS team and is key in identifying and driving strategies with IT, Health Analytics, and others in QI for enhancing data quality central to quality measurement. Key efforts in 2024-2025 to enhance data quality and completeness include:
    - Partnership worked with the DHCS Data team to better understand how it receives fluoride varnish claims and encounters that can be counted towards the Topical Fluoride for Children (TFL-CH) MCAS measure, most of which are billed to Denti-Cal from FQHC, RHC, and Tribal Health Dental Centers and then sent to Partnership. As a result, Partnership was able to identify fluoride varnish services completed by FQHC, RHC, and Tribal Health Dental Centers and receive approval from our HSAG HEDIS auditor to include in the MY2024 HEDIS Annual Project. These Dental Centers must follow specific coding requirements for their fluoride varnish services to be successfully sent to Partnership via DHCS, and in 2025 Partnership is actively working with Dental Centers throughout its network to implement the coding requirements and monitor progress.
    - Partnership piloted the use of Datalink, an NCQA Certified Data Aggregator Validation vendor, to more fully address the ongoing transition of several NCQA HEDIS measures to require data collection by Electronic Clinical Data Systems (ECDS) methodology. Learnings from this successful pilot in MY2024 HEDIS projects has identified adaptations for expanded use of DataLink in MY2025 HEDIS projects.
    - Partnership gained auditor approval to integrate a supplemental Medical Record Review project to improve measurement of the entire MY2024 W30 measure eligible population in MCAS. This supplemental Medical Record Review addressed numerous known points of failure in the Medi-Cal eligibility and enrollment process that have been limiting administrative data capture of newborn visits. The results of this pilot had a dramatic impact on the rates for both W30 sub measures, resulting in both rates scoring above the 75th percentile for MY2024. The W30 Medical Record Review is being adopted within the HEDIS Annual Project going forward.

- Considerable efforts were dedicated to building relationships with expansion providers and evaluating emerging quality data and performance trends in 2024-2025. In early FY 2024–2025, executive leadership restructured regional operations from three to six regions for improved local support. QI's Performance Improvement teams were realigned accordingly to ensure sufficient capacity and alignment with the expanded regional model. These regional interactions helped Partnership quality improvement staff support organizations in identifying improvement opportunities going forward, upon using their MY2024 QIP results with anticipated MY2024 HEDIS results soon to follow.
- In Partnership's legacy counties, QI continued coaching efforts across its lowest performing PCP practice tier through coupling our Enhanced Provider Engagement (EPE) and PCP Modified QIP programs. Performance Improvement staff assessed, supported, and coached lower-performing sites, developing tailored interventions designed to address foundational issues, including financial support to purchase equipment, increase short term access, and addressing health disparities. At the conclusion of MY2024, some provider organizations graduated from the Modified QIP back to full participation in the PCP QIP. At the same time, several providers remained, with a few provider organizations joining these programs for the first time. Improvement advising and project management support were also extended to low through mid-performing practice tiers in pursuit of funding through DHCS' Equity and Practice Transformation (EPT) program, which launched in 2023-2024.
- Performance improvement interactions with providers largely leveraged Partnership's Quality Incentive Programs (QIPs), targeting measures reflecting priorities from the DHCS MCAS and NCQA HPA measure sets. In FY 2024-2025, the Hospital QIP measure set was revised to include the introduction of the 7-day Clinical Visit Follow-Up measure, in anticipation of corresponding HPA measures and continued DHCS focus on managing transitions between care settings. Refinements to the measure are planned for 2025-2026. Additionally, the 2024-2025 measure set included a new measure encouraging hospitals to begin expanding their delivery privileges to midwives and family physicians given continued access constraints in OB services.
- Our steadfast commitment to provider technical assistance was also demonstrated through Improvement Academy trainings, regular joint leadership and operational meetings with larger provider organizations, regionally focused quality meetings with local primary care provider organizations, and state-mandated performance improvement collaborations. Improvement Academy trainings, along with a dedicated series of webinars, highlighting best practices in improving priority MCAS measures were very well attended and received. In local meetings and collaborative interactions, provider teams and coaches focused on closing care gaps through interventions within clinical and operational workflows, fostering a culture of quality within provider leadership, and building capacity for quality improvement.
- Quality Measure Score Improvement (QMSI) workgroups were expanded and optimized to address evolving DHCS MCAS and NCQA Health Plan Accreditation (HPA) measure sets in Pediatrics, Chronic Diseases (including medication management), Behavioral Health, Women's Health, and Perinatal Care. Through local collaboration, Partnership piloted, scaled, or spread improvements across measures including breast cancer screening, cervical cancer screening, chlamydia screening, perinatal care, colorectal cancer screening, controlling high blood pressure, diabetes care management, follow-up after emergency department visits with members having mental health illness or substance use, childhood immunizations, adolescent immunizations, lead screening, and well-child visits. New intervention opportunities continue to be investigated and implemented on an ongoing basis to address lagging measure performance across Partnership's service region. In anticipation of the new Dual Special Needs Plans (D-SNP) launch, a new Elder Care QMSI workgroup was formed in early 2025 to proactively educate staff on quality measures in order to start identifying and planning improvement efforts.
- The QI and Health Equity teams, along with other collaborating departments, continue to partner under its QI and Health Equity Transformation Program (QIHETP). In completing the required NCQA HEA grand analysis

on reducing health care disparities, Partnership used MY2023 HEDIS measure performance to identify potential disparities through an analysis of race and ethnicity, language, and gender data. Partnership prioritized the following as areas of focus and identified corresponding goals, targets, and ongoing interventions to reduce these targeted disparities.

  - Timeliness of Prenatal Care (PPC-Pre): Black/African American Members
  - Timeliness of Prenatal Care (PPC-Pre): American Indian/Alaska Natives
  - Timeliness of Postpartum Care (PPC-Post): American Indian/Alaska Natives
  - Well Care Visits (WCV): All Pediatric Members

- The most recent CAHPS® Composite Scores from 2023-2024 warrant continued focus and expanding improvement efforts on behalf of the health plan and within the provider network. In 2024-2025, CAHPS® Score Improvement activities targeted workforce development, improved access to care, transportation services, direct-to-member activities, and increased Partnership branding and awareness. These activities and interventions are being adapted based on the first ever drilldown CAHPS® survey Partnership completed at the end of 2023-2024 and received results for early 2024-2025. This unregulated drilldown survey provided greater insight into member responses in low performing CAHPS® survey questions. Partnership recognizes continued investments and scaling of successful interventions are necessary to enhance member experience and access to care, which are also key to achieving an improved NCQA Health Plan Rating (HPR).
- The Member Safety – Investigations Team observed an 8% increase in PQI care referrals in 2024 versus 2023, which is largely attributed to the 10-county geographical expansion. The team was staffed adequately to effectively absorb this increased workload. Physician and nurse participation in Peer Review Committee and PQI rounds, inclusive of Partnership medical directors and network providers from diverse specialties, was sufficient to meet the requirements for reviewing and making determinations about PQIs
- The Member Safety – Inspections Team integrated oversight of CPSP requirements and delivery of CHDP-designated provider trainings within its site review process. In anticipation of the sunset of the CHDP Program, Partnership has re-branded its newly implemented training program as the CHILD (Comprehensive Health Interventions for Lifelong Development) trainings. A Quality Training Specialist and Dental Liaison role was created and filled in 2024-2025 to deliver CHILD trainings and serve as Partnership's designated Dental Liaison.
- The structure and function of the quality committees remained stable. Overall, the quality committee structure was sufficient and provided adequate oversight and support to the QI Program and provided sufficient health plan and/or clinical expertise to inform and maintain policies and procedures. In 2024-2025, the overall volume of policy and procedure updates increased. These updates were primarily focused on maintaining NCQA Health Plan Accreditation, preparing for NCQA Health Equity Accreditation, and integrating new and changing DHCS requirements. Some of the increased volume was also associated with the re-organization of departments and functions due to Partnership's recent expansion and increasing regulatory requirements. In the fall of 2024, Partnership started to integrate the new Partnership Advantage (i.e. D-SNP) product line into its policies and procedures, which will continue into 2025-2026. In addition to reporting HEDIS® and CAHPS® annual results, the quality committee structure also received and provided feedback on results from provider access studies, monitoring of grievances and appeals, Initial Health Assessment trends and actions, monitoring of site review results and corrective actions trends, monitoring of potential quality of care issues, evaluations of performance improvement interventions and pilots, and outcomes of the Partnership Improvement Academy activities.
- There were sufficient resources to support the QI Program overall. Given the growing complexity and scope of requirements between DHCS MCAS and NCQA accreditations, sustaining quality improvement support in legacy and expansion counties, and preparing for the launch of Partnership Advantage (D-SNP), several QI Teams within the QI Program grew in staffing with restructuring of resources within select QI teams.

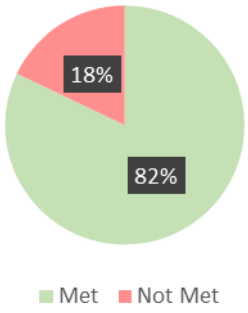
2024-2025 QI Work Plan Summary

Background

Background: The QI Work Plan is designed to track progress on key Quality Improvement (QI) activities and initiatives throughout the year. Approved by our Board of Commissioners and quality committees, it includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service and members' experience. The Work Plan is set on a fiscal year (FY) 2024-2025 schedule. This update includes progress on activities included in the FY 2024-2025 QI Work Plan from July 1, 2024, to June 30, 2025.

Of the 67 goals outlined in the 24-25 QI Work Plan, 56 are "Met" and 11 are "Not Met".

Goal Status July 1, 2024 – June 30, 2025		
Status	**Total Number:**	**%**
Met	55	82.09%
Not Met	12	17.91%



QI Major Milestones and Activities

- `The Dual Eligible Special Needs Plan (D-SNP) Strategy Work Group was formed and met with representatives from across the organization. All Medicare D-SNP measures were reviewed including those in Part C, Part D and Display measures, along with DHCS D-SNP measures for which Partnership will be accountable. Each measure was reviewed to identify measure ownership, data collection and intervention/actions. This information was documented for all measures across the organization. The shared document will be used for other projects to identify business needs by department.
- A new Primary Care Provider (PCP) Incentive Program for organizations contracting to serve Partnership Advantage members has been developed and gained executive approval. The approved proposal included program goals and principles, member and provider eligibility criteria, the measure set, scoring methodology, and payment mechanisms.
- External vendors and internal IT resource capacity were both explored to identify a system solution for performance tracking of the Dual Eligible Special Needs Plan (D-SNP) PCP QIP program. After opting to buy versus build, several external vendors were considered through detailed responses to Partnership's Request for proposal (RFP). A vendor with experience delivering provider-based measure performance solutions was identified as the preferred option and recommended to Partnership's Project Review Board (PRB) in May 2025. The recommendation was accepted, and contracting is underway at the close of 24-25.

- A CAHPS D-SNP programmatic work plan and timeline have been developed with framework informed by research into survey methodologies and conversation with other local health plans in California. Ongoing coordination with the identified survey vendor and CAHPS team will help further implementation planning.
- A detailed review of D-SNP requirements was completed by the Member Safety Quality Investigation team. No changes are needed to Partnership's current Peer Review Committee (PRC) policy or to the current Potential Quality Investigation (PQI) process to accommodate D-SNP.
- The Member Safety Quality Investigation team completed UAT testing and upgraded its PQI process tool to Sugar, Version 14. This tool is used to maintain PQI cases end-to-end through the process and for storage.
- The Member Safety Inspections Team piloted a "Quality Management Overview" document that is completed prior to each scheduled site review. Each Overview details recent QI interactions, status check on sites, and updates on HEDIS, QIP, and Performance Improvement programs and initiatives. These details are reviewed with the site's staff during the completion of the Medical Record Review (MRR). Post review surveys of Site Review nurses revealed mixed feedback. Most nurses found sharing this additional quality information beneficial to conducting the site review. A few warm hand-offs to the PI and QIP teams also resulted.
- The Inspections Team developed provider training materials to reflect Child Health and Disability Program (CHDP) requirements. The delivery of these training materials is now the responsibility of managed care plans. Training topics include: vision, hearing, fluoride varnish application, anthropometric screenings and information on vaccines for children (VFC). These materials have been distributed to the provider network with issuance of certificates upon staff completion.
- Pharmacy conducted concurrent review of Latent Tuberculosis Infection (LTBI) medication treatments and provided timely provider notification to all identified potential LTBI treatment regimen gaps, which results from late refill, non-adherence, inappropriate prescribing, and/or inappropriate dispensing.
- The Primary Care Provider Quality Incentive Program (PCP QIP) reviewed its existing Data Validation framework to identify areas for improvement, based on learnings over the past year. The team added a dedicated Non-Clinical Measure Preliminary Period for providers to review and validate their final data before Partnership completes scoring and payment. The team also detailed key steps in the existing eReports clinical validation period and updated the process for verifying HIE connections by provider organization.
- A designated QIP Workgroup developed provider education materials to inform and influence Member Experience improvement activities. The MY2025 specifications now include a URL resource link within the Patient Experience Unit of Service measure description.
- The Quality Measure Score Improvement (QMSI) initiative successfully engaged five measure-specific workgroups. Each workgroup monitored and reviewed measure performance, as data was available, identified and completed score improvement activities for all stated deliverables by the end of the fiscal year. Highlights include:

  1. Pediatrics
     - Expanded promotion of Healthy Babies Growing Together Program to include Partnership's Provider Network and specific messaging on an expanded $100 member incentive offering for timely completion of childhood immunizations required by HEDIS measure, CIS-10
     - Launched a new Human Papillomavirus (HPV) 2nd Dose Reminder Program Pilot to affect HEDIS immunization measure performance under IMA-2
     - Launched a new provider educational webinar on Developmental Screening in the First Three Years of Life (DEV) in preparation for more focused DEV measure improvement work in the provider network

- Extended the PCP QIP Unit of Service (UOS) group well care visits' measure to include members eligible under either the Well Child Visits in the First 15 Months (W15) or Well Child Visits for ages 15-30 months (W30) measure
- Conducted Topical Fluoride for Children (TFL-CH) data investigation to identify and better address known data source gaps in related MCAS measure reporting
- Completed a Child and Adolescent Well Care Visits (WCV) Disparity Sprint Campaign focused on improving well child visit completion in 4Q 2024 among disparate populations identified by DHCS from MY2022 MCAS Annual HEDIS reporting.
- Continued work on the DHCS-mandated Performance Improvement Project (PIP) to improve W15 completion rates in African American members in Solano County, while looking for spread opportunities in other areas of Partnership's service region.

2. Behavioral Health
   - As part of the DHCS-mandated Non-Clinical PIP, implemented a pilot to track and improve the follow up care for patients with mental health (FUM) and substance abuse disorder (FUA) after emergency department (ED) discharge aiming to increase the percentage of PCP notifications for a provider partner's assigned members (DHCS Non-Clinical PIP)
   - Executed the DHCS-mandated IHI Behavioral Health Collaborative Project in partnership with Nevada County
   - Engaged County Departments of Behavioral Health (DBH) to utilize Sac Valley Med Share Data Exchange for follow-up after mental illness (FUM) data
   - Facilitated collaboration amongst several departments, including: Behavior Health, Care Coordination, Population Health, Pharmacy, Health Equity's Tribal Health Liaison, and Quality Improvement. This collaborative group monitored and evaluated interventions aiming to improve FUM and FUA measures scores.
   - Increased embedded Community Health Workers (CHWs) in hospital Emergency Departments
3. Management of Chronic Diseases
   - Monitored, evaluated, and improved the use of the Diabetes management program offered by TeleMed2U
   - Implemented a pilot of a comprehensive, service-intensive diabetes management program with Gojji
   - Brought the blood pressure control strategies into alignment with best practices of at least one primary care practice
   - Implemented a retinal eye exam grant to support providers in improving the rate of diabetic members receiving an annual retinal eye exam
   - Implemented improvements to the Cologuard bulk ordering program to better serve a broader group of Primary Care providers
4. Women's Health
   - Facilitated integration of cervical cancer screening HPV Self Swab across our network to affect the corresponding measure (CCS) rate
   - Identified 3 practices in counties with Chlamydia Screening in Women (CHL) rates below the minimum performance level (MPL) and conducted 1 on 1 provider education
   - Promoted incentives for "Increasing Screening Mammogram Capacity" in the Hospital Quality Incentive Program (H-QIP)
   - Elevated promotion of the Growing Together Program's increased incentive to impact postpartum rates

- Identified counties with race/ethnicity disparities for post-partum visits and supported connection to Enhanced Care Management (ECM) Birth Equity (BE) providers to support members accessing post-partum care

5. Elder Care
   - Identified all D-SNP measures which fall within the QMSI workgroups by work group domain for further focus in D-SNP implementation planning.

- The Performance Improvement (PI) team collaborated with the far northern consortia to bring QI awareness and education to providers serving members in Partnership's Redding and Eureka Regions through several activities and forums.
- Four (4) new expansion provider organizations were added to the Joint Leadership Initiative (JLI) series.
- Improvement Academy offered six (6) virtual trainings in 2025 highlighting priority MCAS measures including Pediatric Preventative Care for Ages 0 - 30 Months, Pediatric Preventative Care for Ages 3 - 17 years, Chronic Disease and Colorectal Cancer Screening, Perinatal Care and Chlamydia Screening, Breast and Cervical Cancer Screenings, and Diabetes Control. Improving Member Outcomes webinar attendance ranged from 53 to 90 attendees, with each session representing 28 to 45 unique organizations. Of attendees who completed the post-session evaluations for all six webinars, 99% selected "strongly agree" or "agree" when asked if the webinar was relevant and useful.
- Improvement Academy hosted three (3) ABCs of Quality Improvement in-person trainings with 100% of survey respondents, representing 37 unique provider organizations, reporting being extremely satisfied/satisfied with this course.
- The Healthy Kids Growing Together Program conducted two (2) cohorts focused on contacting any 3-6 year-old who has never had a well-child visit in a set timeframe and offered an incentive to complete a well-child visit within 90 days prior to their 4th, 5th, and 6th birthday. Over 2600 children participated and received member incentives.
- The Primary Care Provider Quality Incentive Program (PCP) QIP Breast Cancer 50th percentile benchmark has been met in the legacy Southeast, Southwest, and Northeast regions. This improvement was largely influenced by 77 Mobile Mammography event days, resulting in 2,162 completed breast cancer screenings.
  - 15 Mobile Mammography event days were held at Tribal Health Centers.
  - 14 Mobile Mammography event days were held at Enhanced Provider Engagement (EPE) provider organizations.

FY24/25 Final Goal Status: Delayed/Terminated

Project or Program	Goal	Status Details	Next Steps
2.g. Partnership Quality Dashboard (PQD)	**Goal #1**: By June 30, 2025, apply annual development updates of the MY2025 HEDIS® Monthly Exploratory Dashboard in accordance with identified stakeholder needs (Contingent on	Delayed	Delay due to revised HRP® launch date. Deliverable 4 will be completed in CY Q3 of 2025.

	HRP® implementation). **Goal #2:** By June 30, 2025, apply annual development updates of the PCP QIP Provider and Internal View Dashboards in accordance with identified stakeholder needs.		Delay due to revised HRP® launch date. Deliverables 4-5 will be completed following the implementation of HRP®.
2.h. Enterprise Information Management	**Goal #1:** By December 31, 2024, integrate the HRP® version of the HEDIS® monthly project data into the Enterprise Data Warehouse and use this data to create the HRP® version of the HEDIS® PQD modules.	Delayed	Delay due to revised HRP® launch date. Deliverable 3 will be completed following the implementation of HRP®.
3.c. Palliative Care Quality Incentive Program (PC QIP)	**Goal #2:** By June 30, 2025, complete CY 2024 PC QIP evaluation.	Delayed	Payment processing for the Palliative Care QIP 2024 measure period II (July-December) did not begin until March 2025. This goal is on track to be completed, but not until July 2025.
3.e. Enhanced Care Management Quality Incentive Program (ECM QIP)	**Goal #2:** By December 31, 2024, complete CY 2023 ECM QIP evaluation.	Delayed	Due to this program only offering one measure from its inception spanning from 4th quarter CY 2022 to 4th quarter CY 2023, an evaluation of CY 2025 will be completed to provide a robust evaluation of the present program's five measures with year over year performance trend analysis. This goal is scheduled to be

			completed during the 2025-2026 QI Work Plan.
4.b. Missed Opportunities and Member Engagement	**Goal #1:** By June 30, 2025 Incorporate missed opportunity data and feedback from the 23/24 goal and include in the member engagement dashboard currently in development and publish externally for providers to use.	Delayed	Delay due to revised HRP® launch date. Deliverables 2 and 3 will be completed following the implementation of HRP®.
5.b. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Dual Eligible Special Needs Plan (D-SNP)	**Goal #1:** By June 30, 2025, select and contract with a Medicare Dual Eligible Special Needs Plan (D-SNP) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) CMS-approved vendor.	Terminated	A survey vendor has been identified. However, it was determined that contracting with a survey vendor is not required during this fiscal year (24-25) and will be addressed at a later date if or when the need arises.
8.d. Provider Coaching and Engagement	**Goal #2:** By June 30, 2025, the Performance Improvement teams will engage with practices in the 10 incoming counties joining Partnership in 2024. We will engage with practices holding 70% of assigned membership for incoming counties around PCP QIP performance.	Delayed	Due to heightened organization sensitivity to requesting too many meetings with our contracted providers, the Chico regional meeting has been rescheduled to July 2025. Deliverable 2 will be completed during the 25-26 QI Work Plan.
8.e. Expansion of Regional Quality Meetings	**Goal #1:** By June 30, 2025, Partnership will implement regional quality meetings in all six (6) operational regions to offer forums	Delayed	Redding, Fairfield, and Eureka regional meetings continue. Santa Rosa, Chico, and Auburn regional offices are currently in planning for

	for regional dialogue to address quality improvement opportunities or barriers.		Quarterly Quality meetings. Deliverable 2 on track to be completed by end of CY 2025.
14.a. Grand Analysis - Continuity and Coordination of Medical Care (QI3) Report	**Goal #1:** By June 30, 2025, Quality Improvement will complete as much as possible of the annual Continuity and Coordination of Medical Care Grand Analysis (QI3) report, given the complete data sets that are available. (The delay for full document completion past June 30, 2025 is required to allow appropriate analysis of all of the data required for the report, some of which is not anticipated to be available for review by June 30th.)	Terminated	Grand Analysis - Continuity and Coordination of Medical Care (QI3) Report is retired under 2025 HPA standards.
14.a. Grand Analysis - Continuity and Coordination of Behavioral Health (QI4) Report	**Goal #1:** By June 30, 2025, Behavioral Health will complete the annual Continuity and Coordination of Behavioral Health Grand Analysis (QI4).	Terminated	Grand Analysis - Continuity and Coordination of Behavioral Health (QI4) Report is retired under 2025 HPA Standards.

National Committee for Quality Assurance (NCQA) Accreditation

QI TRILOGY

NCQA Overview

(National Committee for Quality Assurance)

Partnership strives to improve the health status of members and their care experience to become one of the highest quality health plans in California. The NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA) support Partnership's vision, mission, and strategic goals and fulfill Partnership's contractual obligations with the Department of Health Care Services (DHCS).

NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA) Key Activities

During fiscal year 2024-2025, Partnership focused on advancing key activities and achieving important goals related to NCQA Accreditation. Including:

1) Maintaining compliance of all assigned NCQA Health Plan Accreditation (HPA) Standards and Guidelines, as they became available.
2) Preparing for readiness and maintaining compliance of all assigned NCQA Health Equity Accreditation (HEA) Standards and Guidelines, in preparation for the Initial Survey in June 2025.
3) Report HEDIS® and CAHPS® results to NCQA for HPA requirements by June 2025.

Compliance with NCQA Survey Standards

Per the 2024 DHCS contract, all Managed Care Plans (MCPs), including Partnership, will be mandated to achieve both NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation (HEA) by January 1, 2026.

Partnership successfully achieved NCQA HPA reaccreditation on December 28, 2023. NCQA requires health plans to undergo reaccreditation every three (3) years, and Partnership's next HPA Renewal Survey is scheduled for September 22, 2026. A three (3)-year Renewal Survey timeline has been developed which outlines all key activities to achieve HPA in 2026. In preparation for Partnership's HPA Renewal Survey in 2026, Partnership will conduct a Mock Renewal Survey in October 2025. The Mock Renewal Survey will be a full-scope review of all "Year 1" evidence by our NCQA consultant, who will provide recommendations and address findings on the evidence submitted. Business Owners can also clarify issues and seek guidance during this time. A final report and scoring will be distributed after the conclusion of the Mock Renewal Survey. Activities are currently underway in FY 24-25 to prepare for the Mock Renewal Survey.

NCQA HEA is a relatively new standards program focused on advancing the delivery of more equitable and culturally and linguistically appropriate services across member populations. The NCQA Program Management Team worked closely with Partnership's NCQA Consultant, and key stakeholders across the organization to estimate Partnership's current performance and develop a readiness timeline to achieve the new NCQA HEA by the mandated deadline of January 1, 2026. Partnership's HEA Initial Survey was submitted on June 17, 2025, and formal Accreditation status from NCQA is anticipated September 2025.

The NCQA Program Management Team attended two (2) HEA Town Hall meetings that took place in February and May 2025 respectively. During the Town Hall meetings, the NCQA Program Management Team gained additional knowledge regarding best practices, compliance tips, and NCQA Policy Clarification Support (PCS) frequently asked questions.

Additionally, in April 2025 NCQA released Modifications to Scoring for NCQA Accredited Surveys due to the executive orders issued in January 2025. These modifications are in place until June 2026. The NCQA Program Management Team shared the modifications with Partnership's leadership team and Business Owners, and ensured all appliable modifications were in place for our HEA Initial Survey submission in June 2025. The NCQA Program Management Team continues to monitor for the next update from NCQA, scheduled for release by December 31, 2025, for impact related to HPA and HEA surveys beginning July 1, 2026.

The NCQA Program Management Team strives to maintain up-to-date knowledge of the NCQA Standards and Guidelines, and monitors NCQA's public comment, triannual policy updates and monthly FAQs closely, notifying Business Owners of any impact to their standards and/or approved evidence. The NCQA Program Management Team also maintains a compliance dashboard, which outlines key reporting accreditation metrics, and tracks plan-wide compliance rates. Communications provided by the NCQA Program Management Team were shared via different forums, including newsletters, business owner check-in meetings, and Steering Committee meetings with the executive leadership. Input and direction received from the executive leadership help to define Partnership's NCQA program vision and success for accreditation.

NCQA Health Equity Accreditation Initial Survey

The NCQA Program Management Team has built a solid HEA Program structure to ensure compliance with the HEA requirements which prepared Partnership for our formal HEA Initial Survey, submitted in June 2025. The HEA Program structure mimics that of the HPA Program structure, which has proven to be successful in achieving accreditation. The HEA Program structure includes, but is not limited to, the following activities:

- Host bi-quarterly check-in meetings with all Business Owners to ensure tasks are completed as planned.
- Distribute work plans to Business Owners to identify assigned requirements.
-
- Track all HEA evidence by developing an Evidence Submission Library for each Business Owner.
- Maintain HEA Report Schedules for each Business Owner to track data sources, approving bodies and due dates.
- Maintain the HEA Compliance Dashboard to monitor overall compliance by department and the applicable points achieved by month.

In preparation for Partnership's Formal HEA Initial Survey, Partnership conducted a Mock Initial Survey in August 2024. The Mock Initial Survey was a full scope review of all evidence by our NCQA consultant, who provided recommendations and addressed findings on the evidence submitted. A final report and scoring was distributed after the conclusion of the Mock Initial Survey and Business Owners developed Action Plans to address the gaps and recommendations identified by our consultant. Throughout this time, the NCQA Program Management Team continued to work with Business Owners to ensure all evidence met compliance in accordance with NCQA's look-back period, timelines, and/or expectations.

The HE 2 Workgroup that was formed in Fiscal Year 23/24 continued in Fiscal Year 24/25. Key participants of the Workgroup included: IT, Quality Improvement, and Health Equity. Other departments, including Member Services, Care Coordination, Population Health, and Compliance, also participated based on the selected topics. The HE 2 Workgroup was able to close the gaps on required evidence, ensuring necessary policies, materials and systems were in place prior to our survey submission and an implementation plan is in place for future activities. The HE 2 Workgroup concluded activities in May 2025 and Business Owners were identified to lead the HE 2 requirements going forward.

The activities completed in the HEA key activities and HE 2 Workgroup along with the actions taken following the Mock Initial Survey kept Partnership moving forward with compliance reaching 100% in May 2025. Formal survey results are expected to be received from NCQA in September 2025.

Preparation for HPA Renewal Survey and HEA Initial Survey

The plan-wide NCQA-related HPA and HEA key activities were approved by the NCQA Steering Committee for fiscal year 2024-2025. The HPA key activities included five (5)milestones aimed at ensuring continuous compliance of HPA requirements in preparation for Partnership's next HPA renewal survey, scheduled for September 22, 2026. For the HEA key activities, there were four (4) milestones aimed at readiness of all assigned HEA Standards and Guidelines for Initial Survey, scheduled for June 17, 2025. A summary of the key activities and outcomes towards obtaining NCQA HPA Renewal Survey and HEA Initial Survey are presented below. The HPA and HEA key activities were met, and all milestones were completed, with the exception of one (1) milestone under HPA, which was no longer applicable for fiscal year 2024-2025.

HPA Key Activities: Departments will maintain compliance with all assigned NCQA HPA Standards and Guidelines, following the most up-to-date Standards and Guidelines once available as measured by five (5) milestones:

Milestone 1: Milestone 1 was achieved by Business Owners completing both components timely:

1. All Business Owners provided their acknowledgement by July 25, 2024, due date confirming all documented processes were in compliance with current NCQA HPA Standards and Guidelines. Departments that had revisions to documented processes completed the revisions timely and received approval from our NCQA consultant.
   Applicable Business Owners submitted their screenshots by August 8, 2024, due date. For Business Owners with no screenshot evidence, their acknowledgement was received confirming there is no screenshot evidence.

Milestone 2: Milestone 2 was achieved by Business Owners completing the annual HPA Workbooks. This included:

1. Review of the HPA Work Plan, identifying new Business Owners, Business Sponsors, and Contributors as needed.
2. Review of the Evidence Submission Library, confirming evidence documents and planned target production dates.
3. Obtaining attestations, discussing questions, and evaluating impact among Business Owners and Contributors, as needed..

Milestone 3: Milestone 3 was achieved by Business Owners submitting edits to the HPA Report Schedule and providing their analysis reports timely. All edits were incorporated, and the analysis reports were deemed compliant by the NCQA Consultant

Milestone 4: Milestone 4 was achieved by applicable departments completing the three components related to file review and oversight.

1. Applicable departments participated in a Mock File Review with our consultant in April or May 2025. Audit findings and recommendations were shared with Business Owners and Action Plans were completed and submitted timely by the Business Owners. Risks identified and next steps were presented to the NCQA Steering Committee in May 2025. A targeted mock audit will be held prior to the start of look-back period in September 2025, with the selected departments where the file review requirements were scored "not met". Additional mock audits are recommended within three (3) months of implementation of the new system, Jiva. Additionally, selected teams participated in a Mock File Review for upheld appeals files in December 2024. Findings were addressed via a Corrective Action Plan and discussed at the December CMO/MD meeting, where the NCQA consultant, the pharmacy department and the medical directors discussed NCQA's expectation regarding same-or-similar specialist review of appeals, which the medical directors must demonstrate specific clinical knowledge and experience of the condition, service or procedure in question, when determining if an appeal meets criteria for medical necessity and clinical appropriateness.
2. Applicable departments completed quarterly file review audits of Partnership files. Issues identified, were discussed and addressed, as needed. The UM Team implemented weekly reviews of denial letters and focused on education via a newly formed work group. In addition, the Pharmacy Department updated the letter template to comply with the requirements of appeal notifications. Due to the new credentialing requirements, the Network Services (NS) Team also confirmed the internal audit tools for Partnership files have already been updated and are currently being used to ensure compliance by July 2025. The final quarterly audit in May 2025 was optional as all departments had just completed the full scope Mock File Review with our new NCQA consultant in April or May 2025. The G&A, Pharmacy, and Care Coordination Departments opted not to participate in the May 2025 quarterly audit. NS and UM completed the May 2025 audit timely and issues were addressed, as needed.
3. The NS and UM teams monitored the non-NCQA accredited delegates throughout the goal period. The annual delegation audits for credentialing delegates were conducted in February-March 2025, with no issues identified. Due to the new credentialing requirements, NS also confirmed they will review the Health Industry Collaboration Effort (ICE) Credentialing Audit tool, scheduled to be released by the end of year, to ensure all new NCQA elements and updates are present for 2026 annual delegation audit. The UM team monitored the UM hospital denials weekly and completed the annual delegation audits between March-April 2025. One (1) preliminary finding was addressed with one (1) delegate, and the issue was closed during the preliminary CAP process.

Milestone 5: Milestone 5 was related to evidence submission for the HPA Mock Renewal Survey, which is now scheduled in October 2025, rather than the originally planned date in August 2025. With the change in timing, this milestone no longer applies for FY 24/25. Details for evidence submission will be updated for FY 25/26.

HEA Key Activities: Departments will maintain compliance of all assigned NCQA Health Equity Accreditation (HEA) Standards and Guidelines and prepare for the HEA Initial Survey, in June 2025, as measured by four (4) milestones:

Milestone 1: Milestone 1 was achieved by Business Owners submitting a completed Corrective Action Plan (CAP) to address all applicable recommendations from the Mock Initial Survey.

Milestone 2: Milestone 2 was achieved by Business Owners completing the annual HEA Workbooks. This included:

1. Review of the HEA Work Plan, identifying new Business Owners, Business Sponsors, and Contributors as needed.
2. Review of the Evidence Submission Library, confirming evidence documents and planned target production dates.
3. Obtaining attestations, discussing questions, and evaluating impact among Business Owners and Contributors, as needed.

Milestone 3: Milestone 3 was achieved by Business Owners completing the three (3) components timely:

1. All Business Owners confirmed Documented Processes were in compliance prior to the start of the look-back period. Any edits that were required to bring Documented Processes in compliance were completed by November 2024.
2. All Business Owners submitted their applicable screenshots or provided their confirmation that no screenshots are required prior to the established due dates.
3. All applicable teams have submitted their analysis reports timely; all edits were incorporated, and the analysis reports were deemed compliant by the NCQA Consultant. In May 2025, NCQA announced survey accommodations to support implementation of the executive orders issued in January 2025. These accommodations went into effect for all accreditation surveys submitted on or after February 12, 2025, and will remain in effect until June 30, 2026. Due to the new guidance, Partnership did not submit a subset of evidence, including analysis reports with our HEA Initial Survey in June 2025.

Milestone 4: The NCQA Program Management Team hosted an evidence collection training on January 23, 2025. Submission instructions along with an Evidence Submission Tracker were sent to all Business Owners on January 28, 2025. Business Owners submitted their annotated and bookmarked evidence by the March 28, 2025 due date, with a few known exceptions. These exceptions had later submission dates due to committee review, publication and distribution of newsletters, and select delegation activities. The NCQA Program Management Team collaborated with the Business Owners to ensure all evidence followed the plan-wide submission guidelines. All evidence was uploaded to NCQA's web-based portal, the IRT, prior to our submission date of June 17, 2025.

Overall, the activities outlined above, along with staff that serve as the NCQA Program Management Team, were sufficient and provided strong oversight to achieve the fiscal year 2024-2025 key activities and objectives for NCQA HP and HE Accreditation included in the QI Work Plan.

CAHPS® and HEDIS® Reporting for Health Plan Accreditation

Partnership was required to formally report MY2023 HEDIS® and CAHPS® for HPA by June 2025. HEDIS® and CAHPS® reporting is a requirement that must be fulfilled annually by accredited health plans in order to maintain their accredited status. A health plan may choose the results of the CAHPS® survey to be reported: Adult CAHPS® or Child CAHPS®. For MY2024/RY2025, Partnership chose to submit the Child CAHPS® rates. Partnership also successfully reported HEDIS® HPA rates by the May 23, 2025, mandated deadline. Additionally, Partnership submitted the NCQA Healthcare Organization Questionnaire (HOQ) for the required CAHPS® surveys by the December 29, 2024, required deadline.

NCQA uses the annual HEDIS®/CAHPS® reporting to calculate the Health Plan Rating (HPR) that is released on NCQA's website every September. The HPR is the weighted average of a plan's HEDIS® and CAHPS® measure ratings, plus bonus points for plans with current Accreditation status.

During the next fiscal year, Partnership will continue to work on sustaining compliance of all Renewal Survey requirements through key defined activities, as well as its NCQA Program Management and NCQA Steering Committee structure to assure our readiness for Renewal Survey Accreditation in September 2026.

Partners in Quality

As of November 2021, Partnership became an NCQA Recognition Program Partner in Quality (PIQ) and has been awarded the PIQ stamp by NCQA. The PIQ program recognizes organizations that provide financial incentives or support services to practices seeking recognition through a subset of NCQA programs, including Patient-Centered Medical Home (PCMH) Recognition. This distinction was awarded to Partnership based upon the incentive payment offered to practices who are PCMH providers as well as technical assistance provided for gap analysis or assessment to assist practices with identifying areas to focus transformation. As of November 2021, Partnership is also listed on NCQA's Resource Directory of Incentives website as a PIQ organization. NCQA will reassess our PIQ status on a yearly basis via survey shared with our organization, and update their database accordingly based on our response.

As a result of this recognition, provider practices that are first time applicants and are supported by Partnership will also be eligible for a 20% discount for NCQA Recognition programs. This discount opportunity was shared with the Provider network through articles included in Partnership newsletters throughout FY 2024 – 2025. Further support and motivation for the Provider network to achieve and maintain the PCMH recognition is the PCMH Unit of Service measure included in the PCP QIP. Each measurement year, the Provider network has the chance to earn $1,000 per PCP site for achieving or maintaining PCMH accreditation from NCQA, or equivalent from Accreditation Association for Ambulatory Health Care (AAAHC) or The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Key Benefits of Being a Partners in Quality (PIQ) Recognized Organization:

- NCQA will grant auto-credit on a small subset of HPA Standards and Guidelines
- NCQA offers provider quality data at a discounted rate to organizations seeking to integrate validated quality ratings into their information tools.
- Provider Practices supported by Partnership that are first time applicants will be eligible for a 20% discount off the initial Recognition submission fee when submitting their NCQA application.

Preparations for Partnership Advantage (D-SNP)

QI TRILOGY

Preparations for Partnership Advantage (D-SNP)

During fiscal year 2024-2025, Partnership dedicated significant effort to preparing for the launch of its Medicare Dual-Eligible Special Needs Plan (D-SNP), known as Partnership Advantage, whose go-live date is planned for eight counties in January of 2027. These preparations focused on meeting regulatory requirements, establishing a comprehensive Model of Care (MOC), and integrating Medicare-specific goals and structures into existing Quality Improvement (QI) processes. The work reflects a coordinated, organization-wide commitment to ensuring that Partnership Advantage delivers high-quality, patient-centered care while aligning with CMS Star Rating expectations and other federal and state performance requirements. The following section highlights key activities and initiatives undertaken by the QI Department in preparation for a successful D-SNP launch and ongoing performance monitoring.

Model of Care

Partnership is required by DHCS to implement an Exclusive Aligned Enrollment (EAE) Dual-enrollment Special Needs Plan (D-SNP). Each D-SNP is required to draft a Model of Care (MOC) document which specifies how members receive care, how that care is coordinated, and how the plan intends to ensure that care is accessible, efficient and patient-centered. The MOC was drafted and submitted to DHCS and NCQA for approval in February 2025. Both agencies approved the MOC and Partnership Advantage is anticipated to launch within the following eight counties: Del Norte, Humboldt, Lake, Marin, Mendocino Napa, Solano and Sonoma. The MOC addresses four specific areas: 1) identifying and defining the needs of our most vulnerable population, 2) care coordination, 3) the primary care and specialty care network, and 4) quality improvement and monitoring. The QI Department assumed the lead in continuously updating and formatting the MOC for future submissions by the Regulatory and Compliance Department.

Within the Quality section of the MOC, Partnership defines the processes for monitoring and evaluating D-SNP performance. This process aligns closely with the annual QI Program Description in terms of existing committee structure, quality improvement program structure and overlapping data reporting needs. This structure and additions to the QI Program will supplement Partnership's overall efforts to achieve a high CMS Star Rating.

Integrating Partnership Advantage D-SNP

The QI Department integrated Medicare focused goals throughout the department. The Quality team has specifically focused on adapting to needs in the Quality Incentive Program, HEDIS and CAHPS data monitoring and Potential Quality Issues. An Operational Gap Analysis was performed to assess program needs within the fiscal year and beyond in preparation for program launch. Several projects were executed this fiscal year to supplement existing QI work, including:

- Developing the structure and vendor support for a D-SNP Quality Incentive program
- Addressing PQI issues and developing workflows to incorporate CMS specific requirements
- Developing methods for data capture and analysis for HEDIS as part of a larger Medicare Star Strategy
- Assessing vendor needs for the Medicare CAHPS and HOS surveys

Additionally, new projects included developing the structure and internal support to address overall Medicare Quality reporting needs including CMS Stars, DHCS and MOC reporting. Overall, the QI Department has focused significant efforts to ensure a successful program launch and the ability to monitor and analyze Medicare program data to optimize the quality of member care.

HealthPlan Quality Performance

QI TRILOGY

Overall Summary

In addition to HEDIS® reporting, updates on the following activities were presented to the IQI and physician committees annually: CAHPS®, summary results from specific access studies, Grievances & Appeals, Initial Health Assessments, facility site and medical record reviews, potential quality issues, targeted improvement projects, and the Partnership Improvement Academy. Project measures were reviewed during improvement team meetings. Partnership completed a robust, comprehensive evaluation annually for major programs and quality improvement projects and initiatives.

Partnership HEDIS Reporting Populations – MY2024

The addition of 10 incoming counties to Partnership's network coincides with changes to Partnership's HEDIS Reporting Populations for both DHCS's Managed Care Accountability Set (MCAS) measure set and NCQA's Health Plan Accreditation (HPA). Starting in MY2024, Partnership reported one Plan-Wide rate for all 24 counties in its network for the MCAS measure set to its DHCS auditor, Health Services Advisory Group (HSAG). The Reporting Unit configuration of Partnership regions used until MY2023 (i.e.: Southeast, Southwest, Northeast, and Northwest) has been sunset.

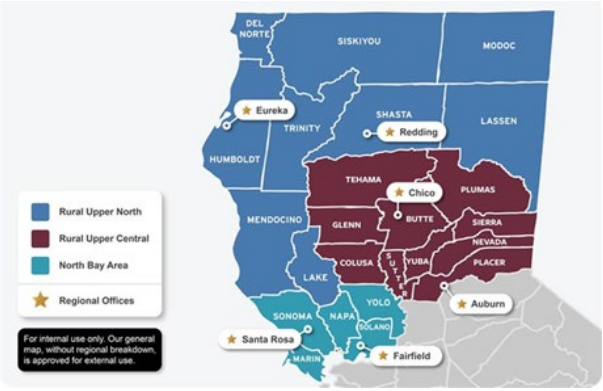
For NCQA reporting, Partnership also reported one Plan-Wide rate for all 24 counties in its network. Rates for each HPA measure are reported to Partnership's NCQA auditor, Advent Advisory.

Population	Description	Purpose
NCQA HEDIS Reporting - DHCS Populations		
Plan Wide	All 24 counties - Plan wide reported rates	DHCS-published HEDIS rates for MCP
County	County level measure rates for each of Partnership's 24 counties	County-level sanctions Withhold measure reimbursement (compiled into Rating Regions by DHCS)
NCQA HEDIS Reporting - HPA Population		
Plan Wide	All 24 counties - Plan wide reported rates	NCQA Star Rating

Population	Description	Purpose
NCQA HEDIS Reporting - DHCS Populations		
Plan Wide	All 24 counties - Plan wide reported rates	DHCS-published HEDIS rates for MCP
County	County level measure rates for each of Partnership's 24 counties	Geographic sanctions and withholds will be applied at DHCS's discretion (applied only to 14 legacy counties in MY2024)
NCQA HEDIS Reporting - HPA Population		
Plan Wide	All 24 counties - Plan wide reported rates	NCQA Star Rating

Starting in 2025, Partnership also reported county-wide MY2024 rates for all MCAS measures and their respective sub-measures to DHCS directly. DHCS intends to hold all California Managed Care Plans accountable for sanctions for all MCAS Accountable measures that did not reach the 50th percentile benchmark at the county level for Partnership's 14 legacy counties. (The 10 incoming counties are not held to performance sanctions for MY2024.)

Starting in 2025, using MY2024 results, DHCS intends to launch its DHCS Quality Withhold and Incentive Program. This program requires Partnership to earn back a percentage of its withheld revenue from DHCS based on performance of a subset of MCAS measures and two (2) CAHPS measures. The Quality Withhold program measures MCAS measure rates aggregated by DHCS Quality Rating Regions. The Rural Upper Central Rating Region, which is made up of the 10 incoming counties to Partnership in 2024, was excluded from this program for MY2024. An illustration of Partnership's network organized by DHCS Quality Rating Regions is shown below.



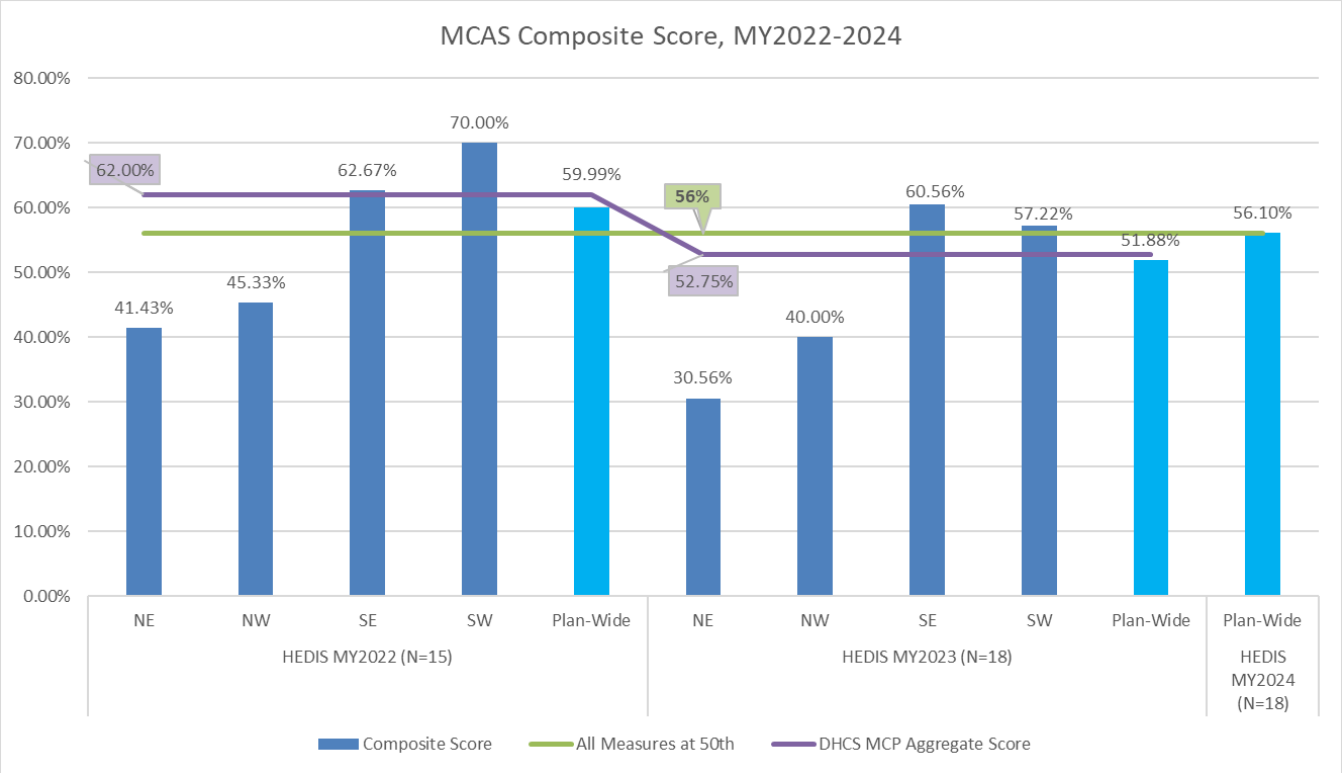
DHCS Quality Rating Region	Counties
North Bay	Marin, Napa, Sonoma, Solano, Yolo
Rural Upper North	Del Norte, Humboldt, Lassen, Lake, Mendocino, Modoc, Shasta, Siskiyou, Trinity
Rural Upper Central	Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba

Overall Health Plan Ranking: DHCS Managed Care Accountability Set (MCAS)

DHCS uses a scoring methodology to determine an aggregated Quality Factor Score (QFS), which ranks health plan performance relative to California Medicaid reporting health plans. Partnership adopts DHCS' scoring methodology to determine Partnership's regional and plan-wide composite scores year over year. Each plan-wide measure is given a score from one to ten (1-10) based on performance relative to national benchmarks. A plan-wide composite score is then calculated by dividing total earned points by total possible points.

The Quality Compass 2024 Benchmarks, which were developed based on national MY2023 performance, are the most currently available benchmarks. These benchmarks were used by Partnership to determine percentile rankings and the following composite scoring year over year analysis. Every fall, DHCS releases a dashboard indicating the plan's regional Quality Factor Scores and associated rankings with other health plans. The results of this ranking will be published upon the release of this information and will be utilized by DHCS to assess mandated improvement activities and any sanctions.

MY2024 HEDIS® Composite Performance Year Over Year Comparison: DHCS Managed Care Accountability Set (MCAS)



➢**Reported Measures held to MPL MY2019:** ABA, AMM-Acute, AMM-Cont, AMR, AWC, BCS, CBP, CCS, CDC-H9, CDC-HT, CHL, CIS-10, IMA-2, PPC-Pre, PPC-Post, W15, W34, WCC-BMI, PCR

➢**Reported Measures held to MPL MY 2022:** BCS, CBP, CCS, CHL, CIS-10, HBD-H9, IMA-2,FUM-30, FUA-30, LSC, PPC-Pre, PPC-Post, W30-0-15, W30-15-30, WCV

➢**Reported Measures held to MPL MY 2023:** AMR, BCS-E, CBP, CCS, CHL, CIS-10, HBD-H9, IMA-2,FUM-30, FUA-30, LSC, PPC-Pre, PPC-Post, W30-0-15, W30-15-30, WCV

Reported Measures held to MPL MY2022: BCS, CBP, CCS, CHL, CIS-10, HBD-H9, IMA-2, FUM-30, FUA-30, LSC, PPC-Pre, PPC-Post, W30-6, W30-2, WCV
Reported Measures held to MPL MY2023: AMR, BCS-E, CBP, CCS, CHL, CIS-10, DEV, HBD-H9, IMA-2, FUM-30, FUA-30, LSC, PPC-Pre, PPC-Post, TFL-CH, W30-6, W30-2, WCV
Reported Measures held to MPL MY2024: AMR, BCS-E, CBP, CCS, CHL, CIS-10, DEV, HBD-H9, IMA-2, FUM-30, FUA-30, LSC, PPC-Pre, PPC-Post, TFL-CH, W30-6, W30-2, WCV

Note: *MY2024/RY2025: Total Points Earned: 101 Points out of 180 Total Points (18 measures included)*

- Because MY2024 marks a transition year in terms of reporting regions, only a plan-wide composite score is displayed for MY2024. Year-over-year trending of the plan-wide composite score will begin in MY2025.
- In MY2024 there were 18 measures held accountable to the MPL.
- The increase in Composite Score between MY2024 and prior years reflects significant improvement in several pediatric MCAS measure rates, including Well Child Visits Birth – 15 Months (W30-6), Well Child Visits 15-30 Months, and Lead Screening in Children (LSC). Interventions to support these rate increases are described below in the *Supplemental Data within the HEDIS Annual Project* section.

MY2024 continued to host two (2) required separate audits:

- DHCS / MCAS required reporting: Health Service Advisory Group Auditor (this report's focus)
- NCQA HEDIS® Health Plan Accreditation / HPA: Advent Advisory Auditor

In MY2024, Partnership observed an increase in overall membership by approximately 36.7%, to 906,964 assigned members in December 2024. The changes in membership reflect the addition of 10 new counties to the Partnership network, as well as the departure of members assigned to Kaiser sites, who moved to Kaiser as their Medi-Cal Managed Care Plan.

- Incoming counties added approximately 316,000 members to Partnership.

- Approximately 82,000 members assigned to Kaiser departed from Partnership. The decrease in membership primarily impacted Solano, Sonoma, Napa and Yolo Counties.

The impact of population shifts in Partnership's network impacts HEDIS measure eligible populations differently, depending on each measure's continuous enrollment requirements as defined in the NCQA HEDIS MY2024 Technical Specifications. A subset of measures require continuous enrollment greater than 1 year for a member to be included in the measure's eligible population, which meant that very few members from incoming counties met the criteria to be included in the measure in MY2024. For the MCAS measure set, these measures with very small eligible populations for incoming counties in MY2024 are:

- Asthma Medication Ratio (AMR)
- Breast Cancer Screening, ECDS (BCS-E)
- Well-Child Visits in the First 30 Months of Life (W30)

Supplemental Data Within MY2024 HEDIS Annual Project

Partnership was able to use a number of new supplemental data sources in the MY2024 HEDIS Annual project. Two of the additional supplemental data sources piloted approaches that will continue in MY2025.

Supplemental Data Pilots within MY2024 HEDIS Annual Project:

Electronic Clinical Data Systems (ECDS) Vendor Pilot: Partnership piloted the use of Datalink, an NCQA Certified Data Aggregator software, in MY2024, and received auditor approval to include records from two (2) EMR vendors (eClinical Works and Nextgen) in the MY2024 HEDIS Project. Records from six (6) provider organizations, within Partnership's provider network, were included in the MY2024 HEDIS Annual Project. Our analysis shows promising results from the Datalink pilot:

- The MCAS (Report Only) and HPA measure sets include seven (7) Depression Screening measures. Datalink was the sole source of data for six (6) of the seven (7) Depression Screening measures.
- Five (5) of the seven (7) Depression Screening measures exceeded the 50th percentile as a result of the inclusion of Datalink data.
- Datalink also made a positive impact on administrative rates for MCAS and HPA measures, including Controlling Blood Pressure (CBP) and Glycemic Status Assessment for Patients with Diabetes (GSD).

The HEDIS team will adapt the Datalink Data Aggregator project in MY2025 to add additional EMR's and practices. Priority will be given to Perinatal QIP practices, for which Datalink data submission will be a gateway measure in the 2025-26 Perinatal QIP; and Equity Practice Transformation funding awardees, who must report HEDIS-like Depression Screening rates bi-annually to meet program milestones and earn incentive dollars.

Medical Record Review for Well-Child Visits in the First 30 Months of Life (W30) Pilot: Partnership has historically scored below the 50th percentile on both W30 measures, though our PCP QIP rates for the W15 measure (Well Child Visits Birth – 15 Months) have been above the 50th percentile since MY2022. The QI department devoted time and resources to researching root causes for the discrepancy between HEDIS and QIP rates in 2024 and identified numerous points of failure for newborn visits to be counted towards the HEDIS rate using administrative data.

As a result of this analysis, the HEDIS team piloted a supplemental Medical Record Review of the entire W30 measure eligible population in early 2025, which was accepted as a supplemental data source by our HSAG auditor. The supplemental Medical Record Review made a dramatic impact on the rates for both W30 sub-measures, and both W30 sub-measure rates scored above the 50th percentile for MY2024.

The HEDIS team will adopt the W30 Medical Record Review within the HEDIS Annual Project going forward. The team will also look for additional opportunities to use the Medical Record Review process to improve measure rates in MY2025.

New Supplemental Data Sources within MY2024 HEDIS Annual Project:

Sacramento Valley MedShare (SVMS): SVMS is a Health Information Exchange used by practices and health systems throughout Northern California. In MY2024, Partnership received auditor approval to use Immunization, Pharmacy, and Measurement (blood pressure data) records towards the HEDIS Annual Project. In previous years, not all three record categories were approved for use in the HEDIS Annual Project.

Root cause analysis of fluoride varnish coding: Partnership worked with DHCS in 2024-2025 to better understand how it receives fluoride varnish claims and encounters that can be counted towards the Topical Fluoride for Children (TFL-CH) MCAS measure, most of which are billed to Denti-Cal from FQHC, RHC, and Tribal Health Dental Centers and then sent to Partnership. As a result, Partnership was able to identify fluoride varnish services completed by FQHC, RHC, and Tribal Health Dental Centers and receive approval from our HSAG auditor to include in the MY2024 HEDIS Annual Project. These Dental Centers must follow specific coding requirements for their fluoride varnish services to be successfully sent to Partnership via DHCS, and in 2025 Partnership is actively working with Dental Centers throughout its network to implement the coding requirements and monitor progress.

- NCQA released changes to two existing clinical measures used in DHCS MCAS for MY2024:The former Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) measure was revised to Glycemic Status Assessment for Patients with Diabetes (GSD).
- Colorectal Cancer Screening (COL-E) using ECDS methodology replaced Colorectal Cancer Screening (COL), which was an administrative measure.

Partnership successfully launched our HEDIS® MY2024/RY2025 data collection and reporting audits incorporating all changes as noted above.

DHCS MCAS Accountable Measures

In MY2024/RY2025 HEDIS® Annual Final Reporting, DHCS is holding managed care plans (MCPs) accountable and imposing financial sanctions on 18 selected Hybrid and Administrative measures performing below the minimum performance level (MPL -50th national Medicaid percentile) by county, as described above.

Results of an additional 20 MCAS measures were reported but were not part of the accountability measure set in MY2024 ("reporting only measures"). The full list of MY2024 MCAS measures can be found on the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Documents/Managed-Care-Accountability-Set-Reporting-Year-2025.pdf Finally, Partnership also reports to DHCS three (3) Long Term Care (LTC) measures designated as reporting only:

- Number of Outpatient ED Visits per 1,000 Long Stay Resident Days (HFS)
- Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization (SNF-HAI)
- Potentially Preventable 30-Day Post Discharge Readmission (PPR)

The 18 MCAS Accountable measures did not change between MY2023 and MY2024, with the exception of the replacement of the former Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) measure with Glycemic Status Assessment for Patients with Diabetes (GSD). As in MY2023, two (2) non-HEDIS® measures were included in the MCAS Accountable measure set, based on the 2023 CMS Core Measure Set: Developmental Screening in the First Three (3) Years of Life (DEV), an administrative measure specified by CMS and Topical Fluoride for Children (TFL-CH), an administrative measure specified by the Dental Quality Alliance (DQA). Per APL 24-004, DHCS designates MPLs for CMS Core Set measures in the current MY using previous Federal Fiscal Year (FFY) benchmarks as its basis.

The measure performance analysis that follows is based on the performance of the 18 accountable MCAS measures per NCQA Quality Compass 2024 Benchmarks, developed from MY2023 performance.

MY2024 MCAS Plan-Wide Rates

The table below shows Partnership's MY2024 rates for the MCAS measure set at the Plan-Wide level. These are the measure rates that were used to calculate the estimated MY2024 Composite Score shown above.

MCAS Accountable Measure Rates, MY2024, Plan-Wide (24 counties)

Domain	Measure Description	Acronym	Measure Type	Rate	Benchmark Percentile
Pediatric	Childhood Immunization Status—Combination 10 only	CIS	Hybrid	28.22%	50th
	Developmental Screening in the First Three Years of Life (Total, All Ages)	DEV	Admin	29.65%	<50th
	Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV) only	IMA	Hybrid	40.39%	66.67th
	Lead Screening in Children	LSC	Hybrid	71.78%	75th
	Topical Fluoride for Children, Numerator 1 Total - Dental or Oral Health Services	TFL	Admin	12.40%	<50th
	Well-Child Visits in the First 30 Months of Life - 2+ visits 15-30 months	W30-2+	Admin	72.22%	66.67th
	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months	W30-6+	Admin	67.05%	75th
	Child and Adolescent Well-Care Visits	WCV	Admin	48.83%	33.33rd
Cancer Prevention	Breast Cancer Screening, Non-Medicare Total	BCS-E	ECDS	56.29%	50th
	Cervical Cancer Screening	CCS	Hybrid	59.12%	50th
Reproductive	Chlamydia Screening in Women	CHL	Admin	55.58%	33.33rd
	Postpartum Care— and Postpartum Care	PPC-POST	Hybrid	89.54%	95th
	Prenatal - Timeliness of Prenatal Care	PPC-PRE	Hybrid	85.40%	50th
Chronic Disease	Asthma Medication Ratio, Total 5 to 64 Ratios > 0.50	AMR	Admin	64.71%	33.33rd
	Controlling High Blood Pressure, Total	CBP	Hybrid	69.59%	75th
	Glycemic Status Assessment for Patients With Diabetes—Glycemic Status (>9%), Non-Medicare Poor Control	GSD>9	Hybrid	32.60%	50th
Behavioral Health	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up	FUA-30	Admin	33.27%	33.33rd
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up	FUM-30	Admin	29.01%	<10th

Key:
Above HPL MEASURES (>90th)
Below MPL MEASURES (<50th)

Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population

GSD - HbA1c Poor Control is an inverted measure; a lower rate results in a better performance.

Some highlights of MY2024 Plan-Wide MCAS performance include:

Measures above the High-Performance Level (90th percentile):

- One (1) measure, Prenatal and Postpartum Care: Postpartum Care, scored above the 90th percentile at the Plan-Wide level.

Measures above the Minimum-Performance Level (50th percentile) :

- The two Well Child Visits in the First 30 Months of Life (W30) measures improved dramatically as a result of the W30 Medical Record Review. The W30-6 measure improved 24.96% from MY2023, to the 75th percentile; W30-2 improved 7.67% to the 62.5th percentile.
- The Lead Screening for Children (LSC) measure also improved dramatically between MY2023 and MY2024, gaining 12.66% to the 75th percentile in MY2024.
- Two immunization measures - Childhood Immunization Series (CIS-10) and Immunizations for Adolescents (IMA-2) - have Plan-Wide rates above the 50th percentile; these measures have been challenging measures for the Plan in past years.
- Other measures above the 50th percentile include: Breast Cancer Screening (BCS-E), Cervical Cancer Screening (CCS), Controlling High Blood Pressure (CBP), Glycemic Status Assessment for Patients with Diabetes (GSD), and Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre).

Measures below the Minimum Performance Level (50th percentile):

- Three (3) measures – Asthma Medication Ratio (AMR), Chlamydia Screening for Women (CHL), and Child and Adolescent Well Care Visits (WCV) scored below the 50th percentile and are opportunities for performance improvement for Partnership in MY2025 onward.
- Four additional (4) measures – Developmental Screening in the First Three Years of Life (DEV), Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA-30), Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30), and Topical Fluoride for Children (TFL-CH) - have rates below the 50th percentile that are partially due to significant data completeness issues. Three of the four measures (FUA-30, FUM-30, TFL-CH) are dependent on data exchange between DHCS and Partnership, and Partnership has documented and DHCS has acknowledged that completeness issues still exist in the data exchange. The fourth measure, DEV, has an ambiguous value set directory and is challenging for PCP's to code accurately, which leads to incomplete claims and encounters data from Partnership's provider network. Partnership intends to appeal any sanctions received from DHCS on these four measures, since data received is insufficient to represent these measures' true performance within our provider network.

NCQA Health Plan Accreditation (HPA) – Health Plan Rating (HPR) Methodology

As an NCQA-Accredited Health Plan, Partnership is required to report HEDIS® and CAHPS® data annually. This reporting started in June 2022 for MY2021. Reporting for MY2024/RY2025 will be formally assessed by NCQA for Partnership's publicly reporting Health Plan Rating (HPR).

- Health Plans are given the option to choose to report the Adult CAHPS® survey results or Child CAHPS® survey results.
- Partnership chose to report the Child CAHPS® survey results for MY2024.

- In addition to CAHPS measures, there were 43 clinical HEDIS® measures requiring plan-wide level reporting for the HPA Annual Project.
- At the close of 2024-2025, Partnership awaits NCQA's formal assessment and final HPR for MY2024. Partnership has utilized NCQA scoring methodology and anticipates achieving a 3.5 Star Rating.

NCQA has released the current Health Plan Rating Methodology: (Plan-wide)

- NCQA ratings are based on three (3) types of quality measures:
  - Measures of clinical quality from NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®); and
  - Health Outcomes Survey (HOS); measures of patient experience using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®); and
  - Results from NCQA's review of a health plan's health quality processes (NCQA Accreditation). NCQA rates health plans that choose to report measures publicly.
- The overall rating is the weighted average of a plan's HEDIS®, HOS, and CAHPS® measure ratings added to any Accreditation bonus points (if the plan is accredited by NCQA), which is then rounded to the nearest half point and displayed as stars.
- The overall rating is based on performance tied to dozens of measures of care. The rating is calculated on a 0–5 scale including half points with five (5) being the highest. Performance includes three (3) subcategories (also scored 0–5 in half points):
  1. Patient Experience
  2. Rates for Clinical Measures
  3. NCQA Health Plan Accreditation

MY2024 HPA Star Rating Results

Partnership Projected HPA Star Rating Results with the Child CAHPS® Survey Results:

Estimated Star Rating with Child CAHPS® Survey Results: 3.5 Stars

HEDIS HealthPlan Accreditation Star Rating Scoring MY2024 With Child CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2023	TOTAL ACCRD Score MY2024	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	60	146	141	175	2.916666667	3.5
Patient Experience	7.5	9	13	19.5	2.600	2.5
Prevention and Population	19.5	50	54	65.5	3.359	3.5
Treatment	33	87	74	90	2.727	2.5

Estimated Star Rating with Adult CAHPS® Survey Results: 3.5 Stars

HEDIS HealthPlan Accreditation Star Rating Scoring MY2024 With Adult CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2023	TOTAL ACCRD Score MY2024	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	60	146	138	170.5	2.841666667	3.5
Patient Experience	7.5	9	10	15	2.000	2
Prevention and Population	19.5	50	54	65.5	3.359	3.5
Treatment	33	87	74	90	2.727	2.5

For Partnership's full HPA performance, refer to Star Rating Score Dashboard, Appendix (E).

Summary of HEDIS Measures in the Primary Care Provider Quality Incentive Program (PCP QIP)

The table below provides a summary of Measures Managed Care Accountability Sets (MCAS) for Medi-Cal Managed Care Plans Measurement Year 2024 | Reporting Year 2025 included in Partnership's Quality Incentive Program (QIP) measure sets.

	Measurement Year 2024 | Reporting Year 2025			
HEDIS® Measures	**MCAS Accountable/Reporting**	**MY2023 PCP QIP Measures**	**MY2024 PCP QIP Measures**	**QIP Program**
Asthma Medication Ration (AMR)*	Accountable	X		PCP QIP – removed from QIP in MY2024
Breast Cancer Screening (BCS-E)*	Accountable	X	X	PCP QIP
Controlling High Blood Pressure (CBP)	Accountable	X	X	PCP QIP
Cervical Cancer Screening (CCS)	Accountable	X	X	PCP QIP
Childhood Immunization Status (CIS) – Combo 10	Accountable	X	X	PCP QIP
Colorectal Cancer Screening (COL-E)	Reporting	X	X	PCP QIP
Eye Exam for Patients with Diabetes (EED)	Reporting	X	X	PCP QIP
Glycemic Status Assessment for Patients with Diabetes—Glycemic Status (>9%), Poor	Accountable	X	X	PCP QIP QIP uses the inverse of this measure: Good Control,

	Measurement Year 2024 | Reporting Year 2025			
HEDIS® Measures	**MCAS Accountable/Reporting**	**MY2023 PCP QIP Measures**	**MY2024 PCP QIP Measures**	**QIP Program**
Control (GSD)				HbA1c Good Control <9%
Immunizations for Adolescents (IMA) – Combo 2	Accountable	X	X	PCP QIP
Lead Screening in Children (LSC)	Accountable	X	X	PCP QIP MY2023: UOS measure MY2024: Clinical
Postpartum Depression Screening (PDS-E)	Reporting	X	X	Perinatal QIP
Prenatal Depression Screening (PND-E)	Reporting	X	X	Perinatal QIP
Prenatal and Postpartum Care (PPC) – Postpartum Care	Reporting	X	X	Perinatal QIP
Prenatal and Postpartum Care (PPC) – Timeliness of PrenatalCare	Reporting	X	X	Perinatal QIP
Prenatal Immunization Status – combo (PRS-E)	Reporting	X	X	Perinatal QIP
Well-Child Visits in the First 30 Months of Life—0 to 15 Months—Six or More Well-Child Visits (W30-6)	Accountable	X	X	PCP QIP
Child and Adolescent Well-Care Visits (WCV)	Accountable	X	X	PCP QIP

**Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).*
PCP QIP Measurement Set:
http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx

For Partnership's full summary of HEDIS® MY2024 performance, please refer to Appendix (E).

Quality in Data Governance

QI TRILOGY

Data Governance, Stewardship, and Analytics Integration

Partnership continues to strengthen its data and analytics infrastructure through the combined efforts of its Data Governance framework, Data Stewardship program, and Analytics Center of Excellence (ACE). Together, these initiatives ensure that organizational data is reliable, well-managed, and strategically applied to support quality improvement activities.

The Data Governance and Stewardship functions provide oversight, accountability, and structure for managing critical data assets, while ACE builds on this foundation to advance analytics maturity, promote data literacy, and drive innovation through cross-department collaboration. This integrated approach supports Partnership's goal of delivering data-driven insights to improve member care and organizational performance.

Data Governance

The QI, IT, and Health Analytics Departments play a key role in supporting the Data Governance framework across the organization. Data Governance involves the planning, oversight, and management of data and related resources to ensure they are used effectively and responsibly.

The main goal of Data Governance is to make data available, more reliable, well-understood, and easy to use. There is an important emphasis on partnering with each department to solve data related problems.

The Enterprise Data Warehouse (EDW) Team, within IT, has made significant progress in building a data warehouse system that integrates data from HealthRules Payor® (HRP®) (the new claims system), bringing together member, claims, and provider data into the Data Warehouse and DataMarts. Departments across the organization, including QI, rely on this data to support critical applications and processes.

Following the development of this infrastructure, the Provider Quality Dashboard (PQD) for the Quality Incentive Program (QIP) was developed and tested using data sourced from HRP®. Building the PQD database was successful, and this data was able to be fed into the HRP® version of the dashboards. Going forward into the next year the data will continue to be thoroughly tested in preparation for HRP® go live.

Data Stewardship

The Data Stewardship program is one key process under the Data Governance framework. In preparation for the introduction of HRP®, the team partnered with several departments to identify the data stewards for some of the data domains and established roles and responsibilities.

The goals and deliverables set for FY 2024-2025 included the following:

- Integrate the data from the new claims systems (HRP®) into all QI processes. This would include both HEDIS® and PQD.
- Integrate membership, claims, and provider data from the HRP® claims system into the EDW DataMart.
- Integrate Sutter supplemental data into the QI processes including the HEDIS® project.

The EDW Team was able to successfully integrate data from the new claims system, HRP®, into all QI processes. This included the HEDIS® project, the PQD, and EDW DataMart's which are provided to end users to use for reporting and analyzing data. By doing this it will allow for the QI processes to seamlessly switch sources of data for their projects, dashboards, and reporting when the new claims system goes live. Multiple iterations of testing have been performed to ensure the data from the new system will meet quality standards and the EDW Team will continue to oversee this as the go live date approaches.

A successful connection was made with Sutter to ingest their supplemental data, which could be used toward their quality measurements. In the past fiscal year, this data was able to successfully be included in Sutter's PCP QIP measurement scores and assisted us in gaining more data on our members while they were able to improve their program scores. The current connection was a one-time feed and further process improvement will take place next year to gather this data more frequently and use it in the HEDIS® project.

Analytics Center of Excellence

Partnership's Analytics Center of Excellence (ACE) was established in January 2024 as a virtual, cross-functional entity designed to integrate IT, business, and analytics functions across the organization. Its purpose is to align analytics initiatives with organizational strategy and to guide the development of analytics maturity, governance, and innovation.
ACE was created with the following core objectives:

- Operationalize the organization's analytics strategy
- Drive data governance and promote data literacy
- Identify and coordinate cross-functional analytics projects
- Standardize data management practices and data products
- Foster innovation in analytics
- Enhance collaboration across departments and reduce duplication of effort

ACE comprises several interconnected groups, each playing a distinct role:

- Analytics Steering Committee: Oversees the activities of the ACE groups and reports to the existing Data Governance Council. It is formed by representatives of the business units, IT and the Lead Team, and meets every other month, or as needed.
- Lead Team: Responsible for coordinating ACE operations and for realizing its functions. The Lead Team works closely with Governance Personnel, the Analytics Council, and business stakeholders to perform its functions.
- Analytics Council: Cross-departmental forum for analysts to discuss data issues, inform of new data or tools, contribute to the development of data standards, identify training, knowledge sharing, and prevent duplication of effort.
- Data Governance Council: Involved in developing and maintaining the data stewardship program.

Despite organizational constraints, ACE has delivered several important achievements:

- Data Literacy: Launched learning modules via the Learning Management System (LMS), supporting a foundational goal of improving data fluency across departments.

- Develop Advanced Analytics Capability**:** Established a Data Science function to support complex analysis, such as applying machine learning to provider network gap analysis and using RAND's Bayesian surname geocoding to address missing demographic data—critical for improving equity analysis.
- Cross-Team Integration: The integration of a long-standing Senior Quality Improvement (QI) Analyst into the Health Analytics (HA) team, along with enhanced collaboration between QI, HA, and Enterprise Information Management (EIM), has improved both operational efficiency and the integrity of analytics in QI projects.
- Data Standardization: Initiated a data catalog and glossary while also defining consistent classifications for race and ethnicity across datasets.
- Artificial Intelligence Governance Awareness: Developed a draft Artificial Intelligence policy. While the draft policy is still pending finalization and formal approval by leadership, it demonstrates early recognition of the need for governance around emerging technologies.
- Analytics Council Engagement: With 42 active participants from departments including IT, Finance, Grievance and Appeals, Quality Improvement, Care Coordination, and Population Health, the Council has become a key platform for sharing projects, addressing data quality concerns, and promoting standard practices.

While progress has been made, ACE's development has been hindered by several structural and cultural challenges. Leadership turnover and loss of key Lead personnel have stalled strategic momentum, and proliferation of several key initiatives requiring organizational priority have reduced the attention and resources available for ACE activities.

To ensure long-term success and impact, the following recommendations are proposed at the close of 2024-2025:

1. Update the ACE charter to reflect lessons learned, redefine the roles of each group with clarified deliverables, and consider more agile, outcome-oriented governance practices. Through this charter update, re-establish executive sponsorship given changes in executive leadership and immense organizational growth since the original charter was developed and adopted.
2. Position innovation as a core part of ACE's function, supported by leadership and cross-functional input
3. Enhance communications and visibility by improving internal awareness of ACE activities through regular updates, success stories, and shared outcomes.

Partnership Quality Dashboard

The Partnership Quality Dashboard (PQD) is one of many dashboard projects that can be accessed on Partnership's Tableau server landing page. This page houses multiple healthcare quality measure data dashboards and supports Partnership's data and analytics objectives. Dashboards visualize key performance indicators for multiple Partnership department stakeholders, including behavioral health, population health, care coordination, data quality, cost avoidance, member access and utilization projects. The PQD dashboards focus their scope on visualization of source data maintained by the Quality Improvement (QI) Department, HEDIS®, and Quality Incentive Program (QIP). These dashboards enable providers and Partnership staff to prioritize, inform, and evaluate quality

improvement efforts. PQD supports year-over-year performance trending and enables analysis across geographic regions and demographic aggregates.

The PQD is maintained by staff in Partnership's QI, IT, and Finance departments. Annual dashboard development involves evaluation of project data needs, documentation of business requirements, data and dashboard development, and user acceptance testing. Data Governance principles are applied throughout the development and maintenance process to ensure accuracy, consistency and responsible use of the data. Ongoing maintenance of dashboards throughout the year involves monthly warehousing of both HEDIS® and QIP source data and issue resolution. PQD training is a key project activity conducted throughout the year.

The majority of PQD project goals and deliverables outlined under the 2024-2025 QI Department Work Plan were successfully accomplished during the fiscal year. Delayed PQD goals have dependencies on the HealthRules Payor® (HRP®) integration and will continue into next year. Business rules for mapping primary care provider identification numbers under the new HRP® provider data structure were identified and shared with stakeholders. Other business rules defining data linkages were identified for source data projects (eReports, Inovalon) and tested, to help minimize delays during implementation. Source data validation and user acceptance testing was completed and continues, where needed. PQD dashboards are expected to be updated based on HRP® source data, following implementation. (Note, exact timing of refreshing PQD dashboards is contingent on the final implementation timing of HRP®, which remains pending as of the close of 2024-2025.)

The use of data to identify health inequities is a key organizational focus and was identified as a new goal under the PQD 2024-2025 QI Work Plan.

A health disparity dashboard was soft launched internally in November 2024. The dashboard allows various internal stakeholders to easily see the disparities by measure and by region. This dashboard is a critical step toward changing systems and decreasing disparities. Future phases of this dashboard include further upgrades and giving access to external stakeholders to inform effective collaboration.

Summary of FY 24-25 PQD Dashboards

Dashboard Name	Data Source	Brief Description	Major 2024-2025 Reporting Enhancements
MY2023 HEDIS® Annual Static -Summary of Performance	HEDIS® Annual Measurement Year 2023	MCAS measure performance by Sub-Region and County and color-coded against benchmarks; 16 of 18 MCAS Accountable measures included.	Measurement Year 2023 HEDIS® Final Performance
MY2024 HEDIS® Annual Static -Summary of Performance	HEDIS® Annual Measurement Year 2024	MCAS measure performance by Plan-Wide, DHCS Quality Rating Region, Partnership Region, and County and color-coded against benchmarks. 18 MCAS Accountable measures included.	MY2024 dashboard reflects DHCS transition to Plan-Wide rate reporting and replacement of legacy Reporting Units with County and Rating

Dashboard Name	Data Source	Brief Description	Major 2024-2025 Reporting Enhancements
			Regions for DHCS Accountability programs.
MY2023 HEDIS® Annual Exploratory	HEDIS® Annual Measurement Year 2023	MCAS measure performance by Sub-Region, County and Provider. Color-coded against benchmarks. Stratification by member demographics such as race and gender. Member-level drilldown reports by measure.	Measurement Year 2023 HEDIS® Final Performance (MY 2024 dashboard expected Q3, 2025)
MY2023 HEDIS® Scatterplot	HEDIS® Annual Exploratory Measurement Year 2023	Bubble chart displays measure performance against population size, with break out by various demographic indicators.	Measurement Year 2023 Final Performance (MY2024 dashboard expected Q3, 2025)
MY2024 NCQA Health Plan Accreditation (HPA) Annual Static – Summary and Star Rating Estimation	HEDIS® Annual Measurement Year 2024	HPA measure performance (including 2024 Child and Adult CAHPS scores) by Plan-Wide and County, including year-over-year measure performance. Star Rating calculations displayed based on HPA measure scoring.	New Tableau dashboard. Displays Star Rating using Child and Adult CAHPS scoring scenarios.
MY2023 HEDIS® Monthly Exploratory – Internal View	HEDIS® Monthly 2023	MCAS and NCQA Health Plan Accreditation measure performance by various geographic and demographic aggregates, color-coded against benchmarks. Member-level drilldown reports by measure.	2024 Rolling Year and Year-to-Date Performance (MY2024 dashboard expected Q3 2025)
PCP QIP Internal and Provider View	Monthly eReports Clinical data and QIP Non-Clinical calculated data	Payout by measure for the PCP QIP program, with gaps to target, member drilldown, performance against targets and regional averages.	December-2024 final PCP QIP performance. The QIP Stoplight and Final Statement dashboards are also available on PQD.
Disparity Analysis	2024 PCP QIP Monthly Clinical Data	Breakout of QIP performance by measure at the plan-wide level, and stratified by ethnicity group. View top 10 providers with largest population size for selected ethnicity groups	December-2024 Geographic View dashboard to display measure performance across updated

Dashboard Name	Data Source	Brief Description	Major 2024-2025 Reporting Enhancements
			categories for race and ethnicity. Dashboard is available to the provider network through eReports.
Maximizing Visibility of Quality Data	2024 PCP QIP Year-end Score	Rank PCPs year-end QIP total score by county and display population size, increase or decrease over previous year score.	December-2024 PCP QIP Final Data PCP-level stars ratings added to ranked performance chart.
QIP Stoplight Dashboard	2024 PCP QIP Monthly Data	Member gap-to-target analysis, color coded against benchmarks at the parent organization level.	December-2024 PCP QIP Final Data.
PCP QIP Final Statement	2024 PCP QIP Year-end Score	Payment, points and performance by measure for individual providers. Used for PCP QIP payment.	December-2024 PCP QIP Final Data. This dashboard was updated for Modified QIP providers for 2024.
Perinatal QIP Dashboard	Perinatal QIP supplemental measure data and custom claims and membership calculations	Perinatal QIP measure performance is updated quarterly for provider statements.	
Hospital QIP (HQIP) Final Statement	Supplemental HQIP Performance data	Calculates payment for the Hospital QIP year-end provider payment.	2023-2024 fiscal year-end performance
PQD User Activity	Monthly HEDIS® and QIP dashboard clicks, internal and external (PCP QIP)	Monitors internal and external provider user clicks in HEDIS® and QIP PQD dashboards.	N/A
Well Care Dashboard – Internal View	Custom table for well-care claims for members in measure age ranges	Reports by provider for well visit dates of service for assigned and special members. Internal staff access through PQD.	N/A
Preventive Care Reports – Provider View	Custom table for well care claims and CIS and IMA claims and	Member-level contact information includes all well care, IMA and CIS DOS for assigned members. Priority	Daily refresh starting in January of each measurement year.

Dashboard Name	Data Source	Brief Description	Major 2024-2025 Reporting Enhancements
	California Immunization Registry (CAIR) data	flags for member outreach based on age.	

Provider Network Quality Improvement Support and Initiatives

QI TRILOGY

Quality & Performance Improvement Initiatives and Projects

Overview

In 2024-2025, our Quality Improvement (QI) Team continued to focus on priority measures for Partnership HealthPlan of California, guided by performance indicators from the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) and the National Committee for Quality Assurance (NCQA) accreditation measures. DHCS encouraged prioritized improvement efforts related to Health Equity, as well as measures where significant financial incentives/penalties were introduced or enforced.

We made significant strides in understanding Health Equity (HE) accreditation readiness, laying the groundwork to address identified gaps in care, while aiming for 2025 Health Equity Accreditation. We developed a Health Equity playbook that we now share with providers so they can better identify and understand their own Health Equity related challenges. Additionally, we began developing a Dual Eligible Special Needs Plan (D-SNP) product line, its accompanying Model of Care (MOC), as well as its associated Quality Incentive Program (QIP).

Considerable efforts were dedicated to building relationships, understanding gaps, and producing data in Partnership's geographic expansion. QI and Regional cross-functional staff engaged with providers in the Auburn and Chico Operational Regions, assessing sites and orienting them to data tools and program specifications. This engagement prepared organizations and managed expectations as they receive their initial QIP results and payment summaries for MY2024, with additional HEDIS data to follow, pending finalization of MY2024 results.

California's health care system underwent significant transformations, particularly regarding Quality within Medi-Cal. The state implemented new standardized contracts for managed care plans, emphasizing enhanced quality, access, accountability, and health equity. These contracts introduced requirements such as improved integration of physical and mental health services, culturally competent care, and mandates for plans to reinvest a portion of their profits into community health initiatives. Partnership focused on quality measures and initiatives that moved us in the direction of meeting those goals, with some seeing significant improvement, in large part due to data quality enhancements. Other measures such as vaccination rates, continue to decline due to shifting public messaging on efficacy and importance.

Our QI Team continued efforts related to engagement of lower performing providers, with several graduating back to full participation in our PCP QIP measure sets.. We assessed, supported, and coached lower-performing sites, developing tailored interventions designed to address foundational issues. Some of these efforts included financial support to purchase equipment, increase access, and reduce disparities. Support was also extended to organizations seeking state-directed payment funding for equity and practice transformation initiatives. Our commitment to the Improvement Academy trainings, joint leadership meetings with major provider organizations, practice coaching, mandated work collaborations, and other ad hoc support increased to meet provider needs. The focus of this support was on closing care gaps through clinical and operational workflows, fostering a culture of quality within provider leadership, and building capacity for quality improvement within provider teams.

Internally, QI collaborated closely with key stakeholders, including Population Health, Pharmacy, Behavioral Health, Medical Directors, Health Equity and regional leadership on strategic efforts, such as direct member engagement. Particular emphasis was placed on ensuring proper support for the Local Engagement Teams (LETs) in better understanding local issues and sharing region-specific intelligence within each Operational Region.

Collaboration with Population Health led to alignment and improvement of the CHA/CHIP goals established by counties within the Partnership footprint.

Quality Measure Score Improvement (QMSI) workgroups were expanded and optimized to address evolving DHCS MCAS and NCQA Health Plan Accreditation (HPA) measure sets and anticipated Medicare STARs measures. The QMSI workgroups focused on measure domains specific to Pediatrics, Chronic Diseases, Elder Care, Medication Management, Behavioral Health, Women's Health, and Perinatal Care. These workgroups evaluated opportunities under priority measures included in the DHCS Quality Withholds and Incentive Program, as well as those subject to DHCS sanctions, such as Topical Fluoride for Children and well-child visit measures. Through collaboration with internal staff and external partners, such as Aliados, the Health Alliance of Northern California (HANC), and North Coast Clinics Network (NCCN) consortia, we piloted, scaled, and spread improvements across measures including breast cancer screening, childhood immunizations, adolescent immunizations, and well-child visits.

Partnership incentivized improved performance and the adoption of best practices through Quality Incentive Programs (QIPs), targeting Clinical and Non-Clinical measures aligned with NCQA Health Plan Accreditation (HPA) and DHCS Managed Care Accountability (MCAS) sets. Enhancements to data tools improved visibility and transparency into QIP performance gaps. Financially, Partnership paid out more incentives within the QIPs than any previous year.

These combined efforts have positioned Partnership HealthPlan of California and our provider network to deliver high levels of care and support to our members, amidst challenging national headwinds and potential budget cuts.

Quality Measure Score Improvement

The Quality Measure Score Improvement (QMSI) effort continues to better coordinate service and performance across the organization and to raise Partnership's overall performance in quality measures, as defined under DHCS MCAS and NCQA Health Plan Accreditation (HPA). This effort involved team formation under QMSI to encompass all current and potentially future accountable measures by measure family within each workgroup team: Pediatric, Chronic Diseases (including medication management), Behavioral Health, Women's Health and Perinatal Care. Each workgroup monitored and reviewed all measure performance where data was available, assessed current improvement efforts, identified gaps and initiated new performance improvement activities. In anticipation of the new Dual Special Needs Plans (D-SNP) launch , a new Elder Care QMSI workgroup was formed in early 2025 to proactively educate staff on quality measures in order to anticipate potential improvement efforts needed in the following year.

QMSI workgroups consisted of cross-functional teams led by Quality and included representation from across the organization, such as: Care Coordination, Claims, Health Education, Office of the CMO, Pharmacy, Population Health, Provider Relations, Health Equity, Quality and/or regional leadership. The following summaries include what each measure-family QMSI Workgroup Team achieved in 2024-2025.

Improvement Team Workgroups

Chronic Disease

Expand Exact Sciences Cologuard Bulk Order Program

In 2023 Partnership conducted a pilot project with Exact Sciences who produces the Cologuard Fit DNA colorectal cancer screening product. During the pilot Partnership observed notable improvements in colorectal cancer screening rates with participating providers. Partnership has turned this effort into an ongoing program and has worked closely with Exact Sciences to spread awareness and access to the bulk ordering program. Partnership has created a resources page on its public website to aggregate lessons learned and details on the bulk ordering process. Partnership's Quality team has biweekly check-ins with Exact Sciences to address questions from providers, review data, and facilitate upcoming orders. Exact Sciences has a minimum number of patients required for bulk orders since it is resource intensive for them to do outreach and messaging for patients with an order. Partnership has offered to help facilitate bulk orders for smaller practices who do not have large enough denominators to do bulk orders on their own, with orders going out every few months.

The Chronic Disease workgroup will continue to monitor colorectal cancer screening rates, and specifically modalities to track screening rates by screening type to look for opportunities where Cologuard bulk order may be appropriate based on availability of other screening methods.

Diabetic Retinopathy Camera Grant

In March 2025 Partnership launched a grant program that allowed a select group of providers to apply for a grant up to $10,000 to purchase a diabetes retinal camera. Partnership targeted rural primary care providers who are performing low with higher volumes of patients needing to be screened for diabetic retinopathy. The goal of the grant was not to eventually fund every practice with a retinal camera, but to instead serve as a proof of concept to show practices how to operationalize cameras to earn funds in the PCP QIP program where diabetic eye exams is a clinical measure.

Partnership offered the grant opportunity to 12 practices meeting the criteria above and had nine (9) practices respond with an interest to participate. One provider requested two (2) devices because they have two very rural locations, which Partnership was able to accommodate. To date only one provider has yet to submit their application for funding while the remaining eight (8) providers have executed contracts to purchase devices. Partnership hosted a kickoff webinar outlining the grant program, as well as including a provider practice who successfully implemented retinal cameras who spoke to best practices.

For the remainder of calendar year 2025 Partnership will monitor the participating provider practices to ensure they reach the required thresholds of the contract which is the 50th national Medicaid percentile. Partnership is offering monthly check-ins to ensure there are no unmet needs from the participating provider practices. Partnership will survey providers after the close of the measurement year to understand barriers and best practices to be shared more globally for practices so they can feel confident in purchasing their own cameras and using earned QIP dollars to make themselves whole.

VSP Telephonic Outreach Campaign (as it relates to Retinopathy)

Partnership members are provided with vision benefits through their regular medical coverage and with Vision Service Plan (VSP). The member's general vision coverage includes one eye examination with refraction every 24 months. A second eye examination with refraction will be covered if the member has a sign or symptom indicating medical necessity (Partnership Policy MCUP3102 Vision Care, 2023). Given the current trend in eye care and the

vision care benefits available to Partnership members, Partnership has partnered with VSP to share data on members who are identified as diabetic and are still in need of a retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year. Partnership provides a list of members diagnosed with diabetes to VSP, so they may be flagged in VSP's system. A Partnership Quality Improvement (QI) Improvement Advisor collaborates with a Partnership QI Data Analyst to pull a member list that is shared and sent to VSP.

This triggers three primary actions:

1. Will enroll the member in their established 'reminder' program where the member receives an eye exam reminder in the mail AND
2. When a member presents at a VSP provider, the provider will know to ask about their condition and provide a dilated eye exam AND
3. Send the primary care provider the exam findings and follow-up recommendations via the VSP Primary Care Physician Communication Form

Gojji Pilot with Telemed2U

TeleMed2U, Partnership's vendor for adult specialty care, has proposed a diabetes management pilot, partnering with Gojji and Partnership. Gojji will fulfill orders for continuous glucose monitors and medications placed by TeleMed2U and use technology to make managing chronic conditions, such as diabetes, easier by monitoring patients' glucose levels, providing education and ensuring adherence. For the pilot, it has been proposed to begin with a group of 50 patients we have identified based on certain criteria. The initially suggested criteria were A1C> 10 for >6 months, chronic, comorbid conditions (HTN), frequent hospitalizations, existing home health/case management support and hypoglycemia.

We formed a subcommittee consisting of our Telehealth team, QMSI leads and our data analyst to research which provider would fit the criteria for this pilot. We looked at past performance of a particular group of providers and narrowed it down to two health centers that could potentially benefit the most from this pilot and extra level of care around HbA1c Good Control.

Currently, this pilot is on hold. TeleMed2U has encountered logistical issues working with the vendor and another provider they would like to work through prior to expanding the pilot and sharing across the health care continuum.

Academic Detailing Sessions Through Partnership Pharmacy Team

For measurement year 2025 Partnership added a Unit of Service (UOS) measure to the PCP QIP program. The purpose of this new unit of service measure is to incentivize provider organizations to host a two-part academic detailing meeting with PHC Pharmacy Team/Medical Director. Pharmacy academic detailing helps clinicians improve medication management, improve quality measure performance, and achieve better clinical outcomes for their patients. The UOS measure applies to practices with at least 1,000 assigned members and requires an initial training as well as a follow-up session to review any changes in prescribing practices following the initial training. Provider practices are offered up to $2,500 to help cover costs to get prescribers out of clinic for education.

Pharmacy academic detailing meetings focused on improving medication management through pharmacy claims analysis within the following disease states:

- CBP: Controlling High Blood Pressure
- HbA1c Good Control
- AMR: Asthma Medication Ratio

- Statin therapy in:
    - Cardiovascular disease
    - Diabetes
- Opioid Disorder Measure (only if providers are interested in opioids and MAT)

To date four (4) initial academic detailing sessions have been completed and have been well received, and follow-up sessions will be conducted after providers have ingested and operationalized the recommended practices. Several noteworthy best practices include identifying patients with chronic diseases with no medication fill history or who are on suboptimal therapies. The Chronic Disease workgroup will continue to monitor these measures for positive rate changes for the remainder of the 2025 measurement year to determine if future changes to the QIP UOS measure are warranted.

Asthma ED Visit Follow-Up

The objective for this program is to prevent them from returning to the emergency room because of their asthma by providing asthma related education to members who had an ED visit for asthma in the last two weeks. Population Health will send mailings to these members that contain basic information about asthma and instruct members to call PHC if they wish to speak to a pharmacist for further consultation on their asthma management. These efforts will improve overall health and quality of life and lower the cost of care by:

- Reducing asthma exacerbations
- Addressing medication gaps
- Improving self-management, the member's AMR / medication adherence, communication and coordination of care with PCP and adherence with asthma action plan
- Screening for tobacco use and offering referral to Kick-it California

Scope definition:

- Members that are between the ages of 5 and 64 who have been identified through Collective Medical with an asthma ED event report, with an ED discharge within the last two weeks. (Members will be deemed out of scope if they: do not have Partnership HealthPlan as primary insurance, only have Wellness & Recovery benefits, are on Hospice, are admitted to the hospital, or have a COPD or lung cancer diagnosis.)
- Members will receive a letter after their ED visit informing them that our pharmacists can assist them with managing their asthma as well as how they can obtain an asthma handbook.
- Members wanting to consult with a pharmacist will call Member Services and ask to speak to a pharmacist. From there, Member Services will connect them to the Pharmacy Department, and pharmacists will speak with the members. Pharmacists will obtain a history and answer any questions the member may have. Pharmacist reviews pharmacy fill history for 6 months (Medi-Cal Rx) noting rescue inhaler fill frequency verses controller frequency and calculate the Asthma Medication Ratio (AMR) over the last 6 months for each member. The pharmacist will review items taken from GINA and NIH content points for asthma education provided to patients that have been shown to improve patient outcomes. The talking points could include asthma disease state information, roles of medication, correct use of inhalers, medication adherence, medication side effects, preventing flare-ups / avoiding triggers and having / using an Asthma Action Plan. As part of this program members may be referred to services such as: CHW, CCM, ECM, or other services.
- Members with repeated emergency room visits will be referred to Care Coordination.

Criteria for referring members for case management and providing additional information on asthma:

- Members with 2+ visits within 30 days of each other, regardless of case management history
- Members with 2+ visits in any time frame who have never been case managed or have not been case managed for 6 or more months.

The Care Coordination team is instructed to work the cases with the following goal and interventions:

- Goal: Verbalizes understanding of asthma disease process and management options
- Any relevant Intervention/s
- Assess/address barriers affecting medications/vitamins
- Assist member to access needed medications
- Communicate with provider any concerns/issues related to medication adherence
- Follow up on member's adherence to medication regimen
- Teach/reinforce the actions/importance of prescribed medications

In summary and to-date for 2025 (from January to May), a total of thirty referrals were received by Care Coordination. Partnership attempted to contact all thirty members and eight members agreed to case management. Upon speaking to those members, our population health and pharmacy team set up a total of twenty-three interventions to keep track of their Asthma Diagnosis.

Best Practices for at-home Blood Pressure Monitoring and Member Engagement

The Partnership Medical Equipment Distribution Services (PMEDS) program distributes medical devices to eligible members based on diagnosis of related conditions. This program has been distributing blood pressure monitors to members with diagnoses of hypertension and other related conditions since 2020. Research from the Million Hearts Self-Monitored Blood Pressure Program (SMPBP) indicates blood pressure monitors can be effective in reducing blood pressure rates when used alongside patient education, timely monitoring, medication control, and related nutrition, smoking or lifestyle interventions. We analyzed data from CY2024 comparing end of year Controlling Blood Pressure (CBP) measure compliance (values less than 140/90) for members with and without blood pressure monitors. Evaluation of this data presented barriers in documentation, availability of usable data from multiple sources, manual adjustments to data, and data volume. Upon analyzing data from PQD (Partnership Quality Dashboard) and a more comprehensive data set from electronic data warehouse (EDW), a significantly higher number of members without blood pressure monitors had numerator compliance for the CBP measure compared to a sample population of members who have blood pressure (BP) monitors. The work group has collaborated with a PCP who has experienced success in this measure by utilizing the PMEDS program. When reviewing the data, anecdotal feedback indicates that providers will often prescribe their high complexity patients a home BP monitor compared to those who are managing their hypertension through traditional means. Further evaluation is required to look at member comorbidities and visit histories to confirm this hypothesis. Their workflows and interdisciplinary care approach have been documented and will be ongoing throughout 2025. The work group will consider piloting a similar interdisciplinary approach with interested PCP Quality Incentive Program (QIP) organizations to increase measure success annually. This may increase measure success by implementing workflow best practices alongside the PMEDS program.

The workgroup will continue to meet with this provider on best practices as they will continue to audit quarterly to see the success of the PMEDS program, as well as what they are implementing around new and improved workflows when the patient is coming in for a visit and has hypertension. New processes and best practices consist of re-

checking blood pressure if they are presenting with a value of 140/90, requesting a follow up appointment as soon as one month after being seen if medication is increased at the given appointment and making sure at every appointment contact information is being updated to prevent missed opportunities.

Behavioral Health

DHCS Mandated Non-Clinical PIP: Improving Provider Notifications and Follow-Up for Members with Serious Mental Health Diagnoses (QI)

The Department of Health Care Services (DHCS) has mandated a non-clinical Performance Improvement Project (PIP) focused on enhancing the timeliness and consistency of provider notifications for members with Serious Mental Health (SMH) diagnoses following emergency department (ED) visits. The primary goal of this initiative is to improve the percentage of notifications sent to providers within seven days of an ED visit, thereby increasing the likelihood of timely follow-up care for affected members.

Timely and accurate provider notifications are essential to bridge the gap between emergency care and outpatient follow-up. By promoting greater visibility and utilization of existing alert systems, providers can be better equipped to respond within the crucial seven-day window. Ensuring that providers opt to receive these ED alerts on an instant or daily basis, rather than at less frequent intervals, is critical to achieving this objective.

In 2024, the QI team at Partnership identified an additional tool with the potential to significantly improve provider notification processes: PointClickCare. Partnership subscribes to this platform, which serves as a centralized hub for real-time Admission, Discharge, and Transfer (ADT) messages from EDs and hospitals across California. These ADT messages provide rich, actionable data, including dates and times of ED events, member demographics, assigned Primary Care Providers (PCPs), and associated diagnoses—specifically highlighting members with SMH conditions.

Leveraging the "ED Visits – Mental Health Diagnosis" report within PointClickCare, providers gain enhanced visibility into ED utilization patterns among their assigned members. This enables earlier outreach and intervention, positively impacting follow-up not only within the targeted 7-day window but also within 30 days, when clinically appropriate.

To operationalize this data, Partnership has proposed a targeted intervention in the Northwest region, routing daily PointClickCare reports to a large provider organization. These reports flag assigned members with recent ED visits for SMH diagnoses. In response, the provider organization is developing integrated clinical and operational workflows across its sites to proactively conduct outreach, schedule appointments, and ensure follow-up care is completed within 30 days of the ED event.

A key component of this strategy involves PCP notification workflows based on ADT message access. This proactive approach allows care teams to connect with members who may not typically seek follow-up due to cultural stigma, lack of awareness, or historical mistrust of healthcare systems. Importantly, the ADT messages often include the specific mental health diagnosis from the ED encounter—information that PCPs may not have previously received. Without these details, providers risk addressing only the medical concerns from the ED visit, overlooking critical mental health needs unless the patient self-reports them. This enhanced data empowers care teams to deliver more comprehensive and informed follow-up, increasing the likelihood of effective patient engagement.

This strategy was initially piloted through a collaboration between the Quality Improvement department at Partnership and Open Door in Humboldt and Del Norte counties. A follow-up tracking tool was developed and implemented, supported by weekly data exchanges to promote timely provider engagement and care coordination. Due to the success of the pilot, the collaboration with Open Door has been formally extended for another year. Additionally, based on the promising results, Partnership is now working to expand this approach to additional provider organizations across the region. Ongoing support will include bi-monthly coordination meetings and weekly data sharing to ensure effective implementation and continuous quality improvement.

Key Outcomes and Learnings:

- Regular data exchange to promote shared learning, pattern recognition, and continuous quality improvement.
- Real-time data analysis to support agile adjustments and maintain program responsiveness.
- Focused efforts on increasing the rate of timely notifications and achieving compliance with follow-up targets.

By building upon these learnings and expanding access to real-time data through PointClickCare, this initiative aims to close the loop on care for members with serious mental health needs—ensuring they receive the support and continuity of care necessary for improved health outcomes.

DHCS/IHI Behavioral Health Collaborative: Partnership HealthPlan of California and Nevada County (BH)

Beginning June 3, 2024, the Behavioral Health and Quality Improvement departments at Partnership HealthPlan of California (PHC) embarked on a 15-month collaborative initiative facilitated by the Department of Health Care Services (DHCS) and the Institute for Healthcare Improvement (IHI). This partnership, in coordination with the Nevada County Department of Behavioral Health, aims to improve Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) measures.

Key Outcomes and Learnings:

- The collaboration has significantly strengthened the working relationship between PHC and Nevada County, laying the foundation for ongoing partnership and communication.
- Despite ongoing data misalignment between the County and PHC, the collaborative has initiated efforts to identify data gaps, establish a shared baseline, and apply data-driven strategies to guide targeted quality improvement interventions.
- Piloted standardized screening procedures for bedside.

Sac Valley MedShare Data Exchange: Partnership HealthPlan of California and SacValley MedShare (SVMS) (BH)

To improve data sharing capabilities between Behavioral Health Plans (BHPs) and Partnership HealthPlan of California (PHC), the partnership with SacValley MedShare (SVMS) was expanded to include county participation. Over the course of a 12-month collaboration, 22 out of 24 counties signed participation agreements with SVMS, which allowed various levels of data use and sharing to be integrated into county operations.

Key Outcomes and Learnings:

- The collaboration facilitated the provision of medical data, including real-time admissions, discharges, and transfers, from participating hospitals.
- Some counties implemented opt-in procedures for data sharing, which have limited the number of beneficiaries included in the data.
- Substance use disorder data has not yet been included in the exchange due to varying levels of regulatory uncertainty across counties.

Community Health Worker (CHW) & Emergency Department: Partnership HealthPlan of California (BH)

To bridge the gap between existing Substance Use Navigation (SUN) grants and the implementation of community health workers (CHWs), Partnership HealthPlan of California (PHC) offered a grant of up to $100,000 to promote the use of CHWs in emergency departments. A total of 24 hospitals expressed interest, and 17 followed through during the grant year.
Key Outcomes and Learnings:

- Most emergency department EHRs (Electronic Health Records) were not capturing non-clinical interactions, which made it difficult to promote CHW work as a billable service.
- Staffing challenges arose at some hospitals, including engaging HR to create new job descriptions, adding positions late in budget cycles, and dealing with workforce shortages in certain areas.
- Many hospitals felt that longer grant periods would be necessary to fully capture the impact of the new CHW role

Community Health Assessment- Community Health Improvement Plan (CHA-CHIP) (Pop Health)

As part of the CHA-CHIP initiative, a key project launched in December 2024 in Trinity County aims to improve follow-up care for individuals presenting to Emergency Departments (EDs) with substance use disorder (SUD) diagnoses. The focus is on streamlining and strengthening referral pathways from EDs to County Behavioral Health services to ensure timely, coordinated, and effective connections to care for patients with SUD.

This project involves developing a comprehensive referral system that facilitates direct, consistent communication between EDs and County Behavioral Health. In parallel, it expands outreach and education efforts to increase community awareness of available behavioral health services, substance use programs, and the Partnership transportation benefit that supports access to care. Together, these strategies aim to reduce barriers, promote patient engagement, and improve health outcomes for individuals on the path to recovery.

Although the project is currently on pause due to ongoing restructuring within the County, the work in Trinity County remains an important part of the broader CHA-CHIP initiative. It reflects a continued commitment to improving behavioral health systems, with additional initiatives actively being developed in other jurisdictions to promote system-wide improvements and ensure equitable access to care.

<u>Pediatric Preventive Care</u>

Continue State-Mandated Performance Improvement Project (PIP) Focused on Early Well-Care in Black/African American Members in Solano County

The California Department of Healthcare Services (DHCS) assigned Partnership a Health Equity PIP focused on the Well Child Visit Birth-15 Months (W30-6) HEDIS® Measure for the 2023-2026 time period, based on not

meeting the Minimum Performance Level (MPL) of 50th percentile for the W30-6 measure in any Reporting Unit. Partnership and DHCS agreed to focus the PIP on African American rates of completion of the W30-6 measure. Partnership selected Solano County as the population of focus for this measure based on several factors. Solano County has the highest member population of any of Partnership's counties with a total of 141,387 members as of July 2023. Solano County's Black/African American population represents 17.5% of total members (24,757), the highest Black/African American population of any county served by Partnership. The HEDIS® denominator population represented in Solano County's 0-15 months' age for Black/African American members was 168 in 2022.

This PIP's initial intervention addressed delays in Medi-Cal enrollment, which have a significant impact on all families, including African American families, continuity of care with their chosen PCP and on Partnership's ability to capture all well-child visits in babies' first 15 months of life. Since the W30-6 HEDIS® measure is an administrative measure by NCQA's definition, Current Procedural Terminology (CPT) codes on claims are the only way for Partnership to count a well-child visit as completed. One barrier to success with the W30-6 HEDIS® measure is that most newborns are not enrolled in Medi-Cal until their second month of life and often later. Often times, Managed Care Plans (MCPs) have a difficult time linking a baby's Medi-Cal ID with data about their early care captured under Mom's Medi-Cal ID. This can also result in babies being auto assigned to a PCP that they have not been seeing up to that point, causing disruptions in care. The delays in Medi-Cal enrollment do not only cause undercounts for well child visits within the W30-6 HEDIS® measure but also have a disruptive impact on babies' healthcare throughout our provider network, and erode the relationship between the family, clinical team, and health plan.

During this fiscal year, Partnership formed the W15 Taskforce, a cross-departmental team charged with planning, implementing, and evaluating new initiatives aimed at increasing W15 rates among African American newborns in Solano County. On August 17th, 2024, the taskforce launched a six-week phone outreach pilot project in collaboration with NorthBay Health. NorthBay Health was identified as a key partner due to its unique position as the only labor and delivery hospital in Solano County currently serving Medi-Cal members.

Pilot Design:
The Phone Outreach Pilot Project focused on supporting birthing parents at NorthBay Health with newborn Medi-Cal enrollment, selection of their newborn's primary care provider (PCP), and coordination of early pediatric follow-up.

Upon discharge, NorthBay staff informed Partnership members that they would receive a call from PHC. Patients were told what the call would be about, the number the call would be coming from, and were given the Growing Together Program flyer. NorthBay then emailed Partnership a daily list of members that had been discharged from their Labor and Delivery unit. Partnership staff would then reach out to these members within 72 hours of discharge.

During these calls, Partnership staff covered five key areas:

1. Medi-Cal Enrollment - Inquired if the member completed a Medi-Cal Enrollment Form. If they had not, a form was sent to them.
2. Newborn PCP Selection - Completed a PCP selection form for the newborn. Forms are kept on file while we wait for the baby to be enrolled. The form collects mother's CIN to help us capture well baby visits occurring within the first 2 months of life.
3. Well Baby Visit Scheduling - Assisted moms with scheduling their next well baby visit.

4. Resources - Connected mother to resources as needed (e.g.: transportation to well-baby visit or postpartum visits)
5. Growing Together Program - Encouraged them to enroll in the Growing Together Program.

Pilot Results

- Total number of unique participants:126
    - 81% reach rate
    - 51.6% engagement rate (65 participants)
    - 48 newborn PCP selection forms
    - 55 families enrolled in the Growing Together Program.
- Number of African American Participants: 13
    - 76.92% reach rate
    - 38.46% engagement rate (5 participants)

Key Takeaways

- The warm handoffs by NorthBay staff at discharge played a critical role in establishing trust and improving participation rates.
- The PCP selection process not only supported immediate care coordination but also enhanced PHC's ability to track well-baby visits by linking maternal and newborn records—a common barrier to early pediatric care monitoring.
- Compared to a similar phone outreach campaign running concurrently (which achieved a 25.3% reach rate and a 14.9% engagement rate), the NorthBay pilot's results represent a significant improvement in both reach and engagement.

This pilot demonstrated that targeted, collaborative outreach in a centralized delivery setting—coupled with warm handoffs and structured follow-up—can meaningfully improve newborn enrollment, care coordination, and health program engagement among Medi-Cal families in Solano County. The insights from this pilot will directly inform scalable strategies for broader regional implementation. The taskforce continues to explore new solutions to help overcome barriers in completing timely well-child visits and measuring well-child visits completion.

Increase HPV Vaccine Completion Rates Through 2nd Dose Reminder Mailers

Human papillomavirus (HPV) vaccination is a critical public health measure that protects against several types of cancer, including cervical, oropharyngeal, and other genital cancers. Completing the HPV vaccine series is essential to ensuring long-term immunity and maximum effectiveness. However, national and regional data continue to show gaps in series completion rates.

To address this, the HPV 2nd Dose Reminder Pilot was developed to test a targeted strategy aimed at increasing completion of the HPV vaccination series. Reminder and recall strategies are widely recognized as best practices for improving adherence to vaccination schedules. Research demonstrates that these strategies, especially when automated, can increase HPV vaccination series completion by up to 15%. The Centers for Disease Control and Prevention (CDC), the American Cancer Society, and the National HPV Vaccination Roundtable all recommend integrating parent reminders into overall HPV vaccination plans, especially in managed care settings.

The HPV 2nd Dose Pilot Project identified children under age 13 who are due for their second dose of the HPV

vaccine and mailed a reminder notice to their homes to encourage timely completion. This three-month initiative aims to assess whether mailed reminders can improve HPV vaccine series completion rates.
The evaluation of this pilot project is scheduled for completion just before the close of FY24/25. We hope that the findings from this initiative will help inform broader efforts to close gaps in HPV vaccination and improve health outcomes across pediatric and adolescent populations.

Promote Pediatric Group Well-Care Visits Through Expanded Provider Incentive

Group Well-Care Visits is one (1) proven strategy to increase completion of these important pediatric preventative care services early in a child's life. Last year a new unit of service measure was approved and added to Partnership's PCP QIP to incentivize providers to conduct group well-visit cohorts in the 2024 calendar year, focusing on the 0-15-month old population.

To further support comprehensive well-child care, the UOS measure has been expanded from the 0–15-month period to 0–30 months of life. This extension allows us to capture the two additional well-care visits recommended between 15–30 months, helping ensure children receive all recommended pediatric preventative services through their second birthday. This incentive was approved and is currently part of the 2025 PCP QIP unit-of-service measure, as an expansion of the existing "Peer-Lead Group Visits" measure.

Pediatric and Family practices will continue to be incentivized $1,000 for each cohort of group well-care visits. Each group cohort must meet at least four (4) times across the 30-month timeframe and have at least 16 members in total attendance. The maximum number of cohorts (groups) per year for reimbursement remains at 15.

Develop a Plan-Wide Strategy for Well-Child Visits in the First 15 Months of Life (W15)

From the introduction of the Managed Care Plan (MCP) accountable measure for early baby well-care visits within the first 15 months of life (W15), Partnership has consistently under performed on this measure by approximately twenty percentage points from the Minimum Performance Level (MPL). Over the last several years, Partnership has undertaken many performance improvement efforts focused on completion of early well-baby visits.

While there have been many unique approaches for improving W15, Partnership recognized that the significant efforts were lacking a strategic vision for addressing the complexities that exist in W15 and decided to form a W15 Plan-Wide Strategy Committee. The purpose of this committee was to develop a concerted approach to understanding the current state and strategically planning for future improvement efforts.

The committee launched in October 2024 with a cross-functional stakeholder group including leadership from Population Health, Health Equity, Office of the CMO, Regional Operations Leadership, Quality Incentive Programs, Member Safety, Performance Improvement and Quality Measurement. The purpose of the committee was to develop and implement a guiding strategy for improving performance of well-baby visit across Partnership's service area:

- Link all improvement efforts and provide a more strategic and streamlined approach
- Ensure thoughtful investment of time and resources
- Raise awareness and increase engagement across all stakeholders, both internal and external

The committee developed the following framework for W15 improvement work across the organization:

- Strategy Objective (Multi-Year): Achieve significant annual plan-wide performance increases in W15, initially meeting minimum performance thresholds ,eading to achieving high performance.
- AIM for Calendar Year 2025: Increase Partnership Members' completion rate of 6 well-care visits for babies 0-15 months of age from baseline to goal by December 2025 in established 14-county service region and establish baseline performance in Partnership's new 10-county region in the East:

Geo 14 County	Baseline	Goal
Plan	**42.09**	**50.24**
NE	40.68	48.82
NW	45.26	51.82
SE	36.83	47.61
SW	46.28	52.33

- Pillars for Improvement:
  - Conduct Process and Operational Improvements (within Partnership's control)
  - Improve Encounter Data Capture of Early Well-Child Visits
  - Enhance Provider and Member Engagement and Education Around Early Well-Care Visits
  - Educate and Engage Partnership Staff, Leading to Meaningful Improvement, Plan-Wide
- Driver Diagram for Analysis of W15:
  - Brainstormed challenges and drivers for low performance
  - Centrally documented existing improvement efforts
  - Identified potential new improvement efforts

With a centralized, focused committee focusing on understanding the challenges and current efforts, a path has been established to better identify potential opportunities for improvement and determine the best path forward for success on this important preventative care activity for our most vulnerable population of babies!

Expand Promotion of Healthy Babies Growing Together Program to Provider Network to Increase W15 and CIS10 Rates

Member incentives are widely known as a best practice for improving patient appointment completion rates. Population Health's rebranding of the Growing Together Program (GTP) led to member incentives directly aligning with the CIS-10 and W30+6 MCAS Accountable measures. Improvement advisors, through their engagement with sites, recommended promotion of this program beyond the member population to the provider network.

In close partnership and collaboration with the Population Health team, improvement advisors began promoting the GTP through various modalities including provider coaching, Regional Quality meetings, Joint Leadership Initiative meetings, Improvement Academy Trainings, and leveraging the Provider Relations representatives to promote through site communication.

The impact on CIS-10 and W30+6 rates is pending as this activity will continue into the FY25/26 when the 2025 Measure Year has completed. Population Health is tracking member enrollment to include the referral source of enrollment which will be used during the activity evaluation.

Increase WCV Rates Among Special Populations through WCV Sprint Project

In late August 2024 DHCS notified plans of an opportunity to mitigate losses in Quality withhold dollars by closing disparities in the Child and Adolescent Well-Care Visits (WCV) measure for the top two disparate groups in each of the four legacy reporting regions. The disparities were based on MY2022 HEDIS data which included the White, African American or Black, American Indian/Alaskan Native, Asian, and Native Hawaiian/Other Pacific Islander populations. Plans had until the end of the 2024 measurement year to close these gaps to qualify for points toward the withhold.

Partnership's QI team developed multiple iterations of proposals based on the disparate populations while analyzing the data and seeking input from key provider partners. In October 2024 Partnership's executive team approved the final proposal which offered a $200 incentive for each member of the population who received a well visit and was billed correctly. The incentive was to be used in whatever means the provider saw fit if it contributed toward getting visits completed. Given the tight time and resource constraints, Partnership elected to include a cohort of nine (9) providers who collectively held roughly 42 percent of the target populations. Five (5) of the nine (9) providers agreed to participate in the project with the other four (4) declining for various reasons. Partnership also opted to not include the white population given the large volume of members and instead focused on the smaller populations.

Partnership created custom gap lists because providers could not leverage their existing QIP lists for several reasons: the WCV measure includes ages 3-21 while the QIP only includes 3-17, HEDIS rates include direct members while QIP only includes members assigned to the provider, etc. QI's analysts generated these gap lists which were shared with providers, and updates were distributed showing what claims Partnership had received so that providers could compare their encounter data with the administrative claims.

Upon completion of the project, only 48 of the 380 members in the five (5) participating provider cohort completed well visits before the end of the measurement year for a total incentive payout of $9,600. This is 2% of the 2,459-member cohort for the four reporting regions. Upon closure of the project Partnership surveyed providers to gather feedback on the project. Demographic data was a consistent issue for the providers. The state demographic data for members was less accurate than what providers had in their systems. The timeline was too short for practices to thoroughly plan and subsequently outreach members and complete visits. The end of year holidays also had an impact on both members and staffing. All participants showed commitment to closing disparities for their members and expressed interest in future incentive opportunities, but with the requirement that issues were resolved.

Seeing the desire for incentives to address disparities, Partnership has elected to continue the use of incentives by leveraging the QIP program that providers are accustomed to. Partnership has included a Reducing Healthcare Disparity optional measure in the 2025 PCP QIP. Providers are invited by the QIP team and must reply with their intent to participate in the measure. Those that apply will have a specific population of focus chosen by both the QIP team and Health Equity Officer. Providers will have until the end of the 2025 measurement year to close disparities for those populations to be eligible for up to a 7% enhancement of their total QIP earnings.

Improve Data Capture of Topical Fluoride Application by Conducting a Data Investigation

In the measurement year 2023 Partnership observed a shockingly low rate for fluoride application for the TFL measure, less than 1% across all reporting regions. Partnership solicited providers and dental practices who all said that fluoride was consistently being applied when patients were seeking dental care. Open Door Community Health Centers provided a claims report showing claims were in fact being sent to Denti-Cal for Partnership members with

the fluoride varnish procedure code. When reviewing Partnership's DHCS dental claims data the majority of these claims were visible but there was no record of fluoride application. This was reviewed with DHCS and its data team and it was discovered that DHCS cannot receive the procedure codes for FQHCs, RHCs, and IHS providers. The solution offered was to use a Z29.3 diagnosis code which the state can ingest and share with plans

This prompted Partnership to launch a multi-pronged messaging campaign to providers. Partnership outreached the providers through various channels such as provider operations meetings, regional quality meetings, regional medical director forums, emails, coaching calls, and fax blasts. Following the messaging campaign, QI coaches followed up with practices during coaching calls to see if the codes had been implemented. Some providers had implemented the codes and had no issues while others had reported challenges. Coaches have worked with these practices to try and find solutions and have also leveraged Partnership's new Dental Liaison to assist. As of May, Partnership has started receiving claims with the Z29.3 code from providers who were quick to implement the code into their processes. Partnership will continue to monitor claims and work with practices who have not implemented the code.

Facilitate Educational Webinar for Providers Regarding Developmental Screening in Children

On April 3rd, Partnership HealthPlan hosted a well-attended and informative webinar on **Developmental Screening in** Children, drawing 55 participants from a variety of roles including clinicians, practice managers, and quality improvement (QI) teams. The session provided essential education on the importance of developmental screening in early childhood and practical guidance for implementation in clinical settings.

Developmental screening is a critical component of pediatric care, enabling early identification of developmental delays and allowing for timely intervention. By using standardized tools, providers can better support a child's long-term health and developmental outcomes. Early detection and intervention are key to promoting optimal growth and reducing the impact of potential developmental challenges.
The webinar focused on two main areas:

- Overview of Developmental Screening Tools: Presenters reviewed screening tools that align with guidelines established by the American Academy of Pediatrics (AAP) and the Centers for Medicare and Medicaid Services (CMS), ensuring providers can confidently select appropriate and validated instruments.
- Billing Guidelines: Attendees also received a practical review of billing codes and processes to support accurate and efficient claim submissions for developmental screening services.

Despite the importance of developmental screening, the plan-wide screening rate decreased from 30.03% in 2023 to 29.36% in 2024, highlighting the continued need for provider engagement and support in improving screening rates.

Participant feedback was overwhelmingly positive:

- 100% of respondents strongly agreed the topics were relevant and useful.
- 100% strongly agreed the content was clearly communicated by the presenters.
- 90% rated the educational session as excellent; 10% rated it as good.
- 100% strongly agreed they could now identify at least one AAP-approved developmental screening tool.
- 90% strongly agreed—and 10% agreed—that they could identify appropriate billing codes for developmental screenings.

This session reinforced the value of developmental screening and provided actionable knowledge to improve screening practices across pediatric and family care settings.

Women's Health and Perinatal Care

The Women's Health and Perinatal Quality Measure Score Improvement workgroup began the year analyzing the MY2023 HEDIS® performance for the 8 measures that are assigned to the group: Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening, Timeliness of Prenatal Care, Postpartum Care, Prenatal Depression Screening, Postpartum Depression Screening, and Prenatal Immunization Status. The group looked at the change from the previous year and compared the performance in each sub region to the benchmarks set by NCQA. This analysis led the group to prioritize work on the following measures: Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening, Timeliness of Prenatal Care, Postpartum Care, and Prenatal Immunization Status.

Breast Cancer Screening

In MY2024 The NCQA's Quality Compass Medicaid 50th percentile rate (52.6%) for Breast Cancer Screening was met in Partnership's Southeast and Southwest region. Partnership's Northeast and Northwest region did not meet the NCQA's Quality Compass Medicaid 50th percentile rate. Activities to improve this measure in the past year included Mobile Mammography events and sponsorships, a new measure in the Hospital Quality Incentive Program, and a new monitoring measure in the Primary Care Provider Quality Incentive Program.

Partnership's Mobile Mammography program continued as a strategy to increase Breast Cancer Screening performance. Partnership collaborates with Alinea Medical Imaging and providers to host Mobile Mammography events, helping members complete preventive screenings at their primary care provider sites. Partnership supports the event days with event coordination support on behalf of the Mobile Mammography Program Management Team, event attendance by our Population Health Team, and support from the Performance Improvement team. The goals for this year included: scheduling 60 event days and completing 1500 screenings, focusing engagement efforts on Tribal Health Centers and providers in the Modified primary care provider quality incentive program, and piloting innovative strategies to engage Tribal Health Center patients. In MY24/25 the program completed 77 mobile mammography event days resulting in 2,162 completed screenings. Mobile Mammography events were held at seven Tribal Health Centers, and Partnership led talking circles on screening importance at three Tribal Health Center's Mobile Mammography events.

The Hospital Quality Incentive Program (HQIP) added the 'Increasing Screening Mammogram Capacity' measure to the clinical quality domain for MY24/25. Hospitals were incentivized to increase breast cancer screening access/capacity for Partnership members by at least 5% for partial points and 10% for full points. Data to evaluate the effectiveness of this measure is not yet available and will be analyzed once finalized.

Breast Cancer Screening remains an incentivized quality measure in the Primary Care Provider Quality Incentive Program (PCP QIP) under the clinical domain for ages 50-74 years in MY2024 and MY2025. In MY2025 PCP QIP has added Breast Cancer Screening with an age group of 40-51 years as a monitoring measure. The Monitoring measurement set does not have any points assigned and is intended to provide visibility into performance and access to the member gap-in-care list throughout the measurement year.

Cervical Cancer Screening

In MY2024 The NCQA's Quality Compass Medicaid 50th percentile rate (57.11%) for Cervical Cancer Screening (CCS) was met in Partnership's Southeast, Southwest, and Northwest regions. Partnership's Northeast and region did not meet the NCQA's Quality Compass Medicaid 50th percentile rate. Activities to improve this measure in the past year included conducting an hrHPV Self Swab Pilot, integration of the FDA approved hrHPV self-swab for cervical cancer screening, and continued measure inclusion in the PCP QIP.

A Cervical Cancer self-swab pilot launched in January 2024 with five strategically selected primary care clinics in all four sub-regions of different sizes. The pilot's scale was 200 kits across the five sites. The objective of the pilot is to develop lessons learned and workflows for allowing patients to collect their own cervical cancer screening swabs in conjunction with clinic staff. The criteria for patient inclusion: a current Partnership member, at least 30 years old, and have declined a clinician collected CCS in the past. The self-swab test environments included a normal office visit (55%), mobile mammography event (3%), and field/street medicine (42%). The pilot was called to a close September 2024.

The most common barrier to using the test kits reported by the clinics is the process to register the self-swab kit for testing using a vendor. While some patients are still reluctant to be screened, the pilot showed patients and providers are ready for this option. Learnings from the pilot continue to be shared in provider education.

In May 2024, the U.S. Food and Drug Administration approved two HPV self-collect vaginal tests for cervical cancer screening. In March 2025 Quest and LabCorp launched the Roche Molecular Systems, Inc Cobas HPV test for self-collection with a new CPTII code 87626. Instructions on how to complete the self-swab were developed. In the March 2025 release of HEDIS MY 2025 Value Set Directory CPT code 87626 was included in the High-Risk HPV Lab Test Value Set. In May 2025, the CPT code was added to the CCS code set in eReports. We worked closely with Quest and LabCorp to facilitate integration of the self-swab in our network. An HPV Self-Swab Webinar was held April 1, 2025, with 100+ attendees and the webinar is available on Partnership's website. Information on the self-swab has been shared across the network at Medical Directors Forums, Regional Meetings, Newsletters, 1-on-1 provider education sessions, and during community partner engagements with Aliados Health in Napa, Sonoma, Yolo, and Solano counties, and at Napa's sexual and reproductive health coalition.

Cervical Cancer Screening remains an incentivized quality measure in the Primary Care Provider Quality Incentive Program under the clinical domain for ages 21-64 years in MY2024 and MY2025.

Chlamydia Screening

In MY2024 The NCQA's Quality Compass Medicaid 50th percentile rate (56.04%) for Chlamydia Screening was met in Partnership's Southeast and Southwest regions. Partnership's Northeast and Northwest region did not meet the NCQA's Quality Compass Medicaid 50th percentile rate. Activities to improve this measure in the past year included data analysis, measure inclusion in the Primary Care Provider Quality Incentive Program, CHL Provider education, and development of Measure Best Practices.

In MY2025 Primary Care Provider Quality Incentive Program added Chlamydia Screening (CHL) as an incentivized quality measure under the pediatric practice clinical domain for ages 16-20 years. In MY2025 PCP QIP also added Chlamydia Screening as a monitoring measure for family medicine (ages 16-24 years) and internal

medicine (ages 21-24 years). The Monitoring measurement set does not have any points assigned and is intended to provide visibility into performance and access to the member gap-in-care list throughout the measurement year.

CHL Provider Education An analysis of MY2023 HEDIS region rates and county rates was completed to identify parent organizations and practice sites with CHL rates below the 50th MPL. Practices were selected based on this criteria and PCP QIP participation with over 100 members in the MY2025 PCP QIP denominator. High CDPH reported county CHL incidence rates among females was also factored in. 8 practices were identified for targeted provider training. Outreach to sites begun April 2025. Goal is to provide training to 3 practices and engage 1 in a pilot project. Training sessions have been completed with Ampla Health, and Shasta Community Health is in the planning stages for a CHL pilot.

Prenatal and Postpartum Care:
(Timeliness of Prenatal Care, Postpartum Care, Prenatal Immunization Status)

In MY2024 The NCQA's Quality Compass Medicaid 90th percentile rate (91.07%) for Timeliness of Prenatal Care was met in Partnership's Southwest region. NCQA's Quality Compass Medicaid 50th percentile rate (84.23%) was met in Partnership's Northeast and Southeast regions. Partnership's Northwest region did not meet the NCQA's Quality Compass Medicaid 50th percentile rate. In MY2024 The NCQA's Quality Compass Medicaid 90th percentile rate (84.59%) for Postpartum Care was met in Partnership's Southeast and Southwest region. NCQA's Quality Compass Medicaid 50th percentile rate (78.1%) was met in Partnership's Northeast and Northwest regions. Activities to improve perinatal measures in the past year included Tribal Perinatal Program, Provider Education and Engagement, Perinatal Growing Together Program, Perinatal Provider Quality Incentive Program, Population Health activities, Community Health Assessments/Community Health Improvement Plans, dashboard enhancements from Health Analytics, and the Solano Perinatal Clinical Collaborative.

Partnership's pay-for-performance Perinatal Quality Improvement Program (PQIP) summary of measures for MY24/25 includes: (1) Prenatal Immunization status (TDaP and Influenza Vaccinations), (2) Timely Prenatal Care, (3) Timely Postpartum Care, (4) Prenatal Care-Depression Screening at First Prenatal Visit and (5) Electronic Clinical Data System (ECDS) use. The financial incentives: $100 for Timely Prenatal Care, $50.00 for receiving TDaP and Influenza vaccines, $25 for Depression Screening, and $25 for the 1st postpartum visit and $50 for the 2nd visit. In MY24/25 PQIP had 32 parent organizations encompassing 70 clinics, across 18 of 24 Partnership counties actively participate in the program. PQIP reached more members with perinatal services this year than any other year due to adding seven new providers through our Eastern County Expansion. Evaluating provider performance year-over-year shows and increase in average incentive dollars earned per site.

Tribal Perinatal Program (TPP) aims to improve perinatal health outcomes among California Indian community through a comprehensive approach encompassing training, curriculum development, evaluation, and continuous improvement initiatives. The project scope: Training program development, Curriculum customization, Evaluation framework establishment, Healthcare system education and sensitization education and activities, Pre-conception care optimization, Perinatal support enhancement, Prenatal medical care access improvement. TPP started in April 2024 and has 6 Tribal Health Centers enrolled across 3 cohorts. Core curriculum trainings include: Family Spirit Program, Mental Health First Aid, Motivational Interviewing, and Trauma Informed Care. TPP has also developed a TPP newsletter and resources for members covering various health and perinatal topics. This program addresses disparities identified in prenatal care and postpartum care for American Indian/Alaskan Native members.

The Perinatal Growing Together Program (Perinatal GTP) aims to improve early access to prenatal care and completion of a timely T-dap immunization between 27 weeks and delivery, improve regular post-partum care and complete 2 post-partum visits prior to 84 days following delivery, complete a flu shot if appropriate, and improve well-baby care. Population Health will achieve this goal by encouraging birthing individuals to attend recommended scheduled visits and complete required immunizations. Programmatic goals include improving birth outcomes, reducing maternal/infant complications, and promoting the overall medical, behavioral health, and health habits of parents/guardians/authorized representatives and their babies. In FY24/25 the Perinatal GTP made 23,234 contacts across both the Prenatal and Postpartum Growing Together Program campaigns, outreaching to 12,117 unique members. Of the 4,144 unique members outreached for the Prenatal program, 60.4% agreed to participate. Of the 7,973 outreached for the Postpartum program, 58.5% agreed to participate. Note that the data is present as of May 27, 2025, since at the time of this summary, the fiscal year is still in progress. In addition, The Population Health team conducted a W15 Pilot Project in the fall of 2024 with North Bay Health where staff connected with new parents, asking about the birthing member's experience with their provider, birthing experience, and if they were connected to postpartum appointments. These members were seamlessly transitioned into the GTP Postpartum program for targeted conversations post-birth.

Population Health participates in face-to-face member engagement including attending mobile mammography events, community baby showers, and the Partnership Maternal Photo Shoot. Over the 24/25 fiscal year, Population Health attended a total of 188 events; 59 of those were mobile mammography events and 13 were community events specific to women's health, breastfeeding, or maternal health. The Population Health and Health Equity teams partnered together to host a Maternal Photo Shoot for African American and Hispanic members in December 2024 and May 2025. The event showcased local community partners such as Doula Doula, WIC, Solano HEALS, Partnership staff, and more. This project was the result of a health disparities analysis that informed the organization of disparities among African American/Black and Hispanic pregnant and postpartum members. These events aim to empower mothers and birthing individuals while addressing maternal health disparities in Solano County through meaningful engagement, providing community resources, health education, and support for workforce development.

Healthy Living Coaches within the Population Health team attend multiple counties' Breastfeeding Coalitions, Perinatal Service Coalitions, and Maternal and Child Adolescent Health Advisory Board meetings. At these meetings, they connect with the community, learn about challenges or barriers, as well as educate and share information regarding Partnership and Population Health's perinatal offerings.

Provider Education and Engagement Informational materials have been developed in collaboration with Population Health related to women's health and perinatal health: Doula Services flyer, breast pump guide, WIC resources for GTP, cervical cancer self-swab screening instructions, and presentations with information about Perinatal GTP for the Fostering Connections series and Doula education series. Webinars and Presentations included: Improving Measure Outcomes-Perinatal Care and CHL screening, Raising Quality and Improving Outcomes in Women's Health and Perinatal Care for PQIP Participating Providers, Doula Pathway Webinar, Medical Director Forums, Regional Meetings, Partnership Health Perinatal Services Webinar, and the Perinatal Symposium. Presentations with and without continuing education credits were offered to practices throughout FY24/25. The intended audience for the educational opportunities were practices that provide perinatal women's health services. Recruitment for this education focused on practices who had either not participated in a prior year's training or those who expressed an interest in this education event. The objective was to educate providers about the PQIP and PCP QIP measures and Partnership resources to support members and practices in accessing the Partnership perinatal resources.

Community Health Needs Liaisons within the Population Health department work with all 24 counties to discuss their Community Health Assessments/Community Health Improvement Plans (CHA CHIP), shared SMART goals, and formulate objectives. A goal in Modoc County is to increase access to early entry into prenatal care for Modoc residents, to include Native American residents. Activities towards this goal started August 2024 and include providing transportation education to members via flyer distribution at provider offices and social media posts, and Partnership's Growing Together Program. January 2025 pilot planning began with activities to enhance member education around the necessity of early prenatal care through media outreach campaigns (social media, flyers, Modoc Public Health's provider newsletter, Partnership's provider and member newsletter) and Modoc's home visiting programs or partnering agencies that work with perinatal population. Charter approval was received in May 2025, and the pilot will begin July 2025 with a run time of one year.

The Health Analytics team continued to support initiatives by enhancing existing data reports and developing new recurring reports that provide insights into utilization patterns, enabling targeted outreach and quality improvement efforts. Additions made to the Tableau Maternal Health Dashboard this year included: updates to the Deliveries dataset with a Doula Flag and ECM flag, addition of a Doula Tab and ECM Tab to existing pages, and the creation of a new Doula Services Dataset. As a part of our Health Equity work the Health Analytics team created weekly reporting of currently pregnant and recently delivered Alaskan Native/American Indian members with complicated pregnancies with referrals to care coordination.

The Solano Perinatal Clinical Collaborative continues for FY24/25. The collaborative focuses on addressing health disparities in prenatal care for African Americans in Solano County. They have identified operational and communication barriers that were impeding access. They developed better systems of care across organizations and improved the standards and methods of patient related and professional communication. Meeting every 8 weeks with Partnership Medical Director attending.

Elder Care

In anticipation of the new Dual Special Needs Plans (D-SNP) launch, a new Elder Care QMSI workgroup was formed in early 2025 to proactively educate staff on quality measures in order to anticipate potential improvement efforts needed in upcoming years.

Workgroup participants were identified in January 2025 and monthly workgroup meetings initiated in March 2025. Workgroup meetings were conducted monthly through June 2025 and comprised of the following:

- Workgroup participant expectations and commitments
- Workgroup purpose:
    - Mission: To promote improvement efforts for measures related specifically to the care of older adults
    - Establish workgroup priorities and measure focus
    - Identify and execute new improvement interventions
- 2025 Timeline – Areas of Focus:
    - D-SNP measure education (April – May)
    - Data review (June)
    - Existing interventions and repository development (planned July)

- Measure prioritization (planned August-September)
- CY 2026 goal development and planning for new improvement work (planned October-December)

New Dashboards in Development

During FY2024-25, the Missed Opportunities and Member Engagement dashboards were prepared for final development and deployment in the production environment. Resources needed to complete the deployment were reassigned to finish out the HealthRules Payor (HRP) deployment. After go-live of HRP, the system is expected to go through a period of stabilization, after which resources will be reassessed, reprioritized, and redeployed. This may result in continuation of work on these two dashboards in FY2025-26.

Quality Improvement Coaching

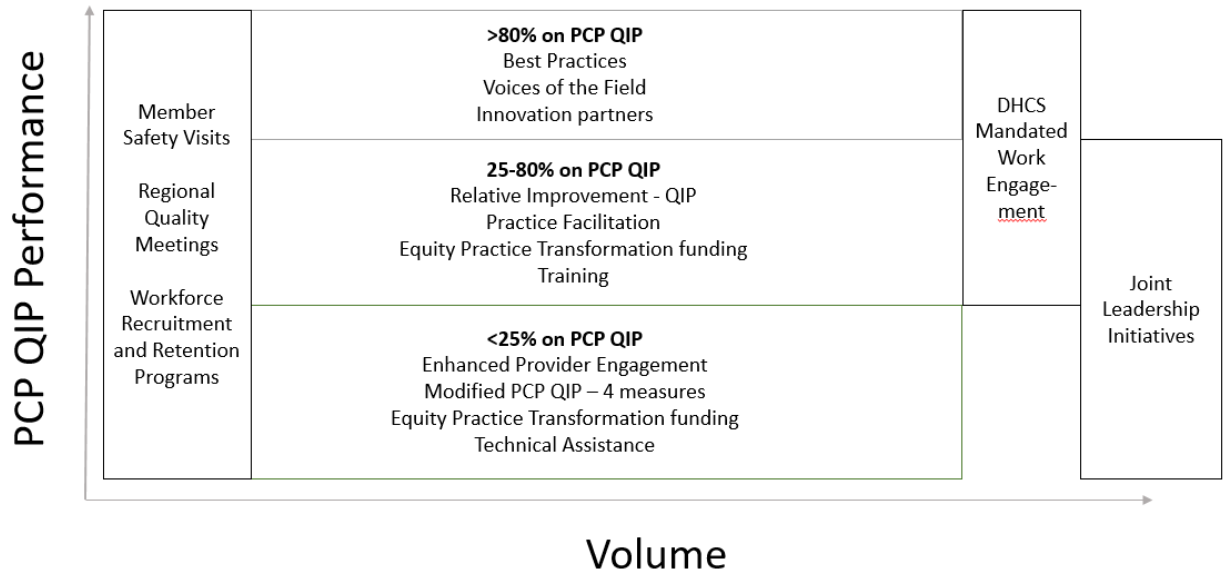
Partnership uses a practice's Primary Care Provider Quality Incentive Program (PCP QIP) scores on clinical measures as a proxy for assessing the strength of a practice's quality program. Each practice is assigned into one (1) of three (3) tiers based on their PCP QIP performance in the previous year, and each tier is associated with coaching and collaborative programs meant to maximize the capacity of the practice for success with the PCP QIP.

The diagram below visualizes the three (3) tiers of PCP practices based on past PCP QIP performance, and the coaching and collaboration programs associated with each tier.

The three (3) PCP practice tiers are:

1. Highest tier: Scoring over 80% of clinical points on previous year's PCP QIP
2. Middle tier: Scoring between 25-80% of clinical points on previous year's PCP QIP
3. Lowest tier: Scoring under 25% of clinical points on previous year's PCP QIP

PCP Practice tiers based on PCP QIP scores, and associated coaching/collaboration programs



In January 2024, Partnership expanded into ten (10) additional counties. Primary care providers in those ten (10) counties participated in the PCP QIP for the first time. For the purposes of this evaluation, coaching with these providers will be discussed separately from the ongoing efforts in our legacy counties. See the **"Expansion Region Coaching"** for an evaluation of that project.

Enhanced Provider Engagement and Modified PCP QIP

Enhanced Provider Engagement (EPE) and Modified PCP QIP are two (2) programs centered around Provider Organizations (PO) who are in the Low Performing Tier. These PO's often have significant infrastructure and workforce challenges and are more likely to be located in rural or frontier areas with inadequate health system infrastructure, and to be serving communities who have historically had less access to healthcare resources. Practices in the Low Performing tier are more likely to have higher rates of leadership and workforce turnover, and a lack of dedicated quality resources and structures. Tribal health organizations are overrepresented in this tier, partially because these health centers center their quality work around the Government Performance and Results Act (GPRA), a quality measure set that is not fully aligned with Partnership's QIP.

In 2023, Partnership launched two (2) new tactics to improve the performance of POs who scored less than 25% of possible clinical points in the previous year's PCP QIP:

Enhanced Provider Engagement (EPE): Recognizing that practices who fall into the Low Performing Tier of the QIP often have significant core challenges with infrastructure, leadership, and funding, the EPE coaching methodology centers around the Building Blocks from UCSF's Center for Excellence in Primary Care. The EPE coaching program focuses on interventions that will impact core areas of a practice such as leadership engagement, use of data systems, empanelment, and clinical team formation.

Enhanced Provider Engagement consists of several stages:

- Completion of a Needs Assessment tool and corresponding Supplemental Survey
- Partnership summary and recommendation for impactful quality interventions, based on Needs Assessment and Supplemental Survey
- Coaching with planning and implementation of interventions designed to impact core quality improvement capacity and measure performance

Modified PCP QIP for Low Performing Providers: Partnership developed and implemented consequences for Primary Care Provider Organizations with persistent low performance in Partnership's PCP QIP. Provider Organizations who are assigned more than 1,000 Partnership members and who earned less than 25% of their clinical points for the previous year's PCP QIP are assigned the Modified QIP. The Modified QIP assignment includes several requirements for Provider Organizations qualifying, including:

- Reduction of QIP clinical domain measure set from 11 to 4 measures
- Required Executive meeting with PO's Board
- Required participation in Enhanced Provider Engagement coaching with PI Team
- Demonstrated improvement in QIP measures to 50% or more of clinical measure points to return to fill QIP measure set by next MY

2024 EPE and Modified QIP Goals:

- 80% participation by POs assigned EPE and Modified QIP
- Coach two high-volume practices in each region and conduct at least one intervention in a measure of focus

2024 EPE and Modified QIP Outcomes: Partnership assigned 14 Provider Organizations to Enhanced Provider Engagement and Modified QIP. Seven (7) of the Parent Organizations continued from last year because they did not earn at least 50% of their clinical points in the QIP which was the graduation criteria. The 2024 cohort had the following outcomes:

81% of POs assigned EPE and Modified QIP engaged with Partnership and completed at least one (1) of the program activities – GOAL ACHIEVED

- 71% of the new POs completed a Needs Assessment
- 100% of POs also participated in coaching activities around opportunities identified by their Needs Assessment
- 43% of POs had a Partnership executive or senior leader present on Partnership's quality program to their Board

POs improved their 2023 PCP QIP scores by an average of 7.29%.

- Providers participating in EPE had an average increase in points earned year-over-year of 7.29% compared to non-EPE providers improvement in Partnership's legacy counties of 2.57%
- Five (5) out of 12 POs earned fewer points than the previous year.

The PI Team continued the EPE and Modified QIP Team in 2025, although it was decided to include POs who scored less than 33% (vs. 25%) of possible clinical points in the previous year's PCP QIP. The 2025 Modified QIP cohort consists of:

- Two (2) POs graduating from the program
- Ten (10) POs continuing the program
- Three (3) POs entering the program
- Two (2) POs exited the program due to membership falling below the required thresholds
- Two (2) POs graduated from their CAP and returned to the program

Expansion Region Coaching

Partnership expanded into ten (10) additional counties beginning January 1, 2024. Between July 1, 2024, and June 30th 2025 performance improvement efforts focused on prioritizing large provider organizations who were most receptive to and could benefit most from improvement coaching. During this time period, an organizational restructuring established a dedicated Performance Improvement team, including a manager and three Improvement Advisors, to focus exclusively on nine (9) of the ten (10) expansion counties. The tenth county was integrated into an already established performance improvement region with other legacy counties.

Of the 220,300 members in incoming counties with a PCP assignment, Improvement Advisors successfully engaged with practices holding 154,150 members (70% of assigned members). Initial outreach was conducted with nine (9) practices in these counties; eight (8) practices were elected to participate in regular coaching sessions in 2024

(though some struggled to establish a regular coaching cadence). An additional three (3) practices, while not participating in regular coaching, engaged through the Equity Practice Transformation (EPT) program, which included Learning Community sessions around QI methodologies and best practices. This participation brought them into regular contact with QI team members.

By the end of the reporting period, coaching is ongoing with ten (10) of the original twelve (12) mentioned previously. The PI Manager has regular touchpoints, with the two other practices to offer assistance and resources as they become available. Initial touchpoints were made with an additional five (5) previously unengaged providers representing an additional 15,197 members during the first five (5) months of 2025. Three more practices began regular coaching in 2025 representing an additional 5,800 members.

In Tehama County specifically, the one expansion county assigned to a separate regional performance improvement team, there are 22,260 members assigned to a primary care provider. Improvement coaching is ongoing with six (6) providers in Tehama County and many providers outside of Tehama County that represent over 75 percent of the Tehama County members assigned to a primary care provider.

Final PCP QIP data for measurement year 2024 showed that approximately 41% of members in the nine (9) eastern expansion counties were assigned to one of six (6) providers earning at least 50% (or more) of their total PCP QIP points. Conversely, thirty-three percent (33%) of members were assigned to 17 provider organizations that earned less than twenty-five (25%) of their total PCP QIP points. The highest performance achieved in this region was 67.85 percent of total available points. (See the table below for full results in this region.)

Performance Category	Number of Providers*	Percent of Members assigned to a Provider in this Performance Category
Earned 50% or more PCP-QIP points	6	41
Earned between 26 and 49.9% of PCP-QIP Points	16	26
Earned 25% or below of total PCP-QIP Points	17	33

* Represents provider organizations except for two (2) Adventist Health sites

Based on established criteria of the modified QIP, twelve (12) provider organizations from these nine (9) counties would have been added to the modified QIP program. Many factors led to the decision to not have expansion county providers enter the modified QIP for 2025. As of June, 2025, the performance improvement team has two new Improvement Advisors adding necessary resources to support the full network in these nine (9) counties. Outreach and engagement of all practices will continue to be the primary focus for the performance improvement team in the expansion region. These practices will continue to see improvement with robust support from the performance improvement team and Partnership's portfolio of supportive resources.

Equity and Practice Transformation (EPT) Program

In January 2024, the Department of Healthcare Services (DHCS) launched the Equity and Practice Transformation (EPT) Program, as a state-wide initiative focused on advancing health equity while reducing COVID-19 driven care disparities. Partnership leveraged this funding opportunity to prioritize organizations with the greatest need for infrastructure and capacity-building support. The EPT funding is divided between three (3) programs; the Initial Planning Incentives Payments (IPIP), the Provider Directed Payment Program (PDPP), and the Statewide Learning Collaborative (SLC).

Initial Planning Incentive Payments (IPIP)

Through the IPIP, Partnership awarded $10,000 to 23 qualifying provider organizations, primarily geared toward small and medium-sized independent practices, to support their PDPP planning and application process. Ten of these provider organizations were already engaged under Partnership's Enhanced Provider Engagement (EPE) strategy in 2023. The remaining $1.2 million IPIP funds have been allocated to two strategic initiatives; updating outdated Electronic Health Record Systems (led by the QI Project Management Team) and the development and implementation of a Primary Care Physician (PCP) Leadership Training Program, (led by the Work Force Development Team). .

Provider Directed Payment Program (PDPP)

A total of 56 provider organizations applied to participate in the PDPP under Partnership. Of those, 27 were invited by DHCS to participate, giving Partnership the third-highest acceptance rate among managed care plans (49%, compared to a statewide average of 29%). These providers span across all Partnership's regions and include five (5) provider organizations contracted with Partnership through the 2024 10-county expansion, eight (8) tribal health centers, and seven (7) provider organizations already engaged through Partnership's EPE program.

Based on the updated funding criteria, there is a possible draw-down of $13M for Partnership's contracted provider organizations upon meeting the practice transformation activities over the program's three-year (3) timeline (January 1, 2024 – December 31, 2026).

All 27 practices successfully submitted their first deliverable, the Year 1 PhmCAT in May 2024. The Year 1 PhmCAT is a practice self-assessment tool designed to help sites reflect on their current performance across key quality domains, identify strengths and gaps, and set priorities for improvement. Completion rates in subsequent cycles, have declined.

Of the 198 practices participating statewide, 85% (169) practices met the criteria for at least one of the five (5) milestone deliverables focused on building empanelment, access, and cycles governance. In comparison, 92% (25) of Partnership's 27 practices met the criteria for at least one of the milestone deliverables. As of June 2025, 78% (21) of Partnership's practices met the criteria for at least one of the May 2025 deliverables, which focused on data implementation, stratifying their assigned HEDIS-like measures based on their population of focus, and completing a second Population Health Management Capabilities Assessment Tool (PhmCAT) to track their foundational progress from the year prior.

Statewide data for recent submission periods is still pending, so it remains unclear whether the decline in submission rates reflects a broader trend. However, several practices have reported challenges in sustaining participation, citing limited staffing, organizational transitions, and shifting internal priorities. In response, Partnership's QI Program

Management and Performance Improvement teams met with these practices to better understand their needs and encourage their continued participation. These conversations revealed that many practices were already actively implementing transformation activities but struggled with translating and aligning their data and responses to complete the milestone deliverables. Partnerships coaching support helped bridge this gap and promote continued engagement.

Statewide Learning Collaborative (SLC)

The Statewide Learning Collaborative (SLC) is designed to support the PDPP awardees in implementing transformation goals, sharing and spread of best practices, practice coaching activities, and achieving the quality and equity goals outlined in their PDPP applications. Participation in the SLC is mandatory for all PDPP participants.

The Population Health Learning Center (PHLC) is facilitating the Technical Assistance strategy within the SLC for practices. They launched three (3) forms of Technical Assistance:

- PopHealth + eLearning curriculum – An eLearning platform with short (10-15) minute training videos and resources available to all practices.
- Peer Learning Cohorts – Practices are grouped into two cohorts (health centers, tribal health and public hospitals in one and private practices in the other) based on region, and size to encourage peer-to-peer learning and application of the curriculum.
- Coaching Pool – This optional offering provides tailored coaching to support implementation of the EPT curriculum. Unlike the common curriculum and the peer learning components, the Coaching Pool is optional and is not funded by DHCS. Practices may purchase a coaching package using their own funds, directed payment dollars, or financial support from their sponsored managed care plan.

In lieu of PHLC's coaching pool, Partnership has a team of coaches dedicated to EPT awardees and may draw on outside experts for specific transformation topics as needed. The success of participating practices is dependent on the collaboration between Managed Care Plans (including Partnership's QI Performance Improvement team, who act as their dedicated coaches and the organization and management from the Program Management team), the guidance and open communication from PHLC and DHCS, and how engaged a practice is with the Technical Assistance activities and the rate of completing EPT milestone deliverables. Through our coaching efforts, we have seen firsthand how aligned support from all parties can drive meaningful practice transformation. Partnership anticipates more data and trends will emerge as the program matures.

Practice Facilitation and Provider Coaching

Practice Facilitation centers around POs who are in the Mid Performing Tier. These POs have demonstrated engagement and some success with the QIP but have opportunities to improve their performance on clinical measures.

Practice Facilitation uses the Institute for Healthcare Improvement's (IHI) Model for Improvement framework to build capacity for provider organizations to implement impactful interventions via Plan-Do-Study-Act (PDSA) cycles and other tools and promote a culture of quality throughout the provider organizations. Improvement Advisors serve as Practice Facilitation Coaches, and their role includes the following duties:

- Provide guidance on QI Project Team make-up and management
- Work with practice's leadership team on QI infrastructure development

- Provide consultative support and tools for project management of QI projects
- Train and support application of the Model for Improvement methodology. Enable workgroup members to implement changes by providing tools, guiding them through rapid-cycle tests of change, and assisting when obstacles are identified
- Provide best practice change ideas and build capacity for brainstorming
- Build capacity for collection and use of measurement data, assess the effectiveness of changes made
- Support change management aspects of QI projects

In 2024, two (2) provider organizations participated in Practice Facilitation, consisting of one (1) provider in the Southwest Region, and one (1) in the Southeast Region. Each provider organization met with a Practice Facilitator at least once a month, including site-specific QI Team members as well as QI leadership. Multiple provider included team members such as clinicians and clinical support team members in their Practice Facilitation team structure. Providers selected at least one (1) PCP QIP measure to focus on throughout the calendar year.

2025 Engagement in Practice Facilitation

In 2025, there were several changes in the POs participating in Practice Facilitation:

- The remaining Southeast Region PO is now in the Modified QIP and is focusing on the four (4) measures of focus.
- The Southwest PO that was working with an Improvement Advisor for Practice Facilitation in 2024, no longer needed this level of coaching, however, remains engaged with their coach in an advising capacity.

Outcomes for the Practice Facilitation program in 2024:

Considering vast improvements that were made to the 2024 HEDIS reported rates for both W30 and CIS measures using supplemental data submissions and lack of practice engagement in the Practice Facilitation structure through 2023 and 2024, the PI Team recommended abandoning the Practice Facilitation program as a stand-alone form of coaching going forward. The structure of Practice Facilitation can be used for any practice who would benefit from additional training and support using the IHI model for improvement. Thus, coaches will use their relationship and individual judgement to employ Practice Facilitations strategies with any practice identified as needing this level of support.

Joint Leadership Initiative

In 2019 the Joint Leadership Initiative (JLI) was implemented in an effort to increase executive level engagement with large, contracted provider organizations that have significant room for improvement on quality metrics.

In FY 2024-2025 the following provider organizations participated in the JLI: Adventist Health, Mendocino Community Health Center, Fairchild Medical Center, Shasta Community Health Centers, Solano County Family Health Services, Oroville Hospital, Wellspace Health, Ampla Health, and Western Sierra Medical Center. Communicare+Ole and Open Door Community Health Center both graduated out of the JLI program due to high performance in 2024. Collectively these organizations are responsible for the care of approximately 209,486 Partnership members, which is about 23% of the health plan's membership as of December 2024. the JLI aimed to provide mutual benefits for these organizations and Partnership, including:

- Significant improvement of quality scores for Partnership
- Maximization of QIP dollars, giving significant additional resources to the organizations

- Improved performance, leading to significant improvement in quality outcomes for members/patients

The FY 2024-2025 QI Work Plan goals for this initiative included:

- Meeting with participating providers in accordance with the tier frequency identified in the prior year, which ranged from a single annual check-in for high performers and up to quarterly meetings for lower performers.
- Transferring responsibility for JLI meetings from Improvement Advisors to Performance Improvement Managers to better align to updated regional structures within Partnership. PI Managers have better visibility to regional activities across their territories.
- Engaging new JLI partners in the expansion counties following their first QIP measurement year.

Overall, the JLI meetings have been well received and have helped improve the relationships with the provider entities. Feedback from participants has also cited that the meetings have allowed focused time to discuss quality issues and provided a platform to discuss provider concerns. When evaluating 2024 QIP performance of JLI providers, it was determined that JLI providers earned 63.90% of possible QIP points on average, which is 5% higher than the non-JLI provider average of 58.90%. When reviewing year-over-year data comparing 2023 and 2024 QIP data, JLI providers increased 2.62% year-over-year compared to non-JLI providers in Partnership's legacy counties who increased by 3.10%. The table below shows performance changes from MY2023 to MY2024 for JLI providers. Two providers, Shasta Community Health Center and Solano County Health & Social Services, declined in 2024 while the others improved compared to the prior year.

Provider Organization	YoY Difference
Adventist Health	5.19%
Fairchild Medical Clinic	14.50%
Mendocino Community Health	7.00%
Open Door Community Health Centers	3.11%
Shasta Community Health Centers	-6.25%
Solano County Health & Social Services	-10.25%
Grand Total	**2.62%**

Expansion of Regional Quality Meetings

For FY 2024-2025, the QI Team continued to expand regional quality meetings to the Chico and Auburn Regions. Following the expansion of regional quality meetings in the Redding and Eureka regions, quality observed increased collaboration within the Northern County provider network which mirrored practices in the Southern Region. These meetings serve as an opportunity to address regional quality improvement topics with local stakeholders. Existing regional meetings include:

Solano Quality Improvement Program Initiative (SQIP-I): This monthly meeting is co-sponsored by Partnership and Aliados Health, the Federally Qualified Health Center (FQHC) consortium that is active in Solano County. The SQIP-I Workgroup engages four (4) of the largest PCPs in Solano County as a collaborative forum for collective learning and for partnership on quality measures that are best addressed on a systems level. In 2023-2024, the SQIP-I Workgroup's projects included:

- Planning activities, including root cause analysis activities, around the DHCS assigned Health Equity Performance Improvement Project (PIP) around the Well Child Visits Birth – 15 Months (W30-6)

measure. The PIP will be focused on increasing the completion rate for the visit series for African American children in Solano County.
- Sharing of best practices around Lead Screening for Children (LSC) measure.
- Presentation on Cologuard bulk ordering program to increase Colorectal Cancer Screening (COL) rates.
- Focused collaborative work on newborn visit workflows, featuring analysis on newborn transitions of care by Solano County's primary inpatient labor and delivery unit and discussion of newborn Medi-Cal enrollment and PCP assignment.

Southeast Regional Meeting: This quarterly meeting engages all PCPs in the Southeast Region. In 2024-2025, the Southeast Regional Meeting's topics included:

- Voices from the Field presentations by PCP quality teams describing best practices for measures such as Cervical Cancer Screenings (CCS) and Unit of Service measures.
- Overview of Partnership programs such as the transportation benefit, member redetermination tools, and the Electronic Blood Pressure Monitor program.
- Presentations by community partners such as First 5 Yolo, presenting on their Welcome Baby program.
- Health Equity Data presentation regarding disparities within QIP outcomes
- Telehealth Services available to members

Lake and Mendocino Quality Meeting: This bi-annual meeting engages PCPs in Lake and Mendocino Counties around quality improvement topics. Following the organizational region restructuring, QI is working with the Eureka Regional Director to determine if this meeting will get integrated into the Eureka Region quarterly virtual format or if it will remain its own bi-annual in-person meeting.

East Region Quarterly Quality Meetings/Monthly Office Hours: The PI and QIP Teams held four (4) sessions for incoming practices in the expansion counties from July 1 through December 31, 2024. This forum, titled "How to Succeed in the PCP QIP", engaged quality teams from incoming practices and helped orient them to Partnership's QIP program and measures, analytic tools, and best practices for success with QIP measures. Topics at these four (4) sessions included:

- Gaining access to eReports and understanding the eReports and Partnership Quality Dashboard interface and features.
- Troubleshooting common problems faced by incoming practices, such as member assignment issues and incomplete data issues.
- Understanding the QIP Equity Adjustment and best practices for acuity coding.
- Strategies and best practices for success with QIP measures.

Regional quality meetings for both the Chico and Auburn regions have been scheduled to start in July, 2025. They will follow the structure of the other regional quality meetings and include a survey of participants to ensure maximum value for our provider network.

Partnership, HANC, and NCCN continue to collaborate to maintain a QI Measurement Systems Toolkit, initially developed and launched in 2017. The QI Measurement Systems Toolkit provides background information on the measures defined under HEDIS®, Uniform Data Set (UDS), Site Reviews, and the PCP QIP. This toolkit also includes measure by measure data sets reflective of consortia member performance across the varying measurement sets. And, recommended best practices from national change packages and regional interventions are also included by measure. A key component of the toolkit is a measure crosswalk that indicates which measures fall under each measure set, as well as what criteria constitutes denominator and numerator compliance, and any exclusions that exist for the measure. The scope of the crosswalk is primarily determined by the PCP QIP measure set versus attempting to offer a fully inclusive view of all the new measures Partnership has taken on via MCAS and NCQA accreditation. The crosswalk acknowledges when a comparable HEDIS® measure exists but does not detail the measure specs, given sensitivity around licensing agreements with NCQA. These tools allow organizations to potentially target measures for performance improvement that affect multiple measure sets. The Northern consortia also continue to cite this toolkit as a key onboarding tool for health center staff either new to QI or taking on new responsibilities under the PCP QIP.

HANC and NCCN offer great avenues for communicating with the largest PCP organizations serving Partnership members in the Redding and Eureka Regions. In the past year, Partnership has leveraged the consortia QI and CMO Peer Networks, which each meet monthly, to share key changes in measure sets, HEDIS®/QIP measure education, HEDIS®/QIP performance results, and emerging best practices from ongoing regional performance improvement projects. It is also a forum by which barriers to achieving improved HEDIS® performance can be openly discussed, informing Partnership's HEDIS® Score Improvement tactical strategies and dialog with DHCS. Historically, HANC and NCCN member organizations perform higher than non-members.

Other QI Provider Resource Updates and Changes

The Performance Improvement (PI) Team publishes a set of Measure Best Practices for each PCP QIP measure on an annual basis. 2025 Measure Best Practices feature Partnership programs and tools, and include best practices around data and coding, member care, and health equity best practices for each PCP QIP measure.

Frequently Asked Questions (FAQs) documents were developed by the QIP Team to support newly enhanced dashboards in the Partnership Quality Dashboard (PQD) called Preventive Care Reports. Each dashboard includes supplemental data for three (3) measures included in the PCP QIP core clinical measure set: Immunization for Adolescents, Childhood Immunization Status – Combo 10, and Well Care Visits in support of the Well Child First 15 Months measure, with well visits between 15-30 months coming later in 2025. The Preventive Care Report FAQs document provides descriptive highlights of each measure dashboard including guidance on how to use the data in support of measure score improvement. The QIP Team also distributes an educational, bi-monthly email DRIP campaign focusing on helpful tips for using the Preventive Care Reports dashboard and other QIP basics to reinforce on-going performance education provided by the PI Team.

Quality Improvement Training

Improving Measure Outcomes

In conjunction with Partnership medical directors, the Performance Improvement Team offered six (6) virtual Improving Measure Outcomes (IMO) sessions to primary care provider organizations between February - April 2025. The webinars aimed to provide clinical background and best practices related to 2025 Primary Care Provider Quality Incentive Program (PCP QIP) measures. Each session was approved for Continuing Medical Education (CME)/Continuing Education (CE) credits through the American Academy of Family Physicians and the California Board of Registered Nursing for 1.0 contact hours per session.

The focus of the webinars and attendance rates are included below:

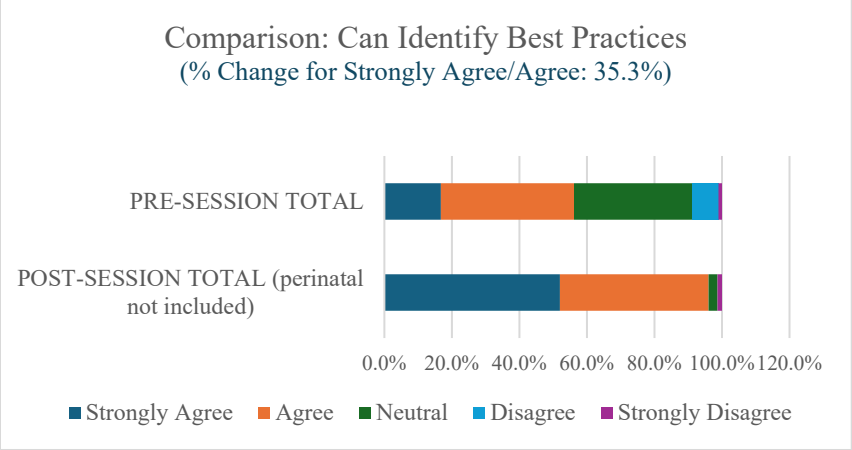
- 02/12/2025 - Pediatric Preventative Care for Ages 0 - 30 Months
  - 90 attendees, representing 36 unique organizations, 12 requests for CME/CEs
    (Webinar covered Well-Child Visits for the First 30 Months of Life, Childhood Immunizations Status, Blood Lead Screening, and Topical Fluoride in Children measures)
- 02/26/2025 - Pediatric Preventative Care for Ages 3 - 17 Years
  - 65 attendees, representing 33 unique organizations, 11 requests for CME/CEs
    (Webinar covered Child and Adolescent Well-Care Visits, Immunizations for Adolescents, Blood Lead Screening, and Topical Fluoride in Children measures)
- 03/12/2025 - Chronic Disease and Colorectal Cancer Screening
  - 79 attendees, representing 45 unique organizations, 9 requests for CME/CEs
    (Webinar covered Controlling High Blood Pressure and Colorectal Cancer Screening measures)
- 03/26/2025 - Perinatal Care and Chlamydia Screening
  - 53 attendees, representing 28 unique organizations, 15 requests for CME/CEs
    (Webinar covered Women and Timely Postpartum Care screening measure)
- 04/09/2025 - Breast and Cervical Cancer Screenings
  - 85 attendees, representing 37 unique organizations, 10 requests for CME/CEs
    (Webinar covered Cervical and Breast Cancer Screening measures)
- 04/23/2025 - Diabetes Control
  - 57 attendees, representing 31 unique organizations, 13 requests for CME/CEs
    (Webinar covered Comprehensive Diabetes Management - HbA1c Good Control, Retinal Eye Exam, and Blood Pressure Control for Patients with Diabetes measures)

Of attendees who completed the post-session evaluations for all six webinars, 99% selected *Strongly Agree* or *Agree* when asked if the webinar was relevant and useful.

All six (6) Improving Measure Outcomes trainings featured one to two leaders from a high-performing provider organization as a "Voices from the Field" presenter, allowing these providers to share their best and promising practices with their peers throughout the provider network.

The target audience for Improving Measure Outcomes trainings were quality improvement staff at primary care physician offices within the Partnership geographic footprint. Marketing strategies for trainings included the following:

- Targeted eblasts for all trainings were sent using the Primary Care Provider contact list and the Improvement Academy contact list.
- QR registration codes were added to all training flyers. This offered additional ease for individuals to register. The total number of scans for IMO webinars was 535.
- Event listing on Partnership website for all trainings.
- Distribution of training flyers to Leadership staff.
- Promotional training event slides were sent to internal Quality Teams (QIP, HEDIS® and Improvement Advisors) to incorporate in upcoming provider trainings/meetings.
- Provider Relations fax blast of training flyers.
- Provider Relations Representatives asked to distribute training flyers.
- Training opportunities included in Quality Improvement, Provider Relations, and Medical Director Newsletters.
- The Patient Safety Team was asked to share training flyers when conducting on-site visits with providers. Additionally, IMO training PowerPoints were shared to ensure on-site education by the Patient Safety Team was consistent with educational messaging.
- Members of the Performance Improvement Team added a customized IMO banner ad to their Outlook signature. The ad touted the webinar series and offered a hyperlink to allow potential attendees to register for the series.



A strategy was implemented at the conclusion of the series to measure the impact of the training offerings whereby an evaluation was sent to participants who attended three (3) or more IMO webinars. The survey was distributed to 49 participants and had a total of 7 responses (14%). The majority of responses to this survey was positive.

Responses were rated on a Likert scale (strongly agree=5, agree=4, neutral=3, disagree=2, and strongly disagree=1). The average for each response was calculated to understand participants' perceived improvements for the following questions. The following table lists each question and Likert score.

Improving Measure Outcomes Webinar Series Evaluation Questions	Likert Score

I can locate appropriate Partnership resources that define measure specifications for the 2025 Primary Care Provider Quality Improvement Program.	4.3
I can identify and implement best practices to improve clinical outcomes for the specific Improvement Measure Outcomes webinar(s) I attended.	4.1
I can apply specific measure outcome performance strategies to a variety of quality improvement (QI) work in several content areas.	4.3
I am able to evaluate our current QI program and assess future needs or gaps.	4.3
I am able to identify care gaps attributed to health inequities, develop strategies to address those care gaps, and successfully implement those strategies.	4.0
I can communicate to interdisciplinary team members (clinical and non-clinical) about QI best practices to improve measure performance.	4.3
Does offering continuing education credits (CMEs/CEs) influence your attendance.	4.0

Overall, respondents indicated their ability to locate resources for measure best practices, quality improvement strategies, and identify and influence care gaps. Based on participant response, CME/CEs credit continue to be valuable to attendees.

ABCs of Quality Improvement

In FY 2024-2025, Partnership offered three (3) in-person ABCs of Quality Improvement (QI) training series for its provider network. The purpose of the ABCs of QI training is to introduce quality improvement concepts to clinical and non-clinical provider staff to improve performance in the PCP QIP.

The all-day trainings covered a range of topics, including:

- What is Quality Improvement?
- Introduction to the Model for Improvement
- How to create an aim statement
- How to use data for improvement
- Why and how to establish outcome and process measures
- Tips for developing change ideas that lead to improvement
- Testing changes with the Plan-Do-Study-Act (PDSA) cycle

Significant collaborative efforts among seasoned Improvement Advisors were brought together to align the ABCs of QI curriculum into a single, cohesive training deck. This was designed to not only ensure that any Improvement Advisor, regardless of region, could effectively deliver the training, but also to provide a consistent and valuable training to all participants across the network.

Attendance and overall training satisfaction were as follows:

- 11/07/2024 – Fairfield: 48 attendees, representing 14 unique provider organizations with 100% of respondents reporting being extremely satisfied/satisfied with this course.
- 01/30/2025 – Ukiah: 21 attendees, representing 8 unique provider organizations with 100% of respondents reporting being extremely satisfied/satisfied with this course.
- 03/25/2025 – Redding: 28 attendees, representing 15 unique provider organizations with 100% of respondents reporting being extremely satisfied/satisfied with this course.

Participants in the trainings included clinicians, front-line staff, quality improvement staff, administrators, and public health professionals. Continuing Medical Education (CME)/Continuing Education (CE) credits through the American Academy of Family Physicians and the California Board of Registered Nursing were offered for each training.

To evaluate the effectiveness of the ABCs of QI training, pre- and post-session knowledge check questions were administered at the beginning and end of each training section, respectively. Each post-session evaluation revealed higher percentages of *Strongly Agree* and *Agree* as compared to pre-session evaluations. Aggregated evaluation results are shown below.

ABCs of QI Evaluation Question	Pre-Session % of Participants Choosing *Strongly Agree* or *Agree*	Post-Session % of Participants Choosing *Strongly Agree* or *Agree*
I understand the Model for Improvement as it relates to health care quality improvement efforts.	54% N=101	98% N=102
I am able to construct an aim statement/differentiate between effective/ineffective aim statements.	29% N=101	94% N=101
I understand when to use a driver diagram and how it contributes to developing change concepts.	12% N=86	96% N=101
I am able to develop a process map for a workflow that is commonly used in our practice.	33% N=86	93% N=101
I am able to identify/design process/outcome/ balance measures relevant to QI projects.	37% N=83	80% N=94
I can identify and implement the components of a run chart to monitor improvement.	34% N=83	79% N=94
I am able to design and implement a PDSA cycle.	39% N=83	89% N=95
I have ideas that I would like to put into action in my workplace that I can test with a PDSA cycle.	45% N=83	86% N=95

Additionally, all post session evaluations asked if the information presented directly related to participant's work. Participants choosing *Strongly Agree* or *Agree* ranged from 76% to 94%.

Several provider sites attending the ABCs of QI agreed to post-training follow-up meetings to track the progress of the AIM Statement developed during the Plan-Do-Study-Act portion of the training.

One example of session outputs includes a Mendocino County provider site whose focused measure was Colorectal Cancer Screening. From the aim statement and driver diagram developed during the ABCs of QI training, this team was able to test their change ideas by utilizing the Plan-Do-Study-Act (PDSA) framework. The provider site shared their PDSA success of accelerating improvement, which included:

- Cologuard patient education
- Offer UPS shipping of Cologuard kits for completed samples
- Offer incentives for returned kits
- Promotion of standing orders for Cologuard
- Outreach/follow-up on outstanding orders

Further check-ins have been established to continue to monitor this provider's successes in driving improvement.

Microlearnings

After informally polling several provider sites on beneficial training types, microlearning modules - intended as short tutorials - were introduced this fiscal period. The first microlearning developed focused on ePrompts, an online tool within Provider Online Services that allows provider office staff to easily access members' preventive screenings due while simultaneously checking their eligibility. The second microlearning, currently in production, will focus on the Preventative Care Dashboard. This tool enhances visibility of well-child visits and immunization status and can be particularly helpful for staff to identify operational processes contributing to pediatric well care completion trends for performance improvement.

Both offerings will be promoted to the provider network through eblasts, newsletters, regional meetings and by posting them to the Improvement Academy web page.

Value Based Pay-for-Performance Programs

Partnership's Quality Incentive Programs (QIP) provided financial incentives, data reporting and technical assistance to providers for improving in key domains of quality: clinical care, patient experience, access and operations, and resource use. The total pay-out for the MY2023-2024 QIP was approximately $51,493,633.57 across the five (5) QIP programs managed within the Quality Improvement (QI) Department. The total payout for MY2023-2024 is reflective of payouts distributed for Fiscal and Calendar year programs. The following is a breakdown of the QIP measurement year ranges included in the total payout of $51,493,633.57:

- Hospital QIP: full measurement year (FY2023-2024)
- Perinatal QIP: full measurement year (FY2023-2024)
- PCP QIP: full measurement year (CY2023)
- ECM QIP: Two partial measurement years (Q3 - Q4 2023 and Q1 - Q2 2024)
- Palliative Care QIP: Two bi-annual payments (Q3 - Q4 2023 and Q1 - Q2 2024)

Primary Care Provider Quality Incentive Program

The Primary Care Provider (PCP) Quality Incentive Program (QIP) Core Measurement Set evaluated four (4) domains of quality: Prevention and Screening, Chronic Disease Management,, Appropriate Use of Resources, Patient Experience, and Access & Operations. The Unit of Service measures provided additional dollars for providing specific services such as Tobacco Use Screening, Advance Care Planning, etc. All primary care providers who have Medi-Cal members capitated to them are automatically enrolled in the PCP QIP.

Program Goals

The PCP program goals and activities outlined in the FY 2024-2025 QI Work Plan were completed and are highlighted below.

- Development of measures for the 2025 PCP QIP by December 31, 2024.
- Partnership adhered to DHCS guidance regarding this program by including a performance threshold for measures that rewarded providers for conducting activities they may already be compensated for through capitation payments.

- Supported providers enrolled in the program by hosting webinars, distributing quarterly newsletters & surveys, provider notifications/reminders, and responding to provider inquiries via phone and email in a timely manner.
- Continued provider engagement and program activities to support quality (HEDIS®) measure score improvement, including monitoring changes to relative improvement methodology, payment methodology, and continuous enrollment requirement.
- Supported provider network and respective sites/clinics in their efforts to use data to improve reporting and performance improvement activities through FY 2024-25.
- Implement process improvement which includes documenting and updating current and new program protocols based on lessons learned.

The PCP QIP program performs annual evaluations. The 2023 Measurement Year evaluation was completed during the fiscal year 2024-2025 and is highlighted below.

MY2023 PCP QIP Program Evaluation Summary

The PCP QIP offers pay-for-performance (P4P) financial incentives. The intent of P4P is to improve access and quality of care across all clinical domains. The PCP QIP, designed in collaboration with Partnership providers, offers substantial financial incentives, data resources, and technical assistance to primary care providers who serve our capitated Medi-Cal members so that significant improvements can be made in the following areas: 1) Prevention and Screening, 2) Chronic Disease Management, 3) Appropriate Use of Resources, 4) Primary Care Access and Operations, and 5) Patient Experience. This evaluation is an analysis of the January 1, 2023 – December 31, 2023, Measurement Year.

Program Performance

PCP QIP performance observed incremental year-over-year recovery from 2022 to 2023 in the following clinical measures:

- Asthma Medication Ratio
- Controlling High Blood Pressure
- Diabetes HbA1c Good Control (<= 9.0%)
- Well-Care Visit (First 15 months)
- Child & Adolescent Well Care Visits
- Breast Cancer Screenings
- Immunization for Adolescents

Provider Experience

In 2023, the annual PCP provider engagement survey was retired due to a lack of participation. This survey was administered to the entire network and received poor response rate year over year. In efforts to continue provider engagement, the PCP QIP team shifted its focus towards offering a higher level of support to its identified low performing providers and newly enrolled providers by administering specific surveys towards these audiences. The intent of these surveys is to evaluate their knowledge of the program & its performance measure tools, provide programmatic reminders and offer education & training. With the administration of these targeted surveys, we have seen a better response rate with 27-53% of the targeted Parent Organizations participating in quarters 3 & 4 of measurement year 2024. These surveys have created a space for the PCP QIP team to have more engagement with these targeted providers and offering additional support. These surveys have been well perceived by the targeted provider network.

PCP QIP eReports System

The eReports system is an online tool provided to PCP participants in the PCP QIP. It serves as a means for providers to track their performance under the clinical care domain of the Core Measurement set at both an organizational level and individual site level. Under the 2024-2025 QI Work Plan, the eReports system was successfully enhanced to support the 2025 PCP QIP clinical measure set and released to providers on-time, in March 2025.

The information from eReports presents providers with member-level data corresponding to eligibility and compliance status under each measure. eReports data sources are: claims, lab data, pharmacy data, California immunization registry (CAIR) data, and the eReports user supplemental upload data. eReports supplemental upload functionality gives the provider the opportunity to upload medical record data to substantiate member compliance where administrative data is unavailable.

In the second quarter of 2025, the PCP QIP Team conducted its annual eReports Upload Audit for measurement year 2024. The QIP Team selected to audit the Child and Adolescent Well Care Visits (WCV) measure. A random sampling was performed, and we identified 34 Parent Organizations who uploaded WCV data into eReports. Sampling results were used to compile the audit list and request supporting medical records. During the 2023 PCP QIP eReports Upload Audit analysis we transitioned our audit approach from penalizing providers with a loss of members in the numerator or denominator to focusing on provider education based on our results. This approach allowed us to take more time with our audit analysis and identify opportunities for improving the quality of our audit through education. Our 2024 analysis will be completed by the end of June 2025.

Hospital Quality Incentive Program

The Hospital Quality Incentive Program (HQIP) is a pay-for-performance incentive program that began in 2012 for selected hospitals in the Partnership network. The purpose of the HQIP is twofold: 1) To help improve the health outcomes of Partnership members served by its contracted hospitals and 2) to help participating hospitals assess the quality of care provided to their patients by serving as a guide to their existing quality improvement efforts. To do this, the program offers substantial financial incentives for hospitals that meet specific performance targets, connects HQIP hospitals with regular training opportunities and resources, and hosts an annual Hospital Quality Symposium (HQS). The HQS supports HQIP participants' work in quality by bringing stakeholders together from each hospital entity across two Partnership regions for thoughtful discussion on high-priority, hospital related topics.

Program Goals

The HQIP program goals and activities outlined in the FY 2024-2025 QI Work Plan were completed and are highlighted below. Partnership completed development of the 2024/2025 measurement year measurement set. Partnership also provided ongoing technical assistance to providers throughout the year and conducted an evaluation of the program for the 2023-2024 measurement year which is summarized below. Through Partnership's geographical expansion the number of hospitals participating in the HQIP increased from 26 to 33 hospitals.

During the 2024-2025 measurement year, Partnership conducted ongoing measure performance monitoring on participating hospitals while providing as needed technical support and updating them on performance status through operations meetings and mid-year performance reports.

Completed Goals

Goal #1: By June 30, 2025, develop the 2025-2026 measurement year Hospital Quality Incentive Program (H-QIP) Measurement Set to support Hospital Performance Improvement.

The 2025-2026 measurement year will include focus areas in the following domains: readmissions, advanced care planning, clinical quality: maternity care, patient safety and operations & efficiency, and patient experience. Measurement set development is informed by insights from the annual evaluation, regulatory needs, and trends in care. In the previous measurement year, two new measures were added, one was removed due to regulatory requirements and several targets were adjusted to encourage continuous quality improvement. This included the introduction of the 7-day Clinical Visit Follow-up measure, which was added in preparation of future DHCS requirements. The measure was refined during the 2024-2025 measurement year as data reports showing follow-up rates and adjustments were made to both the 2024-25 measure set and the proposed 2025-26 measurement set. The 2024-25 measure set also included "phase one" of a measure encouraging hospitals to begin expanding their delivery privileges to midwives and family physicians and another measure incentivizing increased screening mammography capacity.

The 2025-26 measurement set continues down the path of expanding delivery privileges by moving into "phase 2", where hospitals will be required to show evidence of recruitment or hiring of midwives and family physicians. The measure set also introduces a Doula Support measure encouraging hospitals to allow doulas to be part of the birthing process. Additionally, the new Vaccines For Children Program enrollment measure encourages hospitals to take advantage of the resources from the CDPH. Targets were adjusted in response to challenges observed during the 2024-25 MY. This resulted in continuing to place emphasis on follow-up visits and adjusting the Health Equity measure to align with CMS requirements for health equity.

The 2025-2026 measurement set includes the following 17 quality measures:

1. Risk Adjusted Readmissions
2. 7-day Clinical Visit Follow-up
3. Palliative Care Capacity
4. Rate of Elective Delivery Before 39 Weeks
5. Exclusive Breast Mild Feeding Rate
6. Nulliparous, Term, Singleton, Vertex Cesarean Rate
7. Vaginal Birth After Cesarean
8. Increased Screening Mammography Capacity
9. Doula Support
10. Expanded Delivery Privileges
11. Vaccines for Children Program Enrollment
12. California Hospital Patient Safety Organization (CHPSO) Patient Safety Organization Participation
13. Substance Use Disorder – Medication Assisted Treatment
14. Quality Improvement Capacity
15. Hospital Quality Incentive Platform
16. Cal Hospital Compare – Patient Experience
17. Health Equity

Goal #2: Develop Partnership's Hospital Quality Symposium for the 2025-26 HQIP measurement year.

The HQIP Program Manager, Manager of Quality Incentive Programs and the Medical Director for Quality analyzed the August 2024 event by reviewing attendee surveys to help inform the development of the 2025-26

event. The HQIP Program Manager and the Medical Director for Quality also attended an external hospital quality conference in October to look for potential speakers, topics and coordination of ideas for this year's event. Between January and June 2025, the venues, dates and times were solidified. The HQS will take place on July 29, 2025, at Partnership's Fairfield office and on July 31, 2025 at the Sheraton Hotel in Redding. Both events occur from 8:30 – 4:30 with the same agenda and speakers. The speaker engagement process was completed with the selected presenters. The events will include topics on: Health Equity, Substance Abuse Treatment, a Top Performer Panel discussing How to succeed in the QIP, Efficient PointClickCare Workflows to improve follow-ups and Enhanced Care Management, and Data Analytics with the Hospital Quality Institute. Continuing Education Credits will be available for attendees who request them.

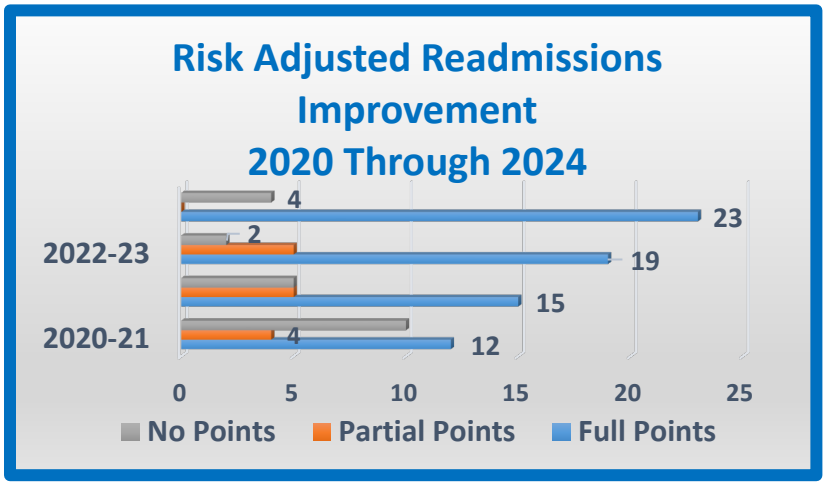
Goal #3: By January 31, 2025, complete evaluation of the 2023-24 HQIP and deliver summary to the Partnership Quality Committee meetings (IQI, QUAC, PAC).

Annually, the HQIP compiles a year-end evaluation utilizing performance relative to targets and performance points distributed by measure. The goal was completed in January 2025. This year's summary and presentation highlighted the addition of 6 new hospitals to the HQIP, as well as the continued increase in hospitals meeting the Risk Adjusted Readmissions measure.

The evaluation summary The evaluation summary included comparison scores from FY2022-23 and FY2023-24. Analysis showed that most of the decrease in scores was due to hospitals who did not meet the Health Equity measure, while increases were due to improved Risk Adjusted Readmission rates, and improved HQI Platform participation. Other notable performances included 15 hospitals earning Top Performer Status of greater than 90%, which included Tahoe Forest Hospital, a first-time participant from the geographic expansion region.

It was determined that the CAIR Utilization measure could be removed due to consistent high performance. The evaluation suggested that other measure targets could be increased in FY2025-26 to encourage continued quality improvement. Most hospitals improved scores in the RAR and Cal Hospital Compare measures.

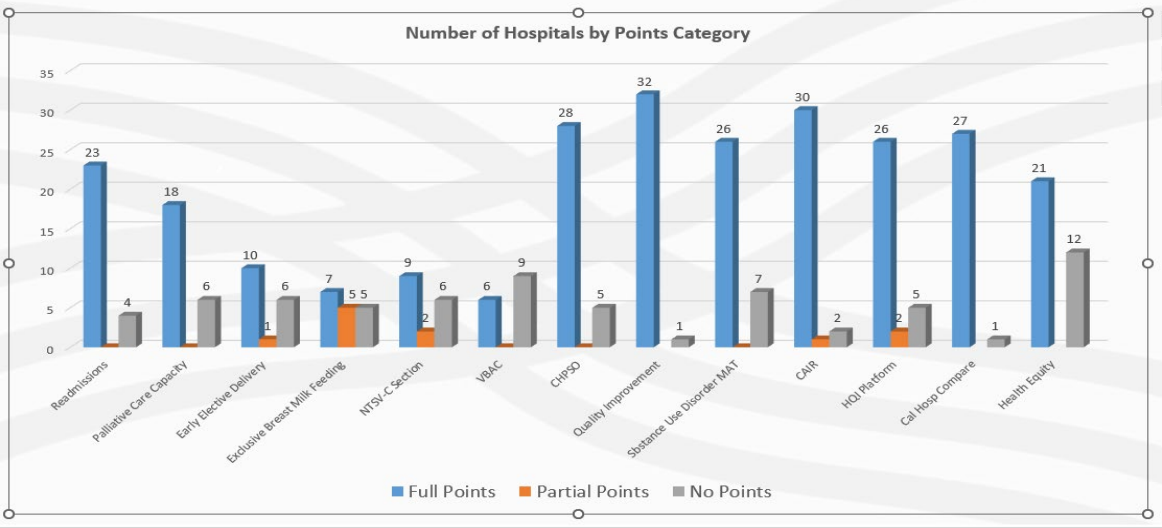
Chart: Risk Adjusted Readmissions Improvement



The FY2024-25 evaluation demonstrated the significant improvement hospitals have continued to make in Risk Adjusted Readmissions scores over the past three measurement years with a 12% positive increase of hospitals earning full points for RAR in 23/24 MY over 22/23 MY. In the 2024-25 measurement set, small hospitals were not held accountable to RAR, therefore rates next year may look different.

The chart below shows the count of hospitals falling into full, partial, and no points categories for each measure. Of note, 12 hospitals did not earn points for the Health Equity measure, which was due to many smaller hospitals not meeting reporting requirements. Several very small-size hospitals expressed their difficulty identifying a significant population with disparities to their overall low volume of patients.

Table: 2023-24 Performance Relative to Targets - Point Distribution by Measure



Perinatal Quality Incentive Program

The Perinatal Quality Incentive Program (PQIP) is a pay-for-performance program offering financial incentives to participating Partnership Health Perinatal Services Program (PHPS), formerly Comprehensive Perinatal Service Program (CPSP) providers and select non-PHPS providers administering quality and timely prenatal and postpartum care to Partnership members.

Program Goals

The PQIP goals and activities outlined in the FY 2024-2025 QI Work Plan were completed and highlighted are below. These goals revolve around the development of the PQIP measurement set for the 2025-26 measurement year, continuing to support provider on-boarding and ECDS implementation to satisfy programmatic gateway measure (ECDS), and annual program evaluation. All three goals were met during the measurement period as noted below.

Completed Goals

Goal #1: 2025-26 Measurement Set Completion

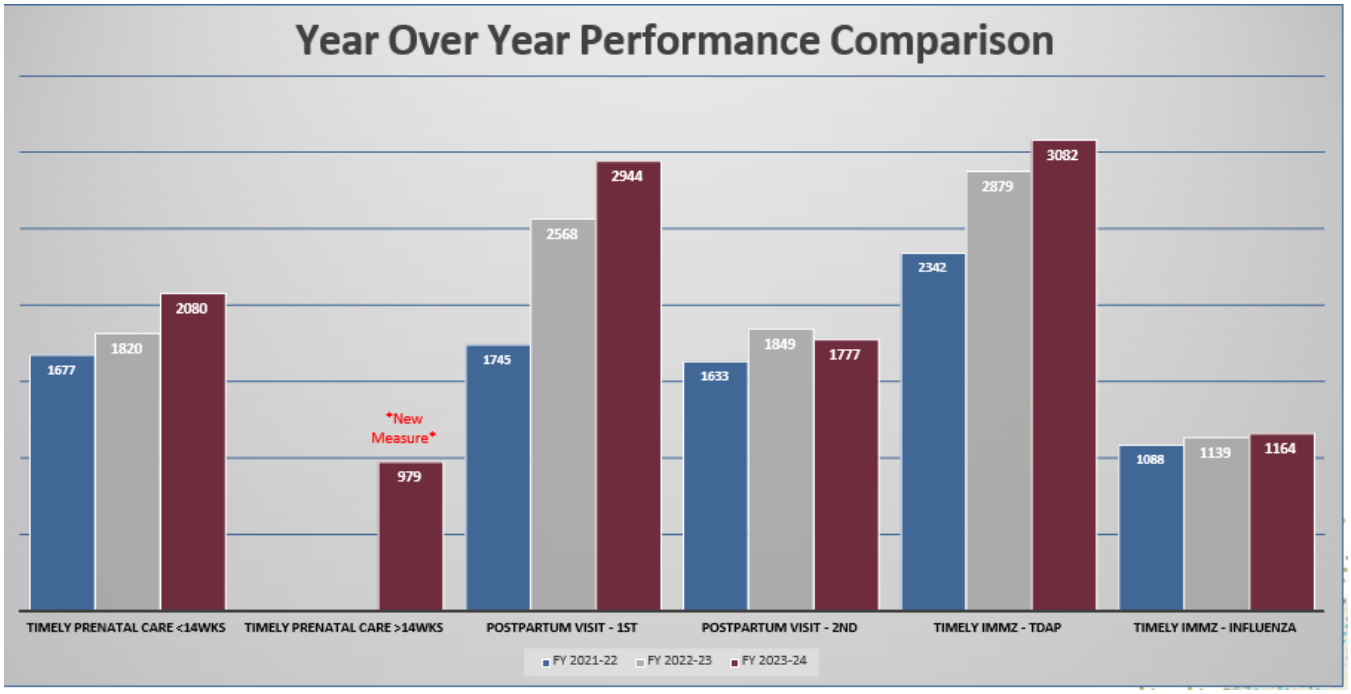
Throughout the measurement period, particularly between January and May, work was completed on the development of the 2025-26 Perinatal QIP Measurement Set. The measure set was developed with direct input from Partnership Medical Directors, perinatal subject matter experts, program managers and feedback from perinatal providers. The PQIP measures tend to maintain a comprehensive yet simple measure set with the intent to improve HEDIS® performance among providers offering prenatal and postpartum services often occurring outside of a PCP visit. While the 2024-25 measure set incentivized providers to contract and connect with DataLink, the 2025-26 measurement set now includes a gateway measure requiring perinatal providers to contract and connect with DataLink an approved HEDIS data aggregator that Partnership is using for data extraction to help meet NCQA requirements for ECDS. The PQIP is also looking to the future in the area of comprehensive assessment. During

2025-26, the PQIP has added a measure to monitor timely prenatal comprehensive assessments. There are no incentives tied to this measure this year, but in future years it will likely be incentivized.

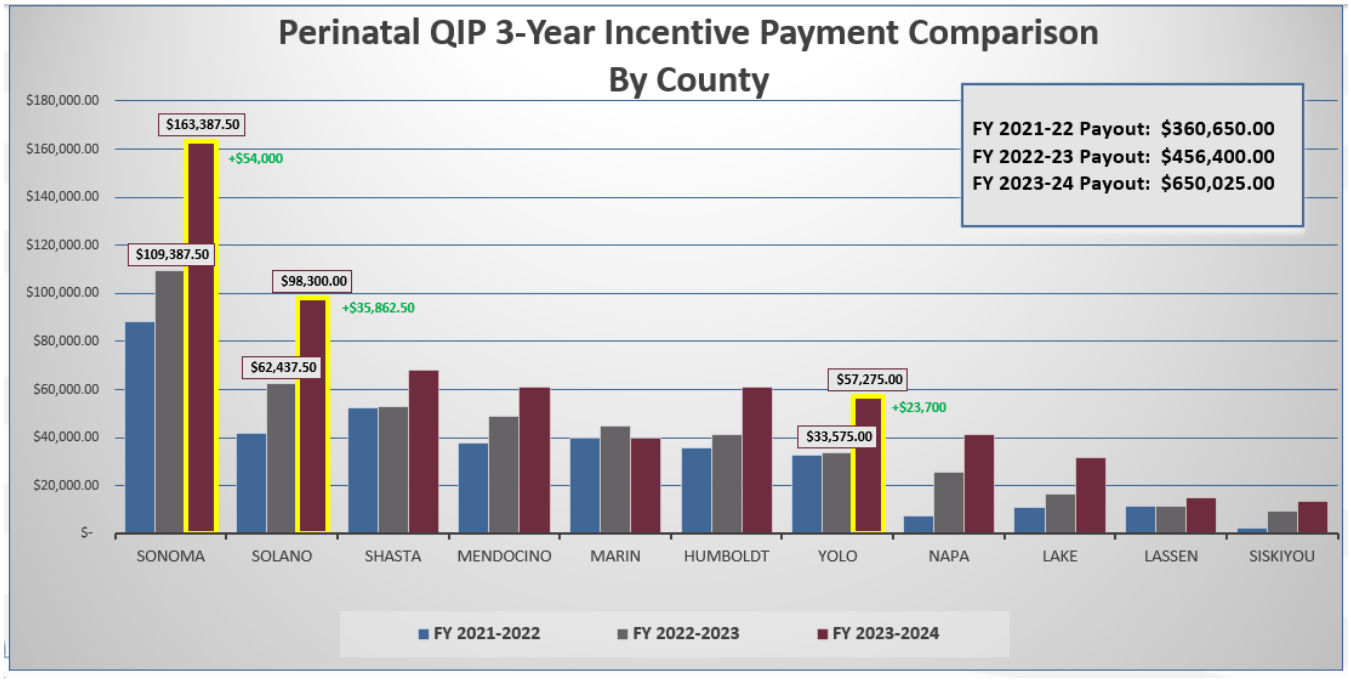
- Electronic Clinical Data System (ECDS) DataLink Implementation
- Timely Tdap and Influenza Vaccine
- Timely Prenatal Care
- Timely Postpartum Care
- Timely Comprehensive Assessments - Monitoring measure

Goal #2: By June 30, 2025, continue to support provider on-boarding and ECDS implementation to satisfy programmatic gateway measure (ECDS).
During the measurement year, the ECDS measure data collection process changed to include DataLink, an approved HEDIS Data Aggregator, as the vendor responsible for extracting data from participating provider Electronic Medical Records (EMR) vs. requiring providers to submit data via Partnership Secure File Transfer Protocol (sFTP) for use by the PHC HEDIS team. This process was newly outlined in the specifications for the Perinatal QIP and the PCP QIP with ground level support offered to all providers to coordinate DataLink contract completion, DataLink integration and data extraction. All contract and data extraction was expected to be completed by 12/31/2024 for Perinatal QIP providers to qualify for 2024/2025 ECDS incentive. There were 19 Parent Organizations who completed the contracting process and had successful data extractions. The goal is for the rest of the providers to complete the process in the 2025-26 measurement year.

Goal #3: By June 30, 2025, complete PQIP program evaluation for FY 23-24.
FY 2023-24 Program Evaluation was written in December 2024, and presented to IQI, QU/AC, and PAC in January 2025. The evaluation is a year-over-year measure comparison between the 2020-21 year through the 2023-24 measurement years. As seen in the first chart below, the program evaluation highlighted that most of the measures saw improvement over the previous two years, with the exception being a slight drop in the number of 2nd postpartum visits. There was an increase for Approved Timely Prenatal Visits and Tdap immunization counts. Contributing factors included: increased provider engagement, follow-ups and training with providers, and Partnership/provider workgroups focusing on improving overall perinatal performance.



The annual Perinatal QIP program evaluation included the three-year comparison of payment across 11 Partnership counties seen in the second chart below, which compares performance by county. All counties except Marin showed improved performance and an increase in overall incentive payments for this fiscal year. It's important to note that the number of participating clinics in 2022-23 and 2023-24 were nearly the same at 98 and 97, respectively. Therefore, the increase represents a true improvement in the number of visits, screenings and immunizations provided to our members.



Palliative Care Quality Incentive Program

In 2017, Partnership began a pay-for-performance program for Palliative Care Quality Improvement Program (PC QIP) providers. The Palliative Care QIP offers sizeable financial incentives to support and improve the quality of palliative care provided to Partnership members. In collaboration with Palliative Care providers, Partnership has developed a simple, meaningful measurement set to measure quality of care using two (2) measures: Avoiding hospitalization and emergency room visits, Completion of POLST (Physician Orders for Life-Sustaining Treatment), and Completion of Standardized PCQC Assessments and use of the Palliative Care Quality Collaborative (PCQC).

The PC QIP program goals and activities outlined in the FY 2024-2025 QI Work Plan were completed. Partnership conducted ongoing performance evaluation of the participants, continued to use the most meaningful and feasible measures available, offered technical assistance to providers throughout the year, tracked all submissions, validated them, and gave participants updates on their performance

The Palliative Care QIP runs on a calendar year, from January 1 – December 31. Providers are paid based on their performance during two (2) six-month measurement periods. In 2024, the program had 10 participants, and a total payout of $2,485,280. Major program activities during 2024 included: new participant outreach and onboarding; webinars, technical assistance, and program communications; work with providers to coordinate data validation and collection for the Palliative Care Quality Collaborative (PCQC) measure; work with analytics to coordinate data collection and validation for avoiding hospitalization and ED visits measure; and distribution of reports to providers.

In mid-February 2025, the Executive Director of Palliative Care Quality Collaborative (PCQC) notified the Palliative Care QIP team of the dissolution of PCQC due to lack of funding to maintain operations. PCQC officially closed their doors on April 17, 2025. In preparation, the Palliative Care QIP team met with PCQC leadership to secure final data needed for the 2024 measurement period II (July – December) payment processing. Providers were notified that March 15, 2025 was the last day to submit critical data via the PCQC platform,

Following PCQC's closure April 2, 2025, Palliative Care Clinician Workgroup meeting was repurposed as an advisory session to discuss the impact on data collection and explore ideas for replacing Measure III, which relied on PCQC assessments. Providers supported introducing a Palliative Care Patient Satisfaction survey as a replacement measure, development of the new measure is underway, with implementation targeted by late summer 2025.
Program strengths include an opportunity for Partnership to decrease utilization and improve quality of care provided to members, strong provider engagement, and connecting providers with useful quality monitoring resources such as PCQC.

Partly due to the aligned incentives of the Palliative Care QIP, the overall financial savings of this program has continued, and the data from PCQC have demonstrated the average performance better than other, non-Partnership palliative care programs.

Enhanced Care Management (ECM) Quality Incentive Program

The Enhanced Care Management Quality Incentive Program (ECM QIP) debuted on January 1, 2022. ECM is a statewide benefit which is part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative organized by the Department of Health Care Services (DHCS). This pay-for-reporting program utilizes Incentive Payment Program (IPP) funds to incentivize providers to present Partnership with quality data tied to the timeliness of required ECM program reporting.

ECM QIP measures are developed based on DHCS directives as well as through collaboration with internal and external stakeholders. ECM data is captured through provider submitted reports and templates, and internal TAR data captured and sorted administratively.

The program's measurement set for the 2024-2025 measurement periods include:

- Timely Reporting (Gateway Measure)
- ECM Care Plans and Release of Information (ROI) Forms uploaded into PointClickCare (PCC)
- PHQ-9 Depression Screening
- Blood Pressure Screening
- Timely Review of ED/Admissions Notifications in PointClickCare

The ECM QIP program goals and activities outlined in the 2024-2025 FY QI Work Plan were completed. . With contribution from the CalAIM/ECM Team, program activities included:

- Ongoing provider outreach and onboarding through annual kick-off webinar and one-on-one virtual meetings
- Clear and concise program communications to share program changes, best practices and measure deadline reminders
- Quarterly measure auditing and scoring, incentive payment calculation and final payment distribution
- Successful collaboration with the CalAIM/ECM Team

The ECM QIP runs on a calendar year, from January 1 – December 31, and ECM contracted providers are automatically enrolled anytime throughout the measurement year. All ECM providers are paid quarterly. The 2024 measurement year included 155 participating provider sites with 124 provider sites earning $5.1 million. This represents an increase of $3.2 million compared to $1.9 million earned by 74 provider sites in the 2023 measurement year.

Program strengths include an opportunity for Partnership to improve quality of care provided to members and encourage provider engagement. Continued data collection will support potential future quality measures for this program.

Long-Term Care Quality Assurance Performance Improvement (QAPI) Monitoring

In 2016, Partnership began a value-based performance program targeting long-term care facilities. The Long-Term Care (LTC) QIP was designed to offer sizeable financial incentives to support and improve the quality of long-term care provided to Partnership members. On December 31, 2023, the LTC QIP was sunset due to the implementation of the State's Workforce & Quality Incentive Program (WQIP).

Assembly Bill 186 (Chapter 46, Statutes of 2022), Nursing Facility Financing Reform, amended the Medi-Cal Long-Term Reimbursement Act to reform the financing methodology applicable to subacute care facilities and intermediate care facilities. The finance methodology authorized the implementation of three (3) major programs, one (1) of which was the Workforce & Quality Incentive Program (WQIP). As a part of the implementation of the State's WQIP, guidance released under *APL 24-009: Skilled Nursing Facilities –LTC Benefit Standardization & Transition of Members to Managed Care* created a requirement for managed care plans (MCPs) to be responsible for maintaining a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided. MCPs must also have a system in place to collect quality assurance and improvement findings from CDPH. MCPs are also required to annually submit QAPI program reports with outcomes and trending data as specified by DHCS.

There are five (5) mandatory elements that an MCPs QAPI program must incorporate. Partnership has developed a framework to demonstrate fulfillment of the LTC QAPI plan requirements as outlined in APL 24-009and is monitoring QAPIs for each of the five (5) DHCS require QAPI elements:

Element 1: Design and Scope
Element 2: Governance and Leadership
Element 3: Feedback, Data Systems and Monitoring
Element 4: Performance Improvement Projects (PIPs)
Element 5: Systematic Analysis and Systemic Action

Working with the Partnership Long Term Support Services (LTSS) Liaison, we continuously work to obtain evidence of QAPI programs currently in effect at each contracted LTC facility. To support this effort, the Partnership Quality Improvement team works with the LTSS Liaison and newly formed Skilled Nursing Facility (SNF) Quality Workgroup to design and maintain a documented Managed Care Plan (MCP) LTC QAPI Program. The Quality Improvement team supports the LTSS Liaison in completing any requested secondary reviews of QAPI attestations determined to be insufficient or incomplete regarding the required Five (5) Key Elements identified by CMS and required for MCP monitoring by DHCS. QAPI deficiencies are tracked internally by the LTSS Liaison and key findings are used as education opportunities during LTC provider luncheons and on-site training with the goal of improving the quality of LTC facilities' QAPI programs.

The Partnership LTSS Liaison also serves as a primary contact for facilities with questions or concerns in post-acute and extended care settings by assisting with TAR processing, claims, grievances, appeals, contracting and many other issues. The addition of the LTSS team and the LTSS Liaison have added increased support to facilities to help them meet designated goals within their QAPI plans.

D-SNP Quality Incentive Program

The Dual Eligible Special Needs (D-SNP) Quality Incentive Program (QIP) is a pay-for-performance program set to launch in parallel with Partnership Advantage. The D-SNP program offers financial incentives to support and improve the quality of our Partnership Advantage members. The program focuses on rewarding high performing providers, 3 STARs and above, that meet our proposed measure set and our Medicare STAR performance metrics. The D-SNP program will roll-out in eight (8) Partnership counties initially and as we continue to refine the D-SNP QIP more counties will be added.

D-SNP QIP measures closely mirror the PCP QIP measure set with the intention of promoting provider familiarity and with the addition of measures reflecting D-SNP enrollee needs. Our quality metric alignment measures are Breast Cancer Screening, Colorectal Cancer Screening, Eye Exam for Patient with Diabetes, Diabetes Care - Blood Sugar Controlled, Controlling Blood Pressure, Statin therapy for Patients with Cardiovascular Disease, and Annual Wellness Visits. D-SNP QIP measures are weighted using CMS metrics and provide flexibility in measure weighting; permitting Partnership to adjust throughout the year to target performance gains where needed.

The review of our current QIP systems show there is more advanced technology available in today's vendor market, offering a higher level of support and responsiveness than what we currently offer in our Medi-Cal QIPs. A new technology system will provide our clinicians with better structure for incentives by offering user-friendly support and a more responsive QIP overall. The D-SNP QIP program will be contracting with a system vendor to perform and maintain payment and performance tracking for the D-SNP QIP.

Our selected system vendor is able to provide payment calculations and offer direct payment to our providers, if needed. The D-SNP program will run on a calendar year, from January 1- December 31st and our contracted D-SNP providers are able to utilize our contracted vendor system starting day one (1) of go-live.

Year 1 Program Focus

Partnership's expansion into Medicare provides the D-SNP QIP team an opportunity to connect with newly contracted Medicare providers and engage them in the D-SNP QIP. In collaboration with our Quality colleagues and Medical Directors, the D-SNP QIP will offer traditional QIP programmatic offerings such as Kick Off webinars, newsletters, provider check-ins and any other support needed in the introductory year of this program,

Member Safety and Quality Compliance Activities

QI TRILOGY

Member Safety and Quality Compliance Activities

Quality Assurance and Member Safety activities include investigation of Potential Quality Issues (PQIs), Site Reviews (including facility site and medical record reviews), Physical Accessibility Review Surveys (PARS) (which assess the level of physical accessibility of provider sites including specialist and ancillary providers that serve a high volume of seniors and persons with disabilities), and monitoring Initial Health Appointment (IHA) rates.

Potential Quality Issues

A PQI is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care which requires further investigation to determine whether an actual quality of care concern or opportunity for improvement exists. The PQI investigation and Peer Review process provide a systematic method for the identification, reporting, and processing of a PQI to determine opportunities for improvement in the provision of care and services to Partnership members and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity. Actions include sending letters with recommendations, issuing Corrective Action Plans (CAP), Focused Reviews, and referral to the Credentials Committee or other oversight entities.

Partnership identifies PQIs through the systematic review of a variety of data sources, including but not limited to: 1) Grievances and Appeals; 2) UM (utilization review); 3) Claims and encounter data; 4) Care Coordination; 5) Medical Record Review; 6) Referrals from other health plan staff, providers and members of the community; 7) HEDIS® medical record abstraction process; and 7) Facility and Medical Record Site Reviews.

The top three (3) referral sources were Grievance and Appeals, Utilization Management and referrals from Partnership Medical Directors. The rest of the PQI cases were referred by other sources such as the Care Coordination Pharmacy departments, and external providers. The top three (3) Referral Types were Assessment/Treatment/Diagnosis, Continuity of Care, and Communication. The top three (3) Provider Types were Primary Care Provider (PCP), Hospital/ER, and Specialist.

Table: A

Region-wide Report (includes expansion region, as of 2024	2023		Grand Total	2024		Grand Total
PQI Referral Rate, Count and Membership	Q1/Q2	Q3/Q4		Q1/Q2	Q3/Q4	
PQI Count	116	111	227	97	150	247
Members Months	4,944,385	4,216,811	8,493,104	5,932,733	5,684,834	11,470,123
Rate per 1,000 Members	0.28	0.32	0.32	0.20	0.32	0.26

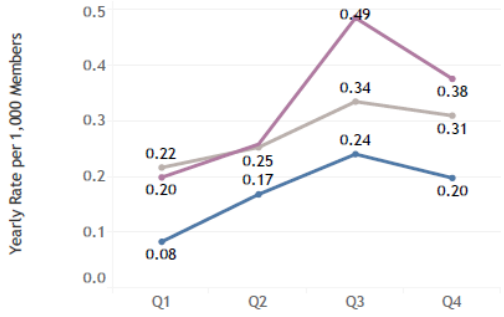
Table: B

Potential Quality Issues
Referral Dates: 2024

PQI Rate, Count and Membership

	EASTERN	NORTHERN	SOUTHERN	Grand Total
Member Months	3,411,853	2,589,914	5,468,356	11,470,123
PQI Count	49	71	127	247
Yearly Rate per 1,000 Members	0.17	0.33	0.28	0.26

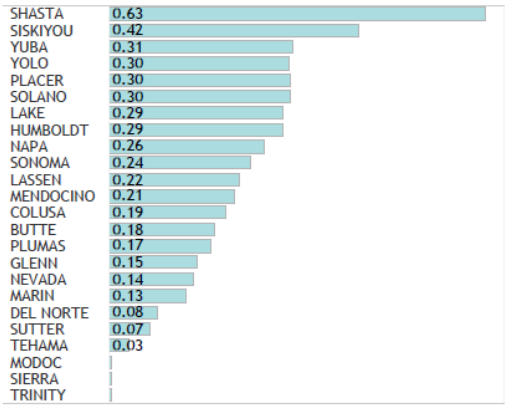
Trend of PQI Rate



Count, Membership and Rate per 1,000 Members by County

Mbr County	Member Months	PQI Count	Yearly Rate per 1,000 Members
SHASTA	862,345	45	0.63
SISKIYOU	230,895	8	0.42
YUBA	432,356	11	0.31
YOLO	643,601	16	0.30
PLACER	716,269	18	0.30
SOLANO	1,674,441	42	0.30
LAKE	415,501	10	0.29
HUMBOLDT	750,672	18	0.29
NAPA	324,264	7	0.26
SONOMA	1,327,491	26	0.24
LASSEN	111,425	2	0.22
MENDOCINO	522,451	9	0.21
COLUSA	124,258	2	0.19
BUTTE	1,026,586	15	0.18
PLUMAS	71,119	1	0.17
GLENN	164,285	2	0.15
NEVADA	342,782	4	0.14
MARIN	560,607	6	0.13
DEL NORTE	149,155	1	0.08
SUTTER	523,801	3	0.07
TEHAMA	369,178	1	0.03
TRINITY	66,483		
SIERRA	10,397		
MODOC	49,761		

PQI Rate per 1,000 Members by County



Yearly Rate per 1,000 is defined as: [(Number of PQIs)/(Membermonths)]*12,000
Created by: Liat Vaisenberg (lvaisenberg@partnershiphp.org)

As illustrated in the preceding tables A & B, in 2024, 247 cases were referred for PQI investigation compared to 128 in 2020, 113 in 2021, 156 in 2022, and 227 in 2023. As expected, PQIs case referrals increased as a result of the expansion to 10 additional counties in January 2024. There was an 8% increase in PQI case referrals in 2024 compared to 2023. Cases from the expansion region accounted for 49 (20%) of the 247 cases referred. A total of 207 cases were processed and closed to completion compared to 151 in 2020, 126 in 2021, 156 in 2022, and 235 in 2023. Closed cases included seven (7) Provider Preventable Conditions (PPC). Providers must report potential PPCs directly via online reporting to the DHCS Audits & Investigation Unit (A&I) after discovery of the event and confirmation that the patient is a Medi-Cal beneficiary.

In accordance with Partnership policy, cases score as P2 or P3 or S2 or S3 (refer to the grid below: *Assignment of Practitioner Performance and Systems Scores), by the CMO/physician designee during the internal weekly PQI rounds,* are reviewed by Partnership's Peer Review Committee (PRC) to determine what actions on the part of the health plan are indicated. A total of 16 cases were reviewed by the PRC in 2024. Assignment of practitioner performance and system scores are based on the reviewed medical records, responses from the facility or provider, other information submitted by the provider, independent Subject Matter Expert reviews, and additional supporting documentation as needed to thoroughly review the case.

A PQI may involve both a practitioner performance issue and system issue. In addition, some cases involve multiple providers who are scored individually. Physician oversight of the PQI/Peer Review process includes weekly PQI rounds attended by an internal team consisting of the Medical Director for Quality, Regional Medical Directors, Associate Medical Directors, the Behavioral Health Clinical Director, a Clinical Pharmacist, the Manager of Member Safety Quality Investigations, the RN Quality Investigators, some RN Clinical Compliance Inspectors, and the Project Coordinator. In addition to the internal PQI team, the PRC committee is comprised of external primary cre physicians and specialists who are currently practicing in hospitals, clinics, and medical groups within the Partnership provider network. Cases with significant concerns are communicated to the Credential Committee at the recommendation of the PRC. Physician and nurse participation in PRC and PQI rounds, inclusive of Partnership medical directors and network providers from diverse specialties was sufficient to meet the requirements for reviewing and making determinations regarding PQIs. In January 2024, a Nurse Practitioner from a network provider facility joined the PRC and subsequently, the PRC policy was updated to include Non-Physician Medical Practitioners as voting members.

One of our main goals for the 2024-2025 growth and improvement strategy was our outreach program focusing on educating acute care hospitals on Provider Preventable Conditions (PPC) reporting to DHCS and Partnership. This is a continuation of our 2023-2024 goal. Four (4) in-service sessions were completed with hospital Quality Staff to ensure they are familiar with the reporting requirements via the DHCS secure online reporting portal. We published an article on PPCs in the Provider Relations Spring 2024 Provider Newsletter. We also conducted several PQI presentations to other internal departments at Partnership.

In an effort to standardize our processes, we implemented new processes, enhanced existing processes and updated our policies and procedures to be aligned with business operations, regulatory requirements, technological advancement and internal practices. By focusing on these key aspects, we increased our efficiency, reduced costs, and improved quality.

Assignment of Practitioner Performance and Systems Scores

Practitioner Performance Severity Scores		
P Score	**Definition**	**Action/Follow-up**
P0	Care is appropriate.	No action required.
P1	Minor opportunity for improvement. Potential for or actual, minor adverse outcome to member.	The reviewer will send a letter and/or secure email to the provider. Response may or may not be required.
P2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for minor or moderate adverse outcome to member.	Send a certified letter and/or secure email to provider of concern, requiring a response. May impose a CAP and/or other interventions.
P3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for significant adverse outcome to member.	ASAP communication by certified letter, secure email and/or direct phone call to the provider of concern requiring a response. Requires a CAP and/or other interventions. May be referred to

Practitioner Performance Severity Scores		
P Score	**Definition**	**Action/Follow-up**
		the Credentials Committee with recommendations from the PRC.
PUTD	Use whenever the PQI cannot be leveled prior to referral to the Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC).	Referral to the Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC). If none identified, it may be through direct contact with the management of the FOC or with oversight of the POC. Refer to the appropriate licensing entity, if indicated.

System Issue Severity Scores		
S Score	**Definition**	**Action/Follow-up**
S0	No system issue.	No action required.
S1	Minor opportunity for improvement. Potential for or actual, minor adverse outcome to member.	The reviewer will send a letter and/or secure email to the provider. Response may or may not be required.
S2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for or actual minor or moderate adverse outcome to member,	Send a certified letter and/or secure email to the provider of concern, requiring a response. May impose a CAP and/or other interventions.
S3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for or actual significant adverse outcome to member.	ASAP communication by a certified letter, secure email and/or direct phone call to FOC/POC, requiring a response. Requires a CAP and/or other interventions. May be referred to the Credentials Committee with recommendations from the PRC.
SUTD	Use whenever the PQI cannot be leveled prior to referral to the Peer Review Organization (PRO) of the Facility of Concern (FOC) or the System of Concern (SOC).	Referral to the PRO of the FOC or the System of Concern (SOC). If none identified, it may require direct contact with the management of the FOC or with oversight of the SOC. Refer to the appropriate licensing entity, if indicated.

Site Reviews

Partnership conducts Site Reviews to ensure that primary care providers have the capacity to maintain member safety standards and practices. Each PCP site is required to pass an Initial Facility Site Review prior to joining Partnership's network. Site Reviews are conducted, at least every three (3) years. DHCS requires that a DHCS Certified Site Reviewer (Registered Nurse) conduct these reviews. Since April 2024, Partnership has maintained two (2) Master Trainers on the Inspections Team along with seven (7) Certified Site Reviewers (CSR). Partnership follows standards and guidelines outlined in APL 22-017 as it was issued on September 2, 2022 and revised September 9, 2022.

DHCS issued updated Facility Site Review (FSR) and Medical Record Review (MRR) Tools that went live on July 1, 2022. Effective July 1, 2022 providers were scored on the newest tools (2022 Version). DHCS later released updated FSR/MRR tools (2024 Version) with additional requirements that were implemented on January 1, 2024 as required. Any additional DHCS updates are disseminated to site review nurses and primary care providers as they are published.

Currently, Partnership continues to educate sites on the 2024 FSR/MRR Tools to assist sites in understanding the new requirements. Best practices are shared with sites to help drive improvement. Education is provided onsite during the exit interview process of site reviews and is additionally offered as separate educational sessions to all sites. Each site receives an educational packet during the exit interview that consists of information such as: Initial Health Appointment (IHA), Adverse Childhood Experiences (ACES)/Developmental Screening, Blood Lead Testing, Interpretive Services, CalAIM Enhanced Case Management (ECM), Doula Services, Telemed Program, Medical Equipment Distribution, Transportation Benefits, and Potential Quality Issues (PQI).

Certified Site Reviewers address areas identified from the review tool that do not meet the DHCS guidelines at the time of discovery during the Site Review. Partnership nurses also use this time to provide educational feedback to provider staff (i.e., handouts on TB risk assessments, reviewing IHA/Blood Lead Screening [BLS] and any other identified problem areas faced by the provider). For some areas, as required by the Site Review APL, corrective action plans (CAPs) are issued to the provider. If the site is issued a Critical Element corrective action plan (CE CAP), the site is scheduled to have a virtual CE verification with a nurse to validate all CE's were corrected appropriately. An interim assessment is also conducted at the halfway point between periodic reviews. The interim assessment addresses all Critical Elements and any additional CAP criteria from the sites last review (if applicable). Sites are supported throughout the entire CAP process to ensure site success.

Facility Site Reviews

Reviews completed from 7/1/2024-5/19/2025

Overall, the Facility Site Review domain scores remained very high in 2024. There are some areas in need of improvement. Through the Facility Site Review process, Partnership identified and communicated to providers where specific improvement is needed, with the following areas commonly cited:

- Emergency Medications and Dosage Chart
- Documentation of education/training for Non-Licensed Medical Personnel is maintained on site
- Eye Charts
- PPE in rooms with autoclaving
- Non-Safety Needles
- Spore Testing Monthly
- Management of a positive spore test

FSR Performance	2022-2023	2023-2024	2024-2025
Access & Safety	95%	96%	96%
Personnel	92%	94%	93%
Office Management	98%	98%	98%

Clinical Services	97%	98%	99%
Preventive Services	97%	99%	97%
Infection Control	95%	98%	98%

Medical Record Reviews

Reviews completed from 7/1/2024-5/19/2025

Format and documentation domain scores for the Medical Record Review (MRR) remained fairly high – within the 90th percentile range. The number of Adult and Pediatric Preventative measures were greatly increased with the release of the 2022 and 2024 MRR Tools. Partnership has been working with sites to understand the new guidelines and where specific improvement is needed.

Areas for improvement:

- All entries are signed, dated, and legible
- Member Risks Assessment/Subsequent Risk Assessment (IHA)
- Certified Screening Tools
- Advance Healthcare Directive
- All Preventative Healthcare Measures

MRR Performance	2022-2023	2023-2024	2024-2025
Format	97%	98%	98%
Documentation	94%	93%	94%
Coordination of Care	97%	96%	98%
Pediatric Preventive	81%	81%	80%
Adult Preventive	77%	76%	72%
OB Preventive	97%	90%	89%

Provider Billing Guide

As part of the FY 22/23 Department SMART Goals, the Inspections Team joined with the Claims Team to create a new provider billing guide to assist sites in correctly coding for preventative services. The guide covers Adult and Pediatric preventative services. The billing guide lists the preventative services from the Medical Record Review (MRR) Site Review tool and includes demographics along with the corresponding billing codes. By supporting providers to use the proper billing codes, providers will be able to better demonstrate completion of preventative services required by quality measures and the DHCS Site Review Tools. PCP sites and OB sites are provided with laminated copies of this guide at the Site Review exit interview. (Providers have given us positive feedback and have asked for additional copies of the billing guides to assist their site in better billing practices). Partnership continues to utilize this tool and updates the document quarterly or as needed.

Provider Educational Trainings

Site review measures correspond to priority quality measures defined under the DHCS Managed Care Accountability Set (MCAS) as well as those required for reporting and scoring under NCQA Health Plan Accreditation. Providers are encouraged to engage in educational sessions to drive improvement throughout the communities they serve. Partnership offers educational sessions as needed to our provider network through various forums.

Providers are offered one-to-one educational training sessions with a Certified Site Review Nurse (CSR RN) at every Site Review. Education is provided as requested. Educational offerings are provided through multiple forums such as provider newsletters, the Partnership website and regional meetings. Trainings are tailored to each specific site to assist sites with overcoming barriers and to provide best practices.

In anticipation to the new Site Review tools, Partnership emailed and offered education to PCP offices focusing on the new 2022 and 2024 Site Review Tool changes as well as the Initial Health Appointment (IHA) and Blood Lead Screening. This is in addition to the education provided at every Site Review exit interview. Partnership will continue to offer one-to-one educational sessions to sites to help support our provider network to be successful.

In anticipation of the sunset of the Child Health and Disability Prevention (CHDP) Program, Partnership has taken on the responsibility of training providers and staff on CHILD (Comprehensive Health Interventions for Lifelong Development) trainings, rebranding CHDP. As of May 2024, Partnership has been offering CHILD trainings to primary care provider (PCP) offices. Training topics include hearing and vision screening, anthropometric measurements, BMI calculation, fluoride varnish application, and immunizations, all in alignment with the DHCS CHDP Transition Plan. PowerPoint training materials were developed using CHDP references provided by the California Department of Health Care Services (DHCS) and in collaboration with CHDP offices across the counties served by Partnership. We currently offer training via Webex with an education specialist or through videos that are available on our website.

We have added an additional role to the Inspections Team: Quality Training Specialist and Dental Liaison. This position is responsible for delivering provider education such as the above-mentioned CHILD trainings.

This role also serves providers as Partnership's designated Dental Liaison. As Dental Liaison, this position is responsible for collaborating with providers, internal departments, and other stakeholders to identify process improvements and other improvement activities for enhancing the quality of dental and oral health care our members received. This position maintains current knowledge of related benefit changes from the Department of Health Care Services and standards of care to help improve member health status and quality outcomes while establishing a positive provider experience and rapport.

Improving Blood Lead Screening

Consistent with APL 20-016, Partnership's Facility Site Review (FSR) and Performance Improvement Teams have regularly educated providers on Blood Lead Screening (BLS) and anticipatory guidance for all children ages 6 months to 6 years. Partnership was able to collaborate with some Partnership network county Public Health offices

in order to better support our communities in increasing awareness and testing for Blood Lead. This is an ongoing relationship.

As of May 2023, the Inspections Team (Site Review Team) was able to work with Provider Relations (PR) and join their Operational meetings between Partnership and clinics. These customized meetings with providers and practice staff allow for direct interaction with Partnership staff from multiple departments. They provide a forum for Partnership to present updates on specific topics, review identified gaps in care and to field questions directly from providers about various topics of concern. The Inspections Team is now presenting on BLS and the Initial Health Appointment (IHA) during these meetings.

Blood Lead Screening flyers are given as part of an educational packet at every Site Review. Education is provided 1:1 while on-site during the Site Review exit interview process. Formal education is also offered through various avenues such as provider newsletters, member facing newsletters, webinars, Regional Directors Forums, Partnership's website, etc. Providers receive quarterly lists of members eligible for BLS testing with the expectation they will contact and schedule members to receive the required services they are due for. BLS testing is monitored through the medical record review (MRR) process.

Member Engagement:
Members also receive notifications and reminders through various sources such as member newsletters, Partnership's member website, mailings, community events, etc. Partnership has multiple member programs such as "Growing Together" prenatal and postpartum programs, "Healthy Toddlers and Healthy Kids- Growing Together." These programs help create awareness on multiple topics including blood lead screening.

Physical Accessibility Review Survey

(PARS), aka Part C Review

The purpose of the Physical Accessibility Review Survey (PARS) is to assess provider sites' physical accessibility for Partnership's seniors and persons with disabilities (SPDs) using a set of standards approved by DHCS. Results from the reviews are made available to Partnership's members through its website and provider directories. The findings of these reviews are informational only. Providers are designated as having either "Basic Access" or "Limited Access."

- Basic Access: Indicates that the facility met all 29 critical elements that identify a site's capability of accommodating SPDs
- Limited Access: Indicates that the facility does not meet one (1) or more critical element related to the six (6) indicators listed below:
  - Parking
  - Interior Building
  - Exterior Building
  - Restroom
  - Exam Room
  - Medical Equipment
- Medical Equipment Access: PCP sites only. Demonstrates if a site has a height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient)

PARS Results for PCP and Specialist Offices July 1, 2024-May 23, 2025

Count of PARS-Level	OB	PCP	Spec	Grand Total
Basic	2	72	6	80
Limited	8	82	5	95
Grand Total	10	154	11	175

Initial Health Appointment

In FY 2024/25, Partnership continued its efforts to support and monitor compliance against DHCS requirements for the Initial Health Appointment (IHA). The DHCS contract mandates that each new member receive an IHA within 120 days of enrollment in the health plan. The IHA includes a comprehensive history of the member's physical and mental health, identification of risks, an assessment of needed preventive screenings or services and health education, and development of any necessary diagnosis or treatment plan.

Effective January 1, 2024, one additional requirement was added to the Initial Health Appointment. Now, along with the completion of a history and physical within 120 days of enrollment, providers are required to complete a Member Risk Assessment as part of the IHA.

The initial Member Risk Assessment identifies health and social needs of members including cultural, linguistic, and health education needs; health disparities and inequities; lack of coverage/access to care; and social drivers of health (SDOH).An assessment of at least one of the following risk assessment domains meets the standard:

- *Social Determinants of Health (SDOH):* The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of SDOH include housing instability, food insecurity, transportation needs, utility needs, interpersonal safety, etc. Documented assessments of SDOH in the progress notes or use of an SDOH screening tool meet the standard (ex: Social Needs Screening Tool).
- *Adverse Childhood Experiences (ACEs)* (birth to 64 years old): Potentially traumatic experiences, such as neglect, experiencing or witnessing violence, having a family member attempt or die by suicide, household with substance use problems, mental health problems and other experiences that occur in childhood that can affect individuals for years and impact their life opportunities. Examples of validated screening tools that meet the standards include:
  - The Pediatric ACEs and Related Life-Events Screener (PEARLS), used to screen children and adolescents ages 0-19 for ACEs
  - The ACE Questionnaire for Adults, used to screen adults 18 years and older for ACEs
- *Cognitive Health Assessment*

A Subsequent Risk Assessment shall be completed annually, or more frequently, if any significant changes in health status are identified. This consists of at least one (1) of the risk assessment domains listed above.

Performance and Oversight Activities (FY 2024/2025)
Partnership focused on strengthening provider education, outreach and monitoring.

- Continued provider education through newsletters, regional meetings, site reviews and exit interviews
- Monitored IHA compliance via the medical record review process and site reviews, providing targeted feedback and support
- Enhanced outreach strategies by encouraging providers to regularly access lists of newly enrolled members via the provider portal and to proactively schedule IHA appointments
  Provided members with IHA reminder through new member packets, letter, and the Wellcare Guide.

Internal and external QI committees review the results of completed Site Reviews, including the review of IHA compliance, at least annually. This allows an opportunity to provide constructive feedback regarding the existing processes.

Partnership is currently working on strengthening our internal data analysis by reviewing coding and reporting procedures. This has proven to be a large task and continues to be a topic of discussion.

Recognizing the challenges in achieving high rate of success in this measure, Partnership continues efforts to influence performance on a provider-by-provider basis through the site review process.

Improvement Activities

Efforts Made During Site Reviews:

a. Sites receive a monthly reminder to outreach to their new members and are educated to document their outreach attempts to new members. Partnership provides spreadsheets for the sites to document their efforts, as many sites do not wish to open a new chart before the member is actually located and establishes care. These spreadsheets are reviewed and discussed during the Site Reviews.

Miscellaneous Continuous Efforts:

a. A multi departmental collaborative meeting is held biannually to discuss IHA efforts and opportunities. Participating departments include: Quality, Claims, Provider Relations, Utilization Management, Care Coordination, Member Services, Population Health, and Regional Directors, as available.
b. Newsletter articles: Information continues to be shared through our Provider and Member Newsletters. These articles are available on the Partnership website.
c. IHA Provider education is available on the Partnership website including a webinar for Providers.
d. Newly credentialed providers are educated on the IHA requirement, and a new member packet is sent to members informing them of the importance of an IHA.
e. Member Services mails an initial letter encouraging members to schedule a PCP appointment and will remind members to schedule an IHA if the member calls Partnership.
f. Partnership currently contracts with a vendor to call all newly assigned members to complete Partnership mandated assessments along with recommending an IHA visit (tracked by Care Coordination). Partnership implemented a script change to add the statement “Reminder -Please contact your Primary Care Provider to schedule your important Initial Health Appointment within 90 days of becoming a Partnership member.”
g. Partnership has a “Healthy Growing Together” program and mailers/outreach goes out to babies from birth to 18 months with outbound calls and incentives. This activity particularly focuses on members newly enrolled with the plan, so it provides the opportunity to promote IHAs.

h. IHA is discussed at Operational Meetings with sites along with BLS (see BLS section for further details- page 108.

Delegation Oversight

Partnership's oversight of QI activities delegated to DHCS subcontractors/NCQA Delegates is reviewed and approved at least annually by the Delegation Oversight, IQI, and Q/UAC Committees. Designated leaders within the Member Safety team serve as primary reviewers of Carelon's QI program and distinct quality functions it carries out on behalf of Partnership. A delegation agreement, including a detailed list of delegated activities and reporting requirements, is mutually agreed upon by Partnership and the entity. Currently Partnership contracts with Carelon Behavioral Health (formerly known as Beacon Health Options) to administer non-specialty mental health consistent with NCQA standards.

Latent TB Infection – 12 Dose Treatment

The Pharmacy Department led an intervention to track, monitor, and evaluate member adherence to Latent Tuberculosis Infection (LTBI) treatment regimen. The goal was to create a Business Object Report utilizing Medi-Cal Rx Contractor pharmacy claims data whereby the health plan clinical pharmacist can timely and proactively identify members who are at risk of becoming non-adherent to their LTBI regimen. Prescribers are notified at Day 16 and Day 20 of members late on their refills and out of medication. The objective is to inform the prescribers so they can reach out to members to refill their medications before the adherence gap exceeds the CDC allowed gap which would requires the member to restart the regimen.

Since July 2023, a total of 148 notification letters were sent for identified treatment gaps from 314 members (28 members had two (2) or more treatment gap notifications sent to their prescribers). Of the 314 members, 120 members (~38%) completed a refill of their LTBI medications after the prescriber notification and 66 (~21%) completed their prescribed LTBI regimen by the recommended timeframe.

For notification timeliness, 84% of notifications were sent by Day 16 and 6% by Day 20. 10% were beyond Day 20 due to claim reversals, delay in confirmed LTBI diagnosis, or missed tracking.

The Day 16 and Day 20 notifications provide an opportunity for the prescriber to engage the member on continuing their LTBI regimen rather than being informed the member did not complete their regimen and would require a restart. Additionally, the monitoring to cover all LTBI regimens identified more treatment gaps, as well as provided an opportunity to educate prescribers and pharmacies on the different LTBI regimens and common mistakes that occur with prescribing and dispensing LTBI regimens. Lastly, we are working with county public health by sharing information on instances of LTBI treatment gap and collaborate with public health on improving LTBI treatment completion rates. Currently, we are sending our LTBI pharmacy claim information to public health officers of 7 counties.

As needed, the health plan pharmacy technician or clinical pharmacist will also contact the dispensing pharmacy to assist with coordinating Isoniazid and Rifapentine refills or identified inappropriate dispensing. The clinical pharmacist will continue to track LTBI therapy gap and non-adherence as well as validate pharmacy claim data from Medi-Cal Rx. Partnership continues to advocate to the California Department of Public Health (CDPH) for

consideration of an interface between the Medi-Cal Rx prescription data with CalREDIE, the health information and management system used by County Public Health departments and CDPH. If CDPH and Medi-Cal Rx can effectuate this interface, it will allow public health agencies to actively monitor, track, and trend LTBI detection and treatment.

Quality in Member Experience

QI TRILOGY

Care for Members with Complex Needs and Community Partnerships

Partnership HealthPlan of California is committed to supporting members with complex health and social needs through coordinated care, strong community partnerships, and focused quality improvement initiatives. During FY 2024-2025, these efforts centered on advancing equitable, high-quality care and improving member experience across our regions. This section highlights our work to enhance care for members with complex needs, including maternal and child health, complex case management, and transitions of care, to ensure services are safe, coordinated, and effective. It also describes our collaboration with counties and community organizations to expand provider capacity and strengthen local resources to improve access to care. In addition, it reflects our efforts under the CAHPS® / Member Experience Program, which evaluates member feedback to identify opportunities for improvement in access, service delivery, and overall satisfaction. Together, these initiatives demonstrate Partnership's ongoing commitment to addressing health disparities, improving outcomes, and enhancing the experience of care for the communities we serve.

Care for Members with Complex Needs

With the goal of improving HEDIS® rates for PPC-Pre, PPC-Post, W15, and to comply with California AB2193 (Maternal Mental Health Screening, 2018), Partnership's Population Health Department decided to review and revise the Growing Together Program by conducting an assessment that asks questions on a variety of topics, including social determinants of health and mental health. Efforts of this revision also consisted of continued focus on HEDIS® measures to support and reinforce maternal participation in prenatal and postpartum appointments, obtaining well-child exams for children within the first 15 months of life, and encourage members to take advantage of mental health services during and after pregnancy. Assessment tools were developed in 2021 to work with members who are progressing with a healthy pregnancy and well babies, and the team worked to improve early identification of pregnant women in 2022. Over the 24/25 fiscal year, the percentage of participation across programs is a follows: Prenatal 59.8% and Healthy Babies 64.7%*. When the team identifies a pregnant, postpartum, or baby that might need additional services, the team will submit a referral into Care Coordination for case management.

*All percentages are current as of May 21, 2025; date range is July 1, 2024-May 21,2025.

Complex Case Management

Partnership's Care Coordination (CC) Department has continued to monitor for any updates in Complex Case Management (CCM) activities to meet DHCS and NCQA requirements and strive for continuous compliance and improvement. The CC Department has been using the online NCQA Auditing Tool to keep track of CCM Cases. CCM Cases are continuously audited to ensure compliance with NCQA standards and to identify opportunities for additional training and tools to support the staff—primarily Nurse Case Managers and Social Workers—who conduct CCM assessments. We are collaborating closely to finalize our plan for the CCM Assessment in preparation for Jiva's go-live implementation. The CC Department recently had a mock audit with our NCQA Consultant in April 2025, and we are working on getting the necessary recommendations integrated in our current practices. Ongoing efforts are being made to ensure the assessment, audit tool, staff training, and any additional necessary activities are successfully completed to maintain continuous compliance with our CCM program. With the implementation of D-SNP, we are proactively ensuring that our CCM policy remains current and undergoes a

thorough review to maintain compliance and alignment with program requirements. The CC Department has decided to implement a CCM Close-Out Letter to be issued upon case closure, once all goals have been successfully met. We initiated the draft in May 2025 and are collaborating with the Communications Department to obtain the necessary approvals, ensuring the letter is finalized in time for Jiva's go-live. The CC Department is expanding with the addition of new Nurse Case Managers and Social Workers. To support their integration, CCM new hire trainings are conducted as needed, offering comprehensive guidance on program requirements to ensure staff proficiency and regulatory compliance. The department remains committed to maintaining survey readiness across the CCM program and services and continues to actively promote the CCM program to members.

Community Resource Web Pages

Partnership has recognized that community resources provide significant support to its member population and their health and well-being. In December 2018, Partnership's Population Health Team created web-based community resource pages that show the various resources available in each county by resource type. New resources are added to the existing pages as they are identified. The community resources pages are organized by county and use pictographs and titles to be mindful of readability and education-level, ensuring easy access for all literacy levels. Over the past year, the Population Health Team has partnered with Communications to add new resource pages for the 10 expansion counties and ensure they have all twenty-five categories available and populated. Additionally, in September 2024, the Population Health team launched a new category for all twenty-four counties – Tribal Health and Wellness. This resource category showcases resources that are specific to tribal communities or members of American Indian/Alaska Native (AI/AN) descent. The creation of this category is an acknowledgement of the unique health challenges faced by AI/AN communities and is also a step towards equitable healthcare but providing culturally relevant and easily accessible local resources. The Population Health Team validates all resources in each page no less than annually, and shares county resource page web links with providers, members, and community-based organizations to promote the programs and services offered within a member's community.

Services and Patient Experience

A vulnerable time for a member is when they are transitioning across settings. The Transitions of Care (TOC) Assessment/Survey was archived on April 21, 2025, following the revision and implementation of the Transitions of Care (TCS) Assessment/Survey, which replaced the TOC Assessment/Survey in Care Coordination. The Care Coordination Department continues to assist members in transitioning across different settings (hospital to home or other levels of care), across benefits (exhausting residential treatment service benefits for substance use disorder or transitioning from curative care to hospice care), or transitioning from pediatric to adult care. Members are often vulnerable to information loss across the care continuum, fragmented care, and challenges navigating the health care system. Case leads provide support by connecting members with outpatient resources, clarifying prescriptions, educating them on benefits and available services, and helping to establish or re-establish care with providers. The program-specific assessment is utilized to ensure all needs are effectively identified and addressed, preventing any gaps in support. Previous TOC reports in Care Coordination identified members that had been discharged from the hospital with a length of stay longer than five days, and complex members that were transitioning from pediatric to adult care. Daily TCS reports indicate members within any DHCS-defined High Risk TCS population who is transferring from one setting or level of care to another.) Members who have been identified and/or are part of Complex Case Management (CCM)/Enhanced Care Management (ECM) have their Transitional Care Services rendered by the same case manager.

As we transition to Jiva, we are ensuring the seamless integration of the TCS workflow. Moving forward, the TCS Assessment/Survey will fully replace the TOC Assessment/Survey. We remain committed to ensuring the accurate and timely completion of the TCS Assessment/Survey while continuing our efforts to provide comprehensive support to our members. There were 157 adult members who completed TOC services, and 155 completed Adult TOC Satisfaction Surveys between January 1 and December 31, 2024: a survey completion rate of 99%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Adult TOC Satisfaction Survey. The average score ranged from the lowest at 2.64 to the highest at 2.98, which exceeds the goal average of 2.5. The results of the Adult TOC surveys and the many positive comments left reveal a high satisfaction rate among the members surveyed. Our adult members report good outcomes with this program, and we will continue providing this benefit under the TCS program.

Survey Questions	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my health issues.	2.97	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager)	2.98	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.91	Yes
After working with the case management team, I feel my ability to manage my healthcare needs is better.	2.92	Yes
My health has improved since working with my case management team	2.71	Yes
I was able to safely transition between Providers with the help of my Care Team	2.78	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with my case management team.	2.64	Yes
I was provided the available equipment, medication and/or services that were needed.	2.87	Yes

There were 62 pediatric members who completed TOC interventions, and 37 of them provided responses for the Pediatric TOC Satisfaction Surveys between January 1 and December 31, 2024: a response rate of 60%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Pediatric TOC Satisfaction Survey. The average score ranged from the lowest at 2.58 to the highest at 2.95; well above the goal average of 2.5. The results of the Pediatric TOC surveys and the many positive comments left reveal a high satisfaction rate among the members surveyed. Families report

good outcomes with this program for our pediatric members, and we will continue providing this benefit under the TCS program.

Survey Questions	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my child's health issues.	2.86	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	2.92	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.78	Yes
After working with the case management team, I feel my ability to manage my child's healthcare needs is better	2.76	Yes
My child's health has improved since working with our case management team	2.56	Yes
I was able to safely transition my child between Providers with the help of my Care Team.	2.69	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	2.58	Yes
My child and I were provided with the available equipment, medication and/or services that were needed.	2.95	Yes

There were 17 adult members who completed TCS services, and 16 completed Adult TCS Satisfaction Surveys between January 1 and May 27, 2025: a survey completion rate of 94%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Adult TCS Satisfaction Survey. The average score ranged from the lowest at 2.50 to the highest at 3.00, which exceeds the goal average of 2.5. The results of the Adult TCS Surveys and the many positive comments left reveal a high satisfaction rate among the members surveyed. Our adult members report good outcomes with this program, and we will continue providing this benefit.

Survey Questions	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my health issues.	3.00	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager)	3.00	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.88	Yes
After working with the case management team, I feel my ability to manage my healthcare needs is better.	2.75	Yes
My health has improved since working with my case management team	2.50	Yes
I was able to safely transition between Providers with the help of my Care Team	2.88	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with my case management team.	2.63	Yes
I was provided the available equipment, medication and/or services that were needed.	2.69	Yes

There were two (2) pediatric members who completed TCS interventions, and two (2) of them provided responses for the Pediatric TCS Satisfaction Surveys between January 1 and May 27, 2025: a response rate of 100%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Pediatric TCS Satisfaction Survey. The average score ranged from a low of 2.50 to a high of 3.00, both exceeding the target average of 2.5. The results of the Pediatric TCS Surveys and the many positive comments reveal a high satisfaction rate among the members surveyed. Families report good outcomes with this program for our pediatric members, and we will continue providing this benefit.

Survey Questions	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my child's health issues.	3.00	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	3.00	Yes
My team referred me to medical and community resources that were valuable and helped me.	3.00	Yes
After working with the case management team, I feel my ability to manage my child's healthcare needs is better	3.00	Yes
My child's health has improved since working with our case management team	3.00	Yes
I was able to safely transition my child between Providers with the help of my Care Team.	2.50	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	3.00	Yes
My child and I were provided with the available equipment, medication and/or services that were needed.	3.00	Yes

Access to Care

Annually, Partnership collects data from a variety of sources to evaluate all aspects of information related to Network Adequacy to ensure Partnership provides members with adequate network access for needed healthcare services. The provider types covered include primary care clinicians, medical specialists, pharmacies and hospitals. Partnership follows both the DHCS and NCQA requirements. A detailed analysis of access to care data is included in the Assessment of Access and Availability (NET 3) Grand Analysis Report. The following provides a preliminary high-level summary of the data available to date.

Analysis was conducted in collaboration between the Quality Improvement, Network Services, and Health Analytics Teams. Based on opportunities identified, interventions are defined, and measurable goals are set, to improve network adequacy.

The following access to care findings reflect information included for the calendar year 2024 in the 2025 Network Management Grand Analysis Report.

- **Member Grievances**

  For the reporting period of January 1, 2024 through December 31, 2024, Partnership did not meet the established goal of 2.47 grievances per 1,000 member threshold, having recorded 2.83 grievances per 1,000 members in 2024. This number represented an increase in grievances per 1,000 members when compared to the 2.25 grievances per 1,000 members in 2023. An increase in the total submission of grievances was to be expected due to the ten-county expansion Partnership undertook in 2024. A national shortage of healthcare workers combined with an aging provider population has contributed to ongoing access challenges; however, Partnership did experience a decrease in the percentage of access related grievances. In 2024, there were a total of 5,477 grievances submitted by our members and the analysis attributes 42% of all cases to access related issues. In comparison to the 2023 reporting period, there were a total of 3,572 grievances submitted by our members and the analysis attributes 43% of all cases to access related issues.

- **Member Appeals**

  For the reporting period of January 1, 2023 – December 31, 2023, as well as the reporting period of January 1, 2024 – December 2024, Partnership met the threshold of less than or equal to 0.57 per 1,000 members for access to care appeals and second level grievances. Partnership had 15 less total Appeals and Second Level Grievances in 2024 than in 2023 resulting in a decrease of 2%.

- **Out of Network (OON) Requests**

  For the period of January 2024 – December 2024, as a plan, Partnership met the goal of less than 20 per 1,000 members for referrals. Out of 5,916 OON Referral requests submitted in 2024, 3,803 were approved with equal distribution throughout the service regions.

  A deeper look shows that Modoc county failed to meet the threshold with 37.3 referrals per 1,000 members. Access in Modoc county is much harder due to rural terrain and a patient population that is typically too small for a specialist to maintain viable practices. Placer county had the highest number of referrals overall; however, the threshold was met at 18.7 per 1,000 members.

  The three specialties with the highest OON referrals included: Oncology/Hematology with 64.7% of approved referrals used, Dermatology with only 12.5% of approved referrals used, and Optometry with only 1.2% of approved referrals used. Of the 3,803 approved referrals plan-wide, 1,377 (36.2%) were used.

- **Practitioner Availability (Ratio and Geographic Availability)**
  - *Measured through the 2024 Network Adequacy Report Availability of Practitioners (NET 1, Element B, C).* Primary Care Practitioners overall, Family Practice, and Pediatrics all achieved a "met" score for number of practitioners to members for the reporting period. Partnership expanded into 10 new rural counties in 2024 and experienced a 38.8% increase in total membership compared to 2023. We have been able to maintain access to primary care for all ages by having a stable Family Medicine network. The Provider Recruitment Program provides incentives for Primary Care practitioners to join our network. Partnership is actively recruiting for all categories of Primary Care, specifically in our rural areas that traditionally have a lower number of providers.
  - The six (6) high volume specialties utilized by members remained unchanged from 2023 to 2024. The six (6) specialties include Obstetrics/Gynecology, Cardiology, General Surgery, Orthopedic,

Ophthalmology, and Dermatology. Plan-wide, the provider ratio standards and geographic distribution for all high-volume specialist providers were met. No plan-wide interventions are indicated.
    - Plan-wide, the provider ratio standards and geographic distribution for our high impact Oncology/Hematology specialty providers were met. No plan-wide interventions are indicated.

- **Practitioner Accessibility (Appointment Time Standard)**
  Measured through the 2024 Third Next Available Appointment Provider Survey
    - As a plan, one (1) of the four categories of primary care appointments fell below the established median 10-day appointment goal in 2024. Non-urgent adult primary care appointments fell short with a 6.7 decrease from 2023
    - As a plan, two (2) high-volume specialties fell below the established median 15-day appointment goal in 2024 as compared to three (3) in 2023. Dermatology fell short of the goal in both the southern and eastern regions. Obstetrics Gynecology fell short across all regions.

- **Member Experience**
  The 2022-2023 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Composite Scores taken from the ME7 CAHPS® Results Report revealed the Adult Composite score for getting needed care and getting care quickly both had a slight decrease as compared to 2023. Both failed to meet the benchmark. In Year 2023-2024, we received 130 more complete surveys than in Year FY 2022-2023 giving us an increase in response rate of 1%. All questions met the 100 sample size criteria for both measurement periods. The CAHPS program raised the plan performance benchmark to the 33rd percentile from the 25th. The Child composite scores for both measures experienced a slight increase from 2023, however, both measures failed to meet the benchmark. In Year 2023-2024, we received 48 more complete surveys than in Year FY 2022-2023 giving us an increase in response rate of 1.2%. All questions met the 100 sample size criteria for both measurement periods. The CAHPS program raised the plan performance benchmark to the 33rd percentile from the 25th.

Member Services Access

The Member Services Department monitors and analyzes internal Call Center performance as well as the performance of our contracted delegates. Performance is based on Partnership's established service level(s) below:

- 80% of Calls Answered within 30 Seconds
- 30 Second Average Speed of Answer
- 10% or less Abandonment Rate

To monitor delegate performance, Partnership requires delegates to submit a monthly performance report in which Partnership tracks and trends results against the established service levels on a quarterly basis. Delegate performance is reported out through our Delegation Oversight Review Subcommittee (DORS). The delegates that are currently within Member Services' purview are Carenet, and Carelon. With that said, it is important to note that Carelon's Call Center function will transition in-house and no longer be delegated. While the transition date is still fluid, internal efforts are targeting Fall 2025.

At the department level, Member Services also track quarterly delegate Call Center performance through inter/intradepartmental collaboration and reporting.

Additionally, the Carenet/Partnership Joint Operations Quarterly meeting provides an open forum for both entities to collaborate and discuss areas of opportunities. Carenet's participation and efforts in this collaboration have led to continued progress around sustaining service level standards memorialized through their respective Master Service Agreement.

Opportunities for Improvement

Partnership operates in a broad service area encompassing urban, suburban, and rural settings. Partnership's provider network is challenged by a national shortage of providers, competition from other entities, and an aging provider community. Because of this, Partnership has developed a multi-pronged approach to recruit and retain providers.

Activities to Improve Access

Opportunity

Increase the number of contracted primary care and high-volume specialty care practitioners.

- Partnership has updated the Provider Recruitment Program (PRP) that offers a sign-on bonus for providers that are new to the Partnership network. If they are a currently practicing provider, they must come from outside of the Partnership 24 county service area. Providers completing a training program within the Partnership service area qualify for consideration for an award from the program. This updated program is active between January 2024 – June 2025 with the bonuses being paid out over multiple payments over a 60-month term for physicians, NPs, and PAs, 24 months for behavioral health clinicians, and 12 months for certified SUD counselors. The strategy is to recruit and hold providers in place longer term. To date there has been an increase in accepted offers with 168 awards approved on average over 12 months, (as compared to a historical average going back to 2014 of 86 awards per year). Family Medicine has been the majority provider specialty awarded, representing nearly 57% of the program awards to date. Partnership was able to recruit 208 new primary care practitioners to the network between January 2024 – April 2025, with 5 of them recruited to 4 of our most rural counties, including Sierra, Modoc, Plumas, and Trinity, whose geographic area is 75% or more rural (according to the US Census Bureau definition). Initial recruitment and retention details look favorable, but we may not know completely until the 60-month time period and further payments take place.
- Partnership continued to expand its efforts to strengthen recruitment for specialty providers, including obstetrics providers (physicians, women's health nurse practitioners, certified nurse midwives) whose clinical care focuses on perinatal care, including labor and delivery, to the 2024 PRP. Fifteen obstetrics providers have been awarded since January 2024.
- Partnership added a physician medical resident retention bonus to the 2024 PRP. The bonus is intended to help retain resident graduates to the region if they committed in their third year of residency to stay in practice with a Partnership-contracted provider organization following graduation from their training program. Since January 2024, 8 residents have qualified for the resident retention bonus and accepted offers to practice in northern California following their graduation.
- Partnership launched a provider retention initiative (PRI) pilot in January 2024. The PRI is intended to recognize primary care clinicians, those who offer perinatal services (including labor and delivery) and/or obstetrics/gynecology, and psychiatrists who have devoted their careers to the safety net, while helping to incentivize additional years of service from them. Our hope is that the PRI will help preserve institutional knowledge and clinical leadership and mentorship within our network, while an emerging generation of

providers can learn from and train with these committed health professionals. Since January 2024, 65 providers have been awarded and have committed to practice for 3 additional years.

- Partnership conducted a survey of specialty providers in 2024 to better understand our specialty network. Partnership's workforce team continues to analyze the data to learn what strategies and tactics could help increase access to specialty care.
- Partnership's workforce development team continues to complete environmental scans with partners and analyze data from our access studies. We will continue to use this information to engage with our leadership to inform and recommend strategies for FY 2025-2026, which include the PRP and PRI.

CAHPS® Program | Member Experience

Overview

At Partnership HealthPlan of California (Partnership), our commitment to members goes beyond policy or compliance, it is rooted in purpose. As of December 2023, we proudly served over 663,822 members across our legacy 14-county service area. While Partnership expanded to serve an additional 10 Northern California counties (as of January 2024), this evaluation focuses exclusively on our legacy regions to ensure consistent year-over-year trend analysis. It reflects our ongoing commitment to listen, learn and lead work that improve our members' healthcare experience. As a member-centered organization, we recognize that member experience fundamentally shapes our healthcare delivery success.

What We Measured and Why it Matters

Through coordinated efforts across departments, we capture member feedback through two primary channels:

- Annual regulated and non-regulated surveys (Calendar Years: 2022-2023)
- Grievance and appeals reporting (Calendar Years: 2023-2024)

We maintain a comprehensive view of our performance by evaluating both historical trends and current National Committee for Quality Assurance (NCQA) Member Experience data. This analysis drives our continuous improvement efforts and supports our commitment to delivering high-quality healthcare services. Detailed trending analyses and supporting documentation can be found in Appendix B: Member Experience (ME 7) Report.

Together, these data sources offer a more complete picture of how our members truly feel. From survey responses to the concerns raised through appeals, each insight helps us better understand what matters most to the people we serve.

Accreditation Compliance

NCQA requires accredited health plans to conduct an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. The Agency of Healthcare Research and Quality (AHRQ) designed and governs this survey.

CAHPS® Survey Objectives

The CAHPS® survey captures member-reported experiences with their healthcare, through three key focus areas:

1. Measuring how effectively plans meet member expectations and goals

2. Determining which service areas most impact overall member satisfaction
3. Identifying opportunities for quality improvement in care delivery

The structured evaluation process below highlights the disciplined approach that Partnership applies to quality improvement efforts to continuously enhance service quality and member care experience.

I. Introduction

This evaluation provides retrospective performance analysis that links previous fiscal year (FY) reporting period (FY 2023-24) outcomes to FY 2024-25 Organizational Goal activities. This comprehensive review enables us to assess historical performance while informing strategic quality improvement initiatives.

This analysis evaluates plan-covered members' experience and quality metrics for Measure Year 2023, Reporting Year 2024, and Fiscal Year 2024-2025.

Note: In this evaluation, "Partnership" and "Plan" refer to Partnership HealthPlan of California.

II. Scope of Evaluation

The FY 2024-25 QI Evaluation draws on a comprehensive, evidence-based methodology to assess member experience and inform targeted strategies. This multi-dimensional evaluation integrates both qualitative and quantitative insights to guide meaningful improvements in service delivery and member outcomes.

Key Components:

1. Member Experience Data	2. Grievances and Appeals Data
• CAHPS® survey results • Service quality metrics • Member satisfaction indicators	• 2024 Annual Report • Ongoing complaint monitoring • Trend analysis

The evaluation process follows an evidence-based methodology incorporating:

3. Quantitative Analysis	4. Qualitative Analysis
• Year-over-year CAHPS® survey results • Statistical trending of key metrics • Benchmark comparisons against national standards • Internal performance indicators	• Member narrative feedback • Contextual assessment of survey responses • Process evaluation findings • Implementation effectiveness review

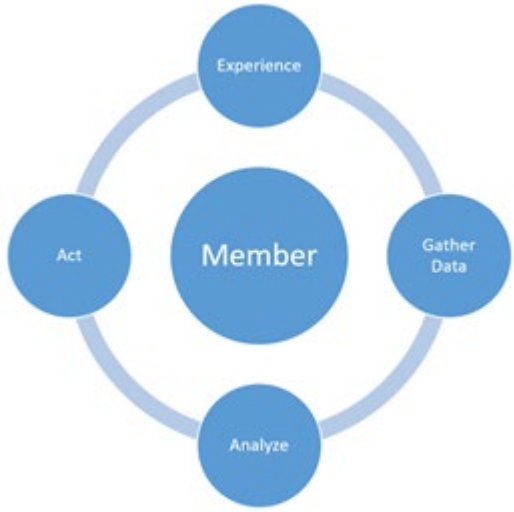
This integrated analytical approach enables Partnership to:

- Identify statistically significant trends
- Pinpoint high-impact improvement opportunities
- Develop data-driven action plans
- Track progress against strategic objectives
- Demonstrate alignment with organizational mission

Ultimately, these insights drive informed, decision making to enhance member experience and health outcomes, and reinforces Partnership's commitment to delivering high-quality, equitable, and responsive managed care delivery.

III. CAHPS® Program Framework and Methodology

The CAHPS® program operates on a comprehensive member-centric Continuous Quality Improvement (CQI) framework that drives evaluation and enhancement of member experience. This framework encompasses:

Core Components	CQI Diagram
• Member experience assessment	
• Performance analytics	
• Outcome measurement	
• Data collection and validation	
• Targeted improvement initiatives	

CAHPS® Regulated Survey Methodology

The plan contracts with an NCQA-certified vendor annually to administer the CAHPS® Regulated survey from February to May. It employs a multi-protocol engagement strategy in English and Spanish to enhance outreach and inclusivity by utilizing mail, phone, and digital options. The protocol begins with a mailed questionnaire, followed by a reminder letter and a second questionnaire in the second month. Phone outreach includes a reminder call before the second mailing and up to three follow-up calls in the third month for non-responders. Members can also complete the survey online through a secure portal or by scanning a QR code.

CAHPS®

The survey sample frame size includes qualifying Adult and Child member populations. Each member must have continuous Partnership primary coverage for the prior year, six (6) months (July 1 – Dec 31), and have been treated by a contracted provider within our network. Annual survey results provide a retrospective data set on key NCQA ratings and composite measures (Tables I and II).

Grievances and Appeals

The Grievance & Appeals (G&A) Department is responsible for investigating, monitoring, and reporting member dissatisfaction regarding their experience with Partnership's Medi-Cal plan. Routine G&A reports shared internally and externally provide real-time insight into service dissatisfaction.

Evaluation Summary

Grievances

Partnership experienced a 6.3% growth in membership, rising from 638,303 members in 2022 to 678,546 members in 2023. Alongside our membership increase, there was a rise in Grievances received in 2023, leading to an increase in Grievances filed per 1,000 members from 4.00 to 5.26, Table VI. The analyses observed a decrease in the number

of Appeals and Second Level Grievances filed in 2023, resulting in a decline in Second Level Grievances filed per 1,000 members from 1.19 to 1.02, Table VII.

An observed 6.3% increase in membership in 2023 may have contributed to a 28.5% increase in Grievances filed, that led to three (3) Grievance thresholds not being met: Access, Attitude/Service, and Quality of Care. Access issues mainly consisted of long wait times for providers and transportation issues such as the driver arriving late and missed rides. Attitude/Service issues were mostly regarding insufficient communication between the member and the provider's office. Communication and treatment plan disputes were the most frequently reported Quality of Care concerns. Two (2) categories, Billing/Financial and Quality of Provider Office, did meet the threshold for 2023, Table VI.

Table: VI

Grievances Only Reporting Period: Annual 2022 vs. 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Avg PHC Membership	Grievances	Grievances p/1,000	Avg PHC Membership	Grievances	Grievances p/1,000	Threshold	Threshold Met?
Access	638,303	1,055	1.65	678,546	1,526	2.25	1.82	No
Attitude/Service		1,278	2.00		1,752	2.58	2.20	No
Billing/Financial		113	0.18		106	0.16	0.19	Yes
Quality of Care		106	0.17		186	0.27	0.18	No
Quality of Provider Office		4	0.01		2	0.00	0.01	Yes
TOTAL		2,556	4.00		3,572	5.26	4.40	No

Appeals & Second Level Grievances

The Appeals and Second Level Grievances saw an overall decrease in numbers. While four (4) categories (Access, Attitude/Service, Billing/Financial, and Quality of Provider Office) successfully maintained stability by not exceeding the 10% threshold. One (1) category, Quality of Care, saw an increase from one (1) case in 2022 to nine (9) cases in 2023, surpassing the threshold. These cases consisted of treatment plan disputes that caused delay in the care the members received and communication issues such as the provider not returning the members' calls, Table VII.

Table: VII

Appeals & Second Level Grievances Reporting Period: Annual 2022 vs. 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Avg PHC Membership	Appeals & SLG	Appeals & SLGs p/1,000	Avg PHC Membership	Appeals & SLG	Appeals & SLGs p/1,000	Threshold	Threshold Met?
Access	638,303	332	0.52	678,546	350	0.52	0.57	Yes
Attitude/Service		47	0.07		33	0.05	0.08	Yes
Billing/Financial		382	0.60		297	0.44	0.66	Yes
Quality of Care		1	0.00		9	0.01	0.00	No
Quality of Provider Office		0	0.00		0	0.00	0.00	Yes
TOTAL		762	1.19		689	1.02	1.31	Yes

CAHPS® Measure Year 2023 | Reporting Year 2024 Plan Performance

A summary of the MY 2023 CAHPS® survey performance for Adult and Child, identified barriers, Fiscal Year (FY) 2024-2025 intervention and improvement focus are outlined below

Adult

Measured performance compared to the plan's 33rd percentile benchmark ranking indicates member dissatisfaction in the following measures. In comparison to MY 2022 ranking performance, MY 2023 demonstrates an overall ranking decline in seven (7) of nine (9) measures, Table I.

Table: I

Measure Attribute	Plan Performance		
	MY 2023 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2023 Ranking Compared to MY 2022
Rating of Health Plan (% 8, 9, 10)	<5th	Not Met	Decline
Rating of Health Care (% 8, 9, 10)	5th	Not Met	Decline
Rating of Personal Doctor (% 8, 9, 10)	51st	Met	Improvement
Rating of Specialist Seen Most Often (% 8, 9, 10)	41st	Met	Improvement
Getting Needed Care (% Always or Usually)	7th	Not Met	Decline
Getting Care Quickly (% Always or Usually)	<5th	Not Met	Decline
Care Coordination (% Always or Usually)	11th	Not Met	Decline
How Well Doctors Communicate (% Always or Usually)	48th	Met	Decline
Customer Service (% Always or Usually)	18th	Not Met	Decline

Healthcare Effectiveness Data and Information Set (HEDIS) Quality Compass (QC) Benchmarks

Child

Measured performance compared to the plan's 33rd percentile benchmark ranking indicates member dissatisfaction in the following measures. In comparison to MY 2022 ranking performance, MY 2023 demonstrated an overall ranking improvement in seven (7) of nine (9) measures, and one noted as maintaining similar ranking, with a marginal decline of 3.5% in score performance with Rating of Health Care, Table II.

Table: II

Measure Attribute	Plan Performance		
	MY 2023 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2023 Ranking Compared to MY 2022

Rating of Health Plan (% 8, 9, 10)	45th	Met	Improvement
Rating of Health Care (% 8, 9, 10)	<5th	Not Met	No Change
Rating of Personal Doctor (% 8, 9, 10)	55th	Met	Improvement
Rating of Specialist Seen Most Often (% 8, 9, 10)	21st	Not Met	Decline
Getting Needed Care (% Always or Usually)	14th	Not Met	Improvement
Getting Care Quickly (% Always or Usually)	9th	Not Met	Improvement
Care Coordination (% Always or Usually)	40th	Not Met	Improvement
How Well Doctors Communicate (% Always or Usually)	22nd	Met	Improvement
Customer Service (% Always or Usually)	89th	Met	Improvement

Healthcare Effectiveness Data and Information Set (HEDIS) Quality Compass (QC) Benchmarks

Identification of Opportunities and Priority

Throughout fiscal year 2024-2025, the focus of Organizational Goal # 4 Access to Care and Member Experience Improvement was to develop and, when applicable, revise existing strategies and tactics by understanding the landscape of the primary care provider and specialty provider networks, identifying gaps, and developing targeted actions (see Appendix B: Member Experience (ME 7) Report).

The QI CAHPS® programmatic framework helping to drive and influence a multi-disciplinary approach to improve the member experience through long and short-term strategies. The team priority this year will pilot a smaller focus at the county and region level to target low performing composite and rating measures linked to access.

Member Experience (ME) – Priority Flag

Partnership determines ME through the analysis of multiple CAHPS® rating and composite measures. The previously noted performance tables demonstrate a continuation of member dissatisfaction. The QI CAHPS® Team intends to shepherd organizational guidance on the measures marked with a priority flag. These measures are considered influence drivers and when those scores improve member experience, the Rating of Health Plan and Rating of Healthcare measures improve.

Causal Factors

While CAHPS® is a retrospective survey, the CAHPS team hypothesizes that the most recent member experiences, whether positive or negative, heavily influence reported satisfaction. Key factors that likely led to member dissatisfaction and subsequent declines in NCQA rating and composite measures, during the measurement period include:

- **County Expansion - HealthPlan Growth**

In January of 2024, Partnership expanded into ten (10) new counties, now serving twenty-four (24) Northern California counties. It is relevant to note the new county members were not included in the HEDIS

CAHPS® sample frame member for MY 2023. The membership growth coupled with the regional service disruption mentioned below created unforeseen operational delays that impacted members requiring plan or service support during this period.

- **Regional Service Disruption**

In April of 2024, contract negotiations and renewal was not reached with Dignity Health. This matter is presently resolved, but while the CAHPS® survey was in the field, thousands of members were impacted through the initial notification and subsequent actions of provider reassignment among many others.

Rating of Health Plan

Partnership focused on two (2) additional barriers outside of the FY 2024-2025 Org. Goals (see Appendix B: Member Experience (ME 7) Report, page 25). The CAHPS® Team used non-regulated survey results to validate and link benefit literacy gaps and themes gathered through members surveyed at in-person community events by Population Health Management (PHM). Benefit themes point to coverage confusion between Partnership and state carve out coverage (Medi-Cal Dental/Pharmacy), vision, and Partnership administered transportation services, and 2) Customer Service calls related to covered benefit or service questions. Member shared comments including calling plan multiple times about the same issue, calls being transferred multiple times, customer service representative provided unclear or incomplete information making it challenging for the members to understand, (see Appendix B: Member Experience (ME 7), page 41).

Access To Care – Priority Flag

Member access to primary and specialty care remained a key focus and priority for Partnership. Through various data sources and the Association for Community Affiliated Plans CAHPS® Collaborative, Partnership recognized a national and regional shortage of clinical professionals, along with many aging professionals nearing retirement (QI Evaluation, see Appendix B: Member Experience (ME 7), page 56). The fluctuations in performance measures for access identified below, combined with the lack of improvement to pre-COVID levels, indicated inconsistencies in access to care and service delivery.

Getting Needed Care (GNC)

Partnership observed a general decline in Adult and Child GNC composite questions (Q9 and Q20), measures, and overall summary rate score. Performance analysis by population is highlighted below.

Adult: The GNC measure declined by -2.4% and did not meet or exceed the plan 33rd percentile benchmark ranking target. The HEDIS Quality Compass (QC) benchmark ranking decline to the 7th percentile ranking from the 14th percentile ranking compared to MY 2022. The highest noted summary rate score of 81.60% occurred in the reporting year (RY) 2021 for MY 2020. The marked -5.6% decline of GNC trend began in the RY 2022, for MY 2021 survey results. Continuing the performance trend, Partnership observed a minimal increase of 0.4% of a percentage point in the RY 2023 for MY 2022, followed by another decline of -2.4% performance in the RY 2024 for MY 2023.

Child: The GNC measure marginally improved by 0.4% of a percentage point, and did not meet or exceed the plan 33rd percentile benchmark ranking target. The HEDIS QC benchmark ranking also improved to the 14th percentile ranking from the 10th percentile ranking compared to MY 2022. Similar yet dissimilar to the Adult trend performance, the highest summary rate score for Child was 83.20% and occurred in the RY 2020 for MY 2019. The marked -2.5% decline of GNC trend began in the RY 2021, for MY 2020 survey

results. Continuing the performance trend, Partnership observes the following: -1.1% (MY 2021) and -2.9% (MY 2022).

Getting Care Quickly (GCQ)

Partnership continued to observe a general decline with Adult and Child GCQ composite (Q4 and Q6.), measures, and overall summary rate score. Performance analysis by population is highlighted below.

Adult: The GCQ measure declined by -1.4% and did not meet or exceed the plan 33rd percentile benchmark ranking target. The HEDIS QC benchmark ranking MY 2023 declined below the 5th percentile ranking established in MY 2022. The highest summary rate score of 80.30% occurred in the RY 2021 for MY 2020. The marked -7.4% decline of GQC trend began in the RY 2022, for MY 2021 survey results. Continuing the performance trend, Partnership observed the following decline of -3.40% for MY2022.

Child: Although the GCQ measure saw a marked improvement score of 2.6%, the measure did not meet or exceed the plan's 33rd percentile benchmark target. The HEDIS QC benchmark ranking mirrored the score performance by increasing MY 2022 below the 5th percentile ranking to 9th percentile ranking in MY 2023. The highest summary rate score for Child was 88.80% and occurred in the RY 2020 for MY 2019. The marked -7.7% decline of GQC trend began in the RY 2021, for MY 2020 survey results. Continuing the performance trend, Partnership observes summary rate fluctuations ranging from an increase of 3% in MY 2021 and another decline of -7.8% in MY 2022.

Rating of Specialist (Rating)

Partnership continued to observe survey performance variations related to the Rating of Specialist measure, GNC, and GQC composite measures linked to specialty providers seen most often. As previously noted, improving member access to Primary Care Providers (PCP) and Specialists Providers was a top priority. Access interventions had been a continued organization focus and is covered in prior Member Experience (ME 7) Grand Analysis reporting periods. The complete details of actions taken during the FY 2023-2024 goal period are available in Appendix B: Member Experience (ME 7) Report, page 27). The trending overview and qualitative analysis by population is provided below.

Adult: The Rating of Specialist (Q22.) measure improved by 5.1%, meeting the plan's 33rd percentile benchmark target and increased the HEDIS QC benchmark ranking to the 41st percentile from the 26th percentile. The highest summary rate score of 71.50% occurred in the RY 2021 for MY 2020. The marked -4.8% decline of rating trend began in the RY 2022 for MY 2021 survey results. Continuing the performance trend, Partnership observed another decline of -2.3% for MY2022.

Child - Priority Flag: The Rating of Specialist (Q22.) measure saw a marked decline -5.7%. The measure did not meet or exceed the plan's 33rd percentile benchmark target. The HEDIS QC benchmark percentile ranking also declined to the 24th percentile ranking from the 34th percentile in MY 2022. The highest summary rate score for Child was 74.4% and occurred in the RY 2020

for MY 2019. The marked -10.8% rating measure decline began in the RY 2021 for MY 2020 survey results. Continuing the performance trend, Partnership observes summary rate fluctuations ranging from an increase of 6.8% in MY 2021 and another marginal decline of -0.9% of a percentage point in MY 2022.

Causal Factors

The ME 7 qualitative analysis also includes findings detailed in the Network Adequacy Assessment Report (NET 3) aligned with MY 2023 CAHPS® survey results. A summary below captures factors that link to member dissatisfaction on respective declines with priority flagged measures.

- Membership 6.3% annual growth.
- Grievance notable findings:
  - As previously noted, the leading filed Grievances in 2023 were Access at 1,526 (43%), almost half of 3,572 closed grievance cases.
  - Grievance cases filed per 1,000 members increased to 5.26 from 4.00, a notable 28.5% increase.
  - Partnership did not meet the access grievance threshold for 2023.
- Geographic impacts
  - Northern county members are experiencing greater travel distance and time to access primary care and specialty care.
  - Northern and Southern County assigned members observed longer wait times to be seen for the following specialists: Cardiology, Dermatology, and Ophthalmology.

FY 2023-2024 Summary of Activities and Interventions

The detailed activities for the FY 2023-2024 Quality Improvement Department Goal CAHPS® Score Improvement (CSI) demonstrated cross-department action focused on interventions (see Appendix C: Member Experience (ME 7) Report, page 27, Table XV). The highlighted examples below showcase completed goals/actions targeting Access and, furthermore, document continuous improvement.

- **Human Resource/Workforce Development Department**
  - **Completed Action:** Improve Access with Provider Recruitment Support. Contracted with a third-party talent search firm to partner and support recruitment and placement of multiple clinical vacancies within the Partnership contracted primary care and specialty care provider network.
  - **Completed Action**: Improve Access with Provider Retention. Successfully added and facilitated a retention bonus to the 2024 Provider Recruitment Program (PRP).

Organizational Goal #4 | FY 2024-2025 Summary

Access & Member Experience

The summary table below includes improvement focus based on the outcome of MY 2023-2024 quantitative, qualitative, causal analysis, and highlights organization priority of member barriers identified through the mentioned (see table: III).

Table: III

INTERVENTION &	IMPROVEMENT FOCUS	GOAL MILESTONE	INTERDEPARTMENTAL COLLABORATION	DEFINITIONS

Improvement Status		#	Yes / No	# of Depts.	• **Adjust:** a lean approach or pivot. A continued focus and intent. • **Continue:** a continuation of intervention or improvement activity and focus. • **Maintain:** score or intervention met. • **Monitor:** intervention or improvement assessment period. • **New:** a new action or intervention.
Continue	Access	1,2	Yes	4	
Continue	Member Experience	2,3,4,5,6,7	Yes		
Continue	Customer Service	3,8			
Continue	Attitude/Service	3,5			
Continue	Health Care Rating	1,2,4,5,6,7	Yes		
Continue	Health Plan Rating	All	Yes		

The two (2) workgroups Access and Member Experience will collaborate through FY 2024-2025 to implement short and long-term strategies and plan development focused on the identified barriers and milestone summaries listed below.

- **Milestone 1:** The **Access Workgroup** will develop and propose a multi-year Access Strategy plan that is inclusive of understanding the landscape of our specialty care and primary care provider network and identifying gaps.
- **Milestone 2:** The **Access Workgroup** will develop and propose a multi-year Access Tactical plan that outlines targeted actions to drive Milestone 1 objectives.
- **Milestone 3:** The **Member Experience (ME) Workgroup** will drive CSI FY 2023-2024 pilot from analysis phase to Strike-Team "action" phase. The enhanced ME improvement strategy is continuous, with the intent to leverage quarterly data (G&A, PHM) sources to drive proactive interventions throughout FY 2024-2025.
- **Milestone 4:** The **Member Experience (ME) Workgroup** will focus on developing and proposing member communication and engagement enhancements through existing platforms or new tool development.
- **Milestone 5:** The **Member Experience (ME) Workgroup** will define and develop Member Informative Session (MIS) program strategy and framework.
- **Milestone 6:** The **Member Experience (ME) Workgroup** will implement Year 1 of the texting program as approved by the monthly texting workgroup.
- **Milestone 7:** The **Member Experience (ME) Workgroup** will continue with Your Partner in Health branding campaign to develop a Partnership Awareness - grassroots communications strategy.
- **Milestone 8:** The **Member Experience (ME) Workgroup** will collaborate with the Quality Improvement Pay-for-Performance Team to explore Unit-of-Service measure development opportunities.

Organizational Goal #4 | FY 2024-2025 Outcomes

Below are the milestone outcomes for the Access and Member Experience workgroups, organized sequentially and showing requirement status and goal completion.

Final Goal Status		
☒ Goal Completed at Full Credit	☐ Goal Completed at Partial Credit	☐ Goal Not Completed

Milestone 1: Access Strategy Development

The Access Workgroup successfully completed Milestone 1 of developing a comprehensive multi-year Access Strategy for specialty and primary care provider networks. Key accomplishments included creating a strategic

framework with defined metrics, implementing advanced network visualization tools, and engaging 15 departments through 22 stakeholder interviews. The team delivered technical solutions including provider exit scoring, network gap analysis tools, and enhanced data reporting capabilities. The strategy incorporated critical elements such as workforce retention, telehealth integration, health equity, and transportation services, while establishing the foundation for tactical implementation in Milestone 2. This milestone met all requirements for framework development, stakeholder validation, and technical infrastructure establishment.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 2: Access Tactical Plan

The Access Workgroup successfully executed Milestone 2 by developing a comprehensive tactical plan for improving specialty and primary care network access. Through extensive stakeholder engagement across 8 key departments, the team produced a detailed multi-year implementation framework with defined timelines and success metrics. Key deliverables included a Provider Gap Analysis Tool, resource allocation framework, and integration strategies for existing services. The plan incorporated lessons from existing quality initiatives while addressing critical implementation factors such as staff capacity, technological infrastructure, and community partnerships. This milestone successfully established the operational blueprint for enhancing provider network accessibility.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 3: Member Experience Improvement Strike Team

The Member Experience Workgroup successfully implemented the CAHPS® Score Improvement (CSI) initiative through a Strike-Team approach, focusing on transportation services and benefit awareness enhancement. Key achievements included implementing Kinetik trip tracking, analyzing 154 grievances, and establishing NCQA-aligned incident thresholds for transportation services. The team strengthened benefit awareness through comprehensive staff training, enhanced communication channels, and strategic partnerships, particularly with DHCS's Smile, California program. Significant improvements were made in data analysis, G&A reporting, and cross-departmental collaboration, resulting in enhanced member service delivery and monitoring capabilities. The milestone exceeded original deliverables across stakeholder engagement, operational enhancement, data analysis, transportation provider accountability, and system-wide benefit awareness.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 4a: Digital Platform Enhancements

The Member Experience Workgroup completed preliminary planning for digital communication enhancements through the Member Portal platform. While the team successfully completed initial requirements gathering, system testing, and stakeholder engagement for SOGI data collection and CAC application integration, implementation has been strategically postponed to align with the upcoming HRP/JIVA platform launch. Key preparatory work included C2 platform testing, SOGI module development, and CAC application framework design. This milestone established the technical groundwork and documentation necessary for future implementation while ensuring seamless integration with the new HRP system.

Required Milestone: ☑ Yes ☐ **Status:** Not Complete AND/OR

Milestone 4b: Mobile Application Assessment

The Member Experience Workgroup completed a comprehensive assessment for Partnership's mobile application initiative through extensive stakeholder engagement and strategic analysis. The team gathered valuable insights from Family Advisory Committee (FAC), Community Advisory Committee (CAC), and Member Services, resulting in a detailed operational assessment framework and requirements inventory. Key deliverables included developing vendor evaluation criteria, establishing feature prioritization methodology, and creating

implementation recommendations based on member feedback. This milestone successfully laid the groundwork for mobile application development by aligning stakeholder needs with operational feasibility and integration requirements.

Required Milestone: ☐ No **Status:** ☑ Completed

Milestone 5: Member Informative Session (MIS) Program

The Member Experience Workgroup successfully established the Member Informative Session (MIS) program framework, securing both executive approval and resources for regional implementation. Key achievements included creating five new positions (4 Member Engagement Specialists and 1 CAC Coordinator), developing partnerships across 24 counties, and implementing a comprehensive cross-departmental collaboration system. The team completed the initial phase by staffing four regional offices (Fairfield, Redding, Auburn, and Chico) and establishing the infrastructure for 48 annual sessions. The milestone delivered a scalable framework for future expansion to Eureka and Santa Rosa offices, supported by robust event tracking systems and sustainable budget planning.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 6: Text Messaging Program Implementation

The Member Experience Workgroup successfully implemented Year 1 of the text messaging program, establishing comprehensive infrastructure, and launching multiple targeted campaigns. The team created a cross-departmental texting workgroup, developed operational parameters, and successfully executed campaigns reaching approximately 100,000 members with remarkably low opt-out rates (0.013%). Notable achievements included rapid emergency response deployment for the Park Fire, implementation of the Welcome Campaign, and execution of multiple health initiative campaigns across three quarters. The program established robust KPI tracking mechanisms and demonstrated operational success through high delivery rates and engagement metrics. This milestone created a scalable foundation for future messaging campaigns while proving the effectiveness of text-based member communication.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 7: Partnership Awareness Communications Strategy

The Member Experience Workgroup launched the "Your Partner in Health" branding campaign, establishing a comprehensive grassroots communications strategy. Working with NKE Strategies, the team developed and secured executive approval for a Strategic Communications Plan focused on community-centered messaging. Key achievements included creating targeted messaging for Congressional visits, advancing immigration-focused communications, and establishing a grassroots engagement framework. The milestone successfully delivered messaging architecture and presentation materials while laying the groundwork for Year One implementation. With strategic planning and executive approval phases completed, the initiative is positioned to move into active implementation.

Required Milestone: ☐ No **Status:** ☑ Completed

Milestone 8: CAHPS® Integration Strategy

The Member Experience Workgroup successfully established an integrated approach to patient experience measurement by connecting clinic-level CG-CAHPS® with health plan CAHPS® scoring. Working with the Quality Improvement Pay-for-Performance team, the group developed unified measurement standards and specific improvement targets, which were successfully incorporated into the 2025 PCP specifications. Key achievements included gaining Technical Work Group consensus on measure modifications, creating comprehensive resource documentation, and establishing clear connections between provider and health plan performance metrics. The

milestone completed all planned implementation steps through July 2024, positioning the program for ongoing stakeholder education and support.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Lessons Learned

ACAP CAHPS® Collaborative: Year 2 Summary

The CAHPS® Team partnered with 10 sister plans through the Association for Community Affiliated Plans (ACAP) CAHPS Collaborative to improve survey performance and member experience.

Key Initiatives and Findings

1. Member Experience Projects

The cornerstone of our work was knowledge sharing between sister plans. Through collaboration, we developed solutions to optimize access to care, enhance needed care scores, and streamline durable medical equipment access.

2. Health Plan Operational Assessment

Our operational assessment uncovered key insights about structure and performance. Through systematic evaluation, we identified organizational strengths in quality metrics and cross-functional collaboration, while noting opportunities to enhance member contact systems, provider experience, and regional access consistency. Priority improvement areas emerged in pharmacy services, healthcare access, and transportation.

3. Enhanced Engagement

To facilitate ongoing learning and collaboration, the team implemented monthly "Office Hours" sessions. These forums proved value by offering real-time problem-solving and best practice sharing among peer organizations.

4. Benefit Literacy Initiative

Perhaps the most significant finding from our MY 2023/RY 2024 surveys was the widespread challenge in benefit comprehension. The most common areas of confusion included transportation, vision, behavioral health, and dental services. This discovery prompted a series of targeted interventions in FY 24/25, including.

- **Targeted Interventions:**
    - **Transportation:** Improved tracking tools, data analysis, and alignment with NCQA standards.
    - **Dental:** Formed a dedicated workgroup, expanded member education, and planned outreach events.
    - **Organizational Support:** Increased staff training, multilingual communication efforts, and digital engagement strategies.

Looking Ahead

The initiatives implemented through this collaborative have laid a strong foundation for continued improvement in member experience. The combination of structural changes, enhanced communication channels, and targeted service improvements positions us to better serve our member population. Moving forward, we will continue to monitor these initiatives' effectiveness and adapt our strategies based on member feedback and performance metrics.

Organizational Goal # 5 | FY 2025-2026 Summary

Member Experience

Building on our FY 2024-25 progress, the Member Experience teams will advance our continuous improvement efforts through FY 2025-26, implementing strategic initiatives to address evolving challenges and achieve the key milestones outlined below.

- **Milestone 1:** The Transportation Department will continue its FY 2024-2025 pilot program connecting member Grievance and Appeal cases with driver performance to enhance service quality and develop data-driven improvement targets.
- **Milestone 2:** The QI CAHPS® team will lead the MX Strike Team pilot by analyzing real-time internal influence drivers to identify and address member dissatisfaction sources, focusing on line staff engagement and causal factors to enhance service delivery effectiveness.
- **Milestone 3:** The Member Services Department will implement one new initiative to improve member experience through operational and service delivery enhancements.
- **Milestone 4:** The QI CAHPS® team will advance dental coverage initiatives to improve member experience through enhanced education, access, and service delivery.
- **Milestone 5:** The Quality Improvement Department will lead a cross-departmental initiative to enhance potential (future-state) Partnership Advantage (Medicare) members' benefit understanding by developing targeted education channels, delivering accessible content that supports effective benefit utilization.
- **Milestone 6:** The Population Health Management Department, in collaboration with the Health Equity team, will advance equitable member engagement by integrating diverse cultural, linguistic, and social perspectives into member experience initiatives.

Conclusion

The FY 2024–2025 Quality Improvement Evaluation reflects Partnership's continued commitment to advancing member experience, access to care, and health outcomes through data-driven, cross-functional collaboration. This year's findings reaffirm the importance of listening to member voices—whether through survey results, grievances, or community engagement—and translating those insights into targeted, meaningful action.

Despite challenges such as workforce shortages, regional access disparities, and growing member needs, the organization has made measurable progress. Improvements in provider ratings and select CAHPS® measures, alongside successful interventions in benefit literacy, transportation, and dental access, underscore the impact of our collective efforts.

Looking ahead, Partnership remains focused on equity, responsiveness, and continuous learning. The insights gained from this evaluation will shape the next cycle of strategic priorities, with an emphasis on sustained improvement, community trust, and alignment with our organizational mission to help the members of our communities be healthy.

Please see Appendix (B) Member Experience (ME 7) Report for a complete review of the FY 2023-2024 analysis, and interventions implemented and proposed FY 2025-2026 programmatic interventions.

Purpose & Overview

The Quality and Accuracy of Information Report tracks the quality results of the information provided to Partnership members received during the following:

- Telephonic inquiry call(s) to the Member Services Department
- General inquiry(s) sent electronically (email) to the Member Services Department
- Partnership's website (self-service, Member Portal) online tools at https://member.partnershiphp.org/.

Member Services reviews the quality and accuracy of information monthly. On an annual basis, we document our findings through the production of this Quality and Accuracy of Information Report. The analysis of results and publishing of this report was a Member Services led initiative. The report was authored by the Member Services Manager of Quality & Training in collaboration with the Associate Director of Member Services. All Partnership department contributors for this report are listed below:

Title / Department	Role
Sr. Director, Member Services & Grievance	Analysis Contributor
Associate Director, Member Services	Analysis Contributor
Manager of Quality & Training, Member Services	Author
Director, Grievance & Appeals	Analysis Contributor
Compliance Manager, Grievance & Appeals	Data Contributor

Methodology

Telephonic Response

Data Source: *Annual Telephone Quality and Accuracy Evaluation*

Member Service Representatives (MSR) are annually tested on the quality and accuracy of telephone support as it relates to "Referrals and Authorizations," "Eligibility and Benefits," and "Member Financial Responsibilities."

The Member Services management team assesses the quality and accuracy of telephonic support provided by an MSR through the administration of the "*Eligibility and Financial Responsibility Knowledge Check"* test. Testing is administered through Partnership's online Learning Management System (LMS) training tool. This tool tracks and trends both individual and overall results. Member Services supervisors review individual MSR testing results and provide a departmental summary for review by the Member Services management team. Through this review, the management team identifies deficiencies and determines appropriate next steps.

In terms of performance standards, a minimum score of 90% is required for individual MSRs and a minimum score of 95% for the collective department. If the management team identifies any departmental trend(s) within the deficiencies, they may place the individual(s) and/or the department on a Corrective Action Plan (CAP). Additionally, the management team provides their analysis to the Member Services Manager of Quality & Training to develop tailored training material that may include, but not limited to:

- Updated desktop procedures/materials
- Instructive and informative email correspondence
- Focused departmental training

In addition, results are summarized annually and documented in the Analysis section of the Quality and Accuracy of Information Report. This report is also presented to the Member Experience Sub-Committee for review and approval.

Quality & Accuracy Member Complaints

Data Source: *Member Phone Call/Email*

Member complaints received against Partnership staff are documented by Member Services supervisors. Other member facing department supervisors also have the ability to file complaints against Partnership staff. This includes complaints filed due to staff providing misinformation or not enough information related to a member's financial responsibility, referrals, and/or authorizations. If a supervisor identifies a training opportunity, they provide tailored support and conduct additional training for the staff member.

Partnership's Grievance & Appeals (G&A) Department provides Member Services with an annual report that includes details on all Partnership staff-related complaints. If trend(s) are identified, the Member Services Manager of Quality & Training may develop tailored training materials that includes, but are not limited to:

- Updated desktop procedures/materials
- Instructive and informative email correspondence
- Focused departmental training

In addition to the annual reporting and analysis, there is an established feedback loop to address any instance of misinformation closer to real time. If the G&A Department identifies that misinformation was provided, the staff member's supervisor is notified and provides feedback, coaching, and monitoring.

Website Self-Service Quality

Data Source: *PartnershipHP.org*

Ten (10) of Partnership's newest Member Services staff audit the functionality and ease of use of Partnership's website. This audit is conducted on an annual basis through the use of a web-based survey tool. Partnership utilizes new employees as their lack of experience in navigating the Member Portal provides a true gauge of what a member would experience as it relates to the ease of use and the quality of information provided.

Performance is measured on a five-point rating scale, where one (1) indicates a poor experience and five (5) signifies an excellent experience with Member Portal's functionality. To ensure consistent evaluation, a performance threshold of 3.0 has been established for each question/activity. Staff members assess the quality and accuracy of the web functionality based on the following:

Changing Primary Care Practitioner:
Was it easy to do?
Was the staff member able to change a PCP?
Was it completed in one attempt?

Determine How/When to obtain Referrals/Authorization:
Was it easy to find?
Was the staff member able to determine how and when to obtain referrals and authorizations for specific services?
Was it completed in one attempt?
Was the information provided useful?

Determine benefits and financial responsibility of a service:
Was it easy to find?
Was the staff member able to find the language that stated that members have no financial responsibility?
Was it completed in one attempt?

Audit findings are summarized and reviewed annually. In the event that the results of a specific question/activity have an average score below 3.0, the Member Services management team shall engage Partnership's Web Development team. These efforts will include recommendations and/or potential enhancements needed for improvement. Similar to the above, the annual report is presented to the Member Experience Sub-Committee for review and approval.

Email

Data Source: Emails submitted via https://member.partnershiphp.org

A designated Member Services auditor selects either 10% of all email inquiries or ten (10) inquiries (whichever is fewer) per month to audit. The auditor determines the quality, accuracy, and timeliness of the email response to the member's inquiry through the following categories:

Email Etiquette
- Identified themselves to the member
- Response protects Member(s) Personal Health Information (PHI)
- Response projects professionalism and politeness
- Correct spelling, grammar, and punctuation

Resolution
- Appropriately identified member reason for email inquiry
- Offered the most appropriate and accurate solution to meet the members' needs
- Communicated at a level that the member would understand

Timeframes and Documentation
- Delivered appropriate acknowledgment or resolution response within one business day of receipt of the Member's request.
- Resolutions are completed by the end of the following business day
- Member's record is documented according to policy

Audit findings are recorded in the Member Services Department audit log, which tracks and trends individual and overall results. Individual audit results are reviewed with the staff member's supervisor and overall departmental results are reviewed by the Member Services management team. Through this review, the department aims to address any deficiencies identified as well as determine appropriate next steps. If the auditor identifies any trends within the deficiencies (meaning an aggregate score that falls below the performance threshold of 95%), they will provide their analysis to the Member Services Supervisor of Quality & Training to develop tailored training which may include, but not limited to:

- Updated desktop procedures/materials
- Instructive and informative email correspondence
- Focused departmental training

Annually, the results are summarized in a formal analysis that is presented to the Member Experience Sub-Committee for review and approval.

Results & Analysis

Telephonic

Member Services Call Center staff completed the Annual Eligibility and Financial Responsibility training and test. The results of this year's testing exceeded the established threshold of 95% as the department scored 98% overall, while a slight improvement over our 2024 results (+.05%) was experienced, it was down 2% compared to our 2023 results. To illustrate the trend, we have organized our findings below which include a comparison of results, year over year (Table 1).

Table 1

	2023	2024	2025
	Quality & Accuracy Question Scores		
Question 1	99%	100%	99%
Question 2	99%	97%	99%
Question 3	100%	100%	99%
Question 4	100%	100%	100%
Question 5	100%	100%	100%
Question 6	100%	100%	100%
Question 7	100%	100%	99%
Question 8	100%	100%	100%
Question 9	100%	97%	100%
Question 10	100%	100%	100%
Question 11	100%	100%	100%
Question 12	98%	77%	83%
Question 13	100%	100%	99%
Question 14	100%	100%	100%
Total:	***100%**	***98%**	***98%**

** Percentages are rounded*

While we met our established threshold, the Manager of Quality & Training collaborated with departmental supervisors to provide one-on-one refresher training. This training focuses on helping staff identify all useful and relevant information a member may need when seeking care from a specialty provider. The additional training was completed in March 2025 and specifically addressed the deficiency reflected in the results for Question 12 (83%). It is worth reiterating that, while we observed a positive shift in the results for Question 12, this area will remain a focal point in the coming year. Below is an overview of our findings as we compared our performance against the previous period:

- Three (3) questions achieved a higher score in comparison to last year (2025 vs. 2024)
  - Question 12: +6%Question 9: +3%Question 2: +2%
- 39/40 staff tested, one (1) leave of absence, four (4) staff members retook the test and passed with a 100% score after the refresher training)
- 67.5% of respondents scored 100% compared to 70.5% in 2024
- 32.5% of respondents scored 93% compared to 29.4% in 2024

Quality & Accuracy Member Complaints

For the 2024-2025 evaluation period, Partnership experienced a total of 306 member complaints against Partnership staff. Of the 306, only one (1) was related to misinformation regarding either "Referrals and Authorizations",

"Eligibility and Benefits", and "Member Financial Responsibilities" (0 in the 2022 – 2023 period). For the purpose of this report, our G&A Department references these types of complaints as an "RAFR" complaint. When comparing this result to the previous evaluation period (2023 – 2024) there were 147 total complaints, with four (4) related to the RAFR reasoning. Upon review, the sole RAFR complaint in this reporting period was identified as a potential coaching opportunity for a Care Coordination staff member. The coaching and other resolution details are documented within the Resolution Column of Table 2.

It is important to highlight that Partnership remained below our established threshold of three (3) total complaints, reducing the total number of RAFR grievances by 75%. While this is a favorable outcome, Member Services will continue annual monitoring of member complaints related to the RAFR reasoning to ensure performance levels are maintained.

Table 2
2024-2025

2024-2025			
Date Received	**Date Closed**	**Issue**	**Resolution**
4/13/2024	5/9/2024	The member is unhappy with her care coordinator and feels she is not helpful and did not return her call. Feels she was given wrong information regarding one of the providers not accepting her as a patient/ The member is needing a referral to specialists for ophthalmology and rheumatology.	The care coordinator's supervisor states the specialist provider would accept the member only if the member was also assigned there for PCP, however, also documents there were training opportunities found in that the care coordinator could benefit from. The supervisor was able to get the 2 referrals approved and reassigned the member to a new care coordinator.

Table 3
2023-2024

2023-2024			
Date Received	**Date Closed**	**Issue**	**Resolution**
2/14/2023	2/16/2023	The member is upset because he feels he is receiving conflicting information regarding a TAR from different people at PHC. The Grievance staff said it was approved and the CC staff said it was denied.	The MSR educated the member regarding the denial of the TAR in question, advised him that his CM in CC would follow up with him, and offered to file a Grievance. The member declined to file a standard Grievance, so an exempt Grievance was filed.
7/31/2023	8/15/2023	Member was unhappy with the TS Unit representative who provided her information about the GMR process. Member had a long trip scheduled, which would include a hotel and meal reimbursement. The representative did not specifically tell member that the meal is something they must pay for and request a reimbursement for. Member usually has very little money and she was under the impression PHC would send meal ticket/vouchers.	PHC TS Unit listened to recorded call and agreed the rep did not explain the process well enough. They provided education and feedback to their staff so that better explanations of the process are given to members. Member asked for help on how to get her receipts to PHC. She lives in Eureka, so I shared the physical address. Member stated she would drop these off at the office.
9/22/2023	10/17/2023	Member dissatisfied that it took 10 months for billing issue to be resolved. Staff member did not know the correct information.	MS Enrollment unit reviewed the concerns. They have implemented a process to monitor timeframes for billing issues. Staff member has been counseled. The process will be reviewed at their department trainings and added to their desktops.
10/6/2023	10/9/2023	The member had communication issues with the MSR who initially assisted her with her referral issue.	The member declined to file a standard Grievance. An exempt Grievance was filed. Supervisor reviewed call and found a training opportunity around referrals / authorizations for palliative care. Feedback was given.

Table 4
2022-2023

2022 - 2023			
Date Received	**Date Closed**	**Issue**	**Resolution**
N/A	N/A	N/A	N/A

In addition, Member Services has introduced a new tracking mechanism to monitor the trend of RAFR complaints. Moving forward, RAFR complaints per 1,000 members will be assessed and reviewed. The membership used for this calculation was obtained through our internal analytics platform, Tableau, and reflects membership data as of December 31, 2024. This new tracking method will continue to be assessed and included in the analysis of our Quality and Accuracy of Information Report.

	# Of Grievances	Membership Base	# of Grievances - Per 1,000 Members
RAFR Grievances	1	906,993	**0.001**
	1	**906,993**	**0.001**

Website Self-Service Quality and Accuracy

As for the results of the current reporting period, it is evident that our overall performance continues to exceed the predetermined categorical threshold of 3.00. However, there was a slight decline of -0.39%, which is primarily attributed to challenges in locating referral, authorization, and financial responsibility information.

Table 5
Year 2025

Changing Primary Care Practitioner:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to do?	4.00	4.00	5.00	2.00	5.00	3.00	5.00	5.00	2.00	5.00	4.00
Was the staff member able to change a PCP?	5.00	4.00	5.00	4.00	5.00	3.00	5.00	5.00	4.00	5.00	4.50
Was it completed in one attempt?	5.00	4.00	5.00	3.00	5.00	3.00	5.00	5.00	3.00	5.00	4.30

Determine How/When to obtain Referrals/Authorization:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to find?	1.00	3.00	5.00	1.00	5.00	4.00	5.00	5.00	3.00	5.00	3.70
Was the staff member able to determine how and when to obtain referrals and authorizations for specific services?	2.00	3.00	5.00	2.00	4.00	3.00	3.00	5.00	3.00	5.00	3.50
Was it completed in one attempt?	4.00	3.00	5.00	2.00	4.00	3.00	5.00	5.00	3.00	5.00	3.90
Was the information provided useful?	3.00	3.00	5.00	2.00	5.00	3.00	5.00	5.00	3.00	5.00	3.90

Determine benefits and financial responsibility of a service:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to find?	3.00	3.00	5.00	5.00	3.00	4.00	5.00	3.00	2.00	5.00	3.80
Was the staff member able to find the language that stated that members have no financial responsibility?	3.00	3.00	5.00	5.00	3.00	3.00	4.00	4.00	4.00	5.00	3.90
Was it completed in one attempt?	3.00	3.00	5.00	5.00	3.00	3.00	5.00	4.00	2.00	5.00	3.80

Table 6
Year 2024

Changing Primary Care Practitioner:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to do?	5.00	5.00	4.00	3.00	3.00	5.00	5.00	5.00	5.00	3.00	4.30
Was the staff member able to change a PCP?	5.00	5.00	5.00	3.00	5.00	5.00	5.00	4.00	5.00	3.00	4.50
Was it completed in one attempt?	5.00	5.00	4.00	3.00	4.00	5.00	5.00	4.00	4.00	3.00	4.20

Determine How/When to obtain Referrals/Authorization:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to find?	2.00	5.00	4.00	4.00	4.00	5.00	5.00	5.00	5.00	5.00	4.40
Was the staff member able to determine how and when to obtain referrals and authorizations for specific services?	2.00	5.00	4.00	4.00	5.00	5.00	5.00	4.00	5.00	5.00	4.40
Was it completed in one attempt?	1.00	5.00	4.00	4.00	5.00	5.00	5.00	4.00	5.00	5.00	4.30
Was the information provided useful?	4.00	5.00	4.00	4.00	5.00	5.00	5.00	5.00	5.00	5.00	4.70

Determine benefits and financial responsibility of a service:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to find?	1.00	5.00	5.00	4.00	2.00	5.00	5.00	5.00	5.00	5.00	4.20
Was the staff member able to find the language that stated that members have no financial responsibility?	1.00	5.00	4.00	4.00	3.00	5.00	5.00	5.00	5.00	5.00	4.20
Was it completed in one attempt?	1.00	5.00	4.00	1.00	4.00	5.00	5.00	5.00	5.00	5.00	4.00

Upon thorough analysis of the results across all categories, it is evident that each reporting category experienced a negative trend compared to the previous year. Additionally, the decline in scoring appears to be linked to the Help page feature on the Member Portal and the format of the current survey questions. Some respondents reported challenges navigating to the Help page, and their feedback on locating referrals, authorization, and financial responsibility information varied due to the structure of the survey question.

To enhance the user experience of the Member Portal, Member Services will partner with IT Web Team to update the instructional language that guides users on the "Help" screen icon. Additionally, to improve the Website Self-Service Quality and Accuracy process for the 2025-2026 review period, Member Services will collaborate with the NCQA Accreditation Team to refine the survey layout, breaking down the questions to ensure responses are accurately captured for both Member Portal and the member-facing website. In addition to the above, we have organized additional year-over-year comparisons, as shown below:

- Total average rating decreased by 9% (2025: 3.92 vs. 2024: 4.32)
- Changing Primary Care Practitioner: -2% (2025: 4.27 vs. 2024: 4.33)
- Determine How/When to obtain Referrals/Authorization: -16% (2025: 3.77 vs. 2024: 4.47)
- Determine Benefits and Financial Responsibility of a Service: -8% (2025: 3.82 vs. 2024: 4.13)
- Total average rating experienced a 1.3% increase over our 2023 results (2025: 3.92 vs. 2023: 3.87)

Email Accuracy and Timeliness

During our recent assessment, we reviewed results of the current period and compared them to the previous period (Table 7-9). Through this review, we noted a continued rise in total volume of email inquiries received. We logged an annual increase of 141 email inquiries compared to the prior period. We attributed the increase to Partnership's membership growth across our 24-county service area.

Table 7

		2024								2025				
Email Inquiries	**Goal**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**Total**
Total Email Inquiries Received	N/A	101	89	89	85	73	93	50	52	97	62	72	71	934
# of Submissions Audited Per Month	10 or 10% of # Inquiries Received	10	10	10	10	10	10	10	10	10	10	10	10	120
% of Accuracy of Information	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% of Emails Responded to Within 1 Business Day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 8

		2023								2024				
Email Inquiries	**Goal**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**Total**
Total Email Inquiries Received	N/A	57	41	56	57	55	53	30	35	113	124	67	105	793
# of Submissions Audited Per Month	10 or 10% of # Inquiries Received	5	5	5	5	5	9	9	9	11	12	8	10	93
% of Accuracy of Information	95%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	98%	99.8%
% of Emails Responded to Within 1 Business Day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 9

		2022								2023				
Email Inquiries	**Goal**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**Total**
Total Email Inquiries Received	N/A	22	39	28	35	30	26	39	26	46	33	64	55	443
# of Submissions Audited Per Month	10 or 10% of # Inquiries Received	5	5	5	5	5	5	5	5	5	5	10	5	65
% of Accuracy of Information	95%	100%	100%	98%	100%	100%	100%	100%	100%	98%	100%	100%	100%	99.7%
% of Emails Responded to Within 1 Business Day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%

Despite the increase in volume of email inquiries since the 2022-2023 period, we observed positive results across all aspects of email communication with our members. This includes response timeliness, and the accuracy of resolutions provided. Our Quality and Training team will continue to conduct monthly audits and report the findings to the intra-departmental workgroup as part of the annual assessment. Additional quantitative findings are presented below:

- Total Email Inquiries Received
  - +18% over the previous reporting period
    - 2024-2025: 934 vs. 2023-2024: 793
  - +111% over the 2022-2022 period
- % of Accuracy of Information
  - +.02% over the previous reporting period
    - 2024-2025: 100% vs. 2023-2024: 99.8%
  - +.03% over the 2022-2022 period

- # of Emails Responded to within 1 Business Day
  - Results (100%) remained stable with no change observed during the previous reporting periods

Summary

Barriers

Our results in accuracy and quality speak to Partnership's continued focus. While no barriers have been identified, we do understand that our performance results have shifted slightly, which has prompted our workgroup to implement an update to Partnership's Member Portal.

Opportunities for Improvement

Similar to the Barriers section, no major areas of opportunity were identified. That said, our internal teams will continue to monitor key areas, with a focus on process improvement and sustainability to ensure continued success. For the 2025-2026 review period, our focus will be to improve the Website Self-Service Quality and Accuracy annual survey results. At the department level, we remain committed to maintaining a strong focus on process improvement and will continue to identify potential opportunities for improvement. Our priorities center on increasing efficiency and upholding high-quality standards to ensure the quality and accuracy of all information provided to members is clear, consistent, and accurate.

Prioritization and Next Steps

Given the results of the current period, our focus will place strong emphasis on the Website Self Service Quality and Accuracy portion. To re-establish our performance levels, the Member Services Manager of Quality & Training will work with the IT Web Team to initiate updates to Partnership's Member Portal. Additionally, the Member Services management team will continue to closely monitor individual employee scorecards, new hire training, and process improvement efforts related to the quality and accuracy of "Referrals and Authorizations", "Eligibility and Benefits", and "Member Financial Responsibilities." The team will also evaluate the need for additional staff-level refresher training on an as-needed basis.

Quality in Grand Analysis

QI TRILOGY

NCQA - Grand Analyses

Partnership has established a strong foundation and framework to engage and build community partnerships with our members, health providers and organizations that serve the tenets of our organizational mission of **"*To help our members, and the communities we serve, be healthy,"*** and vision of **"*To be the most highly regarded managed care plan in California."*** Our commitment of continuous quality improvement is summarized within the six (6) Grand Analyses herein and in addition the complete analyses are provided in the appendices.

Under the 2025 NCQA Health Plan Accreditation Standards, the Continuity and Coordination of Behavioral Health (QI4) report and the Continuity and Coordination of Medical Care (QI3) Report are retired.

Access and Availability (NET3) Report

Partnership is meeting access standards for primary care (adult/pediatrics, newborn, urgent appointments, and telephone and after-hours accessibility) and four of six specialty care, high-volume and high-impact specialties (urgent, telephone, and after hours), based on data from our provider surveys and additional internal analysis. Partnership has experienced a downward trend for adult and pediatric primary care as well as specialty care appointments meeting the appointment standard across both regions since 2020. This coincides with the start of the pandemic. We are experiencing a continued trend of decreasing numbers of providers for multiple reasons including retirement of the baby boomer generation, decreased enrollment into medical schools across the nation, and higher burnout of physicians leading to reduction in available office hours.

While Partnership failed to meet the 15-day appointment standard for Dermatology and Obstetrics Gynecology, this is not due to a lack of contracting with an available service provider. Currently there are no additional qualified providers who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. Partnership monitors appointment access each quarter and works with individual providers who fail to meet the standard to identify strategies for improvement. Partnership requests and receives approval from DHCS for Alternative Access Standards (AAS) on an annual basis for the geographical areas that fail to meet the standard. If a member lives in an area where services are not covered, Partnership will help those members with making the appointment and arrange transportation to see the specialists that are not within the time or distance standard.

Opportunity

Appointment access to non-urgent primary care decreased by 13% in the southern region. Appointment access for obstetrics and gynecology in the southern region decreased by 19.5%. Partnership has identified the need to increase the number of contracted primary care and women's health specialty care practitioners to the network, particularly in the southern region.

Partnership has chosen primary care and women's health provider recruitment as equal high priority opportunities.

- *Planned Action:* Partnership has updated the Provider Recruitment Program (PRP) that offers a sign-on bonus for providers that are new to the Partnership network. If they are a currently practicing provider, they must come from outside of the Partnership 24 county service area. Providers completing a training program within the Partnership service area qualify for consideration for an award from the program. This

updated program is active between January 2024 – June 2025 with the bonuses being paid out over multiple payments over a 60-month term for physicians, NPs, and PAs, 24 months for behavioral health clinicians, and 12 months for certified SUD counselors. The strategy is to recruit and hold providers in place longer term.

    - Effectiveness of Action: To date there has been an increase in accepted offers with 168 awards approved on average over 12 months, (as compared to a historical average going back to 2014 of 86 awards per year). Family Medicine has been the majority provider specialty awarded, representing nearly 57% of the program awards to date. Partnership was able to recruit 208 new primary care practitioners to the network between January 2024 – April 2025, with 5 of them recruited to 4 of our most rural counties, including Sierra, Modoc, Plumas, and Trinity, whose geographic area is 75% or more rural (according to the US Census Bureau definition). Initial recruitment and retention details look favorable, but we may not know completely until the 60-month time period and further payments take place.

- *Planned Action:* Partnership continued to expand its efforts to strengthen recruitment for specialty providers, including obstetrics providers (physicians, women's health nurse practitioners, certified nurse midwives) whose clinical care focuses on perinatal care, including labor and delivery, to the 2024 PRP.
    - Effectiveness of Action: Fifteen obstetrics providers have been awarded since January 2024.
- *Planned Action:* Partnership launched a provider retention initiative (PRI) pilot in January 2024. The PRI is intended to recognize primary care clinicians, those who offer perinatal services (including labor and delivery) and/or obstetrics/gynecology, who have devoted their careers to the safety net, while helping to incentivize additional years of service from them. Our hope is that the PRI will help preserve institutional knowledge and clinical leadership and mentorship within our network, while an emerging generation of providers can learn from and train with these committed health professionals.
    - Effectiveness of Action: Since January 2024, 65 providers have been awarded and have committed to practice for 3 additional years.

Opportunity

Partnership has identified a need to improve member experience associated with access to care. The Adult Composite score for getting needed care decreased from 76.4% to 74.0% and getting care quickly decreased from 69.5% to 68.1%. Both failed to meet the benchmark for the second year in a row.

- *Planned Action:* To leverage more real time data (i.e., Grievance & Appeals [G&A] and Population Health Management [PHM] community engagement responses) on a quarterly basis to examine and respond timelier to topical themes identified directly from our members, including complaints about the health plan and providers. This enhanced method will provide the CAHPS Goal Team more real-time opportunity to measure intervention effectiveness against targeted barriers

Pharmacy & Utilization Management (UM1B) Report: Utilization Management

The Annual Utilization Management (UM) Program Evaluation analyzes all aspects of data related to the UM program, identifies gaps and opportunities for improvement, and updates the program as necessary to ensure the program remains current and appropriate.

Key elements in this annual evaluation include program structure, program scope, processes, and information sources, as well as level of involvement of senior-level physicians and designated behavioral healthcare practitioners in the UM program.

In addition, data for member and practitioner experience with the UM process is evaluated to identify improvement and actionable opportunities. This report does not contain Kaiser Permanente or Carelon Behavioral Health data for evaluation of the UM program. Kaiser Permanente and Carelon Behavioral Health are NCQA accredited, and as such, reports from Kaiser Permanente and Carelon Behavioral Health are reviewed through the delegation oversight process.

Please see Appendix (A) Pharmacy & Utilization Management – UM1B Report: Utilization Management for a complete review of the quantitative and qualitative analyses for the learnings while trying to meet the stated goals for each measure noted above. AND Appendix (A) Pharmacy & Utilization Management (UM1B) Supplemental TAR Report.

Member Experience (ME7) Report

At Partnership HealthPlan of California (Partnership), our commitment to members goes beyond policy or compliance, it is rooted in purpose. As of December 2023, we proudly served over 663,822 members across our legacy 14-county service area. While Partnership expanded to serve an additional 10 Northern California counties (as of January 2024), this evaluation focuses exclusively on our legacy regions to ensure consistent year-over-year trend analysis. It reflects our ongoing commitment to listen, learn and lead work that improve our members healthcare experience. As a member-centered organization, we recognize that member experience fundamentally shapes our healthcare delivery success.

What We Measured and Why it Matters

Through coordinated efforts across departments, we capture member feedback through two primary channels:

- Annual regulated and non-regulated surveys (Calendar Years: 2022-2023)
- Grievance and appeals reporting (Calendar Years: 2023-2024)

The FY 2024–2025 Quality Improvement Evaluation reflects Partnership's continued commitment to advancing member experience, access to care, and health outcomes through data-driven, cross-functional collaboration. This year's findings reaffirm the importance of listening to member voices—whether through survey results, grievances, or community engagement—and translating those insights into targeted, meaningful action.

Despite challenges such as workforce shortages, regional access disparities, and growing member needs, the organization has made measurable progress. Improvements in provider ratings and select CAHPS® measures, alongside successful interventions in benefit literacy, transportation, and dental access, underscore the impact of our collective efforts.

Looking ahead, Partnership remains focused on equity, responsiveness, and continuous learning. The insights gained from this evaluation will shape the next cycle of strategic priorities, with an emphasis on sustained improvement, community trust, and alignment with our organizational mission to help the members of our communities be healthy.

Please see Appendix (B) Member Experience (ME 7) Report for a complete review of the FY 2024-2025 analysis, and interventions implemented and proposed FY 2025-2026 programmatic interventions.

Health Equity (HE6) Report

The HE 6: Reducing Health Care Disparities is an NCQA standard that examines how Partnership stratifies measures by race, ethnicity, language, and sexual orientation, as well as the prioritization and action taken, as necessary, to improve identified inequities. More specifically, the HE 6 report summarizes the work of Partnership to analyze potential disparities within the member population through an analysis of race and ethnicity, language, and gender data, as well as Partnership's effort to implement impactful interventions to reduce inequities and improve any Culturally and Linguistically Appropriate Services (CLAS) identified through the analysis. The measures of focus for the Grand Analysis report are:

1. Controlling High Blood Pressure (CBP)
2. Hemoglobin A1c Control for Patients with Diabetes (HBD)
3. Prenatal and Postpartum Care (PPC)
4. Child and Adolescent Well Care Visits (WCV)

Partnership completed this Grand Analysis in September 2024 as an element of Health Equity Accreditation (HEA), utilizing MY2023 Health Plan Accreditation (HPA) and MY2023 Managed Care Accountability Set (MCAS) final rates.

After Partnership's assessment for statistically significant inequities for the measures of focus, the following disparity classification system was developed to aid in prioritizing disparities based upon measure findings. This is based upon the Strength of recommendation taxonomy used in various clinical guidelines to stratify recommendations:

Disparity Classification

Strong Disparity (Disparity is clearly present when compared to comparator group or goal)
• Meets at least three (3) of any of following factors below
  ○ MCAS Sample Measure
  ▪ One group is performing statistically worse in at least one region when compared to the comparator group
  ▪ Absolute average percentage deficit between group and comparator (minimum performance level) is at least 10% (multiple regions) or 15% in single region in MCAS/HEA measure.
  ▪ Multiple regions (≥2) where specific group falls below 25th percentile per MCAS measure
  ▪ At least 1 region where group falls below 25th percentile
  ▪

Moderate Disparity (Disparity is moderately present when compared to comparator group or goal)
• Meets at least three (3) of any of the following factors
  ○ MCAS Sample Measure
  ▪ Absolute Average Percentage deficit between group and comparator (minimum performance level) is at least 10% (multiple regions) or 15% in single region
  ▪ No group is performing significantly better than comparator group yet at least one (1) group is performing significantly worse per MCAS measure
  ▪ Multiple regions (≥2) where group falls below 50th percentile
  ▪ At least one (1) region where group falls below 25th percentile

Weak Disparity (Disparity is uncertain when compared to comparator group or goal)

- Meets at least two (2) of any of the following factors:
  - MCAS Sample Measure
    - No statistical difference between groups in a region
    - Absolute Average Percentage deficit between group and comparator (minimum performance level) is at least 5% (multiple regions) or 7% in single region
    - Only one (1) region where group falls below 50th percentile and no group falls below 25th percentile

No inequities were identified when stratifying the measures of focus by language or gender. After developing this disparity classification system, Partnership identified the following areas of focus:

HEALTH INEQUITIES AREAS OF FOCUS							
Group	Key Measure	MCAS Number of Regions with Statistically Worse Disparity	MCAS Number of Regions with disparity (below 25th)	MCAS Number of additional Regions with disparity (below MPL – 50th)	Absolute Percent Average BELOW MPL across regions below 50th percentile	Category of Dsparity	Number of Years with Same Disparity
White	Controlling Blood Pressure	-	1	0	-1.21%	WEAK	N/A
	Poor HbA1c Control (>9%)	-	0	1	-6%	WEAK	N/A
	Postpartum Care	-	0	0		N/A	N/A
	Timeliness of Prenatal Care	-	0	1	-4.33%	WEAK	N/A
	Well Child Visits (WCV)	-	1	3	-6.02%	MODERATE	N/A
Native Hawaiian and Other Pacific Islander	Controlling Blood Pressure	0	1	0	-61.00%	MODERATE	N/A
	Poor HbA1c Control (>9%)	0	2	0	-12%	STRONG	N/A
	Postpartum Care	0	-	-	-	N/A	N/A
	Timeliness of Prenatal Care	0	-	-	-	N/A	N/A
	Well Child Visits (WCV)	1	3	1	-11.16%	STRONG	N/A

Hispanic or Latino	Controlling Blood Pressure	0	0	1	4.22%	WEAK	N/A
	Poor HbA1c Control (>9%)	0	0	1	-1%	WEAK	N/A
	Postpartum Care	0	0	0	N/A	NONE	N/A
	Timeliness of Prenatal Care	0	0	0	N/A	NONE	N/A
	Well Child Visits (WCV)	0	0	1	-3.08%	WEAK	N/A

HEALTH INEQUITIES AREAS OF FOCUS							
Group	Key Measure	MCAS Number of Regions with Statistically Worse Disparity	MCAS Number of Regions with disparity (below 25th)	MCAS Number of additional Regions with disparity (below MPL – 50th)	Absolute Percent Average BELOW MPL across regions below 50th percentile	Category of Dsparity	Number of Years with Same Disparity
Black or African American	Controlling Blood Pressure	0	0	0	N/A	NONE	N/A
	Poor HbA1c Control (>9%)	0	1	1	12%	STRONG	N/A
	Postpartum Care	0	0	0	N/A	NONE	N/A
	Timeliness of Prenatal Care	0	2	0	-30.12%	STRONG	N/A
	Well Child Visits (WCV)	1	2	2	-6.57%	STRONG	N/A
Asian	Controlling Blood Pressure	0	0	2	-0.17%	WEAK	N/A
	Poor HbA1c Control (>9%)	0	0	0	N/A	NONE	N/A
	Postpartum Care	0	0	1	-6.71%	WEAK	N/A
	Timeliness of Prenatal Care	0	1	0	-30.12%	WEAK	N/A
	Well Child Visits (WCV)	0	0	4	-6.57%	WEAK	N/A

American Indian and Alaska Native	Controlling Blood Pressure	0	2	0	-11.26%	MODERATE	N/A
	Poor HbA1c Control (>9%)	1	1	2	N/A	STRONG	N/A
	Postpartum Care	1	0	2	-15.57%	STRONG	N/A
	Timeliness of Prenatal Care	1	3	0	-21.78%	STRONG	N/A
	Well Child Visits (WCV)	1	1	3	-5.91%	MODERATE	N/A

While all of the above were identified as areas of focus, Partnership prioritized the following:

1. Timeliness of Prenatal Care (PPC-Pre): Black/African American Members
2. Timeliness of Prenatal Care (PPC-Pre): American Indian/Alaska Natives
3. Timeliness of Postpartum Care (PPC-Post): American Indian/Alaska Natives
4. Well Care Visits (WCV): All Pediatric Members

Partnership first conducted a barrier and root cause analysis for these measures and populations and also identified interventions to reduce the disparities. This is highlighted in the table below:

Timeliness of Prenatal Care (PPC – Pre)	
Group(s) of Focus	Black/African American Members
Percentage Below Minimum Performance Level (MPL)	*NE Region: 9.28% below* *NW Region:50.97* % below Non-Weighted Average: 30.12%
Goal for Specific Group	Improve prenatal visits by at least 5% in the NE or NW region in the Black/African American Member Population within 12 months with the global goal of improvement by 30% in the next 5 years.
Root Cause Analysis	Timely prenatal care is recommended to promote healthy pregnancies via screening and preventative management of a woman's risk factors. Unfortunately, various studies have suggested that fewer timely prenatal visits are associated with poorer pregnancy outcomes such as severe maternal morbidity, maternal death, and infant mortality (Howell, 2018). Research has suggested that insurance availability, transportation, and access to specific providers are key driving factors for receiving timely prenatal care. Partnership identified inequities for Black/African American members in the Northeast and Northwest regions for Timeliness of Prenatal Care.
Barrier Analysis	For prenatal care, researchers found that policy changes that improved eligibility for individuals, made insurance coverage more comprehensive, and improved maternity reimbursement rate was associated with greater attendance in postpartum visits (Saldanha et al., 2023). There has been limited research evaluating prenatal care and postpartum interventions in specific patient groups—namely Black/African American patients.

	Currently, Black/African American women are at least 3x more likely to experience a pregnancy-related death when compared to White women and have the largest disparity among all the conventional population perinatal health measures (Howell, 2018). However, partnership is currently exploring interventions to positively impact their prenatal and postpartum care. In 2023, the Department of Health Care Services (DHCS) added doula services as a covered benefit. In 2023, Sobczak et al. conducted a literature review of 16 studies (cohort and randomized trials) to evaluate the benefits of utilizing a doula. Their findings suggested that doula support decreased incidence of cesarean or premature labor, low birth weight, and epidural/medical pain management. Finally, Partnership conducted a focus-group-like survey of Black prenatal and postpartum members (n=12) to conduct a survey to better understand if the member attended their appointments, as well as to understand the barriers faced, if any at the Solano County Family Health Services site—which has the largest population of Black/African American members. Overall, the members highlighted that they didn't attend their visits due to one of the following three categories: (1) Incorrect Staff Actions, (2) Schedule Unavailability, (3) Lack Of Transportation. This has motivated Partnership to explore utilizing group visits to streamline staff actions, schedule availability, and coordinate transportation. In 2017, Byerley and Hass conducted a systematic review of 38 studies (8 randomized trials, 23 nonrandomized studies, 6 reports of group outcomes without controls) to evaluate group prenatal care in 20,000+ women. Overall, Byerley et al. (2017) found a significant increase in rates of breastfeeding and satisfaction in Black/African American members after implementing group prenatal care interventions. Partnership may explore whether clinical site locations will be interested in conducting a pilot to validate the efficacy of utilizing such group visits with Doulas. Long-term, Partnership will explore utilizing a combination of interventions to likely meet the large threshold of members who are not meeting the goal.
Actions for Direct Clinical/Service Measure Improvement	**<u>Intervention #1: Contracting Doulas in Partnership Network:</u>** Partnership is also investigating what education doulas share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. Partnership has worked to add doulas to the network and has at least one doula in each region of the network. The health equity officer and other staff have ventured into various community events to help with recruiting various Doulas. **<u>Intervention #2: Increase Diversity of OB GYNs:</u>** Partnership is investigating how to improve the diversity among Obstetrics-Gynecology doctors. To this, Partnership is exploring how to do a baseline assessment of the race and ethnicity demographics of OBs within the network to assess. Partnership will then share this information with respective HR departments to provide guidance to the provider recruitment team at Partnership and incentivize increasing diversity hiring throughout the network to reflect the populations served. Partnership has launched a new provider retention

	initiative. Specifically, partnership will provide $45,000 award to a Doctor of Medicine/Doctor of Osteopathic Medicine (DO) or $30,000 award to a nurse practitioner/physician assistant for a 3-year commitment. This intervention will be applicable to all clinical sites—especially OB/GYN sites that inhabit locations that serve a large Black/African American population. **<u>Intervention #3: Encourage Clinical Sites to Utilize Dyadic Care Models</u>** Dyadic care models are considered effective for optimizing the care of both the mother and infant. Dyadic care is considered when a provider provides care for a birthing mother and their infant during the same visit. Specifically, the American Academy of Pediatrics recommends prenatal visits to establish pediatric medical homes and postnatal depression screening for the birthing person during pediatric visit (Choy et al. *PLoS One*. 2024 Apr 16;19(4):e0298927). This is based upon the postnatal period being seen as a critical time to support and improve health outcomes of birthing people and their infants. Unfortunately, pregnancy-related morbidity and mortality often occurs within the 6-week postpartum period, and this has been attributed to difficulty in accessing care. Partnership will continue to advocate for sites to adopt dyadic care models—especially in regions where there are limited OB/GYNs and primary care providers.

Prenatal and Postpartum Care (PPC)	
Group(s) of Focus	American Indian/Alaska Native
Prenatal Percentage Below Minimum Performance Level (MPL)	*NE Region: 9% Below* *NW Region:* 22% below *SW Region:* 34% below *Non-Weighted Average:* 21.78% Below
Goal for Specific Group	Improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement of 22% in the next 5 years.
Postpartum Percentage Below Minimum Performance Level (MPL)	*NE Region: 28% Below* *NW Region:* 3% below *SW Region:* 3% below *Non-Weighted Average:* 11.4% Below
Goal for Specific Group	Improve postpartum visits by at least 5% in the NE region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 12% in the next 5 years.
Root Cause Analysis	Currently, majority of our American Indian/Alaska Native members are located in Humboldt, Mendocino, and Shasta Counties in our NW and NE regions. Tertiary research has suggested that there is a significantly higher rate of maternal morbidity and mortality among this group due to centuries of human rights violations (e.g. massacres, forced relocation, boarding schools)

	which has translated into generational trauma via epigenetics (Burns et al. *Soc Sci Med*. 2023 Jan;317:115584.). In addition, researchers has identified the following predictors of maternal mortality: older maternal age, pre-existing conditions, prior cesarean section, transportation issues, travel time, administrative burdens which limit Medicaid enrollment and prenatal care update; and various structural racism incidents during healthcare interactions.
Barrier Analysis	Research suggests that there are structural barriers that are exacerbating poor outcomes in our American Indian/Alaska Native community. For example, there are purported to be transportation infrastructure, family welfare system, poor prenatal care infrastructure, and blatant racism that are the key upstream factors that are acting as barriers for improving disparities. Within Partnership's service landscape, the region that is experiencing the greatest disparity for this measure is the NW rural region. Currently, many of Partnership's AI/AN members inhabit this area and likely are experiencing lack of clinic access for all providers. Also, various tribal centers utilize various are held financially accountable to government performance and results act (GPRA) versus HEDIS measures—which are considered less stringent. Therefore, various tribal centers do not have the financial incentive to be intensive with hypertension treatments versus non-tribal health centers. To improve relations, Manage Care Organizations (MCOs) and Partnership specifically, has explored hiring tribal health center liaisons to improve the collaboration between MCOs and tribal centers.
Actions for Direct Clinical/Service Measure Improvement	**<u>Intervention #1: Tribal Health Liaison Hiring and Hosting Tribal Center Event</u>** Partnership has hired a full-time Tribal health liaison to positively impact relationships with tribal health centers, tribal health community members, and provide guidance to help support Tribal member needs. Partnership has recognized partnering with the Tribal community as an organizational initiative and is working to positively impact all care received by Tribal members through this partnership and communication with Tribal Health Centers within the network at this time. This work has the potential to improve the member experience of American Indian/Alaska Native members, ensure they are receiving culturally appropriate care, and positively impacting the care received by members who identify with this group. Also, the tribal health liaison will be able to conduct various focal group interviews and possibly identify community-based organizations to able to provide tele-nutrition counseling sessions, funds for delivery of DASH-diet aligned foods. **<u>Intervention #2: Contracting Doulas in Partnership Network:</u>** Partnership is also investigating what education doulas share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. Partnership has worked to add doulas to the network and has at least one doula in each region

	of the network. The health equity officer and other staff have ventured into various community events to help with recruiting various Doulas. In addition, Partnership is trying to contract with doulas in the NE/NW regions to ensure that we are able to outreach to our Tribal community members. **Intervention #3: Advertisements of Transportation Benefit with Translation into Tribal Languages:** Partnership is also investigating what education we can share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. For example, partnership has recognized that many members are unaware of the transportation benefit afforded to them. Therefore, they may be unaware that Partnership is able to pay for the lodging fees and transportation for a tribal member anywhere they would like to go if they are seeking prenatal/postpartum care in a separate county. Finally, Partnership would like to engage with and survey members to assess whether they should advertise certain education materials into different languages to ensure they are receptive to our various tribal communities.

Well Care Visits (WCV)	
Group(s) of Focus	American Indian/Alaska Native Black/African American White
Goal for Specific Group	Improve Well Care Visit attendance by at least 2.5% across multiple regions or at least 5% in 1 single region in any group (e.g.) Black/African American, American Indian/Alaska Native, White within 12 months with global goal of improvement by 5% in the next 5 years.
Root Cause Analysis	Per the DHCS Bold goals, the state is looking to close all racial/ethnic disparities in WCVs by 50% by 2025. Currently, WCVs are low for all populations. A proposed hypothesis of the root cause is that there is a significant shortage of pediatrician providers—who are able to conduct the WCVs. Therefore, there is a limitation in conducting the absolute number of visits for all pediatric members—regardless of race/ethnicity/gender identity. Also, by having certain members miss at least 1 visit, this will likely cause a shift to make it impossible to attain the key number of visits by a certain age. Currently, the American Academy of Pediatrics recommends at least 13 well-child visits between birth and 6 years of life.
Barrier Analysis	Overall, researchers found that Well Care Visits (WCV) was the clinical measure that majority of race/ethnic groups have a disparity of not meeting the minimum performance threshold throughout the regions. This suggests that the low WCV rate is more of a quality concern versus a demographic specific concern.

	Within the American Indian/Alaska Native community, there is a community concern of children being reported for child protective services referrals. Historically, AI/AN children were consistently removed from their homes to adopt western cultures. This has resulted in various family members being concerned with exposing their child to unfamiliar members of the community. Also, Partnership tribal health centers have a challenge with engaging with members due to the ongoing difficulties with recruitment and consistent retention of health workers and leadership. This is due to the Indian health serves being consistently underfunded, leading to rationing of needed services and a crumbling infrastructure. Therefore, Partnership may consider helping with provider recruitment and retention since tribal centers are unlikely to financially compete with other centers. Within the Black/African American community, there is an association with low well child visit attendance due to low levels of maternal education, low income, and poor prenatal care (Wolfe et al., 2018). Partnership can explore implementing interventions to improve tailored interventions to improve well-child care in African American/Black groups. For example, in a systematic review of well care visit redesigns researchers highlighted the efficacy of doing group WCVs. (Coker et al., 2013)
Actions for Direct Clinical/Service Measure Improvement	**<u>Intervention #1: Provider Recruitment Program and Provider Retention Initiatives</u>** Partnership has launched a new provider retention initiative. Specifically, Partnership will provide $45,000 award to a Doctor of Medicine/Doctor of Osteopathic Medicine (DO) or $30,000 award to a nurse practitioner/physician assistant for a 3-year commitment. This intervention will be applicable to all of clinical sites—especially Partnership's tribal centers and sites that inhabit locations that serve a large Black/African American population. **<u>Intervention #2: Group Well Child Visits</u>** Partnership is conducting a pilot with a clinical site to start group well-child visits in a clinical site in Solano county—which has the greatest diversity among Partnership's 14 counties. Long-term, Partnership can explore utilizing a combination of interventions to likely meet the large threshold of members who are not meeting the goal throughout the network. **<u>Intervention #3: Increase Access to BIPOC-related children's book regarding improving immunizations and attending WCVs</u>** Partnership's HEO previously published a children's book, Andres Armor, which teaches BIPOC children the importance of vaccines using knight and dragon analogies. He is exploring donating copies of the book and videos to clinical sites to hopefully increase the number of children wanting to attend WCVs and watching the free information play during their provider visits.

In Partnership's assessment of opportunities to improve Culturally and Linguistically Appropriate Services (CLAS), Partnership met or performed better than the member satisfaction target of maintaining member abrasion or dissatisfaction below 1/10th of one percent (0.10%). The 2023 case filings yielded a score of 0.03% relative to language service utilization and were slightly above the threshold target of (1/10th of one percent) 0.10%. The

analysis workgroup established a priority ranking based on the number of case filings by category. The Language Barrier/Limited English Proficiency category type resulted in roughly 60% of the total grievances within the 2023 Annual Grievance & Appeals Priority by Category Type, which highlights an opportunity for improvement.

Based on member satisfaction with language-related services and the HE 6 Case Analyses, Member Services and Quality Improvement will implement an intervention in the form of an inter/intradepartmental workgroup. This workgroup will place an emphasized focus on analyzing the leading causes of member dissatisfaction as it relates to CLAS. As a result of the associated grievance volume, the Language Barrier/Limited English Proficiency category type will serve as the basis through which Partnership's intervention workgroup will develop improvement activities.

Furthermore, Partnership's Population Health Department will address this unmet goal by addressing the need to provide written materials to members in their choice of format (such as large print, Braille, audio format, or other) to ensure vision-impaired members are able to understand the information Partnership shares. This goal is monitored through the annual C&L Work Plan. This will be done to provide a more proactive approach for language services.

The completed Grand Analysis report will be submitted with all other Health Equity Accreditation documents for review in June 2025. Partnership will continue completing a Grand Analysis report each year, adjusting to meet the needs of the organization's missing and Health Equity Accreditation standards.

Please see Appendix (C) Health Equity (HE 6) Report for a complete review of the assessment for statistically significant inequities for the measures of focus.

Evaluation

Conclusion

Evaluation Conclusion

This concludes the FY 2024-2025 Quality Improvement Program Evaluation, which provides an assessment on performance work outlined in the FY 2024-2025 QI Program Description and Work Plan. Partnership's Quality Improvement (QI) Program was successful over the course of fiscal year 2024-2025 in achieving its quality improvement goals and commitments. Partnership has maintained its NCQA Health Plan Rating (HPR) as 3.5 Star health plan. Partnership continues to leverage its 5-Star Quality Strategy and corresponding tactical and work plans to demonstrate an increased organizational focus on improving quality measure and CAHPS® scores now and into the future. In 2024-2025, Partnership has been able to engage fully in existing and expanding performance improvement and pay-for-performance strategies and programming, including priorities to advance health equity. While, at the same time, Partnership has worked diligently through its QI Program to engage with providers in its 10-county expansion region to help our members in these new communities be healthy. As Partnership moves into 2024-2025, Partnership's QI Program remains committed to striving for its long-term goal of achieving a 5-Star HPR, while also preparing to implement its new D-SNP and achieve NCQA Health Equity Accreditation .

Appendices

QI TRILOGY

Synopsis of Changes to 2025-2026 QI Program Description

Below is an overview of policy MPQD1001 scheduled for approval at the Aug. 20, 2025 Quality/Utilization Advisory Improvement Committee (Q/UAC).

Summary of Revisions (Please include why the change was made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)
Clearer designation of leadership roles carrying authority and responsibility to ensure the program is fully implemented and maintained. For each identified role, the qualifications of staff presently fulfilling each role are detailed in an appendix.
Due to the delayed implementation of Partnership Advantage, Partnership's D-SNP Program, the following changes were made: • The beginning paragraph of the **Scope of Quality and Performance Improvement Program** was revised from summarizing Partnership's plan to include a Dual Eligible Special Needs Plan (D-SNP) by 01/01/2026 to its integration by 2027. • Behavioral health services content within the **Scope of Quality and Performance Improvement Program** was moved to the **Approach to Quality and Performance Improvement** section. • The Quality D-SNP Sub-Committee section was removed since the sub-committee will tentatively start in August 2027. • Expansion of the CAHPS® survey administration to include the D-SNP population was removed.
Under Value Based Payment Programs • The Specialist Quality Incentive Program was removed as the program ended in 2024. • The Enhanced Care Management increased the number of measures their practices are incentivized for from three quality measures to four quality measures, including: Care Plan and Release Information Upload into PointClickCare, PHQ-9 Depression Screening, Blood Pressure Screening, and Timely Review of ED/Administration Notifications.
In addition to annual reports presented to IQI and Q/UAC, the Peer Review Committee also provides monthly reports to the Chief Medical Officer and the Medical Director for Quality, which include cases opened, closed, referrals, and pending PRC review.
Under Site Reviews • Mobile/Street medicine is now part of the Site Review team's scope. • Partnership now conducts Site Reviews on all OB providers up to every three years now that DHCS' Comprehensive Perinatal Service Program (CPSP) has sunset and the Partnership Health Perinatal Service Program has launched.
Under the CalAIM initiative, DHCS transitioned the Child Health and Disability Prevention Program (CHDP) to Partnership. The Inspections team now offers training on all CHDP topics which are reviewed during the Site Review process.
Practice Facilitation is now referred to as Practice Coaching and has expanded and broadened support to the needs of Partnership's entire provider network.
Community Health Assessment & Community Health Improvement Plan (CHA/CHIP) collaboration and Population Health Community Engagement was added to the list of major initiatives under **Community Partnerships**.
The Population Health Community Engagement and Partnerships was added under the **Community Partnership** section.

Quality and Performance Improvement Program Description

September 2025
MPQD1001

Program Approval

	08/20/2025

Robert Moore, MD MPH MBA
Quality/Utilization Advisory Committee (Q/UAC) Chairperson *Date Approved*

	09/10/2025

~~*Steven Gwiazdowski, MD, FAAP*~~*Angela Brennan, DO*
Physician Advisory Committee (PAC) Chairperson *Date Approved*

	10/22/2025

Kim Tangermann
Board of Commissioners Chairperson *Date Approved*

TABLE OF CONTENTS

Program Purpose and Goals	4
Scope of Quality and Performance Improvement Program	5
Authority and Responsibility	6
Approach to Quality and Performance Improvement	17
Cultural Competency	36
Communication Systems	36
Delegation	37
~~Review by Outside Licensing Agencies or Accrediting Bodies~~	38
Sanctions	~~38~~
Annual Quality Improvement Work Plan	38
Annual Quality Incentive Program Evaluation	39
Review by Outside Licensing Agencies or Accrediting Bodies	43
Statement of Confidentiality	39
Statement of Conflict of Interest	40
Appendix A	
Standing Staff Members of Partnership HealthPlan of California's Quality Improvement Committees	41
Appendix B	
Partnership HealthPlan Strategic Quality Plan: Achieving Five-Star Quality	53
Appendix C	
Pathway to Excellence: Partnership HealthPlan of California's Framework for Continuous Learning	66
Appendix D	
Resumes for Key Leadership Positions Accountable for Implementing and Maintaining the QI/PI Program	103

Program Purpose and Goals

Partnership HealthPlan of California's (Partnership) Quality and Performance Improvement (QI/PI) program provides a series of systematic processes to monitor and evaluate the quality of clinical care and health care service delivery to all Partnership members. This includes an organized framework to:

- Review activities and identify opportunities to improve the quality of health care services provided
- Promote efficient and effective use of health plan financial resources
- Promote and improve health equity
- Strike a balance between compliance with and performance on regulatory standards
- Partner with internal and external stakeholders to support performance improvement
- Improve health outcomes of our members

The QI/PI program promotes consistency in -assessing and improving the quality of the full scope of health care services while providing a mechanism to:

- Ensure integration with current community and population health priorities, standards, and goals that impact the health of the Partnership member population
- Ensure alignment with DHCS' Comprehensive Quality Strategy Report
- Identify and act on opportunities to improve care and service
- Identify overuse, underuse, and misuse of health care services
- Identify and act on opportunities to improve processes to ensure member safety
- Identify and act on opportunities to address disparities in health access and outcomes
- Address potential or tangible quality issues
- Review trends that suggest variations in the process or outcomes of care

The QI/PI program adheres to the following goals to improve the quality and effectiveness of clinical care and service to Partnership members:

- Improve the health of the populations Partnership serves
- Enhance the member care experience
- Support the delivery of high-quality clinical care
- Reduce disparities in health access and outcomes
- Ensure member safety
- Measure and encourage appropriate use of clinical resources
- Strengthen a culture of continuous quality improvement within the Partnership network

The QI/PI program accomplishes these goals by:

- Systematically monitoring and evaluating service and care provided
- Continuously improving our data and approach to analytics to validate care outcomes
- Actively pursuing opportunities for improvement in areas that are relevant and important to Partnership members' health
- Implementing strong interventions when opportunities for performance improvement are identified
- Addressing overall member experience by improving provider access and member awareness of the health plan's role and responsibilities
- Promoting a culture of learning and improvement through a framework called Pathway to Excellence: Partnership's Framework for Continuous Learning (P2E)

These goals align with Partnership's mission: To help our members and the communities we serve be healthy.

Applying the model of a learning organization, the measurement and analysis of selected indicators and professionally recognized standards of practice underpin the evaluation of QI/PI activities. The objectives of the program are to:

- Engage providers, members, and community stakeholders to improve quality metrics through identifying opportunities for improvement and acting on opportunities that have the greatest impact on member care. These actions are driven by rigorous data analysis, whenever possible, and through a collaborative atmosphere where new ideas can be explored and tested to enhance learning.
- Improve member experience through enhanced primary care provider (PCP) access.
- Strengthen the data and analytics infrastructure through the development of foundational systems and processes for evaluation of results and decision-making.
- Achieve and maintain pertinent National Committee for Quality Assurance (NCQA) accreditations while ensuring compliance with contractual quality requirements, state and federal quality regulations, evidence-based standards of care, and standards of selected accrediting bodies.
- Equip PCPs to provide recommended high-quality care through provision of information, technical assistance, improvement tools, and financial incentives.
- Optimize value-based programs through measure research and incorporation of best practices.

The objectives, scope, organization, and mechanisms for overseeing effectiveness of monitoring, evaluation, and ~~problem solving~~problem-solving activities in the QI/PI program are assessed and revised at least annually.

Scope of Quality and Performance Improvement Program

The scope of the QI/PI program includes the quality of clinical care and of service for all members. The program presently covers a ~~single product line~~ Medi-Cal (the name for Medicaid in California) product line and includes the anticipated integration of ~~. Partnership is preparing to expand its product line offering to include~~ a Dual Eligible Special Needs Plan (D-SNP), Partnership Advantage, in 2027.~~by 01/01/2026.~~ This is specifically defined as an Exclusively Aligned Enrollment (EAE) D-SNP. Partnership aims to become a Medicare Medi-Cal Health Plan, joining other managed care plans across California, in offering members eligible for both Medi-Cal and Medicare the opportunity for one plan to manage all of their benefits, including care coordination and other wraparound services.

The monitoring and evaluation of clinical issues reflects the population served by Partnership without regard to age group, disease category, or risk status. In partnership with other Partnership departments, the QI/PI program encompasses all aspects of medical care including:

- Diagnoses and procedures with a wide variation in cost or utilization patterns
- Identifying overuse, underuse and misuse of health care services and prescription medications
- Identifying and addressing racial/ethnic and other disparities in health care delivery or outcomes
- Identifying and addressing access or quality issues related to behavioral health services through delegated contracts
- Promoting cultural and linguistic competence of Partnership staff and network practice sites and providers
- Member experience outcomes
- Facility Site Reviews and ongoing monitoring to assess compliance with patient safety standards
- Ambulatory medical records review
- An assessment of physical accessibility of outpatient providers for seniors and persons with disabilities
- Preventive health care guideline compliance
- Chronic and acute care clinical practice guideline (CPG) compliance
- Continuity and coordination of care between PCPs and specialists, different levels of care, PCPs and other provider types, and PCPs and Behavioral Health Practitioners (through the Care Coordination department)
- Accessibility and quality of primary, specialty, and behavioral health care
- Member grievances (through the Grievance & Appeals department)
- Investigation and resolution of Potential Quality Issues (PQIs)
- Provider satisfaction (through the Provider Relations department)
- Provider credentialing (through the Provider Relations department)

- Supporting clinics in achieving patient centered health homes

The QI/PI program encompasses monitoring and evaluation of care and service in the following settings:

- Acute hospital services
- Ambulatory care, including preventive health care, perinatal care, chronic disease management, and family planning
- Emergency and urgent care services
- Behavioral health services* (mental health and substance use disorder)
- Ancillary care services including but not limited to: home health care, skilled nursing care, subacute care, pharmacy, medical supplies, durable medical equipment (DME), therapy services, laboratory, vision, and radiology services
- Long term care placements in skilled nursing facilities, subacute care facilities, and intermediate care facilities.
- Wellness and Recovery Program

*~~The QI program scope as it relates to behavioral health services:~~Refer to the Approach to Quality and Performance Improvement section for more information on Behavioral Health services

~~Mental Health Services:~~

~~Since January 1, 2014, Partnership has provided mental health services for those with mild to moderate treatment needs, pursuant to the Plan's Medi-Cal contract with the State of California. This mandate is detailed in the California Department of Health Care Services (DHCS) All Plan Letter 22-006 (Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services) issued April 8, 2022. As of the start of 2025-2026, Partnership presently delegates the administration of these services to Carelon Behavioral Health, formerly known as Beacon Health Options, in all 24 counties served by Partnership. This mandate is detailed in the California Department of Health Care Services (DHCS) All Plan Letter 22-006 (Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services) issued April 8, 2022.By the start of 2026, Partnership will no longer delegate member-facing responsibilities to Carelon Behavioral Health, including its member access line, grievances & appeals, and care coordination functions. The exact scope and timing of de-delegation is pending finalization in early 2025-2026.~~

~~DHCS assigns Specialty Mental Health Services for mental health conditions deemed to be moderate to severe in terms of level of impairment (also referred to as serious and persistent mental health conditions or SMI) to County Mental Health Plans (MHPs). These include all conditions that meet the medical necessity criteria pursuant to the DHCS Behavioral Health Information Notice (BHIN) 21-073, issued December 10, 2021.~~

~~Mental health QI management and improvement activities are delegated in part by Partnership to Carelon Behavioral Health. Partnership oversight of these delegated QI functions is achieved through: 1) annual and ad hoc audits, 2) semi-annual review of QI reports produced by these entities, and 3) discussion of quality management and development of quality improvement projects, (e.g., improved PCP referral forms, review and monitor quality issues related to neuropsychological testing, additional reports related to QI, and access standards).~~

~~Wellness and Recovery Program:~~

~~On July 1, 2020, Partnership and seven counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) implemented the "Wellness and Recovery" program, a regional substance use disorder services program. As Partnership does for other services, this program description includes the planned structure of quality and performance improvement activities Partnership uses for the overall program.~~

~~The quality infrastructure of the Wellness and Recovery Program is designed to help achieve one of the key goals of the program: the integration of substance use disorder services with the existing physical and mental health service delivery system. It reflects the incorporation of the county-focused quality structure outlined in the state and federal Organized Delivery System (ODS) waiver requirements into the strong, foundational quality structure of Partnership.~~

Authority and Responsibility

Board of Commissioners

The Board of Commissioners on Medical Care (the Commission) promotes, supports, and has ultimate accountability, authority, and responsibility for a comprehensive and integrated QI/PI program. The Commission is ultimately accountable for the quality of care and services provided to members. The Commission has delegated direct supervision, coordination, and oversight of the QI/PI program to the Physician Advisory Committee (PAC), which serves as the main Quality Improvement committee. PAC is supported by two other quality committees – the Quality and Utilization Advisory Committee (Q/UAC) and the Internal Quality Improvement Committee (IQI), which are described in more detail below. The county Boards of Supervisors for each geographic area appoints members of the Commission, which include ~~representation~~representatives from the community, including: consumers, businesses, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health departments. The Commission meets six times per year.

The purpose of the Commission is to arrange for the provision of health care services to qualifying individuals, as well as other purposes set forth in the enabling ordinances established by the respective counties.

Key Roles

The following leadership roles carry authority and responsibility to ensure the QI/PI Program is fully implemented and maintained. The qualifications of staff presently fulfilling these roles are detailed in Appendix D~~XX,~~ which includes documented evidence corresponding to that collected annually on behalf of DHCS. Given the personal details included, this appendix is not posted publicly.

Chief Executive Officer

The Partnership Chief Executive Officer's (CEO) primary roles in quality management and improvement are multifaceted. The CEO maintains a working knowledge of the clinical and service issues targeted for improvement and provides overall organizational leadership and direction in these efforts. In addition, the CEO identifies new and emerging opportunities to strengthen accountability among both internal teams and external partners in driving quality and performance improvement. They are actively involved in the prioritization and oversight of quality improvement activities across the organization and ensure that the necessary resources are available to support the successful implementation of the approved QI/PI program.~~The Partnership Chief Executive Officer's (CEO) primary roles in quality management and improvement are multifold:~~

- ~~Maintain a working knowledge of clinical and service issues targeted for improvement~~
- ~~Provide organizational leadership and direction~~
- ~~Identify new and emerging opportunities to increase accountability by internal and external partners for driving quality and performance improvement~~
- ~~Participate in prioritization and organizational oversight of quality improvement activities~~
- ~~Ensure availability of resources necessary to implement the approved QI/PI program~~

Chief Operating Officer

The Chief Operating Officer (COO) provides strategic leadership and guidance in all health plan operations. The COO has purview over the Member Services, Provider Relations, Claims, Configuration, Grievance and Appeals, Transportation and the Regional Leadership departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The COO's level of involvement fulfills the need for executive support and accountability for data quality improvements, and interdepartmental support for quality improvement interventions and initiatives.

Chief Health Services Officer
The Chief Health Services Officer (CHSO) works closely with leaders in Utilization Management to provide accountability for delegates to meet necessary NCQA accreditation requirements and provide strategic leadership and guidance in the review and revision of provider contracts to ensure QI reporting requirements and ~~value-based~~value-based program contingencies are met. The CHSO also has purview over the Care Coordination, ~~Population Health~~ Utilization Management, Enhanced Health Services, Behavioral Health and Health Equity departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The CHSO's level of involvement fulfills the need for executive support and accountability for improvements with data quality, coordination of activities between QI and these departments ~~including Member Services, and Population Health~~. Collaborates with the Chief Medical Officer and members of PAC, Q/UAC, and IQI in matters involving quality of care, clinical, and medical procedures.

Chief Medical Officer
The Chief Medical Officer (CMO), with the assistance of the members of PAC, Q/UAC, and IQI, as well as the other medical directors of Partnership, is responsible for providing professional judgment regarding matters of quality of care, peer review, clinical, and medical procedures. The CMO is the chair of IQI and Q/UAC and has significant involvement in all QI/PI, Pharmacy, and Health Services activities as well as providing oversight to these programs on a day-to-day basis. The CMO is a Medical Doctor (MD) or Doctor of Osteopathy (DO) with an unrestricted license in the State of California.

Medical Director for Quality
Assists CMO by providing physician support for varying activities within the QI/PI department, including Performance Improvement, Member Safety, Peer Review, and the Quality Incentive Programs, as well as assists with utilization management review activities. This role also serves as management oversight for the Member Safety teams within the QI/PI department.

Medical Director of Medicare Services
This role provides physician leadership in preparation for implementing the Medicare Dual Special Needs Plan (D-SNP) ~~by January 2026.~~ This medical director works closely with the CMO and QI/PI Department to develop policy, strategy, and tactical activities with Medicare leads designated in departments across the organization. As D-SNP is implemented, this role will provide medical leadership for Partnership's Medicare activities, including utilization management, quality, care coordination, pharmacy, grievances, and compliance activities. Also assists CMO, as requested, in supporting broader needs to oversee appropriateness and quality of care delivered through Partnership and for the cost-effective utilization of services.

Senior Director of Quality and Performance Improvement
This role works collaboratively with the CMO to define strategy, develop programs and services, and to evaluate the effectiveness of the QI/PI Program. Together with the QI management team, including the Medical Director for Quality, provides oversight of Facility Site Reviews, investigation of potential quality issues, compliance with NCQA standards, HEDIS® and other performance measure data collection and performance reporting, ~~value-based~~value-based payment programs (QIPs), performance improvement initiatives and programs, external and internal QI training, provider education on the QIPs and HEDIS®, grant application and grant management. This role works to foster greater cross collaboration of QI staff and strategic involvement of other departments to support the execution of tactics defined and maintained under Partnership's 5-Star Quality Strategy.

Chief Strategy & Government Affairs Officer
The Chief Strategy and Government Affairs Officer (CSGAO) reports to the Chief Executive Officer and is a peer to the other executive team members. The CSGAO leads the overall strategic direction of the HealthPlan in consultation with the CEO and Governing Board.

This position is responsible for the operations and executive management of Regulatory Affairs and Compliance

(RAC); Communications, Legal, ~~Provider Relations~~Network Services, and Project Management/Operational Excellence (PMO) departments. This position also oversees our Medicare Duals Special Needs Plan (D-SNP) program.

~~Director of Regulatory Affairs and Program Strategy~~ Senior Director of Regulatory Affairs & Contracting ~~Regulatory Affairs and Compliance Program~~
This position serves as Partnership's Compliance Officer, working to ensure the HealthPlan's ongoing compliance with all applicable federal, state, local, and administrative agency statutory and regulatory requirements. Furthermore, this position serves as Partnership's Fraud Prevention Officer and Privacy Officer; is a subject matter expert in fraud and privacy and is responsible for promoting the prevention, detection, and deterrence of fraud and privacy risks while ensuring PHC complies with all state and federal privacy and fraud laws.

~~Clinical Director of~~ Behavioral Health Clinical Director
The ~~Clinical Director of~~ Behavioral Health Clinical Director holds an MD/DO, PhD or PsyD credential. With the assistance of the Behavioral Health ~~Leadership Team~~team, this individual is responsible for providing professional judgment regarding matters of quality of care, peer review, and clinical policies and procedures through oversight of Partnership activities in the areas of mental health and substance use disorder services as provided by Partnership's delegated behavioral health providers.

~~Behavioral Health Leadership Team~~Senior Director of Behavioral Health
~~The Behavioral Health Leadership Team includes the~~Under the direction of the Chief Health Services Officer (CHSO), the Senior Director of Behavioral Health~~, Senior Behavior Health Manager, and other plan leadership.~~ leads the Behavioral Health team ~~This team~~ to oversee~~s~~ the operations and delegated functions ~~ion oversight~~ of Partnership's mental health and substance use disorder services. Partnership's annual audit of Carelon Behavioral Health stipulates that the organization produces evidence that Behavioral Health Specialists at the level of PhD and/or MD are on their QI Committee or teams that report to their QI Committee. Carelon meets this standard.

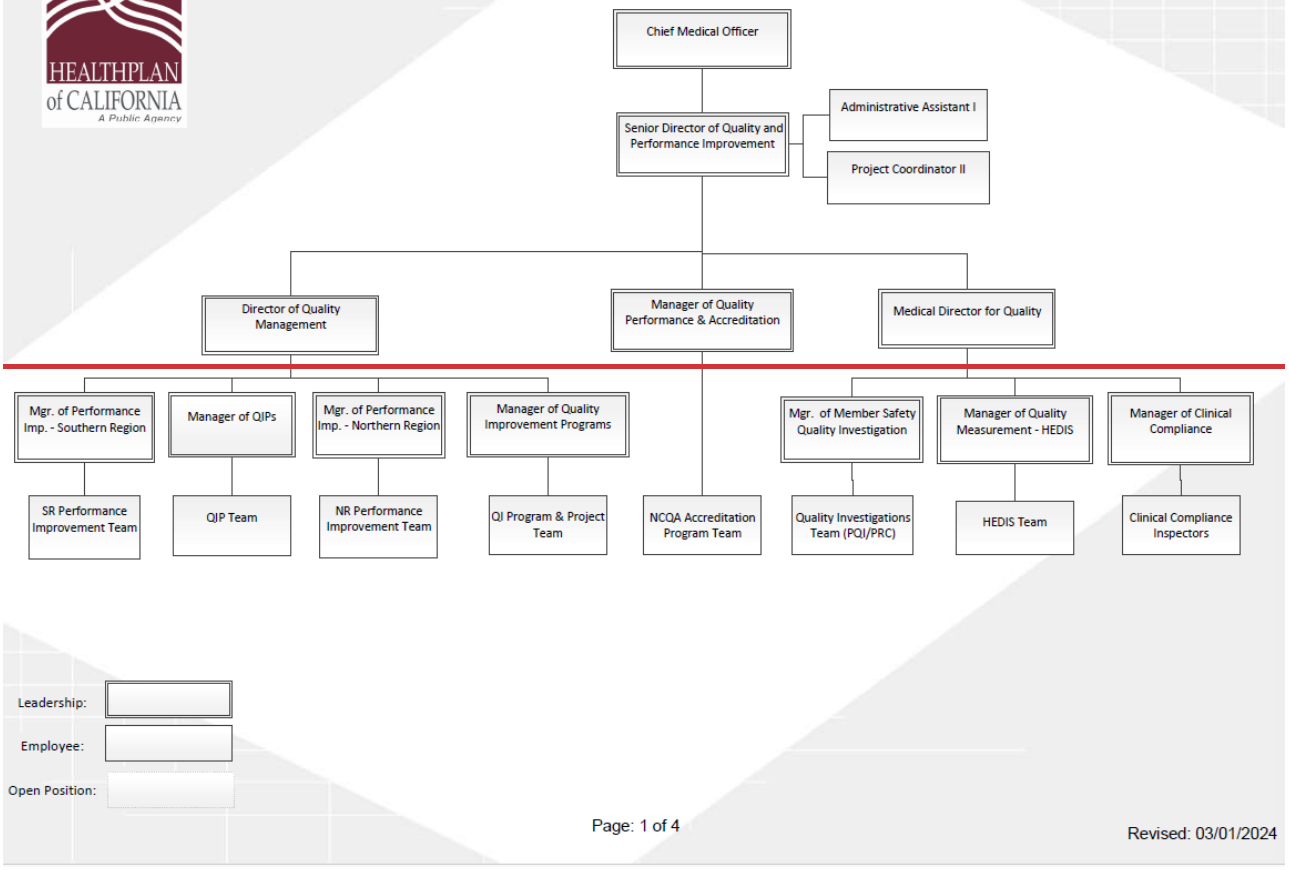
Director of Health Equity (Health Equity Officer)
The Director of Health Equity serves as the Health Equity Officer (HEO) for Partnership.~~,~~ ~~I~~In collaboration with Partnership leaders, the Director of Health Equity leads the development and implementation of strategies that advance diversity, equity, and inclusion across the organization. This role drives systemic change to enhance representation and cultivates programs that foster a culture of belonging. It also promotes awareness of health inequities within our membership and guides the creation of actionable plans to address them. Key responsibilities include identifying opportunities to track, analyze, and reduce disparities in care, with a focus on the varied cultural, linguistic, economic, educational, and health needs of our communities and workforce. In ~~collarboration~~collaboration with the CMO, oversees the Quality Improvement and Health Equity Transformation Program (QIHETP) program operations and assists in the development and coordination of QIHETP policies and procedures.

Director of Population Health Management
The Director of Population Health Management works collaboratively with leaders across the organization, to execute the organization's Population Health Management strategy. This role provides oversight, strategic direction, and support for related initiatives, including those essential to improving quality measure performance and member experience. This role offers ~~clinical~~ guidance and ensures alignment with health care policies, financing, accreditation requirements, and regulations to drive optimal health outcomes for members.

Program Staff
Partnership QI/PI program leadership and corresponding teams are outlined in the organizational chart below.

Partnership HealthPlan of California

Health Services – Quality Improvement
Organization Chart



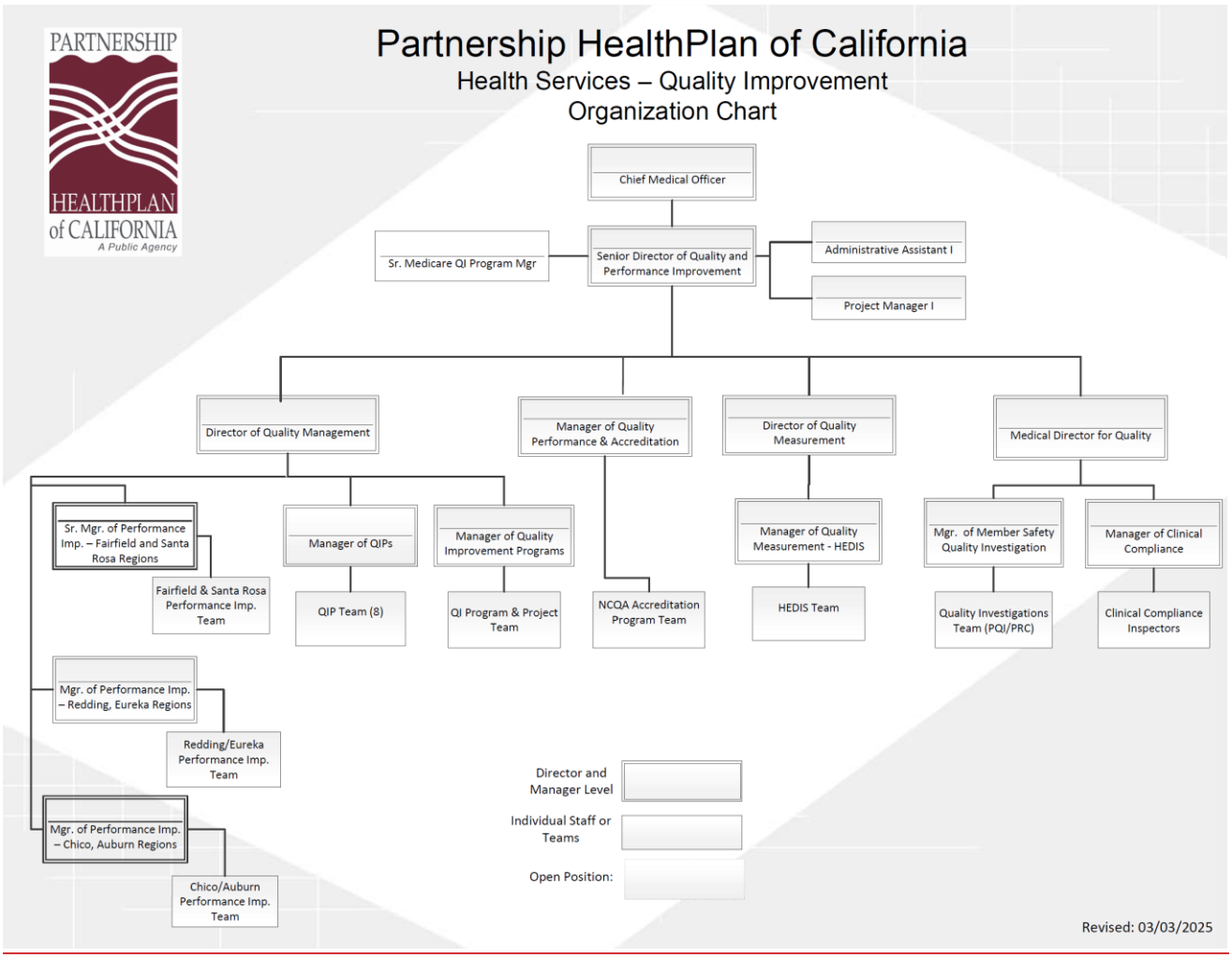
Leadership:

Employee:

Open Position:

Page: 1 of 4

Revised: 03/01/2024

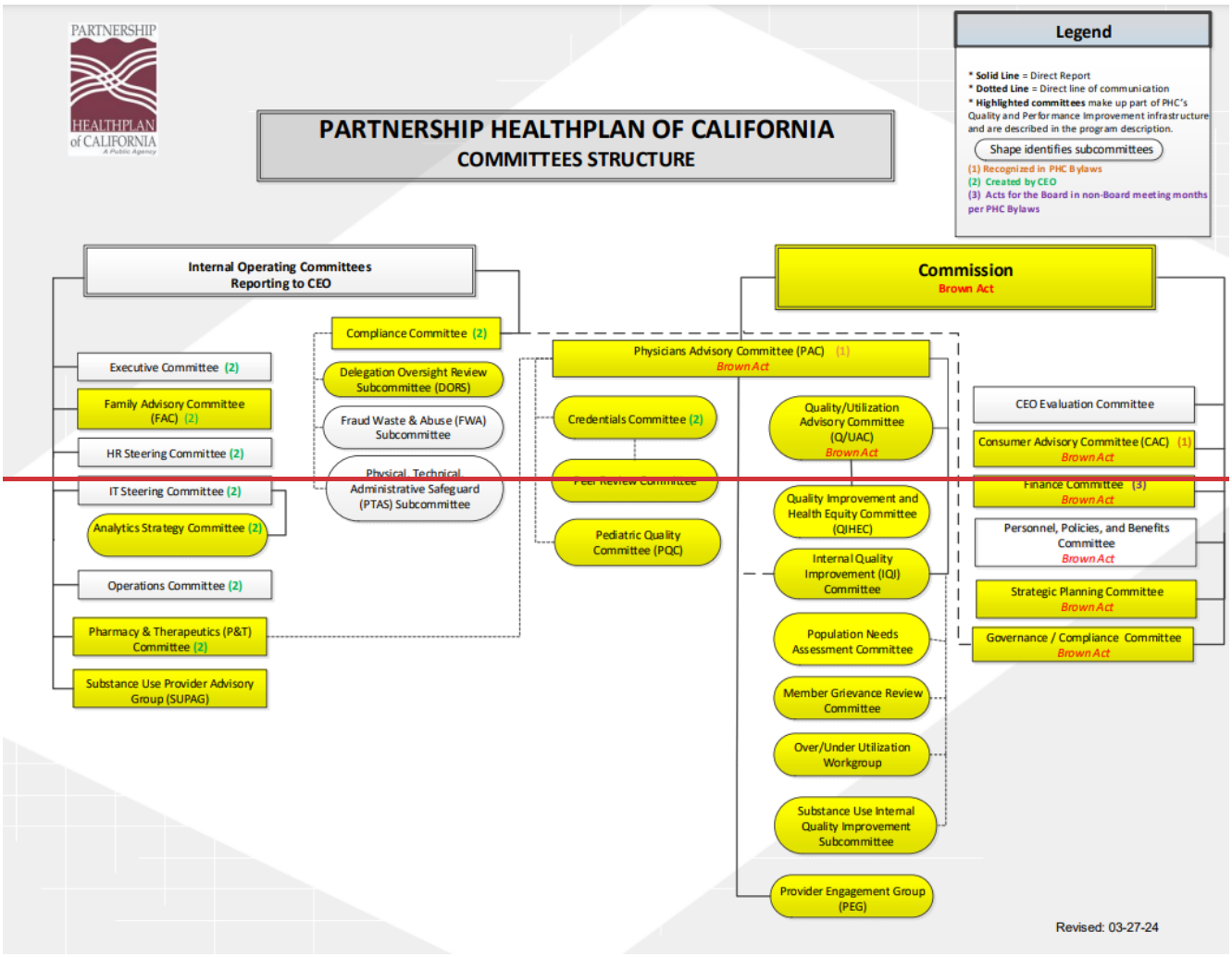


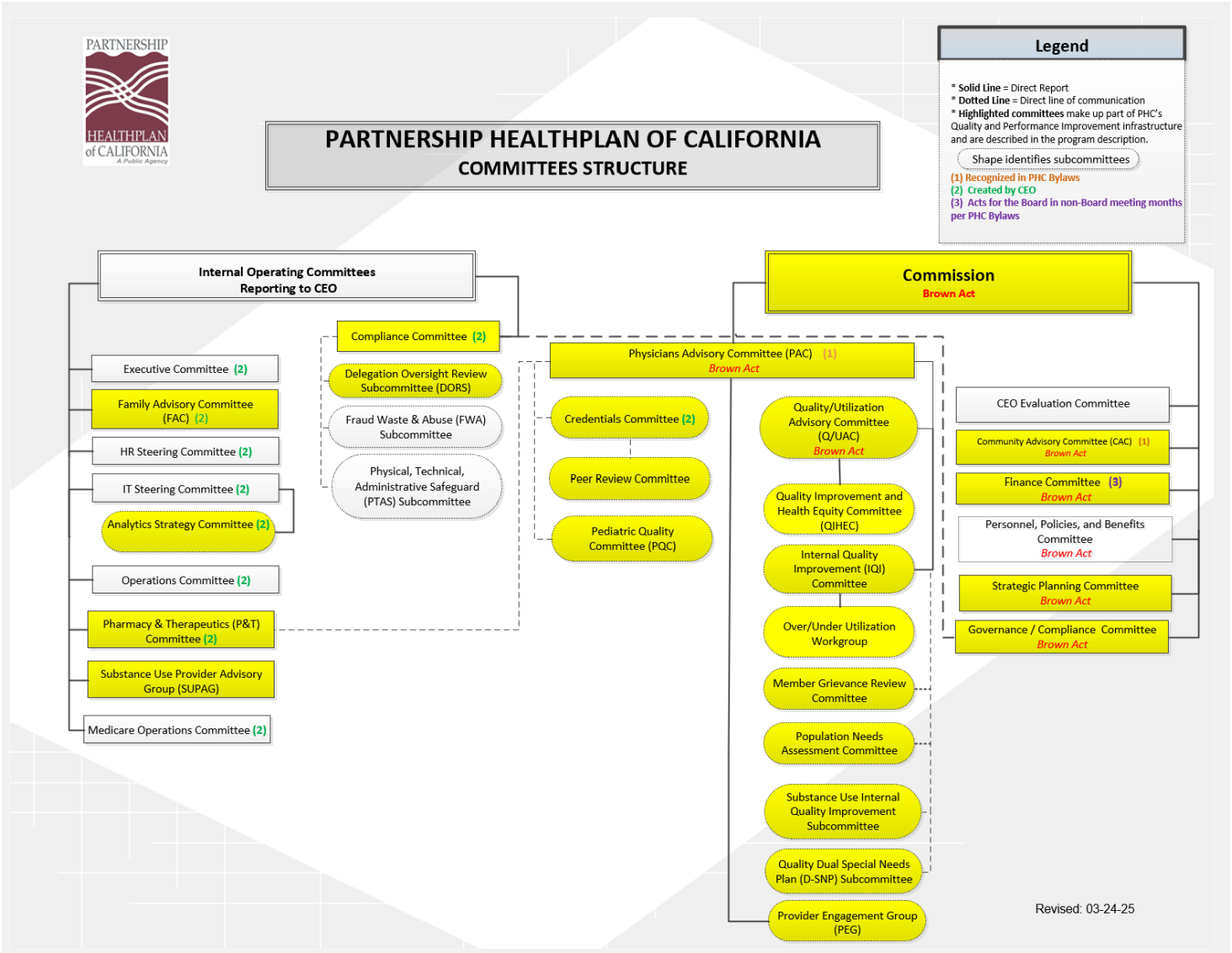
The QI/PI department is structured to provide governance over the QI program and corresponding work plan. Under the guidance of the CMO, the Senior Director of Quality and Performance Improvement and respective directors in QI/PI lead the department in the execution of QI/PI activities outlined in the QI Program Description and QI Work Plan. The department ensures the primary activities related to performance improvement, adherence to regulatory requirements, and the quality and safety of clinical care to optimize members' experience with Partnership are completed through ongoing engagement and the provision of interdisciplinary support to all areas within Partnership.

Committee Functions

Partnership has developed a robust committee structure to support the breadth and depth of multiple facets of QI/PI regulatory requirements and activities. There are several internal operating committees that report to the

CEO and a number of external facing committees, principally PAC and four others that report directly to the Board of Commissioners. Certain committees must adhere to state regulations, including the Brown Act, which provides stipulations for making meetings available to the public. The diagram below describes how committees are organized and the reporting structures. This is followed by a narrative briefly describing each committee, in alphabetical order, essential to the Quality and Performance Improvement infrastructure.




PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
COMMITTEES STRUCTURE
Legend
* Solid Line = Direct Report
* Dotted Line = Direct line of communication
* Highlighted committees make up part of PHC's Quality and Performance Improvement infrastructure and are described in the program description.
Shape identifies subcommittees
(1) Recognized in PHC Bylaws
(2) Created by CEO
(3) Acts for the Board in non-Board meeting months per PHC Bylaws
Internal Operating Committees Reporting to CEO
Executive Committee (2)
Family Advisory Committee (FAC) (2)
HR Steering Committee (2)
IT Steering Committee (2)
Analytics Strategy Committee (2)
Operations Committee (2)
Pharmacy & Therapeutics (P&T) Committee (2)
Substance Use Provider Advisory Group (SUPAG)
Medicare Operations Committee (2)
Compliance Committee (2)
Delegation Oversight Review Subcommittee (DORS)
Fraud Waste & Abuse (FWA) Subcommittee
Physical, Technical, Administrative Safeguard (PTAS) Subcommittee
Commission
Brown Act
Physicians Advisory Committee (PAC) (1)
Brown Act
Credentials Committee (2)
Peer Review Committee
Pediatric Quality Committee (PQC)
Quality/Utilization Advisory Committee (Q/UAC)
Brown Act
Quality Improvement and Health Equity Committee (QIHEC)
Internal Quality Improvement (IQI) Committee
Over/Under Utilization Workgroup
Member Grievance Review Committee
Population Needs Assessment Committee
Substance Use Internal Quality Improvement Subcommittee
Quality Dual Special Needs Plan (D-SNP) Subcommittee
Provider Engagement Group (PEG)
CEO Evaluation Committee
Community Advisory Committee (CAC) (1)
Brown Act
Finance Committee (3)
Brown Act
Personnel, Policies, and Benefits Committee
Brown Act
Strategic Planning Committee
Brown Act
Governance / Compliance Committee
Brown Act
Revised: 03-24-25

Analytics Steering Committee
The Analytics Steering Committee (ASC) is a multidisciplinary forum with representatives from Claims, QI/PI, Office of the CMO, Health Services, Members Services, Behavioral Health, Strategy and Government Affairs, Provider Relations, Finance, and IT. The ~~ACS~~ ASC is part of the Analytics Center of Excellence (ACE), an enterprise-wide virtual framework that functions to promote and coordinate data analytics efforts to generate information, knowledge and wisdom to improve health outcomes, enhance the member experience of care, and reduce or maintain the cost of care by optimizing utilization of data, technology and staff.

The ASC meets every other month throughout the year with the following foci:

- Act as an advocate for data analytics initiatives and projects across the wider organization
- Provide oversight and guidance for Partnership's data analytics projects across all regions
- Provide recommendations based on data analysis and strategic planning
- Inform and advise the Data Governance Council (DGC) on relevant analytic initiatives and cooperates with the DGC to ensure alignment with overall data strategy
- Review and monitor policies to guide data analytics throughout Partnership
- Promote and foster data analytics, data interpretation, and data sharing to improve the utility of data for planning and decision-making, especially related to current issues, initiatives, and integrated problem-solving. (Analytics Champion)
- Establish project goals for the ACE as well as determine how success will be measured
- Act as final authority for resolving issues or disputes on analytics prioritization and needs
- Identify and advise on minimizing project and business risks
- Establish subcommittees as required to facilitate the work of the committee

Compliance Committee
The Compliance Committee, chaired by the Compliance Officer, is an internal committee and has general responsibility to oversee Partnership's compliance and ethics programs. The purpose of the Committee is to oversee Partnership's implementation of compliance programs, policies and procedures that are designed to respond to the various compliance and regulatory risks facing the company; provide an avenue of communication among management, those persons responsible for the internal compliance function, and the Commission; and perform any other duties as directed by the Commission or the CEO.

~~Consumer~~ Community Advisory Committee (CAC)
The ~~Consumer~~ Community Advisory Committee (CAC) is composed of Partnership members, advocates and stakeholders who represent the diversity and geographic areas of Partnership's membership including hard-to-reach populations. The CAC is a liaison group between our members and Partnership, advocating for members by ensuring that the health plan is responsive to the health care and information needs of all members. Additionally, the CAC provides Partnership members with a forum to discuss common issues of interest and importance, while creating a supportive and informative environment. The CAC meets quarterly, reviews and makes recommendations regarding quality improvement activities, provides feedback on quality and health equity initiatives, and serves in the capacity of a focus group. ~~One or more~~Three CAC member~~(s)~~ ~~is~~ are selected to serve~~(s)~~ on the Partnership Board to provide member input and report back to the CAC.

Credentials Committee
The Partnership CMO, or designee, chairs the Credentials Committee. Committee members include a minimum of five contracted network practitioners. The committee meets monthly, excluding July and December. The functions of the Credentials Committee are to:

- Participate in and make recommendations regarding the structure and process for the credentialing and re-credentialing of providers and licensed practitioners
- Participate in the development, implementation, and annual review of related policies and procedures
- Review and approve Partnership staff recommendations for credentialing of practitioners who meet criteria
- Review and approve Partnership staff recommendations for credentialing of practitioners who do not meet exception criteria
- Review qualifications and circumstantial details for contracted practitioners who meet exception criteria

and make credentialing decisions

- Review and evaluate the qualifications of each practitioner seeking re-credentialing as a contracted provider at least every three years and assure compliance with established criteria
- Review ongoing sanctions monthly and member complaints quarterly for each practitioner
- Verify that each provider in the network meets credentialing requirements, including implementation of and adherence to any corrective action plans (CAPs) to meet standards
- Decisions regarding provider credentialing and re-credentialing
- Develop disciplinary or sanction actions of practitioners
- Provide oversight of any delegated credentialing activities

Summary information of credentialing activities is presented to the PAC and to the Partnership Board of Commissioners at regularly scheduled meetings.

Delegation Oversight Review Subcommittee (DORS)
The Delegation Oversight Review Subcommittee (DORS) comprises representatives from operational departments that have oversight responsibility wherein Partnership has assigned authority to an external entity (delegated entity) to perform on its behalf. DORS meets no less than four times per year and is responsible for overseeing agreements and responsibilities between Partnership and its delegated entities. The Subcommittee is tasked with overseeing that delegates are compliant with all applicable state and federal regulations, contractual obligations, and accreditation requirements.

Family Advisory Committee (FAC)
The Family Advisory Committee (FAC) is a member advisory group to the CEO and staff of Partnership. The FAC provides a forum for parents, guardians and caregivers of children with CCS conditions to discuss common issues of interest and importance, to create a supportive and informative networking environment and to advocate for members by ensuring that Partnership is responsive to the diversity of health care needs for all members. Minutes from FAC meetings are reviewed by the PQC.

The FAC membership is comprised of representatives throughout Partnership's geographic service areas who advocate for CCS-eligible children of diverse cultures, ethnicities, genders, ages and disabilities. Meetings are held at least four (4) times per year with the option for additional meetings as needed.

The mission of FAC is to leverage the Whole Child Model (WCM) to enhance the quality of how CCS beneficiaries – and their families – experience care.

Finance Committee
The Board of Commissioners authorizes the Finance Committee to act on matters of urgency when the Board does not meet. Items approved by the Finance Committee are ratified by the full Board at a subsequent full Board meeting. The Finance Committee is comprised of an appointed group of members from the Board, which encompasses representation from across Partnership's entire service region. The Finance Committee meets monthly.

The Finance Committee has the following authority:
- Review and make recommendations on the annual budget
- Review and make recommendations on financial policy
- Review major capital expenditures
- Monitor the financial status of the organization and overall leadership for better management in alliance with the executive team and other Partnership staff

The Committee also advises the Board of Commissioners on the fiscal impact of any changes pertaining to value-based programs as related to:
- Payment structure
- Annual budget

- Prioritizing programs

Governance and Compliance Subcommittee
The Governance and Compliance Committee is a subcommittee of the Commission, has the fiduciary responsibility to oversee Partnership's regulatory Compliance Program, and shall ensure the establishment and maintenance of an effective compliance and ethics program by assuring compliance activities are reasonably designed, implemented, and generally effective in preventing and detecting risks or compliance violations. The subcommittee meets quarterly.

Internal Quality Improvement (IQI) Committee
An internal Partnership committee comprised of appropriate Partnership department directors and staff, the Internal Quality Improvement (IQI) Committee tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation. The IQI Committee meets monthly, at least ten (10) times per year, with the option to add additional meetings if needed, to review policies, procedures, and QI activities. The Partnership CMO (chair of the committee), Director of Health Equity ~~Officer~~, Medical Director for Quality, Manager, Member Safety - Quality Investigations and Health Services leadership as described for Q/UAC attend IQI Committee meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. Multidisciplinary improvement teams may be designated to complete analysis and intervention recommendations for quality improvement issues and activities. Evaluations and recommendations put forward at IQI represent strategies used in local entity engagement to address deficiencies in performance measures for members 21 years of age or less. The IQI Committee serves to integrate quality activities organization-wide, which are then reported to Q/UAC and PAC.

Member Grievance Review Committee (MGRC)
The Member Grievance Review Committee (MGRC) represents a multidisciplinary oversight forum with representatives from Claims, QI/PI, Office of the CMO, Pharmacy, Care Coordination, Utilization Management, Population Health, Member Services, Provider Relations, RAC, Behavioral Health, Enhanced Health Services, and Transportation Services to track and trend Grievances, Appeals, Exempt Grievances, and State Hearing cases. It serves as a collaborative work group to discuss complex cases or improvement opportunities with the following key focus areas: quality improvements, clinical oversight, operational excellence, member experience, and regulatory compliance. Findings may be presented in the Q/UAC, IQI, CAC, Delegation Oversight Review Subcommittee (DORS), and/or Substance Use Internal Quality Improvement Subcommittee (SUIQI) meeting. MGRC is held on a quarterly basis.

Over/Under Utilization Workgroup
The Over/Under Utilization Workgroup is an internal Partnership committee that evaluates services that may be over-or under-utilized compared to optimal utilization. The Over/Under Utilization Workgroup meets quarterly. Its goals are to use the results of the analysis to drive quality improvement activities, accuracy of data collection and analysis, and the most cost-effective use of resources. ~~The CMO~~A designated Partnership Medical Director chairs the committee, and the Health Analytics department supports it. Representatives from Health Services (e.g. Pharmacy, Population Health, Health Equity, Quality Improvement, and Utilization Management), Compliance, Member Services, Operational Excellence/Project Management Office (Op-Ex/PMO), Provider Relations, and Claims also attend. A summary of activity from the committee is annually reported to IQI and Q/UAC, (as part of the Utilization Management Grand analysis) and Partnership's Compliance Committee.

Pediatric Quality Committee (PQC)
The Pediatric Quality Committee (PQC) is the clinical advisory committee for the Whole Child Model (WCM) program. The PQC meets at least four (4) times per year with the option for additional meetings if needed.

The membership of PQC includes the Partnership Whole Child Model Medical Director (Chairperson), CMO (Vice Chairperson), Chief Health Services Officer (CHSO), Pharmacy Director, at least four California Children Services (CCS) paneled clinician providers, CCS Medical Directors designated by each Partnership County, and Nurse Director or Manager as designated by each County CCS program. Other health plan staff and outside experts may make special or periodic reports to the committee or may attend selected meetings by invitation from

the committee chair or designee.

Peer Review Committee (PRC)
The Peer Review Committee (PRC) membership includes external practitioners representing PCPs, board certified specialists and non-physician ~~clinicians~~medical practitioners (NPMP), which include nurse practitioners, physician assistants, certified nurse midwives, and licensed midwives. The Partnership CMO Regional and Associate Medical Directors are also voting members of the PRC. Partnership's RN Quality Investigators and the Manager of Member Safety - Quality Investigations support the Committee. ~~The~~ Partnership's Medical Director for Quality, CMO, or other designated Partnership Medical Director chairs the committee. NPMP may vote to rate providers and/or systems only in areas in which they possess subject matter expertise. All committee members are eligible to vote on issues brought before the committee. The committee meets at least quarterly and on an as needed basis. Peer Review functions are to:

- Review potential and actual quality issues and provider/member complaints and appeals related to quality of care
- Make recommendations for Corrective Action Plans (CAP)~~s~~ and practitioner discipline or sanctions to the Credentials Committee
- Make recommendations on improvements to systems of care based on specific occurrences

Physician Advisory Committee (PAC)
The Physician Advisory Committee (PAC) monitors and evaluates all Health Services activities and is directly accountable to the Board of Commissioners for the oversight of the QI/PI program. PAC meets at least ten (10) times a year. Voting membership includes external PCPs, board certified high-volume specialists and non-physician clinicians. A voting provider member of the committee chairs PAC. The Partnership CEO, COO, Chief Financial Officer (CFO), CMO, Medical Director for Quality, Regional Medical Director(s), ~~Clinical Director of Behavioral Health~~Behavioral Health Clinical Director, and leadership from the following departments including; QI/PI, Provider Relations, Care Coordination, Utilization Management, Network Services, and Pharmacy attend PAC meetings regularly. Other Partnership staff attend on an adhoc basis to provide expertise on specific agenda items. PAC oversees the activities of Q/UAC and other quality- related committees and reports QI/PI activities to the Board of Commissioners.

Pharmacy and Therapeutics (P&T) Committee
The Pharmacy and Therapeutics (P&T) Committee is comprised of Partnership staff and network practitioners including pharmacists, PCPs, and specialists, including behavioral health. The Chief Medical Officer (CMO) or Pharmacy Director (when designated by the CMO) chairs the P&T. The committee makes decisions and recommendations on development and review of the medical benefit drug formulary, pharmacy policies and procedures, new drugs, and drug approval criteria. The P&T meets quarterly, providing regular activity reports and recommendations to PAC, the approval authority for P&T related activities. The P&T Committee also serves as Partnership's Drug Utilization Review (DUR) Board. Partnership's DUR Board conducts retrospective analysis on drug utilization to identify patterns of fraud, waste, and abuse or inappropriate or medically unnecessary care. In addition, the DUR Board makes recommendations for education programs and bulletins to improve drug safety and therapeutic outcomes.

Provider Engagement Group (PEG)
Meetings are held quarterly. This group will include network staff and vary based on subject matter. The purpose of PEG is to educate and update the network about new Partnership programs, benefits, and/or changes mandated by DHCS or Partnership. The Plan staff will target specific network invitees depending upon subject matter to be presented or discussed. Targeted provider audience and invitees include clinic managers, supervisors and other mid-management staff. Minutes of the meetings will be presented to PAC.

Population Needs Assessment Committee (PNA)
The Population Needs Assessment Committee (PNA) is an internal committee serving as a multi-departmental decision-making body whose goal is to carry out the DHCS mandate to meaningfully participate in each Local

Health Jurisdiction's (LHJs) Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). The PNA Committee meetings occur on a ~~quarterly~~ bi-monthly basis to review requests from the counties, and general progress towards shared work on the CHA/CHIP collaborative in Partnership's service areas, including the approval and implementation of the shared SMART (Specific, Measurable, Attainable, Relevant, Time-Bound) goals between Partnership and each of the LHJs in Partnership's service. This committee also meets annually to review and make recommendations for the Population Needs Assessment (PNA) used to fulfill NCQA requirements. The PNA Committee activities and recommendations will be shared with the ~~Quality Improvement and Health Equity Committee (QIHEC),~~ Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC) and Partnership's Board of Commissioners.

~~***Quality D-SNP Sub-Committee***~~

~~The Quality D-SNP Sub-Committee is led by the Medicare Director for~~Medical Director of Medicare Services ~~and includes members from each of the following departments: Quality and Performance Improvement, Care Management, Finance, Strategy and Government Affairs, Pharmacy, Population Health, Health Equity, Information Technology, Health Analytics, Health Services, Utilization Management, Grievance and Appeals, Transportation Services, and Provider Relations. The committee meets a minimum of ten times per year with the option of adding additional meetings if needed. The purpose of this committee is to report on the MOC~~Model of ~~Care (MOC), CMS and DHCS requirements for Partnership's D-SNP program to ensure this vulnerable population of members is receiving quality care. The Quality D-SNP Sub-Committee will serve as a vessel to monitor, plan and correct D-SNP program performance. A summary of activity from the committee is annually reported to IQI and Q/UAC (as part of D-SNP required reporting under Utilization Management) and Partnership's Compliance Committee. The scope of the annual summary includes all information related to the Medicare/D-SNP program including but not limited to:~~

~~MOC performance~~
~~CAPs~~
~~Over/Under Utilization Committee updates as they relate to Medicare~~
~~P&T Committee updates as they relate to Medicare~~

Quality Improvement and Health Equity Committee (QIHEC)

The Quality Improvement and Health Equity Committee (QIHEC) meets ~~quarterly~~ bimonthly ~~for~~ analyzing and evaluating the results of Health Equity related Quality Improvement activities. This includes annual review of the results of performance measures, utilization data, consumer satisfaction surveys, grievance and appeal data, and findings and activities of other Partnership specific committees (e.g., ~~Consumer~~ Community Advisory Committee, Population Needs Assessment Committee, etc.). This committee shall also be responsible for instituting actions to address health-equity performance deficiencies, including policy recommendations, and ensuring appropriate measurement and follow-up of identified performance deficiencies.

The QIHEC provides recommendations to Q/UAC. Q/UAC provides recommendations to PAC.

Partnership Members of the QIHEC include (but are not limited to): CMO, Director of Health Equity ~~Officer~~, Director of Grievance and Appeals, COO, Director of Communications, Director of Health Analytics, Senior Director of Quality and Performance Improvement, Director(s) of Care Coordination, Director(s) of Utilization Management, Director(s) of Population Health, Senior Health Educator, Chief Health Services Officer (CHSO), Director of Pharmacy Services, Regional Medical Director(s), Associate Medical Director(s), Senior Provider Relations Representative Manager, and Senior Director of Member Services. In addition, a broad range of network providers (e.g. Hospitals, Clinics, County Partners, Subcontractors, Downstream Subcontractors, and Members will be solicited to actively participate in the QIHEC.

Quality/Utilization Advisory Committee (Q/UAC)

The Quality/Utilization Advisory Committee (Q/UAC) is responsible to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. This responsibility includes providing significant input on the QI Program Description, Annual Evaluation and Work Plan. Q/UAC voting membership includes consumer representative(s) and external clinicians who represent hospitals, medical groups, and practice sites in geographic

sections of Partnership's service area. Physician and non-physician clinician members also serve on the Peer Review Committee. The Partnership CMO (chair of the committee), ~~Clinical Director of Behavioral Health~~Behavioral Health Clinical Director, Director of Health Equity ~~Officer~~, Medical Director for Quality, Manager of Member Safety - Quality Investigations, and leadership from the Health Services departments (e.g. QI/PI, Utilization Management, Care Coordination, Pharmacy, Population Health, Health Equity, ~~and Transportation Services~~Enhanced Health Services~~)~~, Grievance and Appeals, and Provider Relations departments attend Q/UAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The committee meets monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to PAC and at least quarterly to the Commission.

Activities include but are not limited to:

- Review and approve the QI/PI Program Description, Program Evaluation and Work Plan annually
- Review and approve standardized utilization review criteria and protocols
- Approve and ensure implementation of evidence-based guidelines and policies of medical practice including preventive, chronic care, and behavioral health initiatives
- Analyze summary data and make recommendations for action plans for quality improvement activities
- Assure that appropriate follow-up activities occur for all CAPs and QI/PI activities
- Provide oversight of delegated QI activities except for credentialing activities, which the Credentials Committee reviews

Strategic Planning Committee

The Strategic Planning Committee advises the Board of Commissioners and the CEO on long-range strategic issues affecting Partnership. This committee is appointed by the Board of Commissioners and is comprised of some Board of Commissioners' members and other leaders from the community who are not members of the Board. This committee meets on a quarterly basis.

Substance Use Internal Quality Improvement Subcommittee (SUIQI)

A committee comprised of appropriate Partnership and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for Partnership's substance use disorder services oversight. The Substance Use Internal Quality Improvement Subcommittee (SUIQI) meets at least quarterly. Activities and progress are reported to IQI. This also includes review of:

- Utilization management retroactive and appeals review
- Inter-rater reliability for peer review and utilization management
- Quality of service, quality of facility, and grievances and appeals
- Investigation of potential over-use, under-use, and misuse of services
- Policies related to provision of substance use disorder services

Members of the committee include the Behavioral Health Clinical Director, Senior Director of Behavioral Health, Senior Manager of Behavioral Health, CMO, and representatives from Provider Relations, Member Services, Claims, Compliance, Behavioral Health, and Quality Improvement departments.

Substance Use Services Provider Advisory Group (SUPAG)

The Substance Use Services Provider Advisory Group (SUPAG) monitors Partnership substance use disorder services treatment activities. The committee will meet at least four times per year. Membership includes licensed and certified ~~substance use~~substance u~~s~~disorder service~~s~~ providers and clinicians and others involved in substance use disorder care. The Committee also includes county substance use disorder services administration representatives. ~~The SUPAG advises the CEO on issues related to Partnership's administration of the substance use disorder services benefit.~~

Note: Meeting frequency indicated with each committee is subject to change based on business needs.

Membership in committees is voluntary and open to all who meet the minimum criteria and who are willing to serve. When positions become available, Partnership looks for committee members who reflect the diversity of our communities. Partnership continually evaluates key diversity factors (including, but not limited to: race, ethnicity, language, gender identity, sexual orientation, disability status, etc.) to ensure that committee membership reflects Partnership's membership and provides diverse views. The committee chair will make a good faith effort to review and verbally report (to committee members) key membership demographic information after the publication of the Partnership community reports when a position becomes available, annually. As opportunities present, special efforts will be made to invite candidates who reflect such attributes to continually encourage diversity within committees.

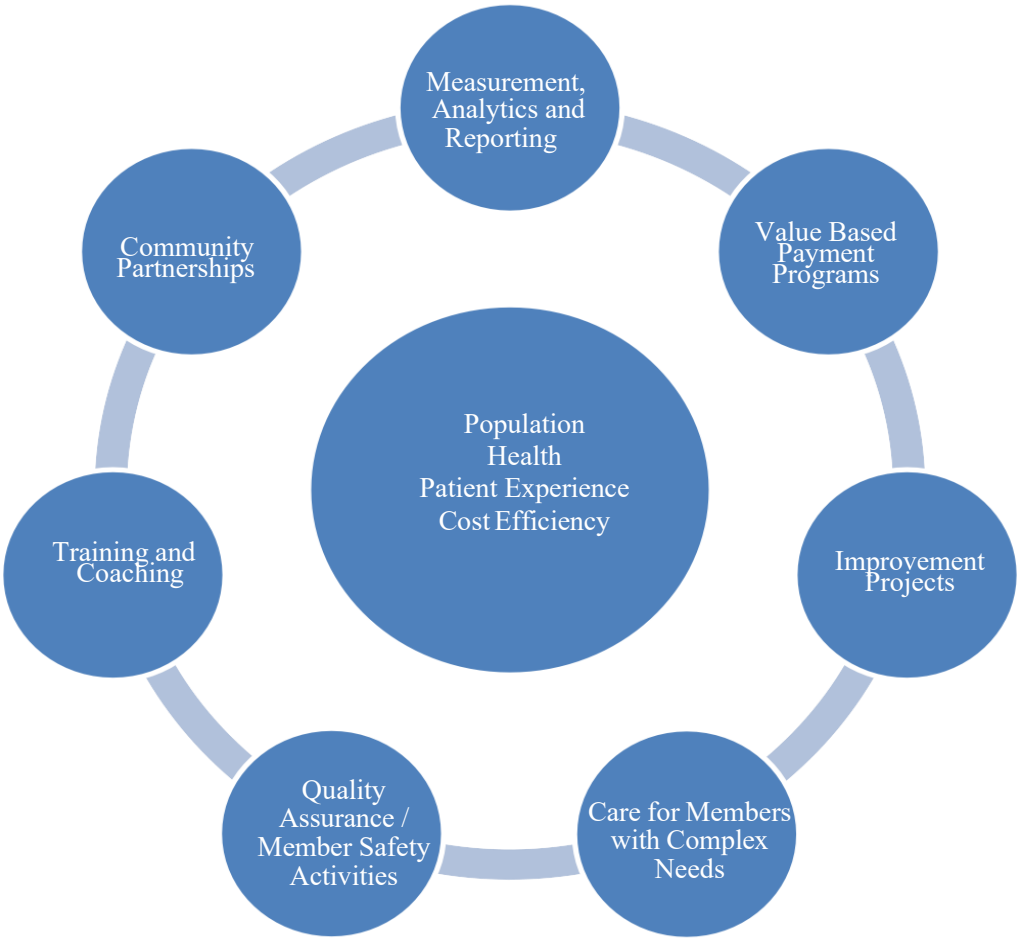
As a tool for evaluating meaningful improvements in DEI and for preparing for Health Equity Accreditation, Partnership will distribute a DEI Survey on an annual basis to assess the diversity of key committees starting in 2024. The annual DEI Survey will allow committee members to provide feedback on improving the diversity, equity, and inclusion within their respective committee. Certain committees are more involved in the decisions for services regarding member experience and clinical care, and therefore such key committees will be prioritized in assessing their respective DEI compositions and opinions. The key committees identified to receive the DEI Survey in 2024 were Q/UAC, PAC, P&T, CAC, PRC, and QIHEC. Committee members will be provided with updated Partnership membership demographic data to compare with the makeup of the organization itself. This information will be utilized to identify at least one (1) opportunity to improve the DEI of key committees.

Approach to Quality and Performance Improvement

Partnership's Quality and Performance Improvement program focuses on simultaneous pursuit of the Institute for HealthCare Improvement (IHI) Quintuple Aim – population health, patient experience, cost efficiency, workforce well-being and advancing health equity – via seven primary levers:

- Measurement, Analytics and Reporting
- Value Based Payment Programs
- Improvement Projects
- Care for Members with Complex Needs
- Quality Assurance and Member Safety Activities
- Training and Coaching
- Community Partnerships

In addition to the Triple Aim (population health, patient experience and cost efficiency), Partnership is committed to pursuing the fourth aim of achieving workforce well-being. This aim ensures providers across our network have adequate resources to provide high-quality care to our members. Additionally, Partnership is dedicated to pursuing a fifth aim of achieving equitable health for all of our members. This aim supports an increased understanding of social determinants of health and working to address disparities that impact the quality and sufficiency of health care provided to Partnership members.



Mental Health Services:

Since January 1, 2014, Partnership has provided mental health services for those with mild to moderate treatment needs, pursuant to the Plan's Medi-Cal contract with the State of California. This mandate is detailed in the California Department of Health Care Services (DHCS) All Plan Letter 22-006 (Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services) issued April 8, 2022. Partnership delegates the administration of these services to Carelon Behavioral Health, formerly known as Beacon Health Options, in all 24 counties served by Partnership. By the start of 2026, Partnership will no longer delegate member-facing responsibilities to Carelon Behavioral Health, including its member access line, grievances & appeals, and care coordination functions. The exact scope and timing of de-delegation is pending finalization in early 2025-2026.

DHCS assigns Specialty Mental Health Services for mental health conditions deemed to be moderate to severe in terms of level of impairment (also referred to as serious and persistent mental health conditions or SMI) to County Mental Health Plans (MHPs). These include all conditions that meet the medical necessity criteria pursuant to the DHCS Behavioral Health Information Notice (BHIN) 21-073, issued December 10, 2021.

Mental health QI management and improvement activities are delegated in part by Partnership to Carelon Behavioral Health. Partnership oversight of these delegated QI functions is achieved through: 1) annual and ad hoc audits, 2) semi-annual review of QI reports produced by these entities, and 3) discussion of quality management and development of quality improvement projects, (e.g., improved PCP referral forms, review and monitor quality issues related to neuropsychological testing, additional reports related to QI, and access standards).

Wellness and Recovery Program:

On July 1, 2020, Partnership and seven counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) implemented the "Wellness and Recovery" program, a regional substance use disorder services program. As Partnership does for other services, this program description includes the planned structure of quality and performance improvement activities Partnership uses for the overall program.

The quality infrastructure of the Wellness and Recovery Program is designed to help achieve one of the key goals of the program: the integration of substance use disorder services with the existing physical and mental health service delivery system. It reflects the incorporation of the county-focused quality structure outlined in the state and federal Organized Delivery System (ODS) waiver requirements into the strong, foundational quality structure of Partnership.

Measurement, Analytics and Reporting

The QI/PI department collects data annually on clinical indicators for Medi-Cal through the Health Effectiveness Data & Information Set (HEDIS®) program. DHCS and NCQA Accreditation are two governing entities that mandate HEDIS® annual reporting. NCQA is the governing entity at the national level, whereas DHCS is the governing entity at the CA State level.

DHCS and NCQA select sets of clinical quality measures that are sourced directly from the NCQA measure library and/or Center for Medicare & Medicaid Services (CMS) measure library in which ~~Medicaid~~ managed care plans are required to report. The DHCS and NCQA clinical quality measure sets also identify measures requiring stratification by race/ethnicity and language per NCQA's designated categorizations.

Partnership annually conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, which measures member experience in the last six months across a set of standard questions. In addition, Partnership cooperates with the CAHPS® survey conducted annually by DHCS for its Medi-Cal population. The CAHPS® survey results, combined with the final rate performance of the HEDIS® clinical quality measures are calculated by NCQA to provide Partnership's overall Medicaid Health Plan Star Rating. Partnership participates in compliance audits for HEDIS® and CAHPS® with the state-contracted External Quality Review Organization (EQRO) and Partnership's contracted audit firms to ensure that survey results and measure rate calculations are in accordance with NCQA and CMS specifications. Utilizing an NCQA certified software vendor, Partnership

calculates and reports the performance, including health ~~equity based~~equity-based stratifications, as required by NCQA and DHCS at the reporting unit level. Separately, Partnership reports CAHPS® survey results at the plan-wide level, and HEDIS® measure performance results at the reporting unit level for its fully delegated subcontractors. Partnership works with the EQRO to report audited results per due dates defined by NCQA and DHCS annually. Partnership utilizes DHCS' EQRO File Transfer Protocol (FTP) website when sending communications containing patient-level data, as required per the direction of the EQRO during the annual performance measure validation audit.

Once submitted to NCQA and DHCS, Partnership further evaluates its performance, and that of its fully delegated subcontractors, versus the NCQA National and DHCS established Quality and Health Equity Performance measure benchmarks. The resulting Annual HEDIS® Performance Summary includes analysis of whether or not Partnership, including its fully delegated subcontractors, met or exceeded the NCQA National and DHCS established benchmarks. Currently DHCS defines high performance level (HPL) for a measure in the Managed Care Accountability Set (MCAS) as being above the 90th percentile of all Medicaid Health Plans nationwide, as promulgated by NCQA. DHCS defines the minimum performance level (MPL) on MCAS measures as being the *average* (median) score of Medicaid Managed Care plans nationally (i.e. the 50th percentile), as promulgated by NCQA. Managed care plans are required to exceed the MPL on MCAS measures, as determined by DHCS. Partnership must conduct additional quality improvement and health equity improvement projects when DHCS established MPLs are not met, per DHCS mandate in the DHCS Quality Improvement and Health Equity Framework Policy Guide. In reporting units where DHCS defined minimum performance levels (MPLs) and health disparity reduction targets ~~(yet to be defined)~~ were not met, the QI program and Quality Improvement and Health Equity Transformation Program (QIHETP) teams collaborate to present recommended action plans centered around performance improvement to IQI and Q/UAC. Partnership also reviews and acts on items identified through periodic reports made available through DHCS, including but not limited to: the Technical Report, Health Disparities Report, Preventive Services Report, and Focus Studies. Partnership responds timely to DHCS actions that may include subsequent focused studies, ongoing technical assistance from the EQRO, financial sanctions, administrative sanctions, and/or Corrective Actions in cases where below MPL performance is reported.

Aside from compliance audits for HEDIS® and CAHPS®, Partnership also conducts annual Encounter Data Validation (EDV) studies, at the direction of the state-contracted EQRO. The goal of this annual study is to evaluate DHCS' encounter data completeness and accuracy through a review of medical records for a specified 12-month study period. The study is focused on a member population continuously enrolled to Partnership during the specified study period with at least one professional visit during the study period. The EQRO selects a random sample of members from which Partnership procures corresponding medical records via provider outreach, submitting the records timely using a process defined annually by the EQRO. Partnership responds timely to actions identified through the EQRO and DHCS in the resulting Encounter Data Validation Report.

Analytics support for the QI program is primarily provided by staff in the Finance, Information Technology (IT), and Quality and Performance Improvement departments. Health analytics including population assessment, case management member stratification, and monitoring of utilization patterns is conducted by the Director of Health Analytics and Health Analytics Analysts who are part of the Finance department. Data Analysts in the QI and IT departments also work collaboratively with Health Analytics to support the following work:

- Partnership Pay-for-Performance Programs (also known as Quality Incentive Programs or QIPs)
- Sourcing and integration of data for HEDIS® annual and monthly reporting
- Monthly reconciliation of QIP data that is used to support tools for providers to monitor their performance, at a site and organization level, on quality metrics and services
- Partnership Quality Dashboard (PQD) front end development and maintenance of this provider-facing HEDIS® and QIP performance monitoring tool
- Development and execution of data collection plans that identify baseline performance and capture the impact of performance improvement interventions
- Analysis of performance data to identify areas for improvement, including creating dashboards and reports to actively measure targeted processes and performance changes over time

- Provision of actionable recommendations and informing stakeholders of the impact of key decisions based on final measure performance data

The Health Analytics team also includes more senior analytics roles, including Data Scientists and Senior Health Data Analysts, who conduct statistical comparisons and analysis when stratifying member level data and corresponding quality outcomes is needed to inform the design and decision-making in quality improvement interventions.

In addition to HEDIS® and CAHPS®, summary results from access studies, grievances, Initial Health Appointments (IHA), facility site and medical record reviews, PQIs, targeted improvement projects, performance improvement activities (including practice facilitation and other quality capacity building activities) are presented to IQI and physician committees at least annually. Measure performance trends are reviewed more regularly through a monthly project and during improvement team meetings. Partnership completes a robust, comprehensive evaluation annually for major programs and quality improvement projects and initiatives.

At the organizational level, the Executive Team and Board of Commissioners review a comprehensive dashboard including metrics across the organization every six months. Each year, the executive team sets organization-wide priorities. A board advisory group on Quality meets three to four times annually to provide feedback and advice on strategic quality issues.

Performance results are shared with external and internal stakeholders through data reports and data presentations given at quality committee meetings, medical director meetings, conferences, provider site visits, webinars, and community meetings.

Through Partnership's value-based programs, providers receive reports showing their performance against established thresholds and Partnership network averages (and/or across peer groups) at least annually, but this information is available on a monthly basis for providers participating in certain QIPs. The Primary Care Provider Quality Incentive Program (PCP QIP) provides PCPs aggregate and member-level data through two interactive online tools: eReports and PQD. eReports refreshes twice a week and allows PCPs to identify those members with gaps in preventive and chronic disease care in support of compliance on the PCP QIP's clinical measures. It also allows PCPs to upload additional data to support measure-specific numerator compliance or exclusion criteria. PQD is a Tableau-based online data visualization and analytics tool that supports analysis of Partnership's HEDIS® and PCP QIP performance data.

Substance Uuse Ddisorder ~~services~~ - focused performance improvement projects are managed by Partnership and administered centrally. The SUIQI reviews data at least annually from eligibility, claims, encounter, and provider data to analyze adherence to protocols and identification of those in need of services; timely access measures; initial and engagement of clients into treatment; fidelity to American Society for Addiction Medicine (ASAM) requirements; and outcome and recovery data. The SUIQI aligns their efforts, where possible, with the EQRO evaluation processes and support their evaluation criteria.

In addition, review of the substance use disorder service system and its integration into overall Plan services are incorporated into the ongoing Partnership measurement and reporting programs. This includes summary results from access studies, grievances, IHAs, facility site and medical record reviews, PQIs, targeted improvement projects, and training activities. These are presented to SUIQI on an ongoing basis and reported ~~up~~ to SUPAG, IQI, Q/UAC, and PAC at least annually. Substance use disorder services performance reports are also shared at various meetings, trainings, and webinars and community meetings.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Program

The Agency for Healthcare Research and Quality (AHRQ), in collaboration with the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA), governs the administration of the CAHPS® survey through a nationally recognized set of standard and survey design principles. ~~program and its established set of survey design principles and standards in collaboration with the Department of Healthcare Services (DHCS) and the National~~

~~Committee for Quality Assurance (NCQA) governs the CAHPS® regulated survey.~~

As an NCQA accredited health plan, Partnership is required to contract with a certified NCQA survey vendor to administer the annual regulated CAHPS® survey.

These survey results capture accurate and complete information about Partnership's member-reported experiences with their health care and provide insights to the quality of care delivered across the ~~as well as a level of care within the~~ Primary Care Provider (PCP) network.

Partnership includes both adult and ~~children in the survey~~child populations in its CAHPS® survey sampling. The data collected informs our assessment of service delivery and helps identify areas for improvement to enhance member satisfaction and health outcomes. CAHPS® results are integrated into ongoing quality improvement efforts, supporting targeted interventions and performance monitoring.

~~and aims to measure our service delivery and member satisfaction. Survey results are one method Partnership uses to determine which areas of service have the greatest effect on member satisfaction and to identify areas of opportunity for improvement, which can help Partnership increase the quality of care.~~

Partnership generates the CAHPS® sample frames, obtains auditor approval, and coordinates with the certified survey vendor to ensure compliance with state and federal survey administration requirements. ~~to support the distribution of the annual survey and obtains auditor approval to send to the survey vendor.~~

~~In preparation for future requirements, Partnership will expand CAHPS® survey administration to include the Dual Eligible Special Needs Plan (D-SNP) population beginning in calendar year 2026. In alignment with NCQA and CMS expectations, Partnership will contract with licensed survey vendor to administer CAHPS® and Health Outcomes Survey (HOS) for the D-SNP line of business. Activities to support implementation of these requirements, including enrollee identification, operational readiness, and interdepartmental coordination was initiated in early 2025 and will continue into 2026/27. While detailed activities are outlined in our Model of Care (MOC), this section affirms that program planning is underway in accordance with regulatory timelines.~~

For additional CAHPS® program inter-department dependencies related to DHCS and NCQA accreditation requirements, please reference the following sections in this document.

- Measure, Analytics and Reporting
- NCQA Accreditation Program Management

~~Additionally, Partnership will conduct CAHPS surveys for the D-SNP line of business with a licensed vendor to ensure all rates and processes are validated and reported per NCQA and CMS requirements. The survey collects information directly from members resulting in meaningful data for use in informing targeted improvement activities and monitoring health plan performance.~~

Program Scope

The CAHPS® Program team oversees the annual survey cycle from implementation through completion. Program oversight includes vendor management and contracting with a certified NCQA® survey vendor.

Additionally, the CAHPS® program team provides oversight for CAHPS Score Improvement goal development and implementation, supported by inter-department collaboration with the QI HEDIS® and NCQA Accreditation Team, as well as the external department partners including; Administration, Communications, Grievance and Appeals, Health Services, HR/Workforce Development, Member Services, OpEx/PMO, Population Health and Transportation.

Survey Results

The contracted NCQA-certified survey vendor ~~completes~~ conducts a ~~thorough~~ comprehensive analysis of CAHPS® survey results,~~analysis~~ comparing current-year ~~Partnership~~ respondent rates and measure performance to~~against~~

~~Partnership's~~ year-over-year~~-~~ results. ~~performance,~~ HEDIS® benchmarks, and ~~, and other~~ nationally derived Medicaid benchmarks through NCQA's Quality Compass®. This analysis provides critical insight into member experiences and highlights trends in care delivery and satisfaction. ~~benchmarks for Medicaid plans.~~

~~Survey HEDIS® Quality Compass performance includes the following rating and composite measures.~~Performance is assessed across a core set of CAHPS® measures, including the following rating and composite domains:

Rating Measures	Composite Measures
Rating of Health Care	Coordination of Care
Rating of Health Plan	Customer Service
Rating of Personal Doctor	Ease of Filling Out Forms
Rating of Specialist	How Well Doctors Communicate
	Getting Care Quickly
	Getting Needed Care

~~Rating of Health Plan~~	~~Rating of Health Care~~	~~Getting Needed Care~~	~~Getting Care Quickly~~
~~Coordination of Care~~	~~Rating of Personal Doctor~~	~~Rating of Specialist~~	~~Customer Service~~
~~How Well Doctors Communicate~~	~~Ease of Filling Out Forms~~		

These measures support Partnerships broader quality improvement goals by identifying strengths and opportunities to improve member experience, access and communication across the provider network and plan services.

Health Plan Rating

The CAHPS® results are an important component of the NCQA 5-star Health Plan Rating (HPR). As an NCQA Accredited Health Plan, Partnership is required to submit and ~~publically~~publicly post the annual CAHPS® scores for one or both survey populations.

The HPR is calculated using a weighted methodology ~~combining~~ that combines HEDIS® clinical performance measures ~~and~~ with CAHPS® ~~scores~~ survey results. ~~to calculate the NCQA 1-5 Star Rating.~~ In reporting year 2024, Partnership earned ~~Partnership earned its first~~ann NCQA HPR of 3.5 Stars, based on submission of the Adult survey population. ~~rating in reporting year 2024, having submitted the Child Adult population.~~

Current CAHPS® scores ~~in~~ across both ~~survey~~ the adult and child populations ~~demonstrate~~highlight significant opportunities for improvement. To address this, ~~T~~the QI CAHPS® Program Charter ~~Score Improvement workgroup~~ guides cross departmental efforts and collaboration with the provider network to drive meaningful improvements and increase star~~t~~ ratings across all survey populations. ~~is charged with driving continuous improvement activities through working collaboratively collaborative engagement across multiple Partnership departments and through the provider network to increase star ratings across the child and adult populations in subsequent years.~~

Value Based Payment Programs

Partnership has value-based programs in the areas of primary care, hospital care, specialty care, palliative care, perinatal care, behavioral health, and enhanced care management. These value-based programs align with Partnership's organizational mission to help our members and the communities we serve be healthy. Partnership uses nine (9) guiding principles to build and strengthen its provider network through value-based program management that promotes the delivery of high-quality, affordable, and equitable care to our members.

1. Pay for outcomes, exceptional performance, and improvement
2. Offer sizeable incentives
3. Actionable Measures
4. Feasible data collections
5. Collaboration with providers

6. Simplicity in the number of measures
7. Comprehensive measure set
8. Align measures that are meaningful
9. Stable measures

The aforementioned guidelines and design of these programs assure no payments are made directly or indirectly to providers as an inducement to reduce or limit Medically Necessary Covered Services to members, per 42 CFR sections 438.3(i) and 438.10(f)(3). Additionally, these ~~value-based~~value-based programs and corresponding financial payments comply with the requirements of APL 19-005. All financial incentive programs, per contract requirements, are reported in the form, manner, and frequency specified by DHCS. Partnership utilizes its value-based programs to compensate its network providers in ways that assure provider accountability for both quality outcomes and total cost of care across the populations served. The same approach will be utilized as alternative payment models are introduced to network providers. Partnership monitors quality performance under these value-based programs and alternative payment models and responds timely, within 90 calendar days, to any DHCS requested reporting. Additionally, on an annual basis, Partnership reports on its network payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) framework categories. Partnership supports the delivery of effective primary care and integrated care through the emergence and use of alternative payment models. In evaluating the effectiveness of primary care, Partnership fulfills DHCS required reporting that reflects its investment in primary care service delivery and promotion of primary care delivery through alternative payment models.

Primary Care Provider Quality Incentive Program (PCP QIP)
This program provides financial incentives, data reporting, and technical assistance to PCPs to improve key domains of quality: clinical care, patient experience, access and operations, and resource use. PAC reviews and approves proposed clinical measures selected for the PCP QIP. A group of providers and administrators ~~(QIP Advisory Group)~~ across counties and practice types recommend measures for the PCP QIP each year in QIP Advisory Group. Following the QIP Advisory Group's recommendations and internal discussions with various Partnership department stakeholders, the draft measures are released to the Partnership provider network during a public comment period. Feedback from the public comment period is shared with the QIP Advisory Group and at internal stakeholder meetings, at which time measure recommendations are forwarded to PAC for review and approval. The measures and detailed specifications can be found on the Partnership website.

Hospital Quality Incentive Program (HQIP)
The HQIP, established in 2012, is a pay-for-performance program for invited hospitals serving Medi-Cal members in the Partnership network. The goal of the HQIP is to improve the quality of care provided to members by offering participating hospitals substantial financial incentives in exchange for meeting selected performance targets.

Participants report on measures across the following measurement domains: advance care planning, clinical quality, operations and efficiency, patient safety, and patient experience. To support improving coordination of care after discharge and increase support for patient self-management, the HQIP includes a ~~readmissions~~ 7-Day Follow-Up measure for all Partnership adult members admitted to the hospital. Like the PCP QIP, Partnership collaborates with hospital partners and internal Partnership department stakeholders to design the program, and PAC reviews and approves the measures selected. The measures and detailed specifications can be found on the Partnership website.

~~Specialist Quality Incentive Program (QIP)~~
~~The Specialist QIP was developed in 2014 to reward in-network specialists for actively accepting referrals and seeing Partnership Medi-Cal members. In order to participate, a specialist must be contracted with Partnership and be located within the Partnership service region. Specialists who work primarily in an inpatient setting are excluded.~~

Palliative Care Quality Incentive Program (PC QIP)

All Partnership contracted Intensive Outpatient Palliative Care provider sites are automatically enrolled in the PC QIP. Providers may earn incentives from the program based on care provided to members who have serious illnesses and have an approved intensive outpatient palliative care treatment authorization request (TAR) on file. Partnership has designed the PC QIP, which offers significant financial incentives to support and improve the access to and quality of palliative care provided by Partnership's contracted palliative care providers. The program also incentivizes the completion of POLST (Physician Order for Life-Sustaining Treatment) for these members and for actively participating ~~in the Palliative Care Quality Collaborative (PCQC) system~~in a data collection system addressing quality assessments reviewed against established quality thresholds.

Perinatal Quality Incentive Program (QIP)

The Perinatal QIP provides financial incentives to participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers providing quality and timely prenatal and postpartum care to Partnership members. Participation is by invitation and requires signing a Letter of Agreement. ~~Since its inception as a small pilot program in 2018, the Perinatal QIP has expanded to include 81 primary care and specialty providers within Partnership's service area.~~ For this incentive program, a simple and meaningful measurement set has been developed and currently includes the following measures: Prenatal Immunization Status, Timely Prenatal Care, Timely Postpartum Care, and Electronic Clinical Data System (ECDS). The current ECDS measure ~~has transitioned grown from an implementation based measure to to a multi-step measure that includes partnership with the Partnership HEDIS® team for full integration and use of ECDS data for Primary Source Verification to its most current iteration~~reflects Partnership's efforts to partner~~ing~~ with an approved HEDIS data aggregator~~,~~ ~~DataLink. To date, the ECDS measure has seen an almost 100% compliance rate from participating Perinatal QIP providers~~. ~~This effort has~~These efforts contributed to the~~The~~ success of this measure ~~with a demonstrated outcome as having~~and ~~has a~~have positively impacted ~~on~~ Partnership's HEDIS® rates and other QIPs who share this measure in their measurement set.

Behavioral Health Quality Incentive Program (QIP)

The Plan's delegated mental health administrator, Carelon Behavioral Health, manages the quality incentive program for the network. The Behavioral Health QIP is administered through the Carelon Behavioral Health network and focuses on measurement-based care by utilizing member screenings over time in participating practices to inform clinical interventions and measure results. The QIP for substance use disorder services focuses on a provider's ability to address members with co-occurring substance use disorder and mental health needs.

Enhanced Care Management (ECM) Quality Incentive Program (QIP)

The ECM Program is a Medi-Cal benefit that replaces the current Whole Person Care (WPC) Pilot and Intensive Outpatient Care Management (IOPCM) activities. ~~Part~~ As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the objective of ECM is to motivate, modify, and improve the health outcomes of seven identified groups of individuals by standardizing a set of care management services and interventions, then build upon the positive outcomes from those programs. Participants are incentivized for ~~three quality measures focused on depression and blood pressure screenings and the timeliness of care plan data entry. The ECM QIP transitioned from~~continues to ~~incentivize~~ing the timely reporting of enrolled members in ECM benefits ~~to making timely reporting a gateway measure with the number of enrolled members~~ as the basis for determining the incentive pool amounts for the quality measures. ~~and incentivizes participants in~~The four quality measures include: Care Plan and Release of Information Upload into PointClickCare, PHQ-9 Depression Screening, Blood Pressure Screening, and timely Review of ED/Admission Notifications. ~~This program continues to develop as CalAIM becomes active through a four phase roll-out to all counties served by Partnership.~~

~~January 1, primary care~~

Improvement Projects

Partnership considers a number of factors to determine where and how to focus its improvement efforts. The Managed Care Accountability Set (MCAS), a subset of HEDIS® measures for which DHCS holds Managed Care Plans accountable; ~~and~~ a subset of HEDIS® measures which carry weight for NCQA health plan accreditation; and most recently the advent of ~~D-SNP~~CMS, DHCS and Model of Care measures aligned with the D-SNP, are prioritized by QI. In addition, QI prioritizes recommendations from the QIHEC's annual evaluation of quality

measure performance data. These recommendations are focused on addressing health-equity performance deficiencies and ensuring appropriate equity-focused interventions are identified to reduce health disparities in alignment with the requirements of the NCQA health equity accreditation and per DHCS mandates.
Additional criteria for selection include:

- Meaningful clinical or service areas to both providers and members
- Measures where improvement projects would impact large populations of members
- Over or underutilization of services
- Clinical or service areas where provider variation in practice is greatest
- Clinical or service areas that present opportunities to address health inequities

Data sources used to determine focus areas include:

- Annual, monthly, and year-to-date performance on HEDIS® measures
- Performance on Partnership's pay-for-performance measures that provide financial incentives to provider organizations to drive improvement, including data on disparities based on factors such as race and ethnicity, preferred language, and zip codes
- CMS Administrative Data
- CAHPS® and other Member Satisfaction surveys
- Grievances and appeals
- Facility site and medical record review results
- IHA rates
- Utilization data
- County level and/or public health data
- Clinical data derived from Health Information Exchange (HIE) with providers

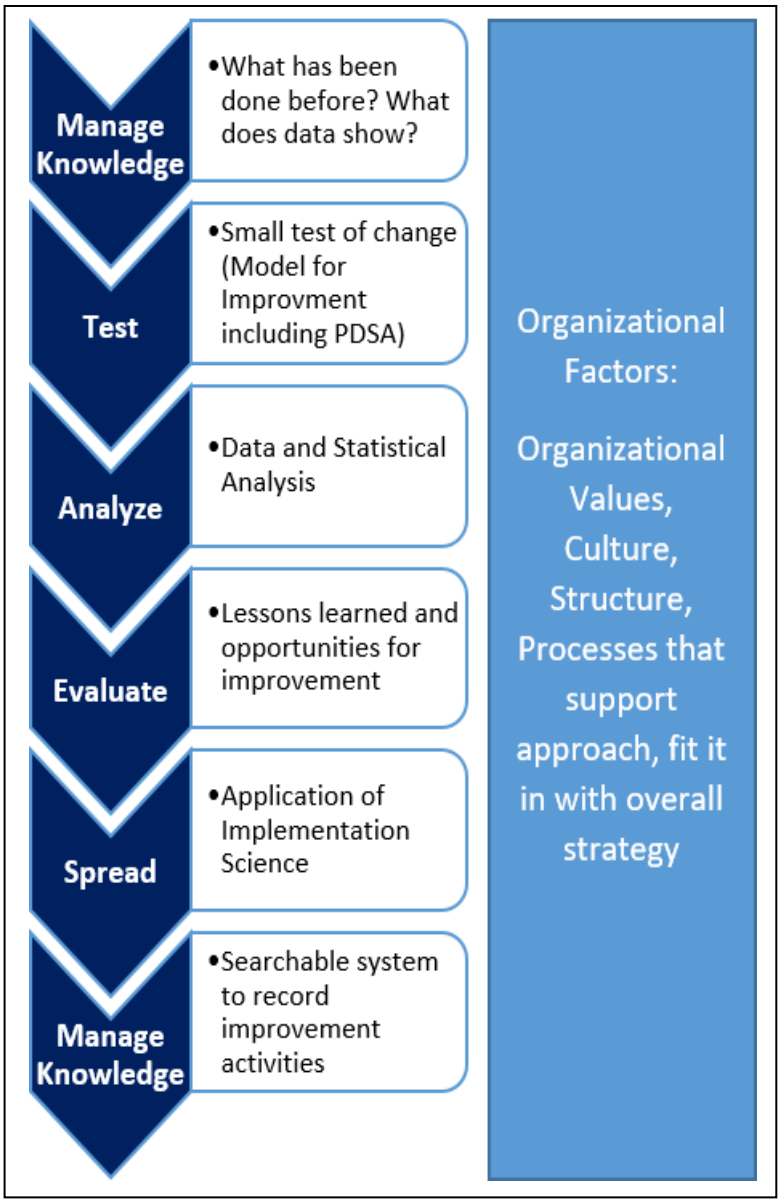
Based on the department that will lead an improvement effort, its leadership and management propose focus areas and projects with guidance from their executive sponsor, other members of the executive leadership team, medical directors, other departments and key stakeholders. For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the QIHETP team supports ongoing QI efforts in the identification of potential quality or equity of care issues, improvement of HEDIS® quality measures in context with social determinants of health. For member-facing improvement efforts, CAC and other member focus groups are often consulted.

The QI/PI department is often the lead for many improvement efforts, particularly those that are mandated or due to poor performance on the Managed Care Accountability Set (MCAS), which are the set of measures that Department of Health Care Services (DHCS) selects for annual reporting by Medi-Cal managed care health plans. This can include mandated improvement efforts to meet disparity reduction targets for specific populations and/or measures as identified by DHCS. Partnership participates in DHCS mandated statewide collaborations and initiatives focused on improving quality and equity of care for its members. Partnership designates staff to attend, at a minimum, quarterly regional collaborative meetings, including those designated as in-person. The QI/PI department also takes the lead on mandated Performance Improvement Projects (PIPs) that are assigned by DHCS. On an ongoing basis, Partnership is required to complete a minimum of two PIPs per Centers for Medicare ~~and~~ & Medicaid Services' (CMS) mandates. PIPs are led by the QI/PI program based on criteria defined by DHCS and overseen by the EQRO, and include at least annual status reports to DHCS. The involvement of fully delegated subcontractors is considered in both mandated short-term improvement projects (Plan-Do-Study-Act) and the PIPs. Once the objective and scope of improvement projects are approved, an improvement team is formed with a lead or project manager and individuals who are involved in the improvement effort. Current year performance priorities are outlined in Partnership's QI Program Work Plan.

For 2024-2025 Partnership has set metrics for success which includes NCQA Health Plan Ranking (HPR) targets. Partnership has formed, in recent years, measure-family-focused workgroups to better coordinate service and performance across the organization and to raise Partnership's overall quality measure performance. This effort is referred to as Quality Measure Score Improvement (QMSI) and consists of cross-functional workgroups led by

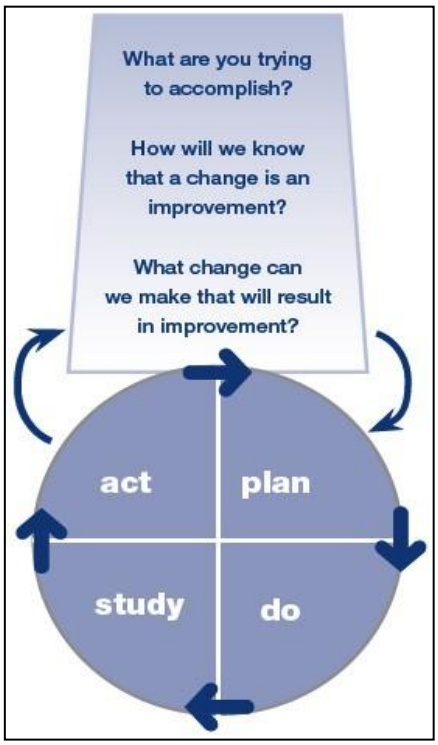
Quality staff with support from Medical Directors and includes representation from across the organization, including: Care Coordination, Claims, Health Education, Office of the CMO, Pharmacy, Population Health, Provider Relations and Regional Leadership. Each workgroup is focused on measure performance analysis, identification of measure focus priorities and efforts needed to close performance gaps. QMSI workgroup areas include pediatrics, chronic diseases, ~~medication management~~, behavioral health, women's health and perinatal care, and elder care. Together these workgroups will identify opportunities and barriers to be addressed to improve care outcomes for members and increase HPR.

Partnership has developed the Pathway to Excellence (P2E) framework for improvement activities. This framework includes six major components as noted below:

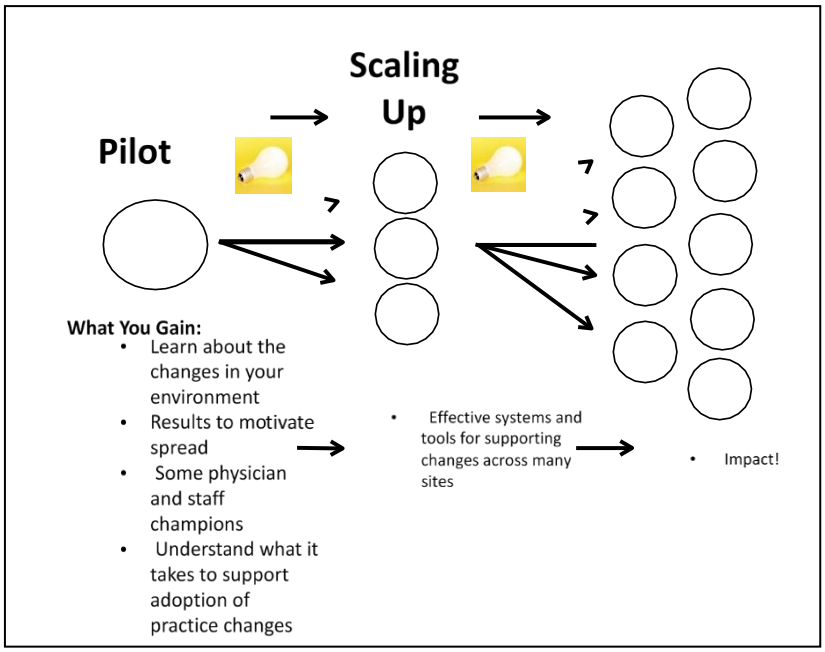


This framework includes several performance improvement methodologies including small tests of change using the Model for Improvement and the Plan-Do-Study-Act (PDSA) cycle, optimizing spread through the application of implementation science with robust project management infrastructure to guide strategic improvement

initiatives and targeted improvement projects. Appendix C has a detailed description of the P2E framework.



Partnership supports spreading effective interventions within and across sites and regions as more is known about the problem, resources, and infrastructure needed to support the change on a larger scale. Within provider organizations and throughout Partnership's provider network, spread is challenging and highly dependent on provider organizations' leadership, culture, and quality improvement infrastructure to do this effectively. The figure below outlines this approach.



A list of current year improvement projects and outcomes are available in Partnership's QI Program Work Plan and annual QI Evaluation, respectively.

Care for Members with Complex Needs (CCM)
CCM is a voluntary program that provides tailored interventions aimed at improving the member's self-management of their health; and increasing the appropriate usage of health and medical resources while reducing the inappropriate utilization of health care resources. These goals are achieved by working with the member/caregiver and the member's interdisciplinary care team to:

- Educate about the member's benefits with managed care and how to use available resources
- Identify and help with understanding of member's medical condition(s)
- Support and encourage self-management skills to promote and optimize the member's personal health goals and well-being
- Coordinate necessary health care services and
- Refer to appropriate medical or social community resources when applicable

Please see the Care Coordination program description for further information regarding the populations targeted and the specific interventions used for Partnership members.

Quality Assurance and Member Safety Activities
Quality Assurance and Member Safety activities include investigation of PQIs; facility site and medical record reviews; assessing the level of physical accessibility of provider sites including specialists and ancillary providers that serve a high volume of seniors and persons with disabilities; and monitoring IHA rates.

Member safety activities are governed in large part by DHCS directives. To stay aware of updates and guidance on conducting member safety activities, Partnership maintains a multi-department system to monitor and implement regulatory guidance, including but not limited to All Plan Letters (APLs) and contract amendments, like those that inform the QI program. APLs are also available and searchable by all staff via the DHCS website.

Potential Quality Issues (PQI) and Peer Review
A PQI is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists. A quality issue is defined as a confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process. The PQI investigation and Peer Review process provide a systematic method for the identification, reporting, and processing of a PQI to determine opportunities for improvement in the provision of care and services to Partnership members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity.

PQIs are identified through the systematic review of a variety of data sources, including but not limited to:

- Information gathered through concurrent, prospective, and retrospective utilization review
- Referrals from any Health Plan staff
- Facility Site Reviews
- Claims and encounter data
- Pharmacy utilization data
- HEDIS® medical record review process
- Medical record reviews/audits
- Grievances and Appeals
- Ancillary providers/vendors/delegates such as Carelon, VSP, etc.
- Provider sentinel/adverse events such as provider preventable conditions that are reported as required by the State

All cases are initially reviewed by an RN Quality Investigator and then forwarded to the CMO or Medical Director for Quality in accordance with Policy MPQP1016. Medical records and other supporting documentation are collected, and where issues are identified, the provider of concern may be given an opportunity to respond. The CMO/Medical Director for Quality review includes assessment of, but is not limited to, appropriate level of care, appropriate tests, therapy and treatment, technical expertise, referral, consultation, timeliness, and adequate documentation.

The RN Quality Investigators, pharmacist representative, and identified Medical Directors review potential quality issue cases at PQI rounds. Severity ratings are designated to identify "Practitioner performance," "System issues," or both. Sometimes, multiple provider performance issues or system issues are identified in the same case and rated accordingly. Upon determination by a Medical Director that a case requires review by the Peer Review Committee, the RN Quality Investigator prepares the PQI case file for Peer Review (see MPQP1053 for the Peer Review Committee policy). The Peer Review Committee reviews concerns and complaints about the quality of care and services provided to Partnerships' members and makes recommendations for actions to prevent reoccurrences of the identified issues ~~investigates member or practitioner complaints about the quality of clinical care provided by Partnership contracted providers and makes recommendations for corrective action~~. The Committee also reviews sentinel conditions identified as having quality concerns. Cases with significant concerns are communicated to the Credentials Committee at the recommendation of the Peer Review Committee.

Annual reports are presented to IQI and Q/UAC showing trends related to referral patterns and quality of care concerns. A monthly report ~~will be~~is presented to the CMO and Medical Director for Quality which includes cases open, closed, referrals, and pending PRC review.

Pharmacy Department Patient Safety Initiatives

Partnership has a number of activities in place to ensure medication safety and adherence for Partnership members. These activities include:

- *Managing Pain Safely (MPS)*. Pharmacy leads an ongoing multi-year initiative to promote the safe use of opioids.
- The Pharmacy Department uses ~~Magellan~~ Medi-Cal Rx Contractor pharmacy data to monitor opioid prescribing and utilization against opioid-related HEDIS® measures: HDO (high dose opioids), POD (opioid use 31 days), UOP (multiple prescribers/pharmacies), and BZD/Opioid concurrent use.
- The Pharmacy Department monitors and evaluates naloxone prescriptions to help promote access and utilization to improve patient safety.
- The Pharmacy Department reviews and analyzes drug utilization to identify high-risk members taking antipsychotic and opioid medications and provides interventions against identified risks.
- The Pharmacy Department monitors antipsychotic pharmacy claims to identify suboptimal medication regimens and adherence for members taking antipsychotic medications. Interventions aim to address and reduce risk for metabolic syndrome induced by antipsychotic medications.
- *Smoking Cessation*. In collaboration with Care Coordination, Partnership offers smoking cessation counseling services to members who indicate "yes" on the Health Risk Assessment (HRA) question, "Would you like help quitting?" Functions include provider outreach, educating members on medication adherence to tobacco cessation products, and assisting with enrollment in the California Smokers Helpline program.
- *Latent Tuberculosis Therapy (LTBI) Monitoring*. LTBI 12 dose monitoring to ensure patients receive appropriate therapy and interact with providers and county public health departments to ensure completion of therapy and identify patients that may have fallen out of therapy.

Site Reviews

Partnership conducts Site Reviews that include a review of the physical site, medical records, and a review that evaluates accessibility for Seniors and Persons with Disabilities (SPDs). Site Reviews are conducted for primary care, OB/GYN, palliative care, substance use disorder services providers, non-accredited sites, mobile/street medicine, and private duty nurses. With the Sunset of Comprehensive Perinatal Service Program (CPSP), Partnership now conducts Site Reviews on all OB providers up to every three years. ~~We are~~Partnership is awaiting an official OB tool and/or APL and further guidance on this topic from DHCS. The internal and external quality improvement committees review the results from the Site Reviews, Initial Health Appointments (IHAs), and Physical Accessibility Review Survey (PARS) Results at least annually. Results from Site Reviews are reported to the DHCS twice per year. The Credentials Committee is notified when Site Reviews are completed.
~~The internal and external quality improvement committees review the results from the Site Reviews, Initial Health Appointments (IHAs), and Physical Accessibility Review Survey (PARS) Results at least annually. Results from~~

~~Site Reviews are reported to the DHCS twice per year. The Site Review Inspections Team sends the Credentials Committee notification when a Site Review and any associated CAPs have been completed.~~

Initial Health Appointments (IHA)
In January 2023, DHCS issued APL 22-030 which changed the name of Initial Health Assessment to the Initial Health Appointment (IHA) and discontinued the requirement of a Staying Healthy Assessment (SHA) questionnaire to be completed by the member and reviewed by the Primary Care Physician (PCP) annually. The Staying Healthy Assessment (SHA) was replaced by the Member ~~Health~~ Risk Assessment.

The Initial Health Appointment must be completed within 120 days of enrollment to the health plan or within 120 days of assignment to a primary care provider (whichever is most recent). The visit must be conducted in the primary care setting and be provided in a way that is culturally and linguistically appropriate for the member.

Partnership collaborates with network practitioners and providers to improve IHA compliance by:

- Identifying areas where training is needed
- Identifying and sharing best practices
- Seeking input from network practitioners about systems Partnership can put in place to improve IHA compliance
- Providing technical assistance, resource materials, and training in areas where indicated
- Reminding providers ~~on a monthly basis~~monthly to review their list of newly assigned members and track outreach attempts to the members
- Publishing provider and member facing newsletter articles
- The Site Review Team offers 1:1 educational training with sites about IHA requirements at every site review exit interview. The Partnership Billing Guide and information on IHA are provided during the site review exit interview process.
- Sending monthly mailers along with address labels for newly enrolled members so providers can reach out to members and schedule an IHA appointment
- Clinical Operational meetings are designed to collaborate between both parties (Partnership and Facility) on procedures and operations to ensure patient quality of care and outcome. Partnership uses this opportunity to present on IHA, Blood Lead testing, and offers additional education on Site Review.

CHDP Training Replacement with Sunset effective 7/1/2024
Under the CalAIM initiative, DHCS has transitioned the Child Health and Disability Prevention Program (CHDP) effective July 1,2024 to Partnership. This transition aligns with the desire to streamline efforts and consolidate care responsibilities, for members 21 years of age and younger.

The Inspections Team now offers training on all CHDP topics and is reviewed during the Site Review process. Training topics include Audiometric, Vision, BMI, Dental Fluoride Varnish Application and Preventative Care, which covers immunizations, CAIR, and blood lead screening. Training courses are offered through a live WebEx session, or they are available online. Once training is completed, a certificate of completion is sent to the site and is valid for 3 years.

Quality Improvement Coaching and Training Support
The Performance Improvement (PI) team offers a variety of coaching and training opportunities to clinicians, administrators and staff to gain quality improvement expertise and to learn from peers. Each initiative prepares provider sites to optimize population health, enhance their patients' experiences of care, promote provider and care team satisfaction, and foster a culture of continuous quality improvement.

Provider Tiering and Enhanced Provider Engagement: In 2022, Partnership began strategic planning to expand provider engagement to engage a wider group of provider organizations (PO's) in building their capacity for quality improvement work. Using the previous year's PCP QIP clinical measure scores, provider organizations are organized into tiers, with coaching programs designed to align with the priorities and needs of the respective organizations.

~~2024-25~~2025-26 provider tiers and respective coaching opportunities are:

- Tier 1 PO's (< 33% of clinical points earned in previous year's PCP QIP): Strong candidates for participating in the Modified PCP QIP, coupled with a Needs Assessment and ongoing improvement coaching
- Tier 2 PO's (~~34~~33-79% of clinical points earned in previous year's PCP QIP): Practice ~~Facilitation~~Coaching, JLI's, improvement pilot or PIP partnership on established MCAS measures
- Tier 3 PO's (>80% of clinical points earned in previous year's PCP QIP): Voices from the Field, innovation pilots on emerging measures
- PO's at any tier: Regional meetings, Improvement Academy trainings

Modified PCP QIP: The Modified QIP is a simplified set of measures given to Provider Organizations with low PCP QIP Scores. Providers are evaluated annually to determine participation. Thresholds for participation are reevaluated and adjusted annually, according to need and available coaching resources.

Needs Assessment and Relationship Building: The Needs Assessment~~s~~ is the initial step for provider organizations assigned to the Modified PCP QIP or who are at risk of placement in it in the following measurement year. Members of the provider organization's leadership team will complete an in-person Needs Assessment with a member of the PI team. The Needs Assessment is a modified version of the Building Blocks of Primary Care Assessment (BBPCA), a tool developed by the UCSF Center for Excellence in Primary Care, and is designed to identify an organization's strengths and improvement opportunities within their quality program. Alternatively, a provider organization can complete a Population Health Management Capabilities Assessment Tool (PhmCAT), a tool published by DHCS as part of their Equity Practice Transformation initiative. The PhmCAT tool is also based on the BBPCA tool, and contains additional questions on health equity, behavioral health, and social health strengths and improvement opportunities within the organization. Completed PhmCAT tools are reviewed in detail with a member of the PI team.

Completing the Needs Assessment allows the provider organization to assess themselves and fosters relationship building with Partnership; it also provides a framework for prioritizing improvement opportunities and committing to activities to build their quality infrastructure and organization-wide culture of quality.

Once the provider organization has chosen areas for improvement, Partnership will offer support through various means including: providing coaching, training opportunities, grant application opportunities and resources, and connecting with outside resources.

Practice ~~Facilitation~~Coaching: In 2020, Partnership initially began offering practice facilitation, a narrower set of coaching tools and support, to PCP organizations with large member assignments and some existing quality infrastructure that had opportunity for improvements in clinical performance. Partnership expanded and broadened support via practice coaching, to meet the evolving needs of the network as it transitioned through the COVID-19 public health emergency. The coaching format is now offered to provider organizations that score between 33-79% of clinical points on their PCP QIP.

Practice ~~facilitation~~ coaches assist primary care practices in the application of evidence-based best practices to quality improvement activities. Working alongside organizational quality teams, the practice ~~facilitator~~ coach provides guidance and resources to facilitate system-level changes. The practice ~~facilitator~~ coach provides a framework for translating evidence-based research into practice by building relationships, improving communication, and facilitating change.

The following are areas where Partnership practice ~~facilitators~~ coaches offer support:

- Provide guidance on inter-disciplinary project team formation and collaboration for QI projects
- Project management – provide guidance and tools on framing and managing QI projects
- QI project development and use of QI tools, methodologies, and best practices
- Provide data analytics training and support
- Provide guidance on change management aspects of QI project
- Coach provider organizations on adopting a culture of quality and advancing quality improvement efforts throughout the organization

Partnership Improvement Academy

The Partnership Improvement Academy encompasses different types of training to support and educate provider organizations about quality improvement. Trainings are added, adjusted, or abandoned based on the needs of the network and are evaluated regularly for opportunities to improve.

ABCs of QI: This program is a one-day in-person training designed to teach healthcare organizations the basic principles of quality improvement including developing aim statements, measures, and change ideas; how to use data and run charts, and testing change ideas on a small scale. The program is offered regionally, several times per year, to meet the needs of the expanding network.

Improving Measure Outcomes: These trainings are 1-1.5-hour webinar learning sessions offering CME/CE and cover the PCP QIP measures

The objectives of the learning sessions are:

- Overview of clinical measure specifications and threshold definitions
- Present documentation recommendations/highlights to maximize measure adherence
- Review regional performance data on clinical measures, including data that show disparities by race and ethnicity
- Review best and promising practices to close gaps in care
- Showcase Voices from the Field, high-performing providers who present their best practices for closing care gaps
- Overview of performance improvement strategies and tools

The target audience is clinicians, practice managers, quality improvement team, and staff who are responsible for participating and leading quality improvement efforts within their organization.

Northern Region Consortia & Partnership Northern Region QI Collaboration: This partnering occurs formally on an annual basis via a written scope of work agreement under which they jointly promote and support QI capacity building in the clinic setting through trainings, improvement advising, peer-to-peer sharing, and conducting annual clinic profiles/assessments. The Northern Consortia membership is comprised of Federally Qualified Health Centers (FQHCs) in the Partnership Northeast, Northwest, East, and Southwest Regions and represent the largest PCP organizations, in terms of assigned member volume. Partnership benefits from the peer network forums the consortia leaders have established amongst its members' QI leadership and CMOs. The QI Peer Network and CMO Peer Network meet every other month~~ly~~, including longer in-person meetings on a biannual basis. Within these peer networks, Partnership is invited to share measure level education, guidance, and technical assistance on the application of performance improvement tools and methods. These interactions occur either as part of recurring peer network meetings or separate webinar offerings targeting peer network members.

Clinically Led HEDIS® Measure Education: HEDIS® Measure Education is also incorporated into provider interactions with Partnership's Member Safety Team. Partnership Member Safety nurses have unique opportunities through their Site Review visits to build rapport with PCP clinical leadership and staff. During the completion of the medical record review portion of Site Reviews, Partnership nurses incorporate measure education and corresponding medical record-keeping best practices during their reviews with providers.

~~Medication Management~~Pharmacy Academic Detailing: Partnership's Pharmacy Department offers provider organizations detailed analysis of their patient's adherence to medication for a number of chronic conditions, to identify opportunities to improve medication management of their condition. Topics covered in Academic Detailing sessions include:

- Increasing prescriber and pharmacist knowledge of the HEDIS® measures for diabetes, hypertension and asthma, Medi-Cal Rx formulary, and proper documentation of diabetes, hypertension, cardiovascular disease, asthma and other diagnoses (e.g., ADHD)
- Analysis of provider organization's pharmacy fill data and measure compliance to highlight prescribing and refill best practices

- Increasing member knowledge and engagement in chronic disease management

Substance Use Disorder Services Support and Training
The Partnership DMC-ODS (Drug Medi-Cal Organized Delivery System) Regional Model program provides clinicians, administrators and staff with quality improvement expertise. Sites are supported so as to encourage integrated care across the Partnership system, to optimize population health, enhance their patients' experiences of care, promote provider and careteam satisfaction, and foster a culture of continuous quality improvement. Trainings provided on a regular basis include American Society for Addiction Medicine (ASAM) criteria and application.

Partnership provides a range of support and services to contracted Drug Medi-Cal Providers. These include:

- Training and technical assistance to help providers improve services and clinical documentation and regulatory compliance
- Conduct regularly scheduled chart compliance reviews, offering guidance and written feedback focused on quality improvement of services
- Provision of resources such as sample forms, audit instruments and other tools that would help providers develop effective systems of quality records management
- Responding to technical questions related to regulations or practices
- Communication with providers and other agencies in order to better understand and interpret program regulations and to address treatment needs
- Responding to grievance and appeals from Partnership members or other concerned individuals in the areas of access, quality, billing, critical incidents or client rights

Community Partnerships
In many cases, the quality improvement efforts that have the biggest impacts on the health of members involve significant community collaboration and coalitions with local entities. Local entities are crucial partners in developing strategies for Partnership to address deficiencies in performance measures. Local entities in Partnership's communities engaged in this collaboration include: county health departments (including public health officers), the four consortia that serve FQHCs in Partnership's community, law enforcement, schools, and various Community Based Organizations (CBOs) or nonprofit agencies. Many providers in Partnership's network provide health care services to Partnership's members and are also partners in larger community-level interventions. This includes primary care physicians, FQHCs, Rural Health Centers, Indian Health Service Health Centers, hospitals, long-term care facilities, specialist physicians, hospice agencies, and community pharmacies. Community partnerships can take place on various levels, from engaging with partners and networking, to actively participating in or convening larger groups to drive change and further large-scale initiatives.

Partnership's participation in community partnerships can be in one of five roles: Leader, Convener, Participant, Funder, and Advocate. Multiple job positions within Partnership attend meetings with various partners and stakeholders, and take on one of these roles depending on their scope of knowledge and decision-making authority.

Some current major initiatives involving community partnerships with local entities include:

1. Mental Health Integration
2. Improving Access to Specialty Care Services
3. Regional Approach to Treating Substance Use Disorder
4. Integrating Medical Records through HIEs
5. Implementing CalAIM including establishing partnerships within each county Partnership serves
6. Improving preventive care quality outcomes for members less than 21 years of age
7. Community Health Assessment & Community Health Improvement Plan (CHA/CHIP) collaboration
8. Population Health Community Engagement

To further elaborate on the community partnerships, the table below highlights a few examples of current and ongoing initiatives, specific to mental health integration and treating substance use disorder:

Community Activities		
Wellness and Recovery	**Mental Health**	**~~School Based~~Other Initiatives**
Collaboration with local hospitals to ~~identify strategy for sustainability of CA Bridge SUN Program~~integrate Community Health Workers within emergency departments to provide warm handoffs to substance use disorder service providers.	Collaborating with counties and Sac Valley Medshare to improve data solution through a single source. ~~Estimated completion date fall 2024.~~	~~Providing technical assistance to County Office of Education to develop closed loop referral processes in line with SBHIP requirements.~~
Shasta County Substance Abuse Coalition	Collaborating with counties to provide resources and support for clients diagnosed with an eating disorder.	Multi-Payer Fee Schedule – participating with school districts ~~who are moving forward in Cohort I~~ to provide school-linked behavioral health services.
~~Shasta County Perinatal Substance Using Taskforce~~	Engaging with non-contracted providers to provide alternate solutions for services to clients with an eating disorder.	Conduct monthly Learning Collaborative with our school partners around behavioral health service delivery.
Humboldt County Drug Medi-Cal Huddle	Streamlining processes internally to offer an option for Partnership to take the "lead" on eating disorder cases where county capacity is lacking.	Meet quarterly with all county Child Welfare Partners to review utilization, coordination of care and discuss services.
Drug Safe Solano ~~County~~ Substance Use Coalition	Streamlining processes internally with other departments for coordinating care for eating disorders and other mental health conditions.	Meet quarterly with all First Five partners to review utilization, coordination of care and discuss services.
~~Shasta County Suicide Prevention Coalition~~	Coordinating with other departments to improve reporting measures related to mental health and eating disorders.	
~~Presentation to Drug and Alcohol Mental Health Advisory Board Shasta~~Meet quarterly with all county Behavioral Health partners to review SUD referrals, coordination of care and discuss services.	Meet quarterly with all county Mental Health Plan partners to review utilization, coordination of care and discuss services.	
~~Siskiyou County Opioid Coalition~~		

Member Input

Members are also crucial partners in informing strategies and interventions Partnership pursues to address deficiencies in performance measures and reduce health disparities. Member input is obtained from member outreach events, member experience surveys, member focus and engagement groups, member grievance and appeals data, CAC feedback, FAC feedback, PCP/specialist access and availability data, Member Services telephone access reports, member suggestions, and member requests for PCP transfers. Consumers are also represented on the Q/UAC and Partnership Board of Commissioners. Member feedback on Health Equity-related interventions is encouraged and requested in our Health Equity playbook, which emphasizes the importance of outreaching and gaining insight from those who are actually experiencing the disparities. Provider organizations are also encouraged to employ similar playbook tactics to improve care within their practices. Various workgroups meet to review the data collected at least quarterly and the workgroups recommend areas for improvement and action plans. These are presented and monitored by IQI. Performance on HEDIS® measures and progress made in other QI activities are shared with Partnership's members through the Q/UAC, CAC, FAC, and

member newsletter. ~~Clients of substance use disorder services may also attend and give feedback at the SUPAG.~~

Physician and Other Clinician Input

Through Partnership's committee structure, clinicians provide input on the quality improvement program including focus areas, strategies to improve care and service, and effective ways for measuring performance in projects. In addition, clinician input is provided on various projects such as the pay-for-performance programs for primary care, specialtycare, and hospitals. Partnership holds "provider comment periods" where physicians and their staff can provide input on priorities for these programs. Across all work, Partnership solicits input on priorities and interventions through committee meetings and other meetings with provider practices and clinic consortiums.

Population Health Community Engagement and Partnerships

The Population Health Management (PHM) department participates in continuous community engagement and outreach, including community partner collaboration. PHM attends various in-person community outreach events and works to build trust among members within each community, as well as community partners. Attendance at community events is imperative for strengthening the relationship between Partnership and external stakeholders. Outreach at these events includes promotion of well-child visits, timely prenatal care and postpartum visits, adult wellness care, and general education about Partnership benefits. Partnership's regional liaisons and leaders in various departments actively participate in both internal and external workgroups to share information and reduce duplication of effort. Through collaborative meetings, these staff members identify community resources that may benefit Partnership members and share these resources with the organization to promote integration into program offerings that meet member needs. Programs within the community or offered through providers may include:

- Enhanced Case Management (ECM)
- Community Supports
- Regional Center participation
- Behavioral Health and Wellness & Recovery services
- Eating Disorder treatment
- Outpatient palliative care
- Other community programs such as WIC, support groups, community collaboratives, etc.

Furthermore, in alignment with DHCS' Population Health Management Policy Guide and 2024 Contract, Partnership works collaboratively with Local Health Jurisdictions (LHJ), hospitals, community providers, other payers, community-based organizations, member representatives, and other community stakeholders on each county's CHA and CHIP report. This collaborative work has replaced DHCS' historically mandated Population Needs Assessment. Together with these agencies, Partnership works with community stakeholders to prioritize local needs and agree upon a shared plan of action to keep the communities and members it serves be healthy.

See MCND 9001 for further details of Population Health Management's community engagement.

~~***NCQA Accreditation Program Management***~~

~~Partnership strives to improve the health status of members and their care experience to become one of the highest quality health plans in California. The NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA) support Partnership's vision, mission, and strategic goals and fulfill Partnership's contractual obligations with DHCS.~~

~~Partnership is a NCQA Health Plan accredited organization as of January 2021, having successfully achieved renewal as of December 2023. HPA~~

- ~~Provides a framework to guide our operational and quality improvement activities.~~
- ~~Provides a nationally recognized standard and definition for a high quality health plan, performance against which will allow Partnership to compare ourselves objectively against other high quality plans.~~
- ~~Offers the only widely available health plan assessment that bases results on clinical performance (HEDIS®) and member experience (CAHPS®).~~

Partnership is on a journey to obtain NCQA HEA. HEA focuses on the foundation of health equity work. HEA

- Builds an internal culture that supports the organization's external health equity work.
- Collects data that helps the organization create and offer language services and provider networks mindful of individuals' cultural and linguistic needs.
- Identifies opportunities to reduce health inequities, improve care and member experience.

Program objectives are outlined separately for HPA and HEA:

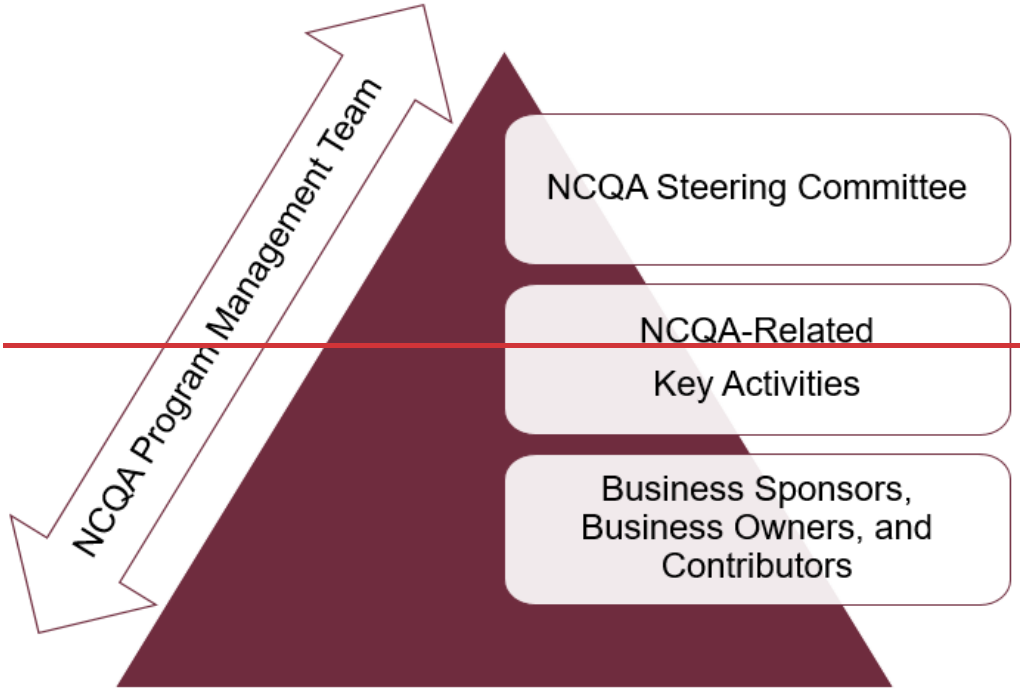
Health Plan Accreditation

- Maintain compliance of all NCQA Health Plan Accreditation (HPA) Standards and Guidelines, following the 2025 Standards and Guidelines, Triannual Policy Updates and Monthly FAQs.
- Monitor plan-wide compliance of HPA requirements through Renewal Survey.
- Successfully submit Partnership's Renewal Survey on September 22, 2026.
- Obtain the renewal of Accredited status by December 2026.

Health Equity Accreditation

- Develop knowledge and build readiness for Initial Survey.
- Monitor plan-wide compliance of HEA requirements for Initial Survey.
- Successfully submit Partnership's Initial Survey (Targeting June 2025).
- Obtain the Accredited status by September 2025.

The NCQA Accreditation Program is managed via a tiered approach. A description of each tier is provided to define roles and responsibilities for each level of the program's governance.



- NCQA Program Management Team
  - Leads and coordinates efforts across each level of NCQA governance.
  - Manages the plan-wide NCQA Accreditation process, specifically:
    - Updates and maintains ownership of NCQA requirements through a plan-wide project work plan.
    - Updates and maintains the plan-wide evidence submission library, a list of required documents that are used to demonstrate compliance.
    - Identifies data needs and reports completion/approval dates through a grand analysis report schedule.
    - Coordinates a plan-wide mock survey with the NCQA consultant.
    - Reviews and assesses the Standards and Guidelines, coordinates any follow-up questions based on NCQA tri-annual policy updates and monthly FAQs.
  - Provides advisory support and guidance across NCQA Accreditation processes, standards/requirements, and HEDIS® and CAHPS® reporting, as needed.
  - Maintains and updates the NCQA compliance dashboard to evaluate progress.
  - Monitors and reports program status, escalates risks/barriers in a timely fashion.
  - Recommends changes to new and/or existing business practices to support and sustain program structure.
  - Facilitates the NCQA Steering Committee.
  - Serves as liaison with Business Owners across the health plan and as the primary liaison to NCQA,our consultant, and Medicaid health plans.
- NCQA Steering Committee
  - Leads NCQA Accreditation efforts by defining Partnership's NCQA program vision and purpose, and provides overall strategic direction.
  - Monitors and reviews program progress relative to goals, timelines and metrics.
  - Champions NCQA Accreditation readiness across the organization.
  - Resolves program conflicts and disputes, reconciling differences of opinion and approach.
  - Evaluates and approves major program components including program timelines, resource allocations, budget, risk management strategies, and program management/governance practices.
- NCQA-Related Key Activities
  - Standards are assigned to departments where the Business Owners reside.
  - Any standards that are not managed by Department goals are managed directly by Business Owners.
- Business Sponsor
  - Holds a Partnership leadership position and is usually from the same department as the Business Owner.

This person has formal authority/ownership for assigned requirements based on business practices.
    - Supports the Business Owner in achieving compliance and addressing any obstacles or barriers to the work and escalates project risks if needed. Escalation will include, but is not limited to, identifying needs for additional communication with stakeholders from regional counterparts, contributors, operational leadership, and the NCQA Steering Committee.
- Business Owner
    - Manages and/or executes the day-to-day work in order to achieve compliance of the assigned NCQA requirements.
    - Maintains deep subject matter expertise across the requirements, which includes reviewing and addressing changes to NCQA standards timely.
    - Collaborates and coordinates activities and deliverables with the contributors. Collaboration will include, but is not limited to, communicating the project's timeline, scope of work, roles and responsibilities.
    - Tracks and reports progress toward compliance with the requirements.
    - Provides periodic updates, at least quarterly, to the NCQA Program Management Team and contributor(s). Updates will include, but are not limited to, progress updates, risks and/or barriers, and staffing changes.
    - Raises issues to the Business Sponsor should challenges occur.
    - Primary contact for evidence preparation and responsible for all submissions.
- Contributor
    - A staff member outside of the Business Owner's department who holds subject matter expertise related to the assigned NCQA requirement(s).
    - Collaborates actively with the Business Owner to ensure successful completion of NCQA-related tasks. This includes, but is not limited to, providing expertise, data, policies, documents, and/or work deliverables timely to meet NCQA Standards.
    - Notifies the Business Owner and the NCQA Program Management Team of any staffing changes.

As part of the NCQA HPA process, Partnership reports HEDIS® and CAHPS® annual results to NCQA in June of each year. Evaluation of HEDIS® and CAHPS® performance is separate from Standards and Guidelines scoring. NCQA assesses Medicaid Health Plan quality based on various clinical measures, including preventive services to keep members healthy and treatments in response to illnesses and chronic diseases. NCQA also evaluates a Health Plan based on customer satisfaction. In September 2023, Partnership earned its first Health Plan Rating (HPR) of 3.5 stars.

Partnership's next reaccreditation survey, or Renewal Survey, is scheduled for September 22, 2026. The table below summarizes key HPA survey dates, as well as HEDIS® and CAHPS® reporting and scoring requirements.

HPA Survey Option	Partnership Survey Status	HEDIS®/CAHPS® Reporting and Health Plan Rating (HPR) Scoring
Renewal	December 2023: Reaccreditation Status received September 22, 2026: Next Renewal Survey submission date November 9-10, 2026: Two-day HPA file review audit December 2026 (targeted): Health Plan Accredited	Annual HEDIS®/CAHPS® reporting (MY 2023) in June 2024 and HPR scoring in September 2024 and annually thereafter.

Partnership has continued its process of building readiness to obtain HEA. A full-scope HEA Mock Initial Survey will be conducted with our NCQA consultant in August 2024. During the HEA Mock Initial Survey, our consultant will review questions and address findings on the evidence submitted. If gaps are identified, Business

~~Owners will submit a Corrective Action Plan (CAP) to address any applicable recommendations. Business Owners will continue to complete the analysis reports and update evidence to ensure the documents prepared for survey submission align with NCQA's look-back period. Partnership is targeting an Initial HEA Survey in June 2025, to obtain the new accreditation before the January 1, 2026 DHCS mandated timeline.~~

Population Health Management Strategies

Since 2017, Partnership has made significant inroads in establishing practices to lay the foundations for creating a Population Health Management (PHM) program. In February 2020, Partnership established the Population Health department. The Population Health, QI/PI, and Health Equity departments and teams conduct coordinated work to support the objectives of quality and equitable care and services for Partnership members through the following activities:

- Provision of guidance and updates on the NCQA standards related to PHM
- Participation in creating and executing QI and Health Equity initiatives that address identified health disparities andopportunities for member engagement/strategic program development
- Assistance in evaluation of initiatives, state-mandated work and performance improvement projects to determine the effectiveness of developed PHM programs
- Review and analysis of HEDIS® measure performance to help determine necessary targeted interventions to improve member health outcomes and well-being
- Development of broad-based member outreach strategies designed to engage members and direct them to their PCP
- Review and periodic revision to value-based programs to ensure they are supporting providers in their attempts to complete recommended missing services for members
- Execution of Partnership Improvement Academy workshops and training programs, as needed
- Local community stakeholder engagement, including support of local LHJ's Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) processes

Population Health, QI/PI, and Health Equity reside within Health Services. The Population Health and ~~Health Equity~~QI/PI departments report up to the CMO and the Health Equity department reports up to the CHSO ~~and the QI/PI department reports up to the CMO~~. The Population Health department maintains a series of documents similar to those maintained by the QI/PI department including the Population Needs Assessment (PNA), Population Health Management Strategy and Program Description, ~~and~~ the Population Health Work Plan, and the Segmentation Report, which are ~~first~~ then ~~reviewed by the internal Population Needs Assessment Committee prior to being~~ presented at IQI, Q/UAC and PAC~~.~~. Of note, the Population Needs Assessment is first reviewed by the internal Population Needs Assessment Committee prior to being reviewed by the remainder of the committees, including several additional committees beyond what are listed above. The Population Health Department also oversees the writing and implementation of the Health Equity Cultural and Linguistic (C&L) Trilogy documents consisting of the C&L/QIHETP workplan, the C&L Program Evaluation, and the C&L Program description; all three of these documents are also reviewed and approved by IQI, Q/UAC, and PAC; they are also reviewed by QIHEC. Each department is led by a director that has a standing meeting time to discuss shared and separate work priorities to further support alignment of activities and optimal outcomes.

See the Population Health Management Strategy and Program Description, ~~for details.~~(MCND9001) and the C&L Program Description (MCND9002) for further details.

NCQA Accreditation Program Management

Partnership strives to improve the health status of members and their care experience to become one of the highest quality health plans in California. The NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA) support Partnership's vision, mission, and strategic goals and fulfill Partnership's contractual obligations with DHCS.

Partnership is a NCQA Health Plan accredited organization as of January 2021, having successfully achieved renewal as of December 2023. HPA

- Provides a framework to guide our operational and quality improvement activities.
- Provides a nationally recognized standard and definition for a high quality health plan, performance against which will allow Partnership to compare ourselves objectively against other high quality plans.
- Offers the only widely available health plan assessment that bases results on clinical performance (HEDIS®) and member experience (CAHPS®).

Partnership is on a journey to obtain NCQA HEA. HEA focuses on the foundation of health equity work. HEA

- Builds an internal culture that supports the organization's external health equity work.
- Collects data that helps the organization create and offer language services and provider networks mindful of individuals' cultural and linguistic needs.
- Identifies opportunities to reduce health inequities, improve care and member experience.

Program objectives are outlined separately for HPA and HEA:

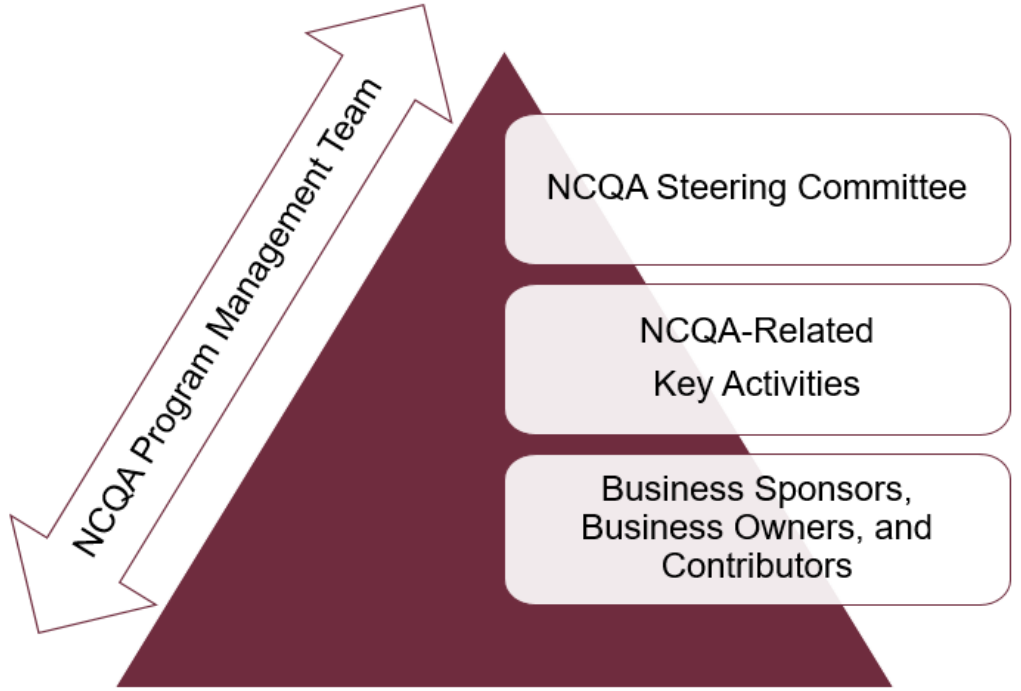
Health Plan Accreditation

- Maintain compliance of all NCQA Health Plan Accreditation (HPA) Standards and Guidelines, following the 2026 Standards and Guidelines, Triannual Policy Updates and Monthly FAQs.
- Monitor plan-wide compliance of HPA requirements through Renewal Survey.
- Successfully submit Partnership's Renewal Survey on September 22, 2026.
- Obtain the renewal of Accredited status by December 2026.

Health Equity Accreditation

- Develop knowledge and build readiness for Initial Survey.
- Monitor plan-wide compliance of HEA requirements for Initial Survey.
- Successfully submit Partnership's Initial Survey on June 17, 2025.
- Obtain the Accredited status by September 2025.

The NCQA Accreditation Program is managed via a tiered approach. A description of each tier is provided to define roles and responsibilities for each level of the program's governance.



- NCQA Program Management Team
  - Leads and coordinates efforts across each level of NCQA governance.
  - Manages the plan-wide NCQA Accreditation process, specifically:
    - Updates and maintains ownership of NCQA requirements through a plan-wide project work plan.
    - Updates and maintains the plan-wide evidence submission library, a list of required documents that are used to demonstrate compliance.
    - Identifies data needs and reports completion/approval dates through a grand analysis report schedule.
    - Coordinates a plan-wide mock survey with the NCQA consultant.
    - Reviews and assesses the Standards and Guidelines, coordinates any follow-up questions based on NCQA tri-annual policy updates and monthly FAQs.
  - Provides advisory support and guidance across NCQA Accreditation processes, standards/requirements, and HEDIS® and CAHPS® reporting, as needed.
  - Maintains and updates the NCQA compliance dashboard to evaluate progress.
  - Monitors and reports program status, escalates risks/barriers in a timely fashion.
  - Recommends changes to new and/or existing business practices to support and sustain program structure.
  - Facilitates the NCQA Steering Committee.
  - Serves as liaison with Business Owners across the health plan and as the primary liaison to NCQA,our consultant, and Medicaid health plans.
- NCQA Steering Committee
  - Leads NCQA Accreditation efforts by defining Partnership's NCQA program vision and purpose, and provides overall strategic direction.
  - Monitors and reviews program progress relative to goals, timelines and metrics.
  - Champions NCQA Accreditation readiness across the organization.
  - Resolves program conflicts and disputes, reconciling differences of opinion and approach.
  - Evaluates and approves major program components including program timelines, resource allocations, budget, risk management strategies, and program management/governance practices.
- NCQA-Related Key Activities
  - Standards are assigned to departments where the Business Owners reside.
  -
  - Activities take place over the fiscal year to ensure compliance is maintained for all HPA and HEA Standards and Guidelines.

- All Business Owners are required to complete the key activities to maintain compliance of all assigned NCQA Standards and Guidelines.

- Business Sponsor
  - Holds a Partnership leadership position and is usually from the same department as the Business Owner. This person has formal authority/ownership for assigned requirements based on business practices.
  - Supports the Business Owner in achieving compliance and addressing any obstacles or barriers to the work and escalates project risks if needed. Escalation will include, but is not limited to, identifying needs for additional communication with stakeholders from regional counterparts, contributors, operational leadership, and the NCQA Steering Committee.
- Business Owner
  - Manages and/or executes the day-to-day work in order to achieve and maintain compliance of the assigned NCQArequirements.
  - Maintains deep subject matter expertise across the requirements, which includes reviewing and addressing changes to NCQA standards timely.
  - Collaborates and coordinates activities and deliverables with the contributors. Collaboration will include, but is not limited to, communicating the project's timeline, scope of work, roles and responsibilities.
  - Tracks and reports progress toward compliance with the requirements.
  - Provides periodic updates, at least quarterly, to the NCQA Program Management Team and contributor(s). Updates will include, but are not limited to, progress updates, risks and/or barriers, and staffing changes.
  - Raises issues to the Business Sponsor should challenges occur.
  - Primary contact for evidence preparation and responsible for all submissions.
- Contributor
  - A staff member outside of the Business Owner's department who holds subject matter expertise related to the assigned NCQA requirement(s).
  - Collaborates actively with the Business Owner to ensure successful completion of NCQA-related tasks. This includes, but is not limited to, providing expertise, data, policies, documents, and/or work deliverables timely to meet NCQA Standards.
  - Notifies the Business Owner and the NCQA Program Management Team of any staffing changes.

As part of the NCQA HPA process, Partnership reports HEDIS® and CAHPS® annual results to NCQA in June of each year. Evaluation of HEDIS® and CAHPS® performance is separate from Standards and Guidelines scoring. NCQA assesses Medicaid Health Plan quality based on various clinical measures, including preventive services to keep members healthy and treatments in response to illnesses and chronic diseases. NCQA also evaluates a Health Plan based on customer satisfaction. In September 2024, Partnership earned a Health Plan Rating (HPR) of 3.5 stars.

Partnership's next HPA reaccreditation survey, or Renewal Survey, is scheduled for September 22, 2026. The table below summarizes key HPA survey dates, as well as HEDIS® and CAHPS® reporting and scoring requirements.

HPA Survey Option	Partnership Survey Status	HEDIS®/CAHPS® Reporting and Health Plan Rating (HPR) Scoring
Renewal	December 2023: Reaccreditation Status received September 22, 2026: Next Renewal Survey submission date November 9-10, 2026: Two-day HPA file review audit December 2026 (targeted): Health Plan Accredited	Annual HEDIS®/CAHPS® reporting (MY 2024) in June 2025 and annual HPR scoring in September 2025.

At the time of preparing the QI Program Description, Partnership is positioned to obtain Health Equity (HE) Initial Survey Accreditation in September 2025, to fulfill the January 1, 2026 DHCS mandated timeline. Partnership will continue its process of sustaining compliance with the HEA Standards and Guidelines throughout the fiscal year. All key stakeholders are required to review NCQA changes and clarifications, including the Triannual Policy Updates and Monthly FAQs, and initiate revisions, as needed, in alignment with NCQA's expectations and look-back period.

Cultural Competency

Partnership is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible beneficiaries. The Health Education, Cultural and Linguistic (HEC&L) team regularly assesses and documents member cultural and linguistic needs to determine whether covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. The HEC&L team also ensures that all cultural and linguistic services are provided in an appropriate manner.

Currently, the Population Health department is responsible for the operations of the Health Education, Cultural and Linguistic Services Program. Additionally, CAC and FAC provide recommendations on the development and implementation of culturally and linguistically accessible services.

Partnership's policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. Partnership has systems and processes to:

- Assess, identify, and track linguistic capability of bilingual employees
- Identify and track linguistic capability of contracted staff in medical and non-medical settings
- Collect data on cultural, ethnic, racial and linguistic needs and prepare biennial analysis to ensure Partnership and its providers deliver services that meet the needs of Partnership's culturally diverse population
- Conduct a PNA and disparity assessment every year to: identify member health needs and health disparities to promote health equity; evaluate Health Education, C&L and QI activities and available resources to address identified concerns; and implement targeted strategies for Health Education, C&L and QI programs and services. Please see the PNA for detailed findings and the related Action Plans.
- Collaborate with the ~~Health Equity Officer~~Director of Health Equity to provide cultural competence, sensitivity, and diversity training to staff, providers and relevant delegates per recommendations from the ~~23-025~~24-016 All Plan Letter

Partnership monitors and evaluates the effectiveness of cultural and linguistic services by reviewing and responding to:

- CAHPS® Survey data
- Member grievance and appeals
- Reports of utilization of interpreter services by language
- Provider assessments and Site Reviews
- Disparities in HEDIS® data

See the Cultural and Linguistic Program Description (MCND9002) and Quality Improvement and Health Equity Transformation Program Description (MCED6001) for additional details.

Communication Systems

Partnership communicates its QI/PI program activities internally and externally through the following mechanisms:

Internal Communications

- ~~At least monthly~~Monthly QI/PI department meetings to provide program and project updates, department priorities and identify critical issues and plans of action
- QI/PI directors and managers communicate more frequently with their respective teams and individual staff throughout each month. This is accomplished via meetings, huddles, and email communications.
- The QI/PI leadership team meets monthly with the Senior Director of QI/PI ~~and CMO~~ to assure timely organizational updates, consistent messaging and prioritization across the QI/PI department. The CMO attends when available or gives input through regular 1:1s with the Senior Director of QI/PI and Medical Director for Quality.
- Recurring meetings with PR, Regional leadership, and Population Health to provide information on key QI/PI projects and other updates on QI programs
- Recurring Health Services Department Leadership Committee meetings to share information regarding improvement activities within the Health Services department
- 5 Star Room QI/PI key information and performance displays in Fairfield and Redding offices
- Department SharePoint pages
- Written department updates provided to all department heads and senior leadership as part of monthly Operations meeting hosted by the COO
- Partnership's internal website PHC4ME
- Quality Measure Score Improvement initiative and corresponding cross-functional workgroups categorized and focused by clinical measure domain
- ~~Annual HEDIS® Week each fall, serves as plan-wide awareness training for all staff~~
- NCQA Newsletter

External Communications

- Quarterly CAC meetings to provider updates on pertinent activities and allow committee members to provide input on initiatives, program design and evaluation
- FAC meetings that occur at least four times per year to share information and solicit input on topics and initiatives that impact CCS members
- Standing Consortia meetings to solicit input from providers
- Regional medical director/quality meetings
- QIP Advisory Groups to solicit input on value based programs
- Periodic feedback from providers via "provider comment periods" on performance metrics and QIP measures
- Quarterly input on QI programs and proposed initiatives via the Board Advisory Group
- Monthly QI/ PI update document that summarizes activities for the QI department and is included in IQI andQ/UAC meeting packets
- Texting campaigns related to closure of quality gaps, relationship building, as well as health education are sent via ~~the Ushur~~Partnership's texting platform.
- Partnership makes ad-hoc updates as needed and conducts bi-annual audits to ensure QI project and program information on the website remains accurate and up to date. ~~Regular updates (at least quarterly) of Partnership website information related to all QI projects and programs~~
-
- Member newsletters released two times per year that include articles covering preventive health and QI/PI projects
- Quarterly Provider Newsletters that include articles specific to QI/ PI in the designated "Quality Corner" section of the document
- Outbound and inbound calls and communication fielded by the Member Services department

- Care Coordination calls with members
- Population Health member outcall projects and campaigns
- Monthly external QI newsletters that describe activities and training ~~resources related~~resources ~~rtd~~to improving quality of care
- Conferences, trainings, onsite meetings, webinars to share best practices across regions
- ePrompts member level reminders about HEDIS® related preventive health services incorporated into Partnership's Call Center system, Provider Online Services system, and online Member Portal

Delegation

Delegated activities to contracted providers are reviewed and approved at least annually by DORS, IQI, Credentials and Q/UAC committees. A delegation agreement, including a detailed list of activities delegated and reporting requirements, is signed by both the delegate and Partnership. Partnership delegates QI for behavioral health to Carelon Behavioral Health.

- Reporting quality improvement activities and analyses to Partnership on a quarterly or semi-annual basis is done for delegated QI activities
- Evaluation includes a review of both the processes applied in carrying out delegated activities, and the outcome achieved toward quality improvement in accordance with the respective policy(ies) and agreement governing the delegated responsibility
- The DORS, IQI, Credentials, and Q/UAC committees review evaluations and make recommendations regarding opportunities for improvement and continuation of delegated functions
-
- Partnership QI/PI staff communicates feedback from the DORS, IQI, and Q/UAC to contract providers andincorporates improvement activities initiated in the annual QI/PI work plan

Review by Outside Licensing Agencies or Accrediting Bodies

Medi-Cal is a federal and state-funded program and CMS has delegated administration of the state program to the California DHCS. CMS permission is required in order for the state to delegate program administration to Partnership. The State must document the cost-effectiveness of the program and provide assurance that program beneficiaries are not negatively impacted by this delegation. Partnership operations, including the QI/PI program, are audited annually by DHCS.

Partnership submits periodic compliance reports to DHCS and undergoes periodic compliance audits. Opportunities for improvement identified through all compliance or regulatory audits are addressed by multidisciplinary teams and corrective action plan development. Implementation of CAPs and other interventions aimed at addressing opportunities~~y~~for improvement are reported to the IQI and Q/UAC. Partnership maintains a compliance plan that includes monitoring and reporting of fraud, waste, and abuse. The Partnership Compliance Committee consists of representatives of each department including QI/PI.

Sanctions

Sanctions may be imposed on Partnership by an established regulatory agency or purchaser due to failure to meet quality metrics or benchmarks, fulfill data quality and reporting requirements, or meet Corrective Action Plan (CAP) requirements. In any of these cases, a quality review team will collaborate and recommend action plans needed beyond those already established through the annual QI Trilogy and organizational goal-setting processes Resulting action plans will be presented for review and approval by the CEO, COO, CMO, Chief Health Services Officer, and Senior Director of Quality and Performance Improvement. Action plans and progress reports are shared with Q/UAC.

Annual Quality Improvement Work Plan

The QI/ PI Annual Work Plan is used to track progress on key QI activities and initiatives throughout the year. The document outlines major activities for the QI/PI department and organization as a whole that advance quality

and performance improvement. The QI/PI Work Plan supports the comprehensive annual evaluation and planning process that includes the annual review and revision of the QI/PI program.

Approved annually by the Q/UAC, PAC, and Board of Commissioners, the QI/PI Annual Work Plan indicates planned QI activities and objectives, timelines, and accountable person for each activity. It includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service, and member experience. The annual evaluation of the QI/PI program is also listed as a specific activity on the QI/PI Work Plan. Goals and associated deliverables are included in the work plan and progress tracked at the level of deliverables. Forms for providing status updates are sent to staff one month in advance of the semi-annual and annual update deadlines to be completed by work plan contributors.

The work plan also includes information on issues that were previously identified. Updates on the monitoring of these issues is provided semi-annually, when work plan contributors provide status updates on whether deliverables driving goals are complete, on track, delayed or require additional explanation. These issues are tracked in a separate worksheet within the work plan.

Annual Quality Improvement Program Evaluation

The overall effectiveness of the QI/PI program is evaluated in writing annually by IQI and Q/UAC and is approvedby Q/UAC, PAC, and the Commission. The QI Program Evaluation includes:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
- Trending of data on key measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis and evaluation of distinct programs, initiatives and QI-related work as well as the overall effectiveness of the QI/PI program and of its progress toward influencing network-wide safe clinical practices. The summary of effectiveness also addresses the adequacy of the organizational resources involved in the QI/PI program.
- The annual QI Work Plan goals and associated deliverables are informed by the QI Evaluation. The evaluation provides summations and analysis of many of the key activities outlined in the accompanying work plan. In turn, if there are opportunities for improvement identified in the evaluation of prior year initiatives and work conducted to support the goals of the quality improvement program, these opportunities are translated into goals with actionable deliverables for the next year's work plan. The results in the QI Evaluation, particularly those tied to the need to revisit allocated resources, for committees, standing programs and other related activity are assessed and if changes are deemed necessary, they are reflected in the QI/PI program in the subsequent year.
- The annual QI Work Plan goals and associate deliverables informed by the Model of Care and the performance improvement efforts aligned with the D-SNP program, specifically those associated with CMS and DHCS-specific quality metrics.

The following are separate evaluations and not included in the QI Program Evaluation:

- Evaluation of the ~~c~~Cultural and L~~l~~inguistic ~~competency work plan~~Program activities
- Evaluation of Utilization Management and Care Coordination activities
- Evaluation of the Population Health program
- A comprehensive evaluation of member grievance and appeals
- Evaluation of the Quality Improvement and Health Equity Program and corresponding work plan activities, as defined in the program description for the Quality Improvement and Health Equity Transformation Program (QIHETP)

A summary of the QI Program Evaluation, including a description of the program, is provided to members or practitioners upon request.

Statement of Confidentiality

Confidentiality of provider and member information is ensured at all times in the performance of QI/PI program activities through enforcement of the following:

- All members of the Q/UAC and Credentials Committee are required to sign a confidentiality statement that is maintained and securely stored in the respective QI or Provider Relations files.
- All QI/PI and Utilization Management documents are restricted solely to authorized Health Services department staff, members of the PAC, Q/UAC, PRC, and Credentials Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to, Peer Review and ~~Credentialing~~ Credentials meeting minutes and agendas, QI and Peer Review reports and findings, PQI and QI files, Utilization Managementreports, or any correspondence or memos relating to confidential issues where the name of a provider or member is included.
- Confidential peer review documents that are protected by California Evidence Code §1157 are designated "Confidential – Protected by CA Evidence Code 1157."
- Confidential documents are stored in locked file cabinets or restricted network folders with access limited to authorized persons only.
- Confidential documents are destroyed by shredding.
- Partnership has designated a Privacy Officer responsible to oversee compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal privacy laws.

- Partnership maintains administrative structure, reporting procedures, due diligence procedures, training programs and other methods to ensure effective compliance in use and disclosure of members' Protected Health Information (PHI).

Statement of Conflict of Interest

Any individual personally involved in the care and/or service provided to a member or an event or finding undergoing quality evaluation cannot vote or render a decision regarding the appropriateness of such care. All members of the Q/UAC and Credentials Committee are required to review and sign a conflict of interest statement, agreeing to abide by its terms.

Original Date: QI/UM Program Description 04/22/1994 – Effective 05/01/1994
Revision Date(s): 08/16/95
As: Quality Management Program – July 1997
Revision Date(s): January 2000, March 2002, (QD100101) October 2002, September 2004, May 2006, (MPQD1001) May 2007, April 2008, May 2009, October 2009 *(re-signed)*, May 2010, April 2012, March 2013, March 2014, March 2015, March 2016, March 2017, November 2017, *October 2018, February 2019 *(Amended)*, September 2019 *(Amended);* September 2020; September 2021; September 2022; September 2023

*Effective October 2018, Approval Date reflects the month in which the Physician Advisory Committee reviewed and approved.

Appendix A: Quality and Performance Improvement Program Description
Standing Staff Members of Partnership QI Committees

(Does not include external physician or consumer membership;
see committee description for those details)

Partnership Analytics Steering Committee Standing Members	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Director of Health Equity~~Health Equity Officer~~
Provider Relations	Senior Director of Provider Relations
Claims	Senior Director of Claims
Finance	Chief Financial Officer
	Deputy Chief Financial Officer
	Director of Health Analytics
	Senior Director of Financial Planning and Analysis
Information Technology	Chief Information Officer
	Senior Director of Enterprise Information Management
	Director of Data Warehouse
	Director of Data Governance
Behavioral Health	Senior Director of Behavioral Health
Administration	Chief Strategy & Government Affairs Officer
Member Services	Director of Member Services

Partnership Board Meeting Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer ~~/ Deputy CEO~~
	Chief Strategy and Government Affairs Officer
	Director of Regulatory Affairs and Program Development
	Behavioral Health Services Administrator
	~~Northern Region Executive Director~~
	Regional ~~Manager~~Directors
	Associate Director of Communications and Public Affairs
	Assistant Board Clerk / Executive Assistant to the CEO
	~~Executive Assistant /~~ Board Clerk
Claims	Director of Claims
Finance	Chief Financial Officer
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Director of Care Coordination Operations (NR)
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Director of Health Equity~~Health Equity Officer~~
Human Resources	~~Senior Director of Human Resources~~Chief Human

Partnership Board Meeting Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
	Resources Officer
Information Technology	Chief Information Officer
Member Services	Director of Member Services
Provider Relations	Senior Director of Provider Relations

Partnership Compliance Committee Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer ~~(also serves as the Compliance Officer)~~
	~~Senior Director of Northern Region~~
	~~Director of Regulatory Affairs and Program Development~~Senior Director of Regulatory Affairs & Contracting
	Senior Director of Behavioral Health
	~~Regional Manager of Administration (Eureka)~~
	~~Regional Director of Administration (Santa Rosa)~~
Claims	Senior Director of Claims ~~(SR)~~
	Director of Claims ~~(NR)~~
Configuration	Director of Configuration
Finance	Chief Financial Officer
	Director of Internal Audit (Finance)
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination andPopulation Health)	Chief Medical Officer
	Chief Health Services Officer
	Director of Pharmacy Services
	~~Manager, Member Safety Quality Investigations~~Manager Quality Assurance and Patient Safety
	Senior Director of Care Management
Human Resources	~~Senior Director of~~Chief Human Resources Officer
Information Technology	Chief Information Officer
Member Services	Director of Member Services
	Senior Director of Member Services
	Director of Grievances and Appeals
~~Provider Relations~~Network Services	~~Senior Director of Provider Relations~~Director of Network Services
Project Management/ Operational Excellence	~~Associate~~ Director of Operational Excellence and Program/Project Management Office

Partnership ~~Consumer~~ Community Advisory Committee (CAC) Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Senior Director of Behavioral Health
	Regional Director(s)
	Regional Manager(s)
	Manager of Communications
	Program Manager I, Communications
	Communications Specialist
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Regional Medical Director(s)
	Chief Health Services Officer
	Director of Health Equity
	Associate Director of Population Health
	Manager of Population Health
	Senior Health Educator
	Health Educator
Member Services	Senior Director of Member Services and Grievance
	~~Senior Manager~~Director of Member Services
	Associate Director of Member Services
	~~Supervisor(s)~~Manager of Member Services
	Member Service Representative
	CAC Coordinator
	Administrative Assistant(s) of Member Services
Grievance & Appeals	Director of Grievance and Appeals
	Supervisor of Grievance and Appeals

Partnership Credentials Committee Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Regional Medical Director(s)
	Associate Medical Director(s)
	Medical Director for Quality
Provider Relations	Senior Director of Provider Relations
	Associate Director of Provider Relations
	Senior Manager of Systems Team and Credentialing
	Credentialing Supervisor
	Credentialing Specialist(s)

Partnership Delegation Oversight Review Sub-Committee Standing Members	
Department Represented	**Position Title**
Administration	Sr. Director of Regulatory Affairs and Program Development
	~~Chief Operating Officer~~
	Compliance Program Manager
	~~Delegation Specialist~~ Project Coordinator
	Supervisor of Program Integrity
	Associate Director of Operational Excellence and Program/Project Management Office
	Senior Manager of Regulatory Affairs
	Behavioral Health Services Administrator
	Director of Grievance and Appeals
	~~Grievance and Appeals Compliance Manager~~
	~~Manager of Governance and Compliance~~
	Compliance Auditor
Claims	Director of Claims
	~~Manager of Claims~~
Finance	Sr. Manager of Business Decisions and Analysis
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	~~Chief Health Services Officer~~
	Director of Pharmacy Services
	~~Associate~~ Sr. Director of Care Coordination
	Director of Population Health
	~~Director of Care Coordination Operations (NR)~~
	Director of Utilization Management
	Manager, Member Safety-Quality Investigations
	Medical Director
	~~Associate Director of Utilization Management Regulations~~Director of Enhanced Health Services
	Director of Transportation
	~~Associate Director of Transportation Programs~~Director of Quality Improvement
	~~Director of Health Services (NR)~~
	Supervisor of Health Education
Member Services	~~Director of Member Services and Provider Relations (NR)~~
	Sr. Director of Member Services
Project Management/Operational Excellence	Associate Director of Operational Excellence and Program/Project Management Office
Provider Relations	Senior Director of Provider Relations
	Director of Provider Relations
Network Services	Director of Network Services

Partnership Family Advisory Committee (FAC) Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Director of Care Coordination
	Associate Director of Care Coordination
	Chief Health Services Officer
	Senior Health Educator
	Manager of Grievance and Appeals

	Senior Director of Care Management

Partnership Finance Committee Standing Members	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Health Services Officer
	Chief Strategy and Government Affairs Officer
	Senior Director of Behavioral Health
	Northern Region Executive Director (ad hoc)
Finance	Chief Financial Officer
	Deputy Chief Financial Officer
	Senior Director of Accounting/Controller
	Senior Director of Fiscal Policy and Strategy
	Senior Director of Financial Analysis
	Director of Internal Audit
	Director of Facilities
Human Resources	Senior Director of Human Resources (ad hoc)
Information Technology	Chief Information Officer
Provider Relations	Senior Director of Provider Relations

Partnership Governance and Compliance Subcommittee	
Department Represented	**Position Title**
PHC Governance & Compliance Committee Standing Staff Invites	Chief Strategy & Government Affairs Officer
	Director of Regulatory Affairs and Program Development
	Chief Executive Officer
	Chief Operating Officer
	Chief Information Officer
	Chief Financial Officer
	Chief Medical Officer (optional)
	Board Clerk
Five (5) members from the Board of Commissioners, with at least one board member representing each of the geographic regions.	

Partnership Internal Quality Improvement (IQI) Committee Standing Members	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Regional Manager(s)
	Compliance Manager of Grievance and Appeals
Configuration	Configuration Department Leadership
Finance	Director of Health Analytics
Health Services (e.g. Utilization	Chief Medical Officer – Committee Chair

Partnership Internal Quality Improvement (IQI) Committee Standing Members	
Department Represented	**Position Title**
Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Medical Director for Quality – Committee Vice Chair
	Medical Director for Medicare Services
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Behavioral Health Clinical Director
	Senior Director of Behavioral Health
	Director of Health Equity ~~(Health Equity Officer)~~
	Director of Quality Management
	Director of Population Health
	Directory of Pharmacy Services
	Director of Care Coordination
	Director of Utilization Management
	Director of Enhanced Health Services
	Associate Director(s) of Utilization Management
	Associate Director of Population Health
	Manager of Care Coordination Regulatory Performance
	Manager Member Safety – Quality Investigations
	Manager of Clinical Compliance – Quality Inspections
	Senior Director of Care Management
	Senior Health Educator
	Associate Medical Director(s)
	Regional Medical Director(s)
	Utilization Management Policy Analyst
Member Services	Senior Director of Member Services & Grievance
Provider Relations/~~Credentialing~~Network Services	Senior Director of Provider Relations
	~~Associate~~ Director of ~~Provider Relations~~Network Services

Partnership Member Grievance Review Committee (MGRC) Standing Members	
Department Represented	**Position Title**
Administration (e.g. Regulatory Affairs & Compliance, Network Services, and Legal Affairs)	~~Director of Grievance and Appeals~~
	~~Grievance and Appeals Compliance Manager~~
	~~Manager of Grievance and Appeals~~
	~~Senior Grievance and Appeals Nurse Specialist~~ Regional Director
	~~Director of Legal Affairs~~ Chief Operating Officer
	Legal Analyst
	Senior Manager of ~~Governance and Compliance~~Regulatory Affairs & Compliance
	~~Regulatory Compliance Specialist~~
	Program Manager II
	~~Northern Region Executive Director~~
	~~Senior Director of Behavioral Health~~
	~~Senior Program Manager of Behavioral Health~~
Grievance & Appeals	Director of Grievance & Appeals
	Grievance & Appeals Compliance Manager
	Manager of Grievance & Appeals
	Senior Grievance & Appeals Nurse Specialist
	Senior Manager of Behavioral Health

Partnership Member Grievance Review Committee (MGRC) Standing Members	
Department Represented	**Position Title**
Behavioral Health	Senior Manager of Behavioral Health
Claims	Director of Claims
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Chief Health Services Officer
	Medical Director of Quality
	Director of Pharmacy Services
	~~Manager of Clinical Pharmacy~~Senior Clinical Pharmacist
	Director of Care Coordination
	Director of Care Coordination Operations
	Director of Utilization Management Strategies
	Manager, Member Safety - Quality Investigations
	~~Manager of Quality Incentive Programs~~
	~~Senior Director of Quality and Performance Improvement~~
	Program~~ject~~ Manager II, Quality Improvement
	~~Administrative Assistant II, Utilization Management~~
	Health Equity Officer
	~~Director of Population Health~~
	~~Senior Manager of Population Health~~ Culture & Linguistics Liaison
	Manager of Population Health
Member Services	Senior Director of Member Services
	Director of Member Services
Provider Relations	Senior Director of Provider Relations
	Senior Manager of Provider Relations Representative
	Senior Program Manager ~~II~~
	~~Manager of~~Lead PR Representative~~s~~
	Supervisor of Education Specialist Team
	Senior Provider Relations Representative
Transportation Services	Director of Transportation Services
	Associate Director of Transportation Services
	Manager of Transportation Programs

Partnership Over/Under Utilization Workgroup Standing Members	
Department Represented	**Position Title**
Administration	Regulatory Affairs Manager
	Regulatory Affairs Specialist
	Senior Director of Northern Region
	Director of Operational Excellence and Program/Project Management Office
Claims	Director of Claims (SR)
Finance	Associate Director of Health Data Analytics
	Senior Manager of Cost Efficiency
	Senior Health Data Analyst
	Manager of Health Analytics
	Project Manager II
	Cost Avoidance Manager
Health Services (e.g. Utilization Management, Quality and Performance Improvement,	Chief Medical Officer
	Chief Health Services Officer
	Medical Director

Partnership Over/Under Utilization Workgroup Standing Members	
Department Represented	**Position Title**
Pharmacy, Care Coordination and Population Health)	Behavioral Health Clinical Director
	Director of Care Coordination Operations (NR)
	Associate Director(s) of Utilization Management
	Director of Pharmacy Services
	Senior Director of Quality and Performance Improvement
	Director of Health Equity~~Health Equity Officer~~
	Associate Director of Housing and Incentive Programs
	Associate Director of Care Coordination
	Director of Population Health
	Director of Utilization Management Strategies
	Director of Pharmacy Services
	Regional Supervisor of Utilization Management
	Director of Quality Management
	Senior Manager of Population Health
	Manager of Performance Improvement
	Manager of Clinical Pharmacy
	Manager of Quality Incentive Programs
	Manager of Care Coordination
	Program Manager
Information Technology	Director of Enterprise Information Management
Provider Relations	Senior Director of Provider Relations
	Senior Provider Relations Representative Manager
	Senior Manager of Provider Relations Representatives
	Senior Manager of Provider Network Education and Credentialing
	Manager of Provider Relations Representatives (SR)
	Manager of Provider Relations Representatives (NR)
	Program Manager
	Senior Provider Relations Representative
	Provider Relations Representative

Partnership Pediatric Quality Committee (PQC) Standing Staff Invites *Note: Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Medical Director
	Chief Medical Officer
	Director of Health Equity~~Health Equity Officer~~
	Senior Director of Care Management
	Chief Health Services Officer
	Director of Pharmacy Services
	Director of Care Coordination

Partnership Peer Review Committee Standing Staff Invites *Note: Non-Medical Director Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and	Chief Medical Officer
	Medical Director for Quality

Partnership Peer Review Committee Standing Staff Invites *Note: Non-Medical Director Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Performance Improvement, Pharmacy, Care Coordination and Population Health)	Manager, Member Safety-Quality Investigations
	Supervisor of Member Safety-Quality Investigations
	~~Performance Improvement Clinical Specialists, Member Safety-Quality Investigations~~Quality Investigator, Member Safety
	Project Coordinator, Member Safety-Quality Investigations
	Manager, Clinical Compliance Inspections Team
	Supervisor, Clinical Quality and Member Safety-Quality Inspections
	Clinical Compliance Inspectors, Clinical Quality and Member Safety-Quality Inspections
	Chief Health Services Officer
	Director of Health Equity ~~(Health Equity Officer)~~
	Regional Medical Director(s)
	Associate Medical Director(s)
	Director of Pharmacy Services or Designated Pharmacist
	Behavioral Health Clinical Director

Partnership Pharmacy & Therapeutics (P&T) Committee Standing Staff Invites *Note: Partnership Staff are voting committee members; attendance is not mandatory nor is adelegate required* **P&T invitees, not standing PNT committee members*	
Department Represented	**Position Title**
Health Services	Chief Medical Officer
	Director of Pharmacy Services
	Clinical Pharmacist(s)
	~~Manager of Clinical Pharmacy~~Sr. Clinical Pharmacist(s)
	Behavioral Health Clinical Director
	Regional Medical Director(s)
	Associate Medical Director(s)
	Chief of Health Services Officer
	~~* Manager of~~ Pharmacy Operations Supervisor

Partnership Physician Advisory Committee (PAC) Standing Staff Invites *Note: Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	~~Clinical Director of Behavioral Health~~Behavioral Health Clinical Director
Finance	Chief Financial Officer
Health Services (e.g. Utilization Management, Quality and Performance Improvement,	Chief Medical Officer
	Medical Director for Medicare Services
	Senior Director of Quality and Performance Improvement

Partnership Physician Advisory Committee (PAC) Standing Staff Invites *Note: Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
Pharmacy, Population Health, and Care Coordination)	Chief Health Services Officer
	Director of Pharmacy Services
	Associate Director(s) of Utilization Management
	Director of Health Equity~~Health Equity Officer~~
	Director of Population Health
	Medical Director for Quality
	Senior Director of Care Management
	Regional Medical Director(s)
Provider Relations	Senior Director of Provider Relations
Network Services	Director of Network Services

Partnership Population Needs Assessment (PNA) Committee	
Department Represented	**Position Title**
Population Health	Director of Population Health
	Associate Director of Population Health
	Manager of Population Health
Administration	Regional Director (South)
	Regional Director (Northeast)
	Regional Director (East)
	Regional Manager (North)
	Chief Medical Officer
	Chief Operating Officer
Behavioral Health	Senior Director of Behavioral Health
Health Equity	Director of Health Equity
Health Services	Chief Health Services Officer
Office of CMO	Medical Director (South)
	Medical Director (Northeast)
	Medical Director (East)
	Medical Director (North)
OpEx/PMO	Director of OpEx/PMO
	Senior Manager of OpEx/PMO
Transportation Services	Director of Transportation Services
Utilization Management	Associate Director of Housing & Incentive Programs
Quality Improvement	Senior Director of Quality and Performance
	Director of Quality Management

Partnership Provider Engagement Group (PEG) Standing Members	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Regional Medical Director
Provider Relations	Senior Director of Provider Relations
	Director of Member Services and Provider Relations

Partnership Provider Engagement Group (PEG) Standing Members	
	SR Manager of Provider Relations Representatives Manager of PR Representatives, SR and NR

Partnership Quality Improvement and Health Equity (QIHEC) ~~Transformation~~ Committee Standing Members	
Department Represented	**Position Title**
Administration	Director of Grievance and Appeals
	Chief Operating Officer
	Associate Director of Communications
Finance	Director of Health Analytics
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Director of Health Equity~~Health Equity Officer~~
	Senior Director of Quality and Performance Improvement
	Medical Director for Quality
	Director(s) of Care Coordination
	Director(s) of Utilization Management
	Director(s) of Population Health
	Senior Health Educator
	Chief Health Services Officer
	Director of Pharmacy Services
	Regional Medical Director(s)
	Associate Medical Director(s)
Provider Relations	Senior Provider Relations Representative Manager
Members Services	Senior Director Member Services

Partnership Quality/Utilization Advisory (Q/UAC) Committee Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Associate Director of Grievance and Appeals
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordinationand Population Health)	Chief Medical Officer – Committee Chair
	Medical Director for Quality – Committee Vice Chair
	Medical Director for Medicare Services
	~~Clinical Director of Behavioral Health~~Behavioral Health Clinical Director
	Regional and Associate Medical Director(s)
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Director of Health Equity ~~(Health Equity Officer)~~
	Director of Population Health Management
	Director of Enhanced Health Services
	Director(s) and Associate Director(s) of Utilization Management
	Director(s) and Associate Director(s) of Care Coordination
	Director of Pharmacy Services
	Manager, Member Safety Quality Investigation

Partnership Quality/Utilization Advisory (Q/UAC) Committee Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
	Manager of Clinical Compliance – Quality Inspections
Provider Relations	Senior Health Educator
	Senior Provider Relations Rep Manager

Partnership Strategic Planning Committee Standing Staff Invites *Note: Partnership Staff are not committee voting members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Behavioral Health Services Administrator
	Regional ~~Manager (NR)~~Directors
	~~Northern Region Executive Director~~Senior Director of Regulatory Affairs and Contracting
	~~Associate~~ Director of Communications and ~~Public Affairs~~Government Affairs
	~~Project Coordinator~~Policy Analyst
	~~Project Manager, Northern Region~~
Finance	Chief Financial Officer
	Director of Financial Planning and Analysis
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Director of Health Equity~~Health Equity Officer~~
Information Technology	Chief Information Officer

Partnership Substance Use Internal Quality Improvement Subcommittee Standing Members	
Department Represented	**Position Title**
Administration	Senior Director of Behavioral Health
	Behavioral Health Clinical Director
	Senior Manager of Behavioral Health
	~~Senior~~ Program Manager, Behavioral Health
	Director of Grievance and Appeals
	Regional Director
	Grievance and Appeals Compliance Manager
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Behavioral Health Clinical Specialist ~~(NR)~~
	~~Behavioral Health Clinical Specialist (SR)~~
	Manager of Member Safety – Site Inspections
Claims	~~Supervisor of~~ Customer Service Manager (NR)

Partnership Substance Use Internal Quality Improvement Subcommittee Standing Members	
Compliance	Director of Regulatory Affairs and Program Development
Member Services	Supervisor of Member Services
Provider Relations / Network Services	Senior Director of Provider Relations
	Provider Relations Representative (NR & SR)
	Senior Manager of Network Education and Credentialing Manager of Provider Relations Representatives (NR & SR)

Partnership Substance Use Services Provider Advisory Group Standing Members	
Department Represented	**Position Title**
Administration	Senior Director of Behavioral Health
	Behavioral Health Clinical Director
	Program Manager ~~I~~, Behavioral Health
	Senior Manager of Behavioral Health
	Grievance and Appeals Compliance Manager
~~Provider Relations~~	~~Senior Manager of Network Education and Credentialing~~

Appendix B: Quality and Performance Improvement Program Description
Partnership HealthPlan Strategic Quality Plan: Achieving Five-Star Quality

2020-2025
Introduction

In 2017, Partnership HealthPlan of California (Partnership) created a HEDIS® measure score improvement strategic plan, directed at dramatically improving HEDIS® scores by sub-region. Two imperatives have led us to a major revision of this plan. First, the HEDIS® score improvement strategic plan did not address thelink between the member experience and overall quality. Second, Partnership is on the road to NCQA accreditation, which includes a number of standards outside the patient experience and clinical quality scores and defines many activities throughout the organization that impact both.

The purpose of this 2020 update to the strategic plan is to clearly articulate the long and short-term initiatives Partnership will engage in over the next five years to achieve 5-star NCQA Health Insurance Plan Rating status. NCQA accreditation is the gold standard for measuring performance of health plans in the United States. Full accreditation by NCQA categorizes overall health plan performance from zero to five stars, analogous to the Medicare Stars rating system. A 5-star rating is the highest possible score achieved by just 2 of 171 Medicaid plans nationally in 2019; a score of 4-star or above is considered above average, achieved by 40 health plans nationally.

This document serves as a communication tool for Partnership leadership and staff, Board members, providers and other stakeholders and lays a solid foundation from which an operational plan will be created.

This Five-Star Strategic Plan is an elaboration of the first focus area of Partnership's organizational Strategic Plan: to ensure high quality health care to all our members. This strategic plan also aligns with Partnership's vision - to be the most highly regarded Health Plan in California - and its mission, which transcends service to our members to include the greater community, "To help our members, and the communities we serve, be healthy."

Improving quality not only has intrinsic benefits to our members, but it carries intangible benefits to the organization and the community. When quality improvement activities are aligned with the "quadruple aim" of better health, lower cost, better care and caring for the providers, it assists with making the overall health care system function more effectively and efficiently. A focus on quality also improves the reputation of Partnership in the state, allowing further innovation and influence among state-wide stakeholders.Finally, the principles of quality improvement can influence the organization to more efficiently execute on operational priorities not directly related to quality.

Lastly, in 2019, DHCS moved aggressively towards the use of larger scale health plan sanctions for performance on measures that are below average performance. This places additional financial pressure on Partnership to improve quality measure results within our network.

Organizational Values Supporting Quality

To achieve 5-star quality, Partnership must have an organizational culture of quality which is nurtured by the executive leadership team and Board of Commissioners. Core to this culture are these organizational values (from our organizational strategic plan), with aphorisms reflecting these values.

- Partnerships: Fostering strong partnerships with members, providers, and community leaders to collectively improve health outcomes. "Putting our members first."

- Overall focus on Quality: Focusing on continuous quality improvement in every aspect of the organization and in collaboration with our partners. "Doing the right thing right, the first time andevery time."
- Integrity: Set a standard of professionalism, integrity, and accountability. "Striving for perfection, but embracing the opportunity to learn from imperfection. Excellence is achievable!"
- Innovation: Striving to be innovative and seeking creative solutions. "Willingness to challenge the status quo, and insist on change when needed."

In addition, the Partnership leadership team has several conceptual frameworks focused on quality:

- Balancing Compliance and Performance: Balancing rigid attention to regulatory requirements with flexibility and innovation needed to drive improvement. "Not all change is improvement, but all improvement requires change."
- Promoting Health Equity: Ensuring an organizational culture that recognizes the diverse backgrounds of our employees and supports the institution of practices that consider social determinants of health, the impacts of implicit bias and the provision of fair and judicious healthcare and services to meet the broad based needs of our members. "Everyone has a fair and just opportunity to be as healthy as possible."
- Becoming a Learning Health Plan. "Making decisions based on rigorous data analysis wheneverpossible (instead of based on hope or wishful thinking)." "Creating an atmosphere where new ideas can be explored and where strong, independent teams can test these ideas."

The term "Learning Health Plan" is new in this strategic plan, although many associated tactics are not new. More background and explanation is presented next.

Learning Health Plan

A common underlying theme in most Quality Improvement frameworks is that organizations and teams must embrace continuous learning to achieve their highest potential. Tom Nolan, one of the creators of theModel for Improvement, said "What are the necessary and sufficient conditions for improvement in large systems? **Will, ideas and execution!"**

Donald Berwick describes what will, ideas, and execution means:
"Providing **will** refers to the tasks of fostering discomfort with the status quo and attractiveness for the as-yet-unrealized future. Providing **ideas** means assuring access to alternative designs and ideas worth testing,as opposed to continuing legacy systems. And **execution** was his term for embedding *learning* activities and change in the day-to-day work of everyone, beginning with leaders." -Milbank Quarterly, August, 2019

The Partnership Executive Team and Board are committed to making a profound and deep link between the necessities of using a learning health plan framework to best serve our members and our communities.

The fundamental tenets of a Learning Health Plan are:

1. Using the scientific method to optimize implementation of quality improvement initiatives
   a. Building on prior research/experiences
   b. Rigorous and widespread testing of change on a small scale (using the model for improvement framework)
   c. Tracking of information gleaned from small tests of change so others can retrieve this information and build upon it.
   d. Use of control groups (where appropriate)
   e. Careful data and statistical analysis

f. Using a combination of classic project management methodology with the ConsolidatedFramework for Advancing Implementation Science[1] to have a systematic effective approach to program implementation and building internal expertise in these approaches.

2. Having the leadership and staff to support this approach
   a. Communicate effectively about quality and change, through a mixture of data and stories. "No data without a story, no story without data."

A Learning Health Plan avoids widespread implementations of any unproven projects, without measurement of what the outcome is, performing weak or no evaluation of the project, and continuing theproject without knowing if it is effective. While such projects are often related to regulatory mandates, gathering data on their effectiveness or lack thereof can provide valuable evidence for advocating policy change.

Without using the term "learning organization" or "learning health plan," Partnership has been building the infrastructure and leadership to include most of these elements. For example, creating a Project Management/Operational Excellence Department and Team, creating a Health Analytics Team, doing internal trainings through the Learning Management System and external trainings, conducting efficient but meaningful Return on Investment analyses of several programs, and developing a system of storing lessons learned in small tests of change in the quality department are all examples.

By identifying the elements of a strong learning health organization and standardizing our communicationaround the core principles, we will solidify the cultural values around being a Learning Health Plan.

Process of Developing 5-Star Strategic Plan

Leaders in the Quality Improvement (QI) Department created this strategic plan with input from Partnership leadership and staff via the HEDIS® Score Improvement team and the Analytics, Care Coordination, Population Health, Information Technology (IT), Member Services, Pharmacy and QI departments.

The scope of this strategic plan is rooted in the emerging field of population health management. Population health management, in the context of a health plan, requires assessment and analysis of member needs, stratifying the population into risk tiers and defining segments for targeted interventions. Once population segments are identified, the health plan engages available resources to improve the health and wellbeing of the plan's assigned membership on both an individual and aggregate level. This is distinct from approaching population health with a public health approach –which would encompass coordinated and multi-sector efforts to improve the quality of health for an entire community or communities— an approach which is beyond the scope of this strategic plan.

The Quality Improvement department will lead the implementation of this strategic plan, collaboratively and in partnership with other departments and providers, respecting capacities and competing priorities.

Evaluation

Partnership is committed to testing new approaches and scaling up when new approaches are successful. The QI department will lead efforts to support processes and systems for learning and monitoring progress on the implementation of the NCQA 5-Star Strategic Initiative Plan, and sharing evaluations with Partnership leaders and our community partners.

---

[1] Keith, R.E., Crosson, J.C., O'Malley, A.S. *et al.* Using the Consolidated Framework for Implementation Research (CFIR) to produce actionable findings: a rapid-cycle evaluation approach to improving implementation. *Implementation Sci* **12,** 15 (2017)

Environmental Factors

The following strengths and weaknesses within the organization and opportunities and threats external to the organization were taken into consideration when drafting this strategic plan.

Strengths	Weaknesses
• NCQA Interim Accreditation status attainted - many standards (notably the Population Health Management standards) directly support improved HEDIS® scores. • Significant programming and ability to offer technical assistance to bolster primary care capacity for quality and clinical improvement • Robust pay-for-performance program and commitment to value-based processes. • Supportive data systems including eReports and Partnership Quality Dashboard • Increasing cross-department collaboration • Strong HEDIS® Medical Record ReviewProject processes • New member portal building an infrastructure to outreach to members • Growing internal analytic capacity and standardized data sets support population health analysis • Recent assignment of largest direct member categories to PCPs so that PCP QIP applies	• Competing priorities: major system implementations, multiple goal teams, efforts to comply with NCQA standards, new benefits, new regulatory mandates • Many databases still not integrated or standardized • Data governance processes not deeply institutionalized • Preventive or coordination services Partnership offers are not widely understood or utilized by members • Member input not deeply integrated into member-facing improvement efforts • Limited Partnership experience in outreaching to members to close HEDIS® gaps • Collaboration across Partnership departments sometimes not prioritized over core departmental work. • Confined "single views" of member; gaps in care not visible across health plan data systems • Regional disparities in access and health risk factors
External Opportunities	**External Threats**
• NCQA First Survey Accreditation (11/2020) – roadmap to becoming higher quality plan • Provider network and communities support improved clinical performance and are willing to partner (e.g., Joint Leadership Initiative) • Provider partner bright spots with best practices and excellent quality scores • Pilot programs to enable greater accuracy of member contact information. • Preparation for MediCare Duals Special Needs Plan (D-SNP) • MCHC for all: Enhanced Care Management and In Lieu of Services proposals • Aligned Proposition 56 incentive funding	• Judicial threats to the Affordable Care Act (risk aversion) • Lethargic CMS response to DHCS proposals impact scope and speed of DHCS policy changes • Changing regulatory environment with increasing risk of financial sanctions and other penalties • Proposed changes to public charge policy (decreased enrollment) • Primary care site staff turnover (providers, nurses, medical assistants) • Member access to PCPs for care • PCP capacity for outreach • PPS providers (provider primary care for over 75% of members): PPS system reimburses based on volume, not services provided (removes some options for incentivizing quality activities) • Natural disasters and power outages • Pharmacy Carve Out

HEDIS® Score Improvement Aim Statement

The Partnership Five Star Quality Strategic Plan Aims to achieve the following:

1. A weighted average of all accountable DHCS MCAS measures >50th percentile (in year 1) with yearly improvement afterwards in three years, all individual measures performance will be above the 50th percentile.
2. ≥25th percentile in all adult and pediatric CAHPS® measures year 1; with yearly improvement afterwards
3. 80% of applicable points earned in each standard category of NCQA accreditation standards, including Must Pass elements

These are ambitious goals and will require a significant amount of investment, collaboration, and focus. The Managed Care Accountability Set (MCAS) will grow from 19 measures for measurement year (MY) 2018 to 36 for MY 2020. With the new MCAS measures, the minimum performance level increased from the 25th to the 50th national Medicaid percentile.

See Appendix E for HEDIS® performance in measurement year 2018.

Focus Areas, Goals and Objectives

This strategic plan is centered on five key focus areas: 1) Engaging Clinical Practices 2) Engaging Members 3) Data Infrastructure 4) Accreditation Standards and 5) Access. Specific activities, timelines, resources, and evaluation benchmarks will be developed in an operational plan. See Appendix A for a visual depiction(process map) of Partnership's Achieving Five-Star Quality focus areas and goals.

Focus Area 1: Primary Care Practice Ability to Deliver High Quality Health Care

Partnership recognizes the critical role PCPs play in improving clinical quality performance, as well as optimizing utilization, maximizing access to care and enhancing the patient experience. A central theme within this focus area is to better equip PCPs to provide recommended high quality care through provision of information, technical assistance, improvement tools and financial incentives.

Focus Area 1: PCP Delivery of High Quality Care

Goals	Objectives
A. Supply Actionable Care Gap Data to PCPs	•Optimize: eReports •Optimize: Partnership Quality Dashboard (PQD) •Study: Integrate ePrompts into Provider OnlineServices •Expand: Unblinded quality data sharing •Promote: Electronic Health Record (EHR) workflow optimization, including integration with CAIR
B. Technical Assistance to Support Provider QI Capacity	•Optimize: Mandated PDSA/PIPs/Site Reviews/Prop56 •Expand: Technical assistance offerings, provider education and coaching for large and medium sizedpractices •Sustain: General QI training: ABCs of QI •Adapt: Measure-specific trainings and webinars •Evaluate: PCP leadership development •Study: Partnership leverage for promoting health equity through providers
C. Optimize Pay for Performance Programs	•Optimize: PCP QIP •Optimize: Perinatal QIP •Optimize: Hospital QIP

Focus Area 2: Partnership Engaging Members to Improve Quality Metrics

There is a significant opportunity for Partnership to expand direct-to-member engagement activities to improve MCAS and HEDIS® scores. The goals within this focus area will require Partnership to take on new initiatives and/or expand current initiatives that provide actionable data to Partnership staff, leverage contacts with members through in-reach and outreach, and increase Partnership's presence in communities. Direct health plan contact with members complements the outreach conducted by providers. Partnership Network providers are diverse in size, staffing and resources and may be limited in outreach capabilities for a variety reasons, including competing priorities or absence of supportive technology or workflows. In other instances, members are not assigned to or directly managed by a PCP (e.g., direct members) or the member may have considerablemovement across PCPs during the HEDIS® measurement year.

Focus Area 2: Partnership Engaging Members to Improve Quality

Goals	Objectives
A. Supply Actionable Care Gap Data to Partnership Staff and Members	•Integrate: Prompts into Essette •Integrate: ePrompts into Call Center •Integrate: ePrompts into Member Portal
B. Increase Partnership Member-Engagement Capacity	•Pilot: Reminders into Care Coordination workflow •Study: Integration of reminders into Member Services workflow •Expand: Train Partnership staff on targeted qualitymeasures •Study: New and updated member incentives •Increase: Member input into engagement process •Expand: Partnership Outbound engagement activities •Develop: Digital Engagement Solutions
C. Other Strategies for Member Engagement	•Test: Leverage Community Health Workers/CareManagers on Quality Measures •Study: ED and inpatient settings •Test: Outreach to direct members •Expand: Outreach through identification and participation in grassroots community activities

Focus Area 3: Data, Analytics, and Knowledge Management

A critical element to improving MCAS and HEDIS® quality scores lies in Partnership's ability to strengthen data and analytics infrastructure. Additionally, in order to function under the Learning Health Plan framework, foundational systems and processes need to be developed and established to strengthen how data and improvement study results are evaluated and used in decision-making to further optimize the rate of qualityimprovement. Four goals will help improve the organization's infrastructure needed to support and assessprimary care and member interventions.

Focus Area 3: Data, Analytics, and Knowledge Management

Goals	Objectives
A. Actionable CareGap Data to PCPs, Partnership staff and members	• Objectives in Focus Area 1, Goal 1 • Objectives in Focus Area 2, Goal 2 • Expand: Pilots on improving member contact information • Align: Health education tools on Member Portal with quality measures
B. Data Quality, Timely Access and Completeness	• Optimize: Configuration of new core claims system • Implement: Provider Master Data Management • Expand: Data Dictionaries • Operationalize: Data Stewardship Program • Expand: Health Information Exchange (HIE) • Expand: Clinical Data Repository (CDR) • Operationalize: Partnership Data Governance structure
C. Supportive Analytics	• Expand: Well-constructed Data Marts • Build: Comprehensive member data (Member 360) • Optimize: Analysis and presentation of annual quality measure results • Optimize: Leverage rolling-year monthly HEDIS® data • Integrate: Equity analysis with improvement activities
D. Learning HealthPlan Framework	• Expand: Knowledge Management infrastructure • Develop: Standardized scientific approach to small tests of change • Study: Standardized approach to scaling up/implementation

Focus Area 4: Achieving Health Plan NCQA Accreditation

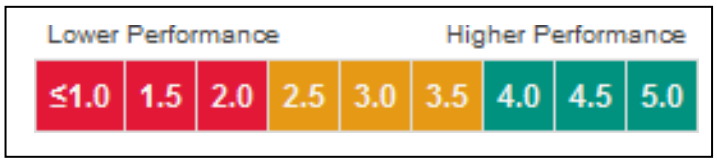
The provision of high quality healthcare to our members is fundamental to Partnership's vision and mission. Wewant to be one of the highest quality health plans in California. NCQA Health Plan Accreditation supportsthis goal by:

- Providing a framework to guide our operational and quality improvement activities. (Many of the activities outlined in the standards are best practices that should be pursued regardlessof our accreditation goals.)
- Providing a nationally-recognized standard and definition for a high quality health plan, performance against which will allow Partnership to compare ourselves objectively against other high quality plans.
- Offering the only widely-available health plan assessment that bases results on clinical performance (HEDIS®) and member experience (CAHPS®).

In the summer of 2019, Partnership received formal Interim Accreditation Status, receiving 50 out of 50 total possible points. Interim Accreditation ensures organizations have a basic structure in place to meet expectations for consumer protection and quality improvement. Interim Accreditation status indicates a strong position and readiness of an organization to move forward with formal First Survey Accreditation, which covers the full scope of the standards and requirements, including HEDIS® and CAHPS® reporting.

First Survey Accreditation is planned for late 2020-early 2021. As noted earlier, two years after that the HEDIS® and CAHPS® scores will be integrated to give a star rating from 0 to 5.

5-Star Scale



As part of the process for setting appropriate goals and areas of focus, the NCQA Project Management Team reviews the accreditation scoring methodology on an annual basis to appropriately apply updates, changes or modifications. Broadly, here are the categories in which we have extracted as areas of focus,which are resource intensive and have significant cross-departmental impact, expressed as goals:

Focus Area 4: Achieving NCQA Accreditation

Goals	Objectives
A. Pass all "MustPass" Elements	• Optimize: Internal file review • Optimize: Delegated file review • Optimize: Delegates following NCQA Standards • Align: Department Goals
B. Strengthen "Grand Analysis" Improvement Activities	• Optimize: Utilization Management • Improve: Member Experience • Optimize: Network Adequacy and Availability • Implement: Population Health Management • Implement: Continuity and Coordinationof Care • Non-Behavioral • Behavioral
C. Prepare for ~~MediCare~~Medicare	• Measure: Baseline MediCare HEDIS®Measures • Address: MediCare HEDIS® Gaps • Evaluate: MediCare incentive programoptions for patients and providers • Plan: Support for overall quality oversight

Focus Area 5: Improving Member Experience through Improved PCP Access

Background: In the 2019 Partnership CAHPS® survey, the areas below the 25th percentile for adult and children werealmost exclusively in the area of perceived access to services. Since the CAHPS® survey will account for about one-third of our accreditation score and is also slated to become an MCAS measure, it is imperative that Partnership explore additional activities to improve PCP access. While the access composite scores in CAHPS® include questions related to specialty access, only PCP access will be included in Focus Area 5. Activities related to increasing specialty access will be covered in the Access and Availability Grand Analysis required as part of NCQA accreditation.

From July-October, 2019 multiple stakeholders[2] were asked to give feedback and suggestions for increasing access to PCPs in the Partnership service area.

> The 54 ideas that were generated were categorized by the degree of control the Clinical Practice has overthe factor, the degree of control the Health Plan has over the factor, as well as a categorization of the cost, effort and effectiveness of each suggestion. See Appendix D for the details.

Prioritization Process:
We eliminated those suggested interventions that were high cost (3-4) and low estimated effectiveness (1). Additional changes were made, based on feedback from Executive Committee. This leads to these 17 objectives, grouped into four goals.

[2] Nine Joint Leadership Initiatives, Physicians Advisory Committee, Strategic Planning Committee, Medical Directors of Partnership, Board Advisory Group on Quality, Executive Committee at Partnership, Operations Committee at Partnership

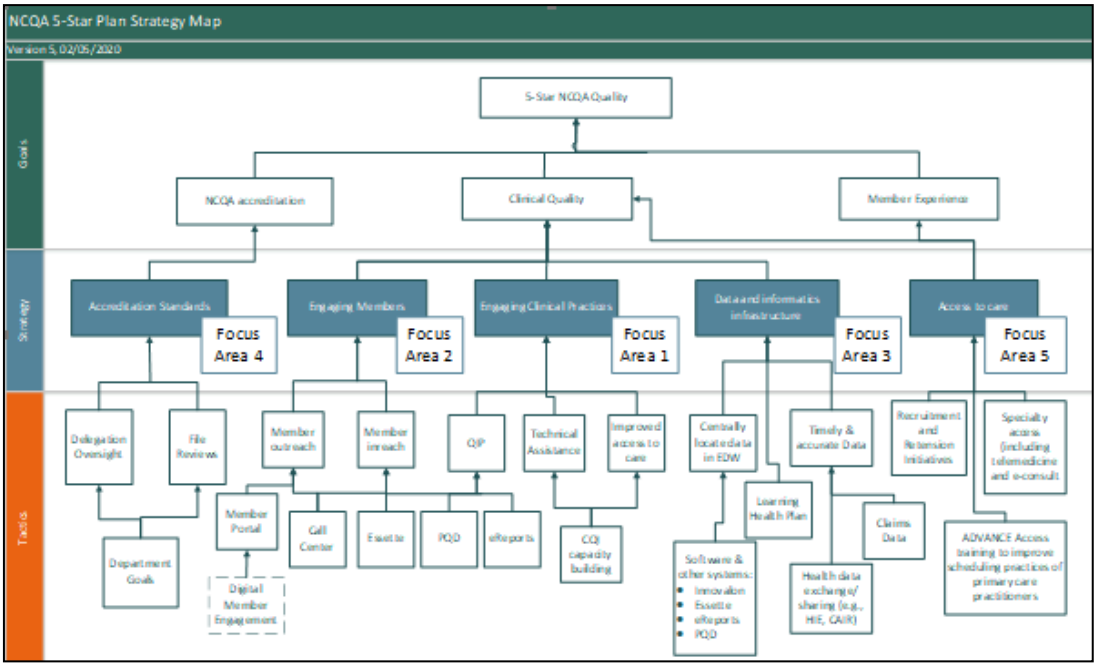
Focus Area 5: Improving Member Experience through PCP Access

Goals	Objectives
A. Recruitment	•Implement: Marketing to Residents within Partnership region •Implement: Marketing to Residents outside Partnership region •Implement: Marketing to out-of-state primary care Residents originally from Partnership counties •Explore: Support partner job search •Study: Support J-1 visa process
B. Retention	•Test: Optimize HPSA scores in shortage areas •Implement: Support providers in completing application/processfor loan repayment •Study: Increase PCP organization reimbursement for sites with greatest challenge via adjustment of PCP-QIP by recruitment difficulty factor •Study: Coordination among local agencies providing supplemental dollars for loan repayment, signing bonus, etc. •Implement: Advocacy for new and larger loan repaymentprograms by state/federal government. •Test: Vetted Locum Tenens providers to provide vacationcoverage •Planning: Proposal for structure for providing social support to providers
C. Alternative Access Options	•Implement: Promoting the leveraging Phone/Video visits toincrease access •Implement: On demand video visits for urgent care •Promote: Advanced Access methodology
D. Learning	•Implement: Exit Interviews of Clinicians leaving the region •Implement: Interview practices that are very successful inrecruiting strong staff

Conclusion

This Partnership Strategic Plan for Achieving Five Star Quality provides a roadmap for using the overall structureand framework of NCQA, modified by requirements of DHCS, to substantially improve quality and ultimately achieve a 5-star rating by NCQA by 2025.

Appendix A – Partnership Strategic Quality Plan



Pathway to Excellence

Partnership Framework for Continuous Learning

Final Workgroup Report June, 2021

Workgroup Members:
Robert Moore, MD MPH
Mark Netherda, MD
Erika Robinson
Nancy Steffen
Caron Lee
James Devan
Naresh Vemparala
Farashta Zainal

From Quality Measure Score Improvement Team Goal #4:

SMART goal #6:

Partnership's transformation as a Learning Health Plan: Define a framework/plan for expanding knowledge management infrastructure relative to best practices in quality measure improvement and operationalizing standardized approaches to small tests of change through scaling and wide-spread implementation.

Milestones:

Final report presented to the executive HEDIS® Measure Score Improvement team by June 30, 2021

Table of Contents

Executive Summary 69
Framework Development 72
Continuous Learning as a Quality Framework 73
Roots in Partnership Culture 73
Definitions of Learning 74
Learning Organization and Quality Improvement 74
Pathway to Excellence Framework Overview 76
Knowledge Management 79
Background Concepts 79
Categories of Knowledge 80
Essentials of Strategic Knowledge Management 80
Strategic Initiatives to Bridge Gaps. 81
Information Technology Resources for Knowledge Management 82
Supportive Leadership Activities for Knowledge Management 83
Small Tests of Change 83
Framework Options 83
Considerations when Planning a Pilot/Small Test of Change 85
Data and Statistical Analysis 87
Analytics Strategic Plan 87
Project Purpose/Business Justification 87
Structure of Analytics Strategic Planning 89
Standards for Evaluation 90
Optimizing Spread: Application of Implementation Science 90
Organizational Factors 93
Plan for Nurturing Organizational Culture 93
Plan for Maturing the Framework 95
Overall Plan 95
Year 2 Activities 95
Bibliography 96

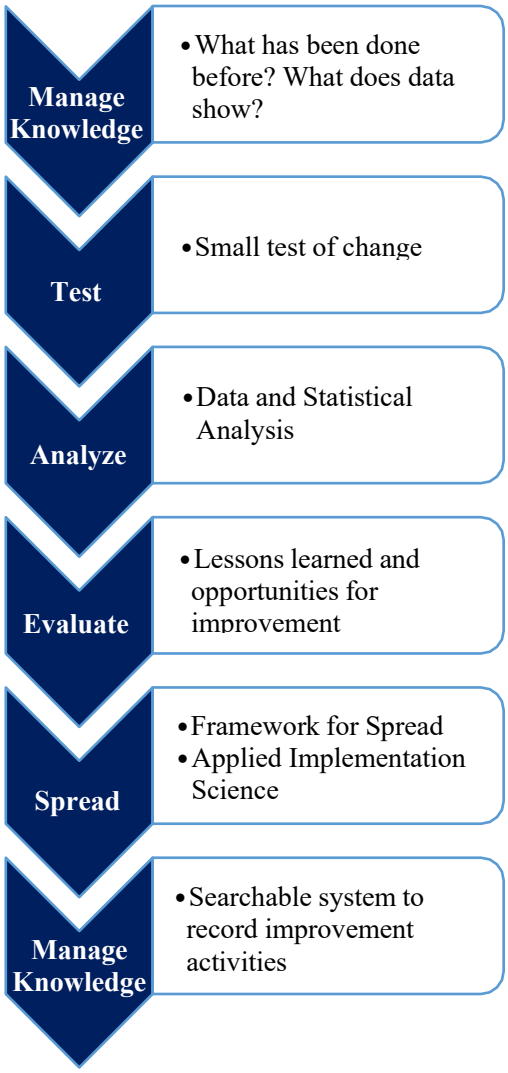
Executive Summary

For years, Partnership's QI Program Description (and DHCS itself) has highlighted the Model for Improvement, whichincludes the well-known PDSA (Plan-Do-Study-Act) cycle as a guiding framework for improving the quality of health are of our members. Yet, as we accumulated positive experience with many small tests of change, Partnership'soverall health plan ranking (comparing a subset of HEDIS® scores with the scores of other health plans) was improving slowly. Recent reports on relative performance on Pediatric Health measures has highlighted lower performance in Partnership's northern regions, which could have an impact Partnership's success with absorbing additional rural counties. While small tests of change (PDSAs) are a key framework in improvement activities, they are not sufficient to achieve larger scale long lasting improvement.

Partnership updated its 5-star Strategic Plan in 2020, and is executing a comprehensive tactical plan related to this plan. A central goal was NCQA accreditation, achieved in January 2021. HEDIS® scores for measurement year 2021 will be the baseline year for rating the health plan on NCQA's 5-star HEDIS® scoring. The COVID pandemic and the Health Edge core claims processing implementation have had a notable negative impact on energy that can be spent by Partnership and our providers on improving health care quality measures. As we move into late 2021 and 2022, we must be ready to re-energize our provider network to improve clinical outcomes.

In 1990, Peter Senge outlined the components of what he called a "learning organization," in his book *The Fifth Discipline: The Art and Practice of the Learning Organization*. The highest performing organizations are the strongest learning organizations, he argues, and they have specific disciplines that characterize being a learning organization. About a decade ago, the term "learning organization" was expropriated by a variety of Health Care Organizations to become a "learning health system." Different organizations and authors had different ideas of what the "system" was, ranging from a geographic system to an integrated delivery system to the entirehealth care delivery system in the United States.

Over the past year, a workgroup of Partnership's HEDIS® score improvement team explored how these concepts of a "learning organization" and a "learning health care system" could be applied to a health plan. The resulting framework is composed of five elements, shown in the diagram below (knowledge management has a role at the beginning and end of the process, so is presented twice):



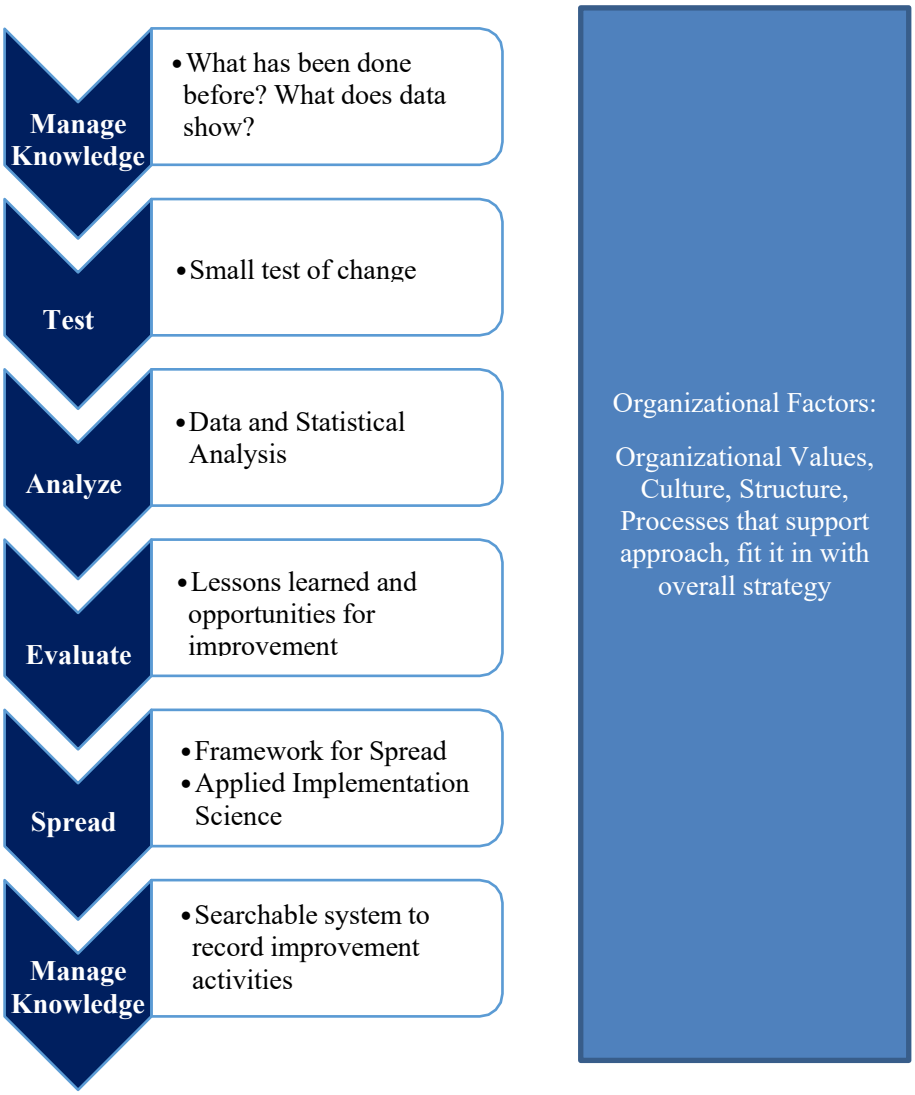
This document provides an overview of each of these key elements, including current activities at Partnership as well as a summary of the academic literature on each topic. Next, several leadership activities and overarching activities are described as critical elements to optimize the successful use of these five elements. We end with a plan for further developing our framework in the 2021-2022 fiscal year and beyond. We believe that adoption of this framework will provide critical support for our NCQA stars status, and contribute to our vision, to be themost highly regarded health plan in California.

A detailed description of the Pathway to Excellence framework can be found after the 2022 update activities section below.

2022 Update and Activities Related to the Pathway to Excellence Framework

Background:

Traditional QI frameworks are missing several key components essential for optimal testing of new ideas and implementation of successful tests. In 2020 to 2021, Partnership researched frameworks and ideas that were missing from traditional QI frameworks into one overarching framework, called the Pathway to Excellence. Major components are summarized here:



A detailed white paper with references is available on Partnership's internal website (Partnership4Me), along with a number of recorded presentations on each of the topics above.

Activities of 2022-23

During 2022, Partnership steadily worked on rolling out the Pathway to Excellence (P2E) Framework, building on an implementation plan created in 2021. Major activities of 2022 and planned activities for 2023 are listed here:

1. Creating in internal website to make P2E materials easily available to Partnership staff.
2. Formal presentations on each of the major topics:
   a. Overall Pathway to Excellence Framework, including coverage of theory of knowledge and learning.
   b. Knowledge Management
   c. Small Tests of Change
   d. Data and Statistical Analysis, including a sub presentation on Using the Data We Have (Health analytics and Data Governance work to continue into 2023).
   e. Evaluation methods
   f. Using Applied Implementation Science to Optimize Spread of Tested Ideas
3. These presentations were given internally:
   a. Operations Leaders

b. Medical Directors
c. Health Services Directors and Managers
d. Recorded for others to review (new staff, new leaders, etc.)
e. Board Quality Advisory Workgroup

4. Externally, the overall framework was adapted and presented to:
   a. Partnership's Hospital Quality Symposium
   b. The California Hospital Quality Council's annual Quality Forum
   c. Additional forums planned for 2023: CPCA Quality meeting in March.
5. Incorporating the major principles of the P2E framework in thinking about our everyday work. (Will continue in 2023)
6. Special focus on Strategic Knowledge Management (KM) Activities (all ongoing, continuing in 2023)
   a. Shared Drive Cleanup by HS departments
   b. SharePoint site cleanup
   c. Use of One-Note for Knowledge Management
   d. Master list of abbreviations updated and posted to SharePoint
   e. Principles for updating external website for KM created.
   f. Use of PowerDMS for Knowledge Management (Plan to implement after fall 2023)
   g. Microsoft 365 and its role in updating KM infrastructure (including external website). Planned for 2023.
   h. IT backup of KM materials on shared drive (2023 topic)

Framework Development

The Pathway to Excellence: Partnership's Framework for Continuous Learning was developed by a workgroup of the HEDIS® Score Improvement Goal Group. The workgroup met monthly to discuss and flesh out different aspectsof this framework and to systematically review the academic literature related to the different elements. A review of pre-existing activities that contribute to these elements was tabulated. Interviews of external organizations working on this framework were initiated, and will continue as our understanding of the framework elements expands.

Original Pathway to Excellence Whitepaper and Plan (2021)

Initially, the workgroup was named "Learning Health Plan" as an extension of the "Learning Health System" concept, but with feedback from the executive team and Partnership's board advisory committee on quality, the framework is renamed "Pathway to Excellence: Partnership's Framework for Continuous Learning."

Workgroup Members:

Robert Moore, MD MPH
Mark Netherda, MD
Erika Robinson
Nancy Steffen
Caron Lee
James Devan
Naresh Vemparala
Farashta Zainal

The workgroup developed this document, an annotated bibliography, several PowerPoint presentations summarizing the key concepts, and notes summarizing the monthly meetings.

Continuous Learning as a Quality Framework

Roots in Partnership Culture

The Mindset of Continuous Learning is rooted in Partnership's organizational culture.
Several of Partnership's organizational values (listed on the Partnership website) support different aspects of quality:

1. Partnerships: Fostering strong partnerships with members, providers, and community leaders to collectively improve health outcomes. "Putting our members first."
2. Overall focus on Quality: Focusing on continuous quality improvement in every aspect of the organization and in collaboration with our partners. "Doing the right thing right, the first time and every time. Excellence is achievable! Striving for perfection, but embracing the opportunity to learn from imperfection."
3. Integrity: Set a standard of professionalism, integrity, and accountability. "Willingness to challenge the status quo, and insist on change when needed."
4. Innovation: Seeking creative solutions. Apply knowledge in new ways.

In addition, two key organizational principles specifically support aspects of being a learning organization:

1. Balancing Compliance and Performance: Balancing rigid attention to regulatory requirements with flexibility and innovation needed to drive improvement. "Not all change is improvement, but all improvement requires change."
2. Continuous Learning: "Making decisions based on rigorous data analysis whenever possible (instead of based on hope or wishful thinking)." "Creating an atmosphere where new ideas can be explored and where strong, independent teams can test these ideas"

The mindset of continuous learning can be expressed in these three credos:

1. We are all very proud of Partnership, the work we do and the systems we have developed. Nonetheless, werecognize that we as individuals and as a company can do better.
2. We strive as individuals to be curious and continuously learn.
3. We also strive as an organization to learn and grow.

While these are organization-wide values, this document will focus on the applications of continuous learning to our work to support our strategic goal of becoming a 5-Star NCQA recognized health plan. This includes work related to improving quality and performance in these Partnership departments: quality, pharmacy, care coordination, utilization management, health analytics, and population health. Of note, some parallel activities in Partnership's operational departments are being organized by the OpEx/PMO department.

Organizational leadership activities are critical for applying this work. This includes ensuring that activities are related to organizational priorities, that staff are supported and motivated, that staff work well cross-departmentally, and that the overall organizational culture is supported.

Knowing is not enough; we must apply. Willing is not enough; we must do.
- Johann Wolfgang von Goethe

Definitions of Learning

Two useful definitions of learning are:
Learning (noun):

1. Process of acquiring information, knowledge or understanding/wisdom
2. The process by which (tacit) knowledge is *created* through the transformation of experience

Note that these definitions are very different from the concept of Machine Learning, a form of Artificial Intelligence (AI), defined as the use and development of computer systems able to learn and adapt without following explicit instructions. We will *not* be addressing machine learning in this report.

Another important distinction is the difference between Learning, Innovation, and Invention. In contrast to learning, innovation and invention are defined as follows:

Innovation (noun): The creation, development, *and implementation* of a new product, process or service, withthe aim of improving efficiency, effectiveness or competitive advantage.

Invention (noun): brand new concept or idea which may not be completely defined/fleshed out/proven.

Learning Organization and Quality Improvement

The idea of a learning organization was defined and popularized in Peter Senge's 1990 book, *The Fifth Discipline: the Art and Practice of the Learning Organization*. His definition of a

Learning Organization (noun): An organization that facilitates the learning of its members and continuously transforms itself.

In the book, Senge details the Five Disciplines of a Learning Organization:

1. Personal Mastery
2. Mental Models
3. Shared Vision
4. Team Learning
5. Systems Thinking

In this context, learning is used as an adjective, modifying organization.

Early reference to the importance of learning in Quality Improvement work also uses learning as an adjective, modifying activities. This is summarized by Don Berwick's analysis of a quote by Tom Nolan, the creator ofthe Model for Improvement:

> "What are necessary and sufficient conditions for improvement in large systems? **Will, ideas, andexecution**!"
>
> - Tom Nolan, creator of the Model for Improvement
>
> "Providing **will** refers to the tasks of fostering discomfort with the status quo and attractiveness for theas-yet-unrealized future. Providing **ideas** means assuring access to alternative designs and ideas worthtesting, as opposed to continuing legacy systems. And **execution** was (Nolan's) term for embedding *learning* activities and change in the day-to-day work of everyone, beginning with leaders."
>
> - Don Berwick, founder of the Institute for Healthcare Improvement

Learning Health System: Another use of learning as an adjective is Learning Health System, first used by the National Institute of Medicine in 2007, to mean that evidence based medicine would be applied reliably throughout the health care delivery system:

> "A learning healthcare system is designed to generate and apply the best evidence for the collaborative healthcare choices of each patient and provider; to drive the process of discovery as a natural outgrowthof patient care; and to ensure innovation, quality, safety, and value in health care."

Evidence based medicine is given a broader definition:

> "to the greatest extent possible, the decisions that shape the health and health care of Americans—by patients, providers, payers, and policy makers alike—will be grounded on a reliable evidence base, willaccount appropriately for individual variation in patient needs, and will support the generation of new insights on clinical effectiveness."

Immediately after this, a subsequent explanation drives back to "information from clinical experience" andclinical effectiveness of interventions.

The Institute of Medicine considers learning as building a knowledge base and translation of this knowledge regularly in the course of patient care.

In the decade that followed, the term learning health system was used in many different senses, depending onhow the author thought about the word "system":

1. U.S. Healthcare Delivery **System**
2. Academic Medical Center as a **System**
3. **System** of translating research into practice
4. Integrated Healthcare Delivery **System**
5. Local or Regional Healthcare Eco-**system**
6. Data Management or Health Information Exchange **System**

We bring this diversity of views to your attention so the reader will be aware that this term is fraught, not tochoose one concept of a Learning Health System over another.

What does the Pathway to Excellence look like?

1. Decisions and conclusions are based on rigorous data analysis whenever possible (instead of based on hope or wishful thinking), while creating an atmosphere where new ideas can be explored.
2. Within this framework, strong independent teams test these ideas, quantitative and qualitative evaluation is performed, knowledge gained is organized for future retrieval, and successful practices are spread effectively.

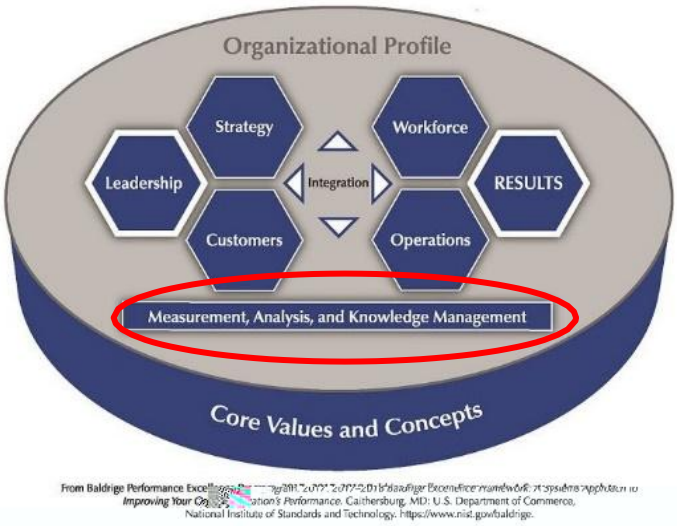
How does this work fit in with other Quality Frameworks?

The Pathway to Excellence Framework shares some themes with two other major quality frameworks: The National Baldrige Award for Quality criteria and the Shingo Model of lean management.

Baldrige Criteria: Four of underpinnings of the Baldrige criteria relate to the *Pathway to Excellence* Framework:

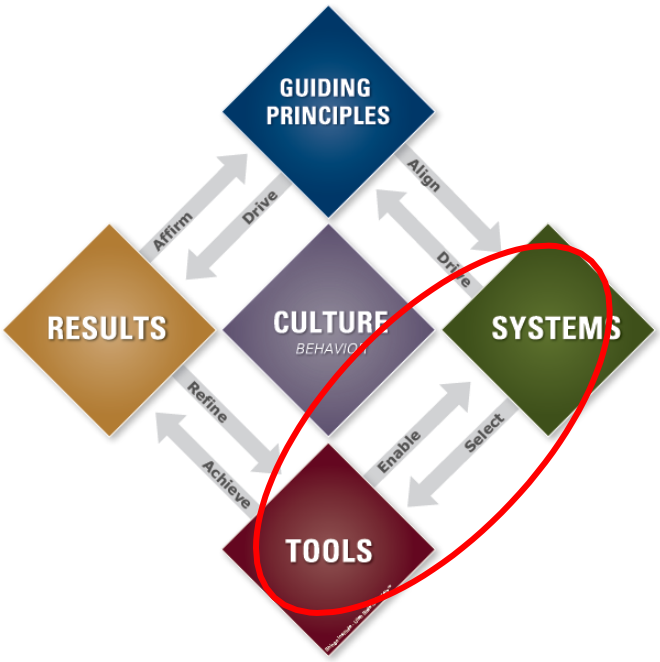
1. Organizational learning
2. Focus on Success and Innovation
3. Management by Fact
4. Delivering Value and Results.

The Organizational Profile of the Baldrige Criteria are shown on the figure below. Of special note, the overarching concepts of measurement, analysis and knowledge management identify three of the elements shared with the *Pathway to Excellence* framework. Also shared is the idea that organizational core values andconcepts underpin the effectiveness of the quality framework.



From Baldrige Performance Excellence Program. 2017-2018 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance. Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology. https://www.nist.gov/baldrige.

Shingo Model: The **Shingo model** of operational excellence asserts that successful organizational transformation occurs when leaders understand and take personal responsibility for architecting a deep and abiding culture of continuous improvement. Leaders lead culture; nurturing the organizational culture is at thecenter of the model. The Shingo Model includes an improvement system, improvement tools, a work system and a management system. While the Shingo model focuses on Purpose, Process, and People, the learning framework described in this paper at Partnership focuses on Process. Process values/principles/behaviours include: continuous improvement, seeking perfection, embracing scientific thinking, and focusing on the process.



Partnership Strategic Plan: The Pathway to Excellence framework will be applied to the first area of emphasis in thecurrent Partnership strategic plan (see below): Access to High Quality Care.

Pathway to Excellence Framework:

After consolidating our information on the Pathway to Excellence Framework, we can summarize this Partnership Framework for Continuous Learning as:

1. Using the scientific method to optimize implementation of quality improvement initiatives
   - Learn from the past: Building on prior research/experiences
   - Small Tests of Change: Rigorous and widespread testing of change on a small scale (using themodel for improvement framework)

- Knowledge Management: Tracking of information gleaned from small tests of change so otherscan retrieve this information and build upon it.
- Careful data and statistical analysis with use of control groups, where appropriate
- Implementation and Spread: Using a combination of classic project management methodologywith the Consolidated Framework for Advancing Implementation Science while having the leadership and staff to support this approach

2. Communicate effectively about quality and change, through a mixture of data and stories. "Nodata without a story, no story without data."

The following sections will summarize each element in greater detail.

Knowledge Management

Background Concepts

Knowledge Management as a field of study has a rather limited literature in relation to health care. There are several journals (including The Journal of Knowledge Management Practice and the Journal of Knowledge Management) and a few books that focus on this area (one is *Strategic Knowledge Management: Driving Business Results by Making Tacit Knowledge Explicit* by Arun Hariharan published in 2015).

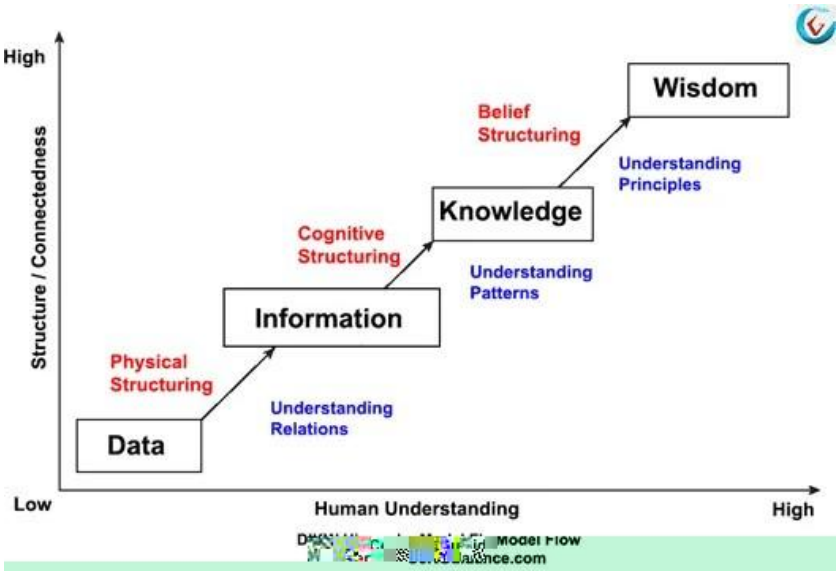
We begin with a brief overview of definitions and philosophy of knowledge.

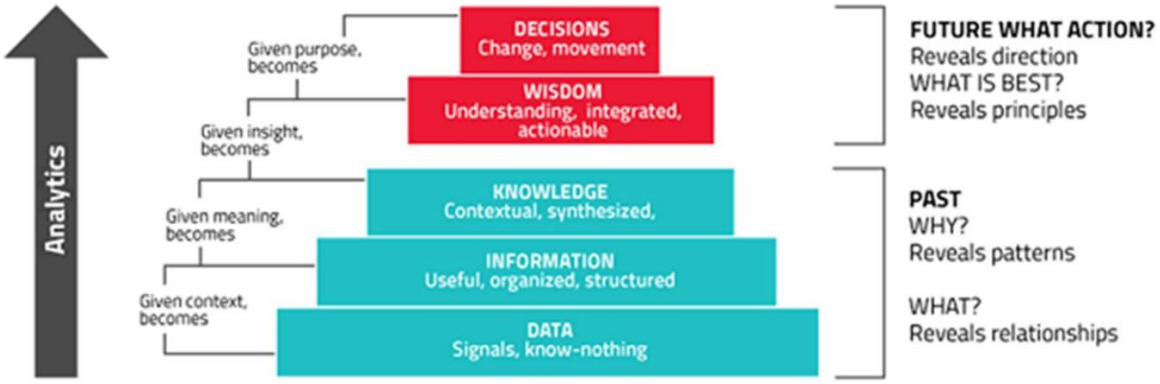
Definitions: Two useful definitions of knowledge are:

1. True belief or understanding of the relations which things and ideas bear to each other and to themselves (Originally from Greek philosophers)
2. Processed information (see below)

DIKW Framework: A key conceptual framework for related knowledge and learning is the Data Information Knowledge Wisdom (or DIKW) Framework, illustrated both as a graph and a pyramid, below. Each level is part of a hierarchy:

a. Data, which is physically structured and related to make
b. Information, which is cognitively structured and pattern recognition to make
c. Knowledge, which with belief structuring and principle definition makes
d. Wisdom, which can be used to prospectively make decisions about future courses of action.





Categories of Knowledge

Categories of Knowledge within an organization can be divided us as follows:

- Individual knowledge: within the brain of an individual, based on their experience, learning or analysis = ***tacit knowledge.*** This tacit knowledge may be possessed by an **expert within** an organization, or by a known **outside expert** who is consulted when needed.
- Individual knowledge: written down or recorded for reference by one person = ***explicit individual knowledge.*** Converting tacit knowledge to explicit knowledge is a central goal in the field of knowledge management.
- Group knowledge: written, recorded or programmed processed information for use by multiple individuals in an organization = ***explicit group knowledge.*** Explicit group knowledge may be derived from either internal sources or from systematic review of external sources. Explicit knowledge is storedin some sort of **knowledge base**, written down on paper or in an electronic format.

Essentials of Strategic Knowledge Management

The overall aim of Knowledge Management is to ensure that knowledge that is relevant to the business, fromany source internal or external, is available at the right place at the right time to enable the right person in thecompany to make the right decisions and implement them so they you achieve the organization's strategic business objectives.

There are three core goals of Knowledge Management

a. Easy and effective application of knowledge/reuse of knowledge. "Use the knowledge you have available."
b. Avoid reinventing knowledge (instead: build on prior knowledge). Don't "reinvent the wheel"
c. Create new knowledge. Apply what has been learned previously to try out new ideas/processes, and measure how well they work.

To robustly apply the principles of Knowledge Management to an organizations two levels of analysis and workmust be conducted:

1. Organizing knowledge and filling gaps (every few years, strategic work)
   a. Identify knowledge capabilities critical to business success (start with 3-5 processes)
   b. Identify a knowledge champion and community of experts for each process to ownknowledge repository of that process.
   c. Conduct knowledge inventory and infrastructure inventory to describe knowledge assetsand map knowledge, divided into internal, external, explicit and tacit. Research should include customer, data, business, market and regulatory framework
   d. Identify knowledge gaps and infrastructure gaps
   e. Define **strategic initiatives to bridge gaps**

2. Applying knowledge to spread or generate new knowledge (ongoing tactical activity)
   a. Storing, vetting, categorizing and transmitting knowledge
   b. Implementing initiatives using knowledge (AKA knowledge translation)
   c. Measuring business results (against benchmarks along with non KM based interventions)

Strategic Initiatives to Bridge Gaps

Broadly, there are three major **categories** of Strategic Knowledge Management Activities:

1. Organizing Explicit Knowledge
2. Organizing Tacit Knowledge
3. Application of existing Knowledge

Major activities in each category are described:

Organizing Explicit Knowledge:

1. Develop a process for gathering knowledge systematically from external sources
2. Develop a standard process for knowledge contribution
   a. Succinct high level summary
   b. Best practices funnel/vetting
3. Establish standardized processes for content management
4. Establish documentation standards for best practices/case studies/lessons learned when project fails

Organizing Tacit Knowledge:

1. Establish communities of practice with knowledge manager (AKA moderator)
2. Organize and define subject matter experts, with the best mechanism to consult them
   a. Pull: mechanism to look for expert in the topic at hand and reaching out to them for input.
   b. Push: experts reach out with information (newsletters, articles, emails etc.)
   c. Combination of Push-Pull: intermediary for contact with experts

Application of Existing Knowledge:

1. Systematic mine knowledge (pull)
a. Gathering information from high performers in a structured way.
b. Review current operational data daily: what needs to be done today? "Use the data we have"
2. Content dissemination (push) (Don't leave it to "chance or choice")
a. Knowledge sharing seminars
b. Publication/dissemination of best practices (newsletter, email)
3. Develop "closed loop processes" to ensure regular review of knowledge for possibility of spread.
4. Determine scope for process for spreading: small scale vs. company-wide
5. Ensure a process is developed for capturing result of knowledge replication/spread, including new knowledge.

Examples of strategic initiatives to bridge gaps that may be selected include:

a. Implementing supportive technology tools
b. Formation of communities of practice
c. Sharing best practices, case studies, lessons learned, both internal and external.
d. Define processes for knowledge sharing (contribution) and knowledge reuse (implementation)
e. HR activities to change culture
f. Corporate learning programs
g. Creating access to experts
ii. Hiring
iii. Consulting
iv. Trainers

Information Technology Resources for Knowledge Management

Features: Here are some features of knowledge management that need IT support:

1. Tools for collaboration and communication between team members
2. Mechanism for storing list of experts with areas of expertise
3. Potential support for other Knowledge Management processes
4. Support of leadership activities promoting Knowledge Management
5. Managing the programs selected to be the organization's **Knowledge Base**: Storing internal and external explicit knowledge contribution, with ability to search and find easily, as well as push certaincontent. This includes knowledge replication and business results.

Contents: Information to be organized within the Knowledge Base includes:

1. Best practices
2. Case Studies
3. Lessons learned
4. Standard documented processes
5. QI projects
6. Innovative ideas
7. FAQs
8. Internal benchmarking
9. e-learning modules
10. Other training material
11. External reports on markets, customers, competitors, regulatory environment, technology trends.

A review of Partnership IT tools that are currently used for some sort of Knowledge Management (and which could beleveraged to better manage additional knowledge) include:

1. Shared drives (baseline data, many other documents)
2. Outlook: email
3. SharePoint: Partnership4Me (document organization)
4. Public Website posting of knowledge for sharing with external partners
5. Microsoft office tools: Excel, Word, PowerPoint, Visio
6. Workfront: has review process and project management functions.
7. PowerDMS: review process for submitted documents. Note that PMO has selected this to be used for capturing end of project write-ups.
8. Prezi (entire 360-degree view)

Supportive Leadership Activities for Knowledge Management

Three key elements of a supportive leadership culture are

1. Sharing of ideas (Interpersonal relationships, professional trust)
2. Willingness to build on others' ideas
3. Giving credit for origination of knowledge

Some techniques that can included to achieve these are:

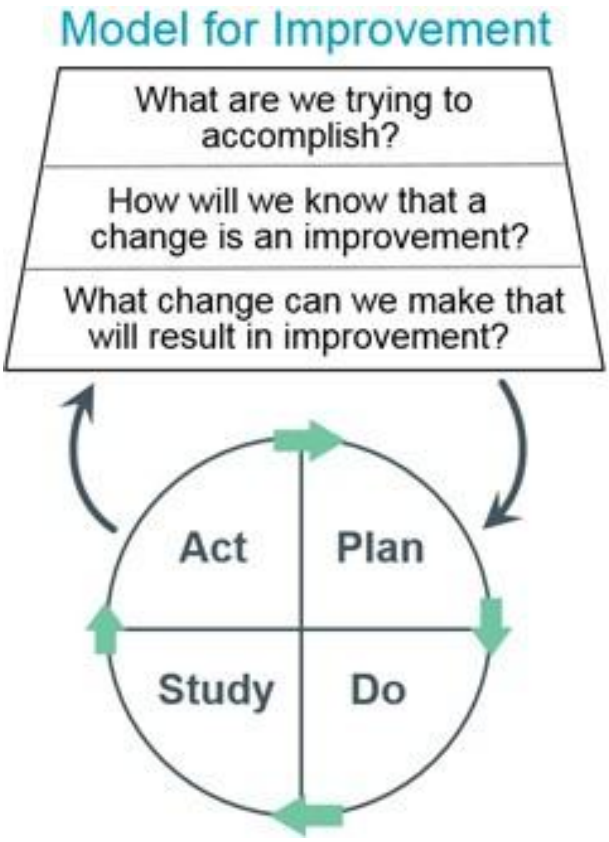
1. Link Knowledge Management to formal recognition (awards), incentives and/or performance evaluation system
2. Capturing measured results: process and outcome measures
3. Capturing and spreading narratives/survey results
4. Senior leadership attention to Knowledge Management and inclusion in strategic planning and organizational dashboards.
5. Designating resources to maintain/curate Knowledge Base over time to assure ease of access andlocation at the right place/time

Small Tests of Change

Framework Options

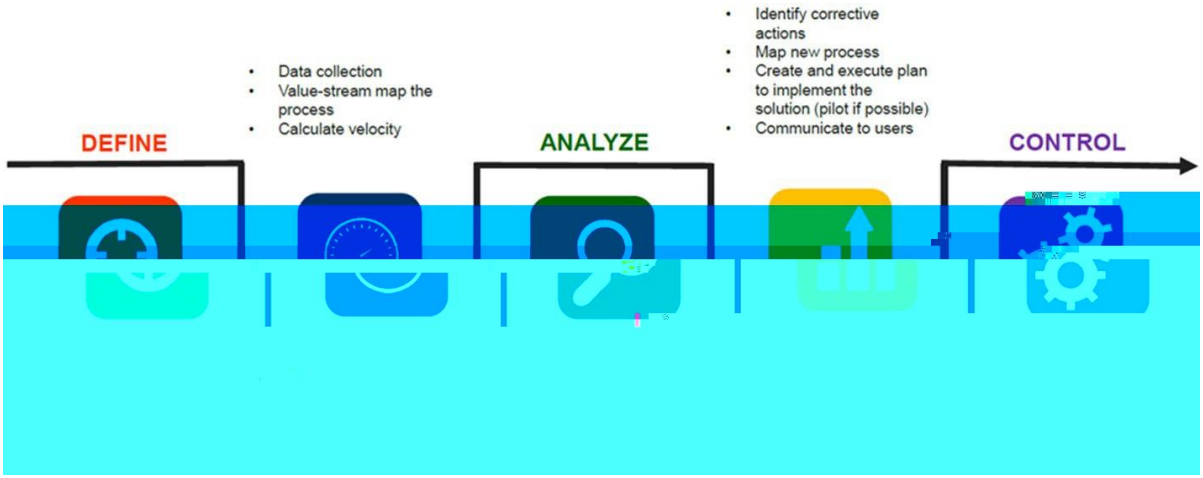
Broadly, when considering a small test of change, we start with a problem and a process.

The model for improvement (includes the PDSA cycle is a problem oriented small test of change: In the Partnership run training *ABCs of QI*, the focus is on the basic concepts of Quality Improvement using the Model for Improvement. The Model for Improvement represents a focus on quality improvement, as opposed to using DMAIC or Lean Six sigma for process optimization or Agile for IT implementations that include doing tests of change.

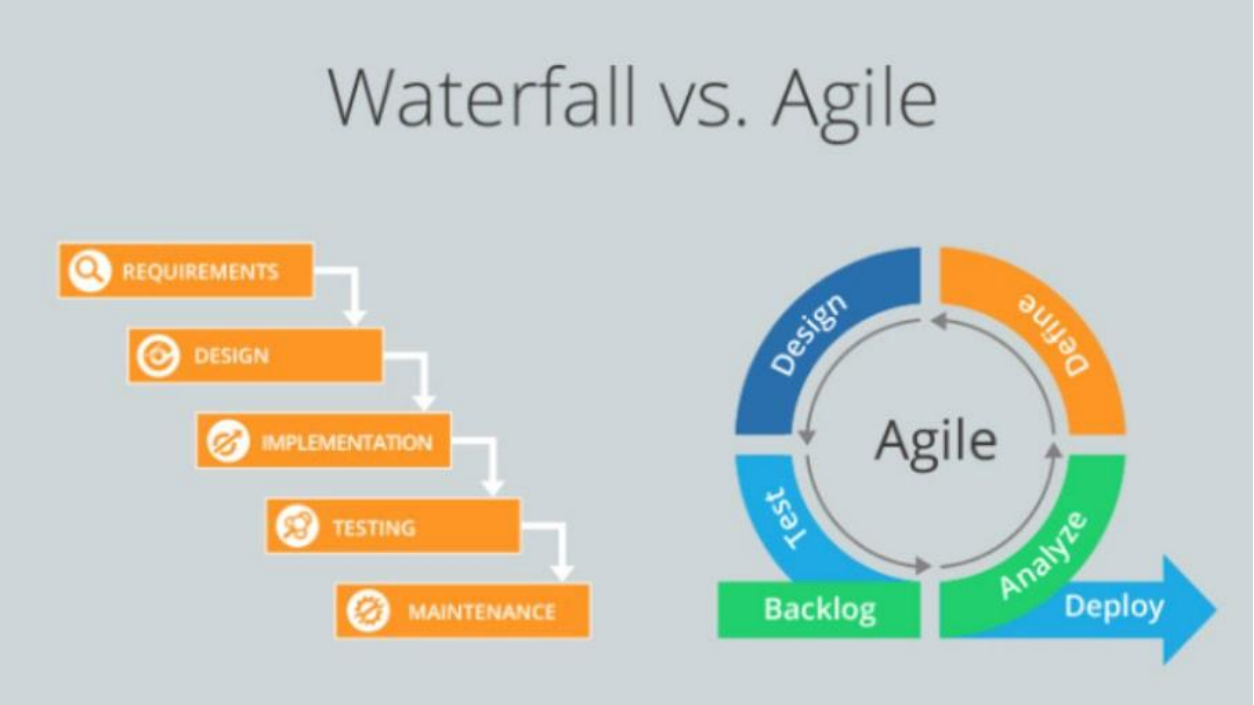


For reference only, we briefly describe DMAIC and Agile; they are not the focus of this document.

Define, Measure, Analyze, Improve, and Control (DMAIC) is a standard process, which often includesapplication of lean/six sigma principles, for process oriented change and optimization.



Agile is a method of implementation that combines pilots/tests with scaled implementation, and is contrasted with the Waterfall method of implementation:



Considerations when Planning a Pilot/Small Test of Change

What size test? Is a test of change big enough for outcome to have meaning? There are three factors to consider: *cost of failure, confidence in intervention, resistance to change* as shown in the following graphic:

Are We Ready to Implement?

Appropriate Scope for a PDSA Cycle

Current Situation		Staff/Clinicians Readiness to Make Change: Resistant	Indifferent	Ready
Low Confidence that change idea will lead to Improvement	Cost of failure large	Very Small Scale Test	Very Small Scale Test	Very Small Scale Test
	Cost of failure small	Very Small Scale Test	Very Small Scale Test	Small Scale Test
High Confidence that change idea will lead to Improvement	Cost of failure large	Very Small Scale Test	Small Scale Test	Large Scale Test
	Cost of failure small	Small Scale Test	Large Scale Test	Implement

The Improvement Guide, Second Edition, Jossey-Bass, April, 2009

API 4

Here are other key factors to consider when designing a pilot in a way that will inform future implementation/scale-up activities. (Al-Ubaydli, List, & Suskind, 2019):

1. Do the research/pilot results scale to larger markets and settings?
2. When we scale the intervention to broader and larger populations, should we expect the same level of efficacy that we observed in the small-scale setting?
3. If not, what are the important threats to scalability? (Al-Ubaydli, List, & Suskind, 2019)
   a. Statistically underpowered (sample size needed)
   b. Difference in population
   c. Negative economies of scale
   d. Program structure difficult to scale
   e. Dosage of intervention will be less with larger scale
   f. Incentives will be different with larger scale
   g. Inputs (staffing training for example) will be different between pilot and spread
   h. Scaling likely to cause substitution effect that wasn't present in pilot
4. What can the researcher do from the beginning of their scholarly pursuit to ensure eventualscalability?

Data and Statistical Analysis

Analytics Strategic Plan

Partnership is has begun the process of building on a Strategic Data Plan to develop a Strategic Analytics Plan. A Charter has been created and initial work has begun, but the need to convert current analytic reports to draw data from Health Edge, and to validate these mappings, has led to this strategic analytic process to be put on hold.

The charter outlines many excellent definitions, aims and purposes, and so is extracted here:

Project Purpose/Business Justification

Definitions of Data and Analytics

Raw Data: discrete pieces of information that flow into the organization

Processed Data: organized and consolidated raw data, the result of which is more easily manipulated through analysis to generate information.

Data Literacy: Competencies to promote the ability to read, understand, create and communicate data as information.

Data Information Knowledge Wisdom Pyramid: A hierarchy of class of models for representing functional relationships between data, information, knowledge and wisdom

Analytics: Systematic computational analysis of data or statistics, used for the discovery, interpretation and communication of meaningful patterns in data.

Project Purpose

To create a framework for an enterprise-wide analytics strategy to achieve the following value/advantage:

- To be more efficient in how we analyze data, eliminating redundancies, and optimizing teams
- To be confident in the processed data we use and share
- To prioritize and evaluate processed data/analytics project needs efficiently and ensure capacity
- To be prepared to respond to processed data/analytics requests in urgent situations
- To make processed data management and analytics processes more transparent
- To standardize quality assurance, presentation, and documentation of processed data products
- To streamline intake processed data and analytics requests
- To conduct data analysis and program evaluations using sound scientific methods
- To make processed data available for self-service review and analysis by different business units
- To develop innovative solutions for systematic data discovery of opportunities, gaps, or risks thatwould improve financial and/or health outcomes
- To operationalize advanced analytics (prediction models, machine learning, time series, statisticaltesting, data mining, etc.)

Aim Statement
In a 5-year period, to develop an enterprise-wide framework to maximize use of data to generate information, knowledge and wisdom to improve health outcomes, enhance the member experience of care,and reduce or maintain the cost of care by optimizing utilization of resources, including data, technology and staff. The focus of the effort include: • Define analytic needs for the business • Strengthen or develop policies and procedures for prioritization, management, access, and documentation of processed data products • Review existing data architecture and identify opportunities to optimize structure • Expand self-service analytics tools • Operationalize/integrate advanced analytics • Increase data literacy
Scope
Draft: **In scope:** any data project that involves data analysis or the creation of a report or a specialized dataset to be used for regulatory reporting, operations, or measuring performance, either for financial or health care purposes. **Not in scope:** projects involved in acquiring, processing, or warehousing raw data from main sources (DHCS, providers, other)
Deliverables
Outcome 1: Identify an analytics governance body Outcome 2: Decide on an analytics team structure and role definitions Outcome 3: Develop standards for data products Outcome 4: Develop a comprehensive strategic plan for the next 5 years

Structure of Analytics Strategic Planning

Data Governance Council • Final decision making body in the data governance structure • Sets overall direction on health analytics strategy and initiatives • Advises and empowers the Analytics Strategy Committee to implement an enterprise-wide analytics program
Analytics Strategy Committee • Prioritizes and communicates efforts between Data Governance Council, workgroups and stakeholders • Ensures the analytics strategy efforts align with the priorities from the Data Governance Council • Provides recommendations (including resource allocation recommendations) to the Data Governance Council • Sponsors, approves and manages plans that support analytics strategy efforts and projects • Forms work groups and defines their scope, based on area of expertise and responsibility

The Pathway to Excellence Workgroup identified a number of specific opportunities in the data and analytics realm that would be part of the Framework for Continuous Learning:

Partnership should consider documenting and standardizing:

1. Review of **commonly used variables** used in outcomes analysis: sources of bias/confounding; how variables are inter-related
2. Description of **data currently available** for retrospective analysis
3. Major **types of statistical analysis** that applies to health plan level work.
4. Selecting **appropriate test for statistical significance**.
5. **Presentation of data**: best practices/Partnership standards in presentation of data

Partnership should standardize and train staff on the process of taking a data need and formulate a data request withjustification. Four key purposes of reporting on data:

1. Looking for trends and outliers. Trends over time, by year, month. Standard stratification approaches include: Geography, Provider site (and parent organization if PCP), Race/Ethnicity, Aidcode, Homeless status, Presence of major mental health disorder. Results should be shared by number and percentage of total (rates); Ideally with Tableau dashboard.
2. Evaluating the impact of a specified intervention (may be part of rough evaluation or formal evaluation). Report using data from data warehouse or other sources, with citation of data sources clearly indicated.
3. Define a detailed list of either members or sub-population for a particular intervention (the requester should be able to define planned intervention, as this determines the fields of the output). Depending on nature of date needed, raw or aggregate data can be generated from pharmacy, claims configuration (Essette), Claims or Finance.
4. Define a list of providers for a particular intervention (the requester should be able to define planned intervention, as this determines the fields of the output).

What are the data and analytic areas do we need to build internal expertise?

1. Communicating analysis to our provider partners, in a way that is not too complex.
2. More advanced database skills, programming (python, R), google colab

For what areas should we seek outside help?

1. Biostatistics/epidemiology
2. Data scientist (study design)
3. Economics/social science to determine methodologies, creative randomization or alternatives
4. Advanced database and programming expertise

Standards for Evaluation

General approach to Evaluation. We should systematically plan evaluation and analytic approach ahead of time and then iteratively. Some questions to answer:

1. Is it possible to prove something?
2. How scientifically sound is the evaluation? What size of intervention is needed?
3. Since the evaluation plan impacts study design, how will the study change?

On a regular basis in reviewing scientific literature we need to seek out and save evaluation methods done by others researchers, for possible future use. This knowledge should be managed logically.

What are major areas of evaluation methods, which Partnership should consider document and standardize?

1. Options for **randomization**, with explanation of factors to consider in choosing one (include ABtesting as option)
2. Options for **control groups**, with explanation of factors to consider in choosing one
3. Description of **ethical framework**: when is consent needed; when an Institutional Review Boardreview is needed (is publication planned).
4. **Standard template for study design**, including: problem analysis, strategy to manage change, proposed interventions, target population, definition of outcomes and potential unintended consequences, baseline outcome rate, anticipated observations/week, unit of randomization, blinding,and implementation of the randomization strategy
5. **List of options for study design** (See Horwitz reference for options)
6. **Overall evaluation framework** options to consider, with explanation of factors to consider inchoosing one.

Optimizing Spread: Application of Implementation Science

Overview: (Dubner, 2020) gives a definition of Implementation Science: Definition of ImplementationScience:

> *It's the study of how programs get implemented into practice and how the quality of that implementation may affect how well that program works or doesn't work.*

Factors to consider, at least once, when making the decision to do a large scale implementation based on resultsof a successful pilot.

The Consolidated Framework on Implementation (Damschroder, et al., 2009) is a Social science construct that seeks to organize the theoretical frameworks and factors that influence the success of an implementation. For a *larger* implementation, it is probably worth spending some time going through the list to consider strategies for improving the success of this particular implementation. For smaller implementations, it is rarely very helpful.In addition, (Al-Ubaydli, List, & Suskind, 2019) notes these reasons for failure of pilots to spread successfully:

1. Spillover and administration quality impacts direct treatment effects.
2. The participant(s) being unrepresentative of the population in terms of direct treatment effect.
3. The statistical estimation error.
4. Economies/diseconomies of scale in participation costs.
5. The participant(s) being unrepresentative of the population in terms of participation cost. (really asubset of number 2)
6. Economies/diseconomies of scale in implementation costs. (4 and 6 go together).

The Science of Using Science: Towards an Understanding of the Threats to Scaling Experiments (Al-Ubaydli, List, & Suskind, 2019) is a more practical consideration of this topic. Some highlights:

1. Consider the myriad of factors that lead results of pilots to not be generalizable with spread, when designing the pilot or small test of change. Initial backward induction to understand, up-front, potential problems with scaling; think like a policy maker when doing the initial study. ("What could possibly go wrong") (See section on PDSA for a list of these)

2. Due to these characteristics of pilots, which make generalizability problematic, the following are recommended:
   a. More precise statistical summaries of the pilots to assess if they actually worked
   b. More frequent replication before attempting spread: If goal is demonstrating 95% confidencethat small scale pilots will scale, may need about 4 independent studies to show the same thingto overcome the possibility of these biases being present.

3. Once decision to spread has been made: the following are recommended to <u>increase chance of success/fidelity:</u>
   a. Detailing the core elements or "non-negotiables" of the intervention
   b. Ensure the facilitators/project managers/staff understand the "whys" or the mechanism behind the intervention effect.
   c. Look for technology to standardize processes and to check fidelity: Upload data of spread sites in a way that can do fidelity testing as data entered. (see Dubner, below)
   d. Original scientist or pilot person also should play an important role in actual role out of program
   e. Carefully measuring program efficacy when program is scaled: (generation of new knowledge.)

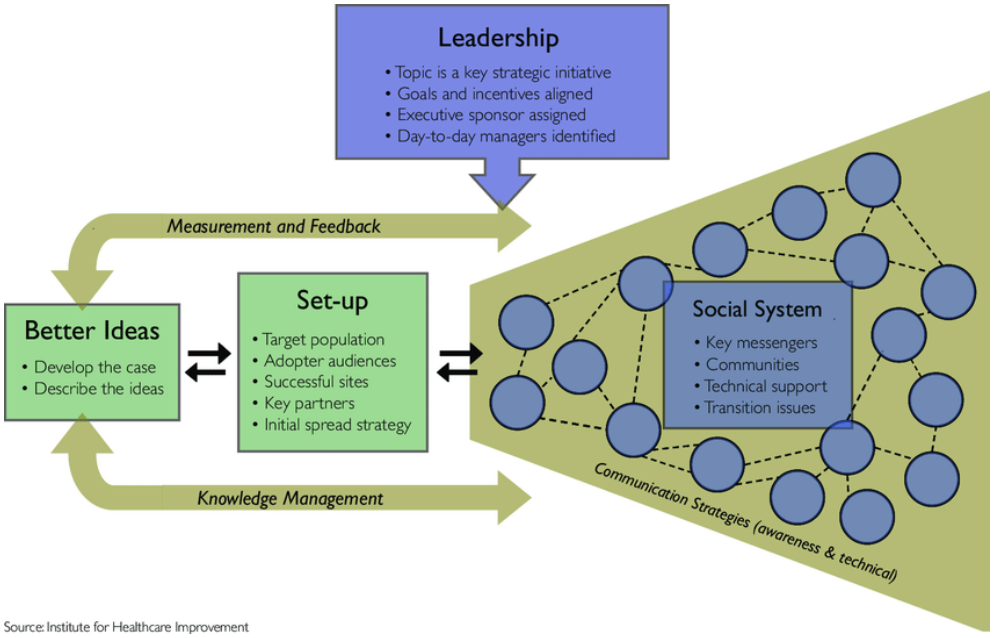
<u>Why spread fails</u>: (Dubner, 2020) summarizes the main five reasons spread/implementation fails:

1. Evidence not there to support scaling in first place
2. Wrong people were studied in the pilot compared to the larger population.
3. Wrong situation was used: voltage drop with change of situation: avoid by preserving "fidelity" oforiginal test. One solution: Upload data of spread sites in a way that can do fidelity testing as dataentered.
4. (Infrastructure/Delivery system of spread very different from system of academic testing.)
5. Need to look at both the supply and demand for the intervention

<u>Elements of successful transitions from projects to programs</u> (Savinsky & Stadelhofer, 2011?) describeselements of successful spread with important pitfalls to avoid.

1. Solidify leadership support
2. Understand current state
3. Define future state
4. Confirm and monitor operational metrics
5. Enlist expertise and appoint a transition leader
6. Engage affected personnel
7. Determine staffing
8. Develop team charters
9. Create and execute transition plans
10. Establish post-transition processes for documentation and evaluation

Framework for Spread (from the Improvement Guide):



Other factors to integrate (from workgroup discussion):

1. For implementations, standard should be a transparency of timeline and milestones
2. Ideally, there would be agreement of what constitutes thorough analysis of animplementation/spread.
3. To manage knowledge of optimal implementations, Partnership should capture examples of case studies towrite up to document best practices in spread, for example: birthday club, Palliative care, MPS, IOPCM
4. Future examples where framework will be helpful include implementation of ECM and Collective Medical Technology's Collective Plan.

Partnership approach to Scale-up and Implementation (Sustainability)

Current Status: Project Review Board (PRB) is the major mechanism for larger, multidepartment projects, for prioritization, estimation of resources and scope. Many, but not all major implementations go through PRB; the trend has been to ensure all do. Considerations: Project management approach, but not always done equally rigorously for every project. Implementations need to be integrated with department and organizational goals. As project becomes a program, there is a transition to Program Management approach to blending into other existing operations—this involves a different skill set than project management.

Organizational Factors

Organizational Factors:
Organizational Values, Culture, Structure, Processes that support approach, fit it in withoverall strategy

In addition to the organization factors listed under the Knowledge Management section, above, the workgroup collected other leadership and organizational activities that would we needed to support the success of the Pathway to Excellence framework.

1. **Nurture Values**: Current Status: Link to communication channels and other activities. Leadersmentoring and demonstrating them. Developing staff expertise. Supportive organizational and management culture. (See separate document)
2. **Systematically review the work we are currently doing,** categorizing by need for knowledge documentation, evaluation, nature of the work, budget, relationship to regulation/quality
3. **Promulgate a Partnership approach** to systematically consider each tactic.

Another view of overall organization framework to support continuous learning activities is from (Bellin Health Case Study, 2015):

1. Cascading structure of Planning, with the 120-day planning cycle forming the core timeline.
   a. 100 days of work, 20 days of evaluating results from last cycle, planning and prioritizing activities/plans for the next cycle. Steps:
      ii. Diagnostic Journey
      iii. Prioritization and Focus
      iv. Organizing the Work
      v. Work Period
      vi. Recalibration
   b. Major systems feeding into this process:
      i. Information gathering: marketing, customer service, strategic analysis, strategicplanning
      ii. System of production/optimization
      iii. System of measurement
      iv. System of improvement
      v. Managed Spread of successful improvements
      vi. System of evaluation
      vii. Building expertise/capturing knowledge (Improvement IQ)
      viii. Strategy room documenting all aspects of this system

Plan for Nurturing Organizational Culture

The workgroup crafted a plan to support supporting the organizational culture towards the principles of the Pathway to Excellence. It is presented here:

What to Share more widely and regularly to promote culture: Key Concepts (see draft PowerPoint)

- Overarching statements of values
- 5 key steps (skip the leadership step for presenting to organization)
- Brief Description of each step

- Key sayings/slogans to represent key ideas in each step: what to do and what not do to
- Use stories to illustrate

Sharing Knowledge about P2E:

- Presentations (Internal and potentially external)
  - Topics:
    - Overview of elements of P2E
    - Knowledge Management
    - Data Analysis/Statistics/Evaluation
    - Small tests of change/scaling up
  - Presentation to leadership teams; record for future.
- Showcased examples
  - Internal: capture, publish, publicize
  - External: lessons learned, capture information
- Smaller Key Message
  - Derived from Larger Presentation
- Slogans
  - Start with those already identified
  - Potential graphics associated with some?

Marketing Paths: Needs timeline and work plan

- Milestones
  - New name selected
  - Plan completed
  - Playbook draft/update
  - Presentations given/saved
  - Awards (Internal and external)
  - External presentations
- Internal communications paths; especially good for smaller key message and slogan
  - Emails
  - Partnership4me
  - Office Hours/VEB
  - Campaign
  - IQI, EQMSI, Ops, Exec
- Durable materials that use name of initiative
  - Trivets
  - Graphics
- Calendar to drip out the slogans etc.
- External communication paths, once core presentation refined
  - PAC
  - Board
  - Board Quality Committee
  - Strategic Planning
  - Clinic Consortia
  - CIN
  - CHCF Leadership
  - CAHP

- LHPC Medical Directors
- State quality convening 2022
- Poster presentation at IHI

Building Leadership Understanding and Commitment

- Incorporate into HS leadership meeting
- After leaders learn about aspects of the LHP, have them give talks to staff

Building Front Line Staff Understanding and Commitment

- LMS training
- Sample Interview questions for staff interviews that demonstrate LHP and ask about traits that would support it
- QI department training (NR and SR)
- Involving staff with aspects of Pathway to Excellence activities that are interesting and outside theirusual work
- Other department trainings/engagement: PMO, pharmacy, medical directors
- Awards for demonstrating aspects of P2E: examples
  - Best graphical presentation of data
  - Evaluation of the year
  - Best case study write-up
  - PDSA of the year
  - Spread process of the year (most likely to be sustained)
  - Project manager of the year
  - Analyst of the year
  - Best meeting facilitator of the year

Plan for Maturing the Framework

Overall Plan

Components of this Framework for Continuous Learning will be divided up and additional detailed documentation based on the recommendation in this document will be generated each year for the next severalyears.
In particular, the work of the Health Analytics Strategy Workgroup will resume in 2022, and may move beyondthe initial focus on analytics to tackle some of the data standardization and evaluation template needs describedabove.

Year 2 Activities

The current plan for activities in year 2 of the Pathway to Excellence are:

1. To spread key concepts in this framework to leadership within the Health Services leadershipteam.
2. To focus on the Knowledge Management section to develop a Strategic Knowledge Management plan and associated action plan, by June 30, 2022. A special area of focus withinthis work will be on regularly reviewing and using data we already have access to.

These will be incorporated into the Quality Measure Score Improvement team goal.

Bibliography

Al-Ubaydli, O., List, J. A., & Suskind, D. (2019). The Science of Using Science: Towards an Understanding ofthe Threats to Scaling Experiments. *National Bureau of Economic Research, Inc. Working Papers.* National Bureau of Economic Research. Retrieved from https://ideas.repec.org/p/feb/artefa/00670.htmlBellin

Health Case Study. (2015).

Berwick, D. M. (1996, March 9). A primer on leading the improvement of systems. *BMJ, 312*, 619-622.

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009, August 7). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science, 4*(50). Retrieved from https://doi.org/10.1186/1748-5908-4-50

Dubner, S. (2020, February 12). Policymaking Is Not a Science (Yet). *Episode 405*. Retrieved from https://freakonomics.com/podcast/scalability/

Etheredge, L. M. (2007, January 26). A Rapid-Learning Health System. *Health Affairs*, w107-w118. Finkelstein, A.

(2020, April 16). A Strategy for Improving U.S. Health Care Delivery -- Conducting More Randomized, Controlled Trials. *New England Journal of Medicine, 382*(16), 1485-1488.

Firestone, J. M., & McElroy, M. W. (2003, November). *Corporate Epistemology: Competing Philosophies of Truth in Business and How They Influence Knowledge Management.* Retrieved from MKCI.org: https://www.kmci.org/media/Corporate_Epistemology.pdf

Hariharan, A. (2015). The Strategic Knowledge Management Handbook.

Horwitz, L. I., Kuznetsova, M., & Jones, S. A. (2019, September 19). Creating a Learning Health System through Rapid-Cycle, Randomized Testing. *New England Journal of Medicine, 381*(12), 1175-1179.

Institute of Medicine. (2007). The Learning Healthcare System: Workshop Summary. Washington D.C.: The National Academies Press.

Keith, R. E., Crosson, J. C., O'Malley, A. S., Cromp, D., & Taylor, E. F. (2017). *Using the Consolidated Framework for Implementation Research (CFIR) to produce actionable findings: a rapid-cycle evaluation approach to improving implementation.* Retrieved from Implementation Science Open Access 12:15: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5303301/

OpEx/PMO. (2020). DMAIC Process.

Platt, J. E., Wienroth, M., & Raj, M. (2020). An Analysis of the Learning Health System in Its First Decade in Practice: Scoping Review. *Journal of Medical Internet Research*, e17026.

Savinsky, C., & Stadelhofer, A. (2011?). Best practices for a smooth project-to-operations transition.

Simon, G. E., Platt, R., & Hernandez, A. F. (2020, April 16). Evidence from Pragmatic Trials during Routine Care -- Slouching toward a Learning Health System. *New England Journal of Medicine, 382*(16), 1488-1491.

Smoyer, W. E., Embi, P. J., & Moffatt-Bruce, S. (2016, December 20). Creating Local Learning Health Systems. *JAMA, 316*(23), 2481-2482.

Venkataramani, A. S., Underhill, K., & Volpp, K. G. (2020, January 7). Moving Toward Evidence-Based Policy: The Value of Randomization for Program and Policy Implementation. *JAMA, 323*(1), 21-22.

Weaver, P. (2010). Understanding programs and projects--oh, there's a difference! *PMI Global Congress 2010--Asia Pacific.* Melbourne, Victoria, Australia: Newtown Square, PA: Project Management Institute.

Annotated Bibliography Available on Request

Appendix D:

Resumes for Key Leadership Roles Accountable for Implementing and Maintaining the QI/PI Program

The order of resumes corresponds to the sequence of key roles outlined in the Authority and Responsibility section of this document.

Chief Executive Officer

Sonja Bjork, JD

[redacted]

Medi-Cal Health Plan Senior Executive

Experienced and mission-driven Medi-Cal managed care Chief Executive Officer with excellent leadership, analytical and strategic planning skills. Engaging communicator and relationship builder with experience in geographic expansion to new service areas. Demonstrated record of success in complex provider contract negotiations. Supportive and hands-on leadership style with ability to motivate teams in achieving organizational excellence, including implementation of new benefits and initiatives that improve services for providers and members.

Areas of Expertise

- Strategic Planning & Execution
- Team Leadership & Development
- Organizational Design & Restructuring
- Budgeting & Fiscal Management
- Contracting & Negotiations
- Medi-Cal Policy Analysis & Implementation
- Employee Engagement
- Community Emergency Response

Select Career Highlights

- Selected as a commissioner on the national Medicaid and CHIP Payment and Access Commission (MACPAC), a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Service and states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP).
- Led expansion of health plan service area to multiple northern California counties. This included organizing network readiness requirements, memoranda of understanding with various agencies and providing expertise on required county board of supervisor enabling ordinances. Established additional regional offices and staffing models to ensure local presence and excellent customer service.
- Led operational departments in obtaining NCQA (National Committee for Quality Assurance) accreditation that required extensive policy and procedure development, reorganization of workflows and support of internal mock audits.
- Successfully implemented numerous Medi-Cal benefits and programs such as CalAIM enhanced case management and community supports, community-based adult services, autism and behavioral health services, including network development through community and provider outreach; oversaw internal operational readiness efforts such as claims configuration, member communication and provider education efforts.

Career Experience

Partnership HealthPlan of California
Chief Executive Officer
2023-Present

- Lead service area expansions, most recently adding ten counties to the health plan, resulting in a 38% increase in membership
- Ensures appropriate staffing levels to meet operational requirements, including a recent increase of almost 30%, while maintaining company culture and achieving a 92% overall employee satisfaction rate
- Guides strategic planning with stakeholders, including the Board of Commissioners, consumers and employees
- Oversees development of $5.9 billion annual budget
- Develops and maintains strong community partnerships in support of the health plan mission
- Identifies opportunities for new approaches to benefit administration
- Supports evaluation and adoption of new technologies to improve efficiency and service
- Lead focused initiatives to address health disparities identified through data analytics and support efforts to attain NCQA Health Equity Accreditation

Partnership HealthPlan of California
Deputy CEO/Chief Operating Officer
2022-2023
Chief Operating Officer
2015-2022

Executive management of multiple operational departments including claims, member services, grievance & appeals, health services (health equity, utilization management, care coordination and population health), provider relations, project management office, configuration department and multiple regional offices within a Medi-Cal managed care health plan.

- Oversight of multiple regional offices to assess and support local needs, community involvement and responsive service
- Led operational departments in establishing and maintaining performance standards to ensure DHCS contract compliance and excellent service to all stakeholders
- Worked with department heads to develop and implement annual administrative budget proposals
- Developed, sponsored and evaluated organizational and departmental goals in support of PHC's mission and vision
- Supported achievement & maintenance of NCQA Accreditation
- Developed and promoted health equity initiatives
- Supported & engaged with Plan's very active Consumer and Physician Advisory Committees
- Led provider recruitment and workforce development program, with focus on rural California
- Managed major benefit implementations within operational departments
- Served as liaison to consortia of Federally Qualified Health Centers, Tribal & Rural Health Centers
- Led health plan's Community Emergency Response Team, whose actions work to eliminate or reduce disruptions to accessibility of health care services to members in community-wide emergencies such as wildfires, flooding, planned public safety power shut-offs and the ongoing COVID-19 pandemic

Partnership HealthPlan of California
Deputy Chief Operating Officer
2014-2015

- Led implementation of new benefits, including coverage of mild to moderate mental health services
- Operationalized the transition of autism services from regional centers to PHC
- Led development of organization's multi-year strategic plan
- Led transition of low income health program (LIHP) into coverage through PHC Medi-Cal managed care
- Coordinated with stakeholders to support establishment of PACE in rural northern California
- Served as liaison to multiple community organizations in strategic grant award program

Partnership HealthPlan of California
Director of Policy & Program Development
Manager of Business Development
2011-2014

- Coordinated and evaluated multiple Requests for Proposals/Requests for Information for outsourcing opportunities
- Managed and implemented Medi-Cal Coverage Expansions for the health plan under the Affordable Care Act which included:

    1) Transition of indigent adults to Medi-Cal (Low Income Health Plan)
    2) Newly eligible to Medi-Cal under the Affordable Care Act
    3) Healthy Families – transition of children from subscriber-based coverage into Medi-Cal

- Led expansion of PHC to eight new rural northern California counties – PHC planning & developing team, educational activities and outreach in the northern region
- Managed the Intergovernmental Transfers (IGTs) process with multiple counties and district hospitals to bring matching federal Medicaid funds to our local communities
- Implemented Community Based Adult Services (CBAS) into Medi-Cal Managed Care

Stahnke & Associates Legal Services for Children
Attorney 2000-2010

As a Certified Child Welfare Specialist, provided high quality legal representation to children in abuse and neglect cases.

- Conducted trials involving complex legal and medical issues
- Performed legal research and analysis in preparing motions, trial briefs and writs of appeal
- Served on steering committee to develop and implement the Dependency Drug Court program which has improved access to substance abuse treatment and services for parents of dependent children
- Provided training to staff members, foster youth, foster parents and agency representatives on local implementation of state legislation affecting dependent children
- Served on advisory committees for various county initiatives including: Team Decision Making; Heart Gallery; Permanent Connections for Foster Youth

Solano Partnership HealthPlan (now Partnership HealthPlan of California)
Grievance Coordinator
1994-2000

Coordinated health plan response to member issues and complaints in order to address member concerns in a fair and timely manner:

- Worked closely with Member Services Director to develop and implement policies and procedures
- Prepared issue briefs and represented health plan at administrative hearings
- Established and facilitated the Consumer Advisory Committee whereby health plan members could provide input and feedback on various aspects of health plan operations
- Analyzed NCQA standards and requirements and ensured member grievance system compliance during mock audits
- Liaison with local legal aid advocacy groups to ensure smooth transition from traditional Medicaid program to managed care environment
- Represented the health plan on the Solano Community Services Task Force
- Served on the State Steering Committee of the California Connections Project

Solano County Legal Assistance
Staff Attorney 1993-1994

Legal services agency serving low-income residents of Solano County in the areas of housing, health care and government benefits. Received foundation grant funding to provide legal representation and advocacy to ensure low-income children's access to health care in Solano County.

- Represented low-income clients at administrative hearings on Medi-Cal and other public benefits issues
- Served on the steering committee of the Community Services Task Force on Managed Care to address health care access issues under the county's new Medi-Cal Managed Care Plan
- Created and coordinated distribution of Medi-Cal outreach material to pregnant teens in order to improve access and utilization of prenatal care services
- Supervised legal interns in providing advocacy to clients in the areas of domestic violence, housing and public benefits
- Served on the National Youth Law Center Statewide Youth/health Advocates Committee

Educational Background

Juris Doctorate
UC Berkeley School of Law, University of California, Berkeley

Bachelor of Arts, Sociology – Concentration in Analysis & Research (CARR)
University of Wisconsin, Madison

Professional & Personal Accomplishments

Commissioner – Medicaid and CHIP Payment and Access Commission (MACPAC) – Appointment Term; 2022-2025

Local Health Plans of California – Member and past chair of COO Committee (2015-present)

Volunteer, Soccer Without Borders – Oakland program for newcomer immigrant and refugee youth (2013-Present)

Statewide CAHP & County Behavioral Health Workgroup (2014)

Child Abuse Prevention Council Practitioner of the Year (2007)

National Association of Child Counsel- Child Welfare Law Specialist (certified in 2006)

Board Member & Board Chairperson, Solano Diversified Services (2006-2010)

Court Appointed Special Advocates (CASA) (2005-2010) Board Member

Solano County Women Lawyers (2000-2010)

Chief Operations Officer

Wendi Davis

Qualifications Summary

- *Dynamic healthcare leader offering 25+ years' comprehensive achievements with non-profit, rural, and integrated healthcare delivery and payer systems.*
- *Expertise in institutional, professional, LTC, Rehab, and Behavioral Health payment regulations and requirements, as well as Medi-Cal Managed Care and EDI technology.*
- *Proven ability to manage various specialties such as Admissions, Health Information Management, Care Coordination & Utilization Review, Physician Credentialing, Claim Adjudication, and Contract Negotiating.*
- *Exceptional strategic planning skills and a history of generating multimillion dollar improvements for multiple Northern California healthcare delivery systems while overseeing operations.*
- *Recognized for ability to incorporate innovative management techniques that result in exceptional employee engagement and retention rates, as well as cultivating strong collaborative relationships with government agencies, public officials and community groups.*

Professional Experience

Partnership Health Plan of California, Redding, CA Nov 2013-Present

Chief Operations Officer June 12, 2023 to present

Responsible for the oversight of operations and executive management of the Claims, Member Services, Configuration, Grievance and Appeals, Transportation, and the Regional Leadership Team. This position provides leadership in organizing the HealthPlan's operations, interdepartmental communication, and participates in goal setting and strategic organizational planning in the development of new business lines and programs.

- Oversight of the HealthPlan's operational departments and regional offices as described above to insure efficient and high quality administration of Medi-Cal Managed Care for 24 counties.
- Works with department directors to establish department goals, improve operational effectiveness, implement work plans and making corrective actions as needed.
- Oversee the provider network and contractual agreements including reimbursement and services.
- Monitors departments' performance and production through comprehensive reporting and progress against goals.
- Provides leadership in interdepartmental projects involving department operations to ensure quality outcomes. Participates in new business planning and program development.
- Participates with counterparts at local health plans throughout California.

Northern Region Executive Director July, 2017 to June, 2023

Oversee the operations of the Partnership HealthPlan of California's Northern Region. Represent the HealthPlan with community agencies, providers and elected officials. Manage staff in Redding and Eureka offices. Work with Plan leadership to assure awareness of the Region's needs and issues; work with Regional staff and communities to promote the interests and values of Partnership HealthPlan within the Region. The Northern Region employees over 175 staff, and provides support and services for the seven northern counties which account for approximately 175,000 members. Establish long range, strategic direction of the Northern Region and ensures departmental goals and objectives support that direction. Establish performance indicators, operating goals, process improvement initiatives, productivity improvements, and cost reduction programs that consistently improved production and quality, as well as provider and member satisfaction. Participate in community healthcare collaborative committees, and improvement projects.

Selected Achievements:

- *Successfully built and established a full service claims processing team and call center.*
- *Developed and implemented a Provider Scorecard program, providing quarterly claims, denial and payment data to providers resulting in a 21% decrease in denials.*
- *99.6% of all claims are processed within 30 days, and maintaining a 98.6% accuracy rate.*

Claims Director *Nov, 2013 to July, 2017*

Directed overall operations for Claims and Customer Service departments in the Northern Region. Established performance indicators, operating goals, process improvement initiatives, productivity improvements, and cost reduction programs that consistently improved production and quality, as well as provider and member satisfaction. Participates in community healthcare collaborative committees, and improvement projects.

Selected Achievements:

- *Successfully built and established a full service claims processing team and call center.*
- *Implemented a paperless work flow system, instituted real time inventory monitoring.*
- *Developed and implemented a Provider Scorecard program, providing quarterly claims, denial and payment data to providers resulting in a 21% decrease in denials.*
- *99.6% of all claims are processed within 30 days, and maintaining a 98.6% accuracy rate.*

Adventist Health System, Santa Rosa, CA Oct 2012-Nov 2013

Regional Executive Director, Revenue Cycle

Responsibility for the Revenue Cycle and workflows region-wide, including Scheduling, Pre-Registration, Insurance Verification, Financial Counseling, Health Information Management, Case Management, Billing and Collections and Customer Service for 4 acute hospitals(including 1 Critical Access facility), 58 Clinics, and 1 Behavioral Health Facility. This includes the centralized pre-registration center as well as the patient access functions at all facilities in the Northern Cal Network, as well as the Centralized Billing Office.

Selected Achievements

- *Increased clean claim rate from 56% to 92%, and decreased denials by 40%.*
- *Consolidated 4 Local Business Offices into one Central Office, while increasing the percent of accounts financially cleared from less than 50% to nearly 90% at all four sites.*
- *50+ Patient Access professionals obtained their CRCR certification through HFMA.*

Kaiser Permanente, Oakland, CA Aug 2007-Oct 2012

Nor Cal Exec Regional Director, Revenue Cycle (June 2010-Oct 2012)

Accountable for the accurate and compliant generation of over 2 million external claims annually, which equated to $2 Billion+ dollars a year for the Nor Cal Revenue Cycle. Outpatient and Physician visits exceeded 25 million encounters and inpatient stay days totaled 900,000 in 2011. Oversight and accountable for the management and ongoing remediation of Epic Resolute Systems, as well as ePremis Billing Systems. Partnered with KP Technology teams for various upgrades and enhancements.

The scope of responsibility included both professional and health system billing, as well as integration with Admissions/Registration, Physician Groups, Health Information Management, Professional Coding, Revenue Integrity, Case Management and Charge Capture. Claims were generated for 21 Acute Hospitals, 175+ clinics, Home Care and Hospice Services as well as professional claims for over 6300 physicians, representing all specialties.

Selected Achievements

- *Consolidated 21 Local Business Offices into one Central Office, and initiated Epic WQ's for all professional billing edits, while* simultaneously decreasing AR backlog by 45 Days.
- *Increased claim accuracy to 92% from a previous level of 47%.*
- *Collaborated with Union and labor leaders to establish productivity and accuracy standards for all staff*
- *Introduced process improvements in Case Management and Patient Financial Assistance to decrease Medi-Cal TAR denials by 83%.*

National Associate Vice President, Revenue Cycle Back End Processes (October 2007-June 2010)

Oversee the processes and procedures for billing and follow-up for Kaiser's 8 national regions. Develop the architecture and functional requirements for the national standard operating model for the back end functions of the revenue cycle, while assisting the local regions with regional projects and initiatives.

Selected Achievements

- *Led the design of the operating model for the BCR project (Billing/Collections HIM and Case Management Re-engineering), and successfully implemented the program in 6 regions.*
- *Co-Sponsored the development and implementation of NEVI-National Eligibility Verification Initiative (Integrated Insurance Verification) which resulted in a 31% decrease in claim rejections.*
- *Assisted in the coordinating and disbursement of $19 million in grant dollars given to aid in the support and expansion of 35+* federally qualified health centers (FQHCs) and 11 free clinics. This work increased and improved access to care for over 75,000 vulnerable and underserved individuals.

Catholic Healthcare West, North State Service Area, Redding, *CA* June 2003 - Aug 2007

Regional Exec Director of Revenue Cycle and Admissions

Manage and direct the Central Business Office and Admissions, for Catholic Healthcare West's North State Region. The Region includes three acute care facilities, 8 clinics, 3 rural health clinics, ground and air life support service, Home Care and Hospice and a SNF.

Selected Achievements

- *Gross AR days from 74 to 58, while decreasing bad debt from 3.2% to 1.5%, and increasing net revenue.*
- *Integrated insurance verification, and an ABN system, to enhance and expand the Pre-Registration System, while initiating an upfront cash collection process and collecting over 1.5 million in 2005.*
- *Increased patient and employee satisfaction scores to 5 star levels.*
- *Awarded the No. 1 CBO in CHW for percent over goal for cash collections in 2004 and 2005.*

Education

Masters of HealthCare Administration: *St. Joseph's College of Maine*
Bachelors of Science: *California State University, Chico 1992*
CHAM Certified-*Certified HealthCare Admissions Manager 2002*
QHC/RHC (Clinical Documentation, Billing and Coding Training) Certification *CPCA 2011*

Professional Associations/Awards

Healthcare Financial Management Association: *Affiliate,1997-Present*
CAHAM ~ Carl Satterfield Statewide Award of Professional Excellence: *1999*
California Association of HealthCare Admissions Management: Served as President, *2003-2012*

Chief Health Services Officer

KATHERINE BARRESI, RN, BSN, PHN, NE-BC, CCM

Chief Health Services Officer

[redacted] • [redacted] • [redacted]

Healthcare Leadership Executive

Dynamic, results-driven healthcare leader with over a decade of executive experience in driving operational excellence and strategic growth within diverse healthcare settings, including managed care, case management, population health, and utilization management. Expert in policy development, cross-functional collaboration, and program transformation with a proven record of success at Partnership HealthPlan of California, impacting the lives of over 900,000 Northern California residents through sustainable health initiatives.

Qualifications

Executive Management: Oversight of multiple departments with 500+ budgeted employees across 6 regional offices, specializing in operational efficiency and interdepartmental alignment.

Regulatory & Compliance Expertise: In-depth knowledge of government sponsored health programs and standards, accreditation requirements, and healthcare policy for managed care.

Population Health & Case Management: Proven track record in directing programs across acute, outpatient, and community settings to enhance patient outcomes.

Data Analytics: Skilled in utilizing analytics for cost optimization and operational insights, supporting quality patient care and fiscal accountability.

Health Equity & Policy Development: Deep expertise in implementing initiatives addressing health disparities and inequities, social determinants of health and collaborating with non-traditional community-based groups.

Leadership & Mentorship: Adept at team building, talent development, and fostering a collaborative culture across diverse teams and stakeholders.

Experience

Partnership Health Plan of California — Fairfield, CA

Chief Health Services Officer — 10/2023 - Present

- Proudly served as a member of the Executive Team for Medicaid managed care plan that provided services and care to over 24 counties in Northern California.
- Responsible for the operational management and leadership for the following Health Services departments: Utilization Management (UM), Care Coordination (CC), Population Health Management (PHM), Health Equity, Behavioral Health, and CalAIM initiatives.
- Provided strategic leadership in organizing the health plan's operations, interdepartmental communication, and organizational goal planning and strategic direction.
- Served as a statewide expert on CalAIM and other various assorted initiatives related to government health care programs to promote solutions for health policy, population management, and clinical quality outcomes.

Partnership Health Plan of California — Fairfield, CA

Senior Director Health Services — 01/2023 - 10/2023

- Clinical and strategic leadership to assigned departments including planning, execution, growth and compliance of various benefits and services
- Dyad to Chief Medical Officer and associated Medical Directors at the Health Plan
- Responsible for providing direction to leaders in areas of health plan compliance and regulatory guidelines related to operations
- Created operational analytics to increase efficiencies, revenue optimization, and cost containment maintaining patient-centric quality expectations
- Change agent for transformation of services and benefits under CalAIM including Enhanced Care Management, Community Supports, Population Health Management, Health Equity, Housing and Homelessness Incentive Program and various other associated initiatives

Experience

Partnership Health Plan of California
Fairfield, CA

Director Care Coordination
02/2020 - 01/2023

- Responsible for the performance, quality and oversight of the various case management programs and services including Complex Case Management, Transitions of Care, California Children's Services Whole Child Model and other associated interventions
- Owned complex business and clinical proposals with executive communication and lead enterprise wide execution; requiring interdepartmental and external resources and teams
- Fostered a culture of collaboration and quality with external community partners and stakeholder to address shared goals and community needs

Partnership Health Plan of California
Fairfield, CA

Associate Director Care Coordination
06/2013 - 02/2020

- Responsible for day-to-day oversight for the operations and implementation of various case management programs and services in the Care Coordination Dept
- Worked collaboratively with others across the organization aligned the appropriate resources to maximize efficiencies and achieve goals
- Proactively identified potential gaps and enacted solutions to decrease organizational and operational risk
- Supported and monitored efforts to enhance staff support and training

Education

Sonoma State University
Sonoma CA

Bachelors of science nursing
01/2012 - 01/2013

- G.p.a. 3.66
- Juliana Johnson Memorial Scholarship Recipient
- Alliance Health Care Scholarship Recipient

Napa Valley College
Napa, CA

Associates degree in nursing
01/2010 - 01/2012

- Degree with honrs
- Nursing Class President
- 160 Nursing Preceptorship hours in Labor and Delivery
- Napa Valley College Foundation Scholarship Recipient
- Bra n Track Nursing Scholarship Recipient
- Elise M. Tarner Memorial Scholarship Recipient
- Geri Glover Scholarship Recipient
- Grant's Fund Scholarship Recipient

Active Licensures & Certifications

Registered Nurse (RN): License #825562 - California Board of Registered Nursing

Public Health Nurse (PHN): License #86817 - California Board of Nursing

Certified Case Manager (CCM): Certification #4215211 - Commission for Case Management

Certification Nurse Executive – Board Certified (NE-BC): Certification #2022003530 - American Nurses Association

Key Competencies

Managed Care Operations · Case Management · Public Speaking · Nursing · Program Development · Population Health Management · HEDIS · Leadership · Policy Analysis · Health Equity · Quality · Change Management · Public Health Nursing · Government Sponsored Health Programs · Regulatory Compliance · Finance · Employee Relations · Vendor Management · Utilization Management · Community Engagement · Team Development · NCQA · Data Technologies · Health Analytics

Volunteering

Registered Nurse (RN)

Napa County Medical Reserve Corps 2020 - Present

Registrant in the county's Disaster Healthcare Volunteers Program (DHV) to provide healthcare needs or supports, on a volunteer basis, during disasters and other emergencies.

Robert Moore, MD, MPH, MBA, FAAFP

Work Address
Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534

Education

2014-17	Western Governors University Master's Degree in Business Administration (MBA) Healthcare Management, February, 2017
1986-92	University of California San Francisco School of Medicine: Doctor of Medicine (MD), May, 1992
1989-90	Columbia University, New York City School of Public Health, Division of Tropical Medicine Master's Degree in Public Health (MPH), February, 1991
1982-86	University of California Berkeley Bachelor of Arts in Biochemistry, May, 1986

Internship and Residency

1992-95	Family Medicine Residency Program Ventura County Medical Center

Post-graduate training

2007-2009	UCSF Center for Health Professionals: California Health Care Foundation Health Care leadership Fellowship, Cohort VII
2003-2008	Harvard School of Public Health, Boston Managing Ambulatory Care: A Program for Physicians in California Community Health Centers (Initial course: 2003, Alumni courses: 2004-2008)
2002	Intermountain Health Care, Salt Lake City Advanced Training Program in Health Care Delivery Improvement
2001	American Academy of Family Physicians, Kansas City Fundamentals of Management Course
2000	University of California, Davis Telemedicine Learning Center Training

Professional Experience and Training

2011-2024	Chief Medical Officer, Partnership HealthPlan of California. Includes professional oversight of grievances and appeals, quality, pharmacy, credentialing, health equity, care coordination, utilization management, behavioral health. Member of executive leadership team, with input on other aspects of health plan operations (claims, member services, provider relations, health analytics, IT, finance, HR). Active participation in Local Health Plans of California (co-facilitator of Medical Directors group) and the Association of Community Affiliated Plans. Advised the California Department of Health Services on assorted health policies.
1995-2023	Family Physician, Ole Health, Napa, California. Outpatient only since 2018.
1995-2018	Active on Medical Staff of Queen of the Valley Hospital, Napa, California
1998-2011	Medical Director, Community Health Clinic Ole (now Ole Health), Napa, California
2006-2011	Chief Medical Officer, Redwood Community Health Coalition (now Aliados Health)
2011	Chief Medical Officer, Redwood Community Health Network
2007-2008	Medical Director, Healthy Moms and Babies (now Ole Health Perinatal Services)
1995-2007	Private Practice in Obstetrics, Napa, CA
1994-99	Emergency Room Physician, Valley Emergency Physicians, several California sites
1994-95	Ventura Urgent Care, Physician
1993-95	Ventura County Emergency Department, Physician

Community Activities

2017-2024	Touro University Community Advisory Council, Member
2013-2020	Steering Committee, Honoring Choices Napa Valley
2013-2024	Board of Directors, Coalition of Compassionate Care for California
2012-2019	Board of Directors, Migrant Clinicians Network
2008-2023	Member of California Improvement Network, a program of the California Healthcare Foundation
2018-2024	Board of Directors, Sac Valley Med Share, a community health information exchange in northern California
2012-2018	Board of Directors, Connect HealthCare, a health information exchange in northern California. Served as Chair and Treasurer.
2009-2011	Chair of the Standardized Measures Group of the Tools for Quality Program, Tides Foundation and California Primary Care Association
2008-2011	Adjunct Assistant Professor of Family Practice, Touro University College of Osteopathic Medicine
2005-2017	Board of Directors, Western Clinicians Network
2009-2012	Medical Advisor to Board of Directors, Clinica Verde, Boaco, Nicaragua
2008-2009	Chair of Clinician's Committee, California Primary Care Association
2007-2008	Chair of Steering Committee, Accelerating Quality Improvement through Collaboration (California Primary Care Association program funded by California Health Care Foundation)
1996-2011	Teaching of Medical Students, Nurse Practitioner Students, Physician Assistant Students, Undergraduate Students at Community Health Clinic Olé
2012-2023	Teaching of Public Health Students at Partnership HealthPlan
1998-2007	Member of Board of Directors, Healthy Moms and Babies, Perinatal service provider

	for low-income women in Napa County (Served as Vice President, Secretary, Treasurer and currently President)
1998-2011	Member, Physician Advisory Committee, Partnership Health Plan of California
2003-2014	Chair of Community Health Committee of the Napa County Medical Society
1995-2003	Volunteer team physician for Napa and Vintage High School football teams
1999-2000	Member, Napa County Online Health Data Exchange Consortium

Research and Publications

2019	Chibber K, Tobey R, Moore R, and Rojasova S. Medicaid Managed Care Plan and Health Centers Advancing Value-Based Payment and Care. Robert Wood Johnson Foundation State Network Blog, November 2019.
2018	Liao J, Hodlofski A, Moore R, Navathe A. Partnership HealthPlan of California: Addressing Opioid Overuse with Behavioral Design Principles. Journal of Delivery Science and Innovation. Volume 6, Issue 1, March 2018, Pages 95-98.
2017	Barnato AE, Moore R, Moore CG, Kohatsu ND, Sudore RL. Financial incentives to increase advance care planning among Medicaid beneficiaries: Lessons learned from two pragmatic randomized trials. Journal of Pain and Symptom Management. Volume 54, Issue 1, July 2017, Pages 85-95.
2017	"EConsult Implementation Success Depends on Workflow" Health Affairs Letter, published March 13, 2017.
2013	"The Placebo Effect: the most powerful treatment we have." Marin Medicine 60 (1): 17-20
2012	"Conflicting national guidelines for mammography result in longer time intervals in between mammograms" Poster Presentation; 2012 Annual Meeting of APHA, Maria Fuchs, Robert Moore
2010	"Using Health Information Technology to Improve Quality" Information Bulletin #15, June 2010. Health Center Controlled Networks Series, National Association of Community Health Centers. Robert Moore, Fred Rachman, Michael Lardiere.
2008	"Cost Effective and Consistent TB screening and LTBI Care" Poster Presentation at Institute for Healthcare Improvement annual meeting, December 10, 2008 in Nashville, TN. Robert Moore, Carlos Avina.
2006	"Group treatment program of LTBI provides more efficient, higher quality care at a Community Health Clinic." Poster presentation at California TB Controllers Association Meeting, May 11, 2006. Luz Hernandez, Juan Martinez, and Robert Moore.
1991	"Chronic maternal morbidity in developing countries: data synthesis and policy suggestions." Presented at the 119th Annual Meeting of the American Public Health Association, Atlanta, Georgia, November 12, 1991.
1989-90	Laboratory investigations on the life cycle of *Trichinella spiralis*. Principle investigator: D. Despommier, Columbia University.
1985-86	"Identifying mutations in duplicated functions in *Saccharomyces cerevisiae*: Recessive mutations in HMG-CoA Reductase Genes," by Michael Basson, Robert Moore, Jules O'Rear and Jasper Rine. Genetics 117:645-655 (December, 1987).

Professional Affiliations

1. American Academy of Family Physicians and California Association of Family Physicians, member since 1992
2. California Medical Association member since 1986
3. Napa Solano Medical Society member since 1995

Certification

October 2005	Fellow, American Academy of Family Physicians (FAAFP)
July 1995	Board Certified, American Board of Family Physicians; renewed 2002, 2009 and 2019
July 1993	Diplomate, National Board of Medical Examiners

Current Certification in Basic Life Support, Advanced Life Support in Obstetrics

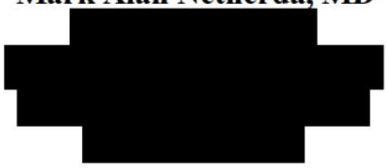
Honors and Awards

2011	Napa Hispanic Network Recognition for Contributions to the Community
2009	California Primary Care Association Hero Award
2008	Lifetime Achievement Award – Napa County Hispanic Network
2006	Values in Action Award for Justice – Queen of the Valley Hospital
2005	Award for Justice – Queen of the Valley Hospital Foundation
2000	Nominee-Values in Action Award for Service and Justice – Queen of the Valley Hospital
1998	Outstanding Physician of the Year – Napa County Medical Society
1997	Health Professional of the Year – Napa County Chamber of Commerce
1997	Nominee-Values in Action Award for Dignity – Queen of the Valley Hospital
1996	Recognition for service to America's underserved – National Health Service Corps
1986-92	Regents Scholar, University of California San Francisco
1986	Certificate of Distinction, University of California Berkeley -For Academic Excellence
1986	Departmental Citation, Biochemistry, University of California Berkeley -Outstanding Graduating Biochemistry Major
1986	Elected Phi Beta Kappa
1985	Robert Gordon and Ida W. Sproul Award, University of California Berkeley -Outstanding Scholarship, Leadership, and Service
1984	Elected to Order of the Golden Bear, University of California Berkeley

Other

Fluent in Spanish

Mark Alan Netherda, MD



CURRENT POSITIONS:
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Medical Director for Quality 06/01/2022 - present
Associate Medical Director for Quality 08/01/2018 – 5/30/2022
Regional Medical Director for Solano and Yolo Counties 09/28/15 – 07/31/2018
Start date: 09/28/2015
4665 Business Center Drive
Fairfield, CA 94534
(707)863-4510

BOARD CERTIFICATION:
American Board of Family Medicine 1991, recertification 1998, 2005, 2012, currently in process

EDUCATION:
Pacific AIDS Education and Training Center
Designate "Key Physician" to be trained in educating and training other healthcare professionals in caring for people infected with HIV. 1992 – 1993

University of California, San Francisco – Fresno
San Joaquin Valley Medical Education Program, Department of Family Medicine
Valley Medical Center, Fresno, CA
Internship 1988 – 1989, Residency 1989 – 1991

George Washington University, School of Medicine and Health Sciences
Washington, DC
Degree – Doctor of Medicine 1988

Stanford University
Stanford, CA
Degrees – Master of Science, Biological Sciences 1984
Bachelor of Science, Biological Sciences 1983

EMPLOYMENT EXPERIENCE:
KAISER PERMANENTE
Family Medicine Primary Care Physician December 3, 2012 - September 7, 2015
401 Bicentennial Way
Santa Rosa, CA 95403
(707)393-4000

COUNTY OF SONOMA
Interim Public Health Officer May 2010 – April 2012
Interim Division Director May 2010 – February 2011
Department of Health Services
625 5th Street
Santa Rosa, CA 95404
(707) 565-4599

WEST COUNTY HEALTH CENTERS
Clinical Consultant providing HCV and HIV care. July 1999 – Aug 2011
6800 Palm Avenue
Sebastopol, CA
(707) 824-9333

COUNTY OF SONOMA
Deputy Public Health Officer
Department of Health Services
July 2008 – May 2010
April 2012 – December 2012
625 5th Street
Santa Rosa, CA 95404
(707) 565-4599

COUNTY OF SONOMA CENTER FOR HIV PREVENTION AND CARE
HIV Primary Care Physician. August 2007 – July 2008
Medical Director. September 18, 1995 – June 2006
499 Humboldt Street, Suite 104
Santa Rosa, CA 95404
(707) 565-7400

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
Associate Clinical Professor, Dept. of Family Medicine, December 1995 – March 2012
Santa Rosa Campus
3320 Chanate Road
Santa Rosa, CA 95404
(707) 576-4000

INTERNATIONAL TRAINING AND EDUCATION CENTER ON HIV
May 2003 – July 2008
University of Washington
901 Boren Avenue #1100
Seattle, WA 98104-3508
(206) 221-7372

Clinical Consultant and Senior Technical Advisor, US-CDC, Namibia
June 2006 - July 2007

Working with the Namibian Ministry of Health and Social Services and US-CDC to develop, implement and manage training programs for physicians, pharmacists and nurses on the use of antiretroviral medications in the public (government) health sector.

Additional in country projects in Namibia:
May 7 – June 7, 2003.
October 10 – 27, 2003.
May 25 – June 6, 2004.
November 10-20, 2005.

OUTPATIENT IMMUNOLOGY SERVICES
COMMUNITY HOSPITAL OF THE MONTEREY PENINSULA
Private Practice. HIV Primary Care. November 1991 – October 30, 1995
23845 Holman Highway, Suite 318
Monterey, CA 93940
(408) 625-4972

NATIVIDAD FAMILY HEALTH CENTER
NATIVIDAD MEDICAL CENTER OF MONTEREY COUNTY
Family Practice Physician. September 1993 – September 1995
945 Blanco Circle, Suite D
Salinas, CA 93901
(408) 422-7998

CUSTOM HEALTH PROGRAM, COUNTY OF MONTEREY
Medical Director – county employee health insurance program, December 1993 – September 18, 1995
1330 Natividad Road
Salinas, CA 93940

HEALTH FIRST CLINIC
Outpatient urgent care and occupational medicine. July 1993 – September 1993
846 Freedom Boulevard
Watsonville, CA 95076

PRIMUS CLINIC OF THE PRESIDIO OF MONTERY
Outpatient family medicine. August 1992 – August 1993
Monterey, CA Clinic closed.

WALK-IN MEDICAL CLINIC
Urgent care medicine. July 1991 – July 1992
Aptos, CA Clinic closed.

APPOINTMENTS:
North Coast Area AIDS Education Training Center
Sonoma County Academic Foundation for Excellence in Medicine
September 1995 – July 2008

Sonoma County Commission on AIDS
August 1997 – June 2006

Chair, Sonoma County Commission on AIDS
Treatment and Care Committee
August 1997- June 2006

Technical Advisory Committee on Medical Aspects of Marijuana
California Medical Association
January 1997 – December 2000

CURRENT PROFESSIONAL ORGANIZATION MEMBERSHIPS:
Sonoma County Medical Association
California Medical Association

Revised 10/2024

Medical Director of Medicare Services

KJ

Kermit Jones

Professional Summary

Medical Director focusing on Medicare line of business, regulatory attorney and Internal Medicine Physician with twenty years of practice experience and expertise in healthcare regulation and policy development

[redacted]
[redacted]
[redacted]
[redacted]

Work History

Partnership In Health - Medical Director of Medicare Services
Fairfield, CA
04/2024 - Current

- Manage multidisciplinary teams to optimize patient care
- Oversee Utilization Management policy development
- Work across departments to implement new Medicare-based lines of business
- Engage healthcare systems and providers on product lines, quality improvement programs and incentive programs
- Participate in Grievance and Appeals hearings, Quality and Utilization, Policy Review and Peer Review Committees
- Participate in contract design for network providers

The Permanente Medical Group, TPMG - Internal Medicine Physician
09/2017 - Current

- Implemented chronic disease management programs for high-risk communities
- Completed over 20,000 distinct clinical encounters
- Healthcare advisor for 2019 U.S. Presidential Campaign

United Health Group, Optum - Medical Director
San Francisco, CA
11/2023 - 03/2024

- Medical Claims Review, Utilization Management and Quality Review

U.S. House Of Representatives - U.S. Congressional Candidate
09/2021 - 11/2022

- Designing most comprehensive healthcare plan of any U.S. Congressional Candidate, available upon request

Skills

- Conversational language skills in Arabic and Hindi
- Experience in statistical modeling in R and using Python for Machine Learning and CNN
- Knowledge and expertise in healthcare regulation, Medicare quality programs and incentives
- Completed Master's Degree level course work in business associations, capital structure and finance

Education

04/2023
Massachusetts Institute of Technology
Cambridge, MA
Machine Learning And Data Science PE Program

05/2012
Columbia University School of International & Public Affairs
New York
M.P.A

05/2005
Duke University
Durham, NC

- Directing largest field operation in California with 20 staff members and 1,000 volunteers reaching 160,000 district residents

Rush University Medical Center - Residency Training, IM Resident
Chicago, Illinois
01/2015 - 01/2017

- Principal Investigator for military veteran's mental health research program for PTSD and other mental health interventions

Hyman, Phelps & McNamara - 2nd Year Associate
Washington, DC
09/2013 - 07/2014

- Drafted legal memos on HIPAA, ERISA, FDA regulations and DOJ-enforcement issues
- Advised large healthcare practices and systems on legal matters, compliance, and risk management

White House - Fellow
Washington, DC
08/2012 - 08/2013

- Senate appointment position for nation's premier mid-career leadership program with dual appointment in White House and Dept of Health and Human Services
- Led White House-level principal meeting on programs to secure veteran's benefits and military to civilian life transition program
- Led study group evaluating performance measures for new NIH institution – NCATS

US Navy - Medical Dept. Head
Camp Pendleton South, CA
04/2007 - 06/2009

- Medical Director of CASEVAC team for USMC 364 Squadron
- Medical Dept Head for joint U.S Marine Battalion of over 3,000 Marines at Camp Pendleton, Ca
- Collaborated with department personnel to coordinate multifaceted solutions to emerging military medicine problems.

National Naval Medical Center - Internal Medicine Intern
01/2005 - 01/2006

- Selected for prestiguous USN Flight Surgeon training program at NAS Pensacola, Florida

---

Affiliations & Select Publications

- Member, State Bar of California 2020
- American Board of Internal Medicine 2017
- Member of American Legion
- Member of the Council on Foreign Relations

M.D., J.D

1997
Georgia Institute of Technology
Atlanta, GA
B.S
magna cum laude

- "Health Is Freedom," Diplomatic Courier, 12/2021
- “Stethoscope Diplomacy in the Middle East,” Foreign Policy, 2/2021
- “Obesity is a major risk factor for dying of COVID-19. We need to take it more seriously,” The Guardian, 6/2020

NANCY L. STEFFEN

[redacted]

Desire a senior leadership role in healthcare operations with emphasis in quality and continuous improvement. Passionate integrator of people, technology, and processes to achieve high quality patient care.

Education

BS Degree in Biomedical Engineering, Minor: Mechanical Engineering
Marquette University, Milwaukee, Wisconsin, 1997-Magna Cum Laude

Certifications

Six Sigma Black Belt – University of Wisconsin-Milwaukee
ASQ Quality Auditor

Summary of Experience

Twenty-seven years of experience leading cross-functional teams in quality assurance, quality improvement, analytics, and enterprise system integrations. Lead administrator of quality management systems and improvement initiatives within managed care, healthcare operations, diagnostic laboratories, and medical device manufacturing settings. Achieve sustainable results by developing effective processes/systems for healthcare teams to deliver value to patients.

Employment History

Partnership HealthPlan of California, Redding, California **July 2015 to present**
A non-profit community based health care organization that contracts with the State to administer Medi-Cal benefits through local care providers to ensure Medi-Cal recipients have access to high-quality comprehensive cost-effective health care. PHC serves over 600,000 people across 14 Northern California counties. Based in PHC's Northern Region.

Quality & Performance Improvement: Promoted May 2022 to Senior Director of Quality and Performance Improvement; responsible for plan-wide leadership of quality and performance improvement programs to substantially improve the quality of care provided to PHC members.

- In collaboration with the Chief Medical Officer (CMO), lead the strategic direction of PHC's quality goals and initiatives, including prioritization of efforts.
- Lead, develop, and coach the Quality staff in hiring, budgeting, training, performance appraisals, goal setting, and resource allocation.
- Oversee PHC's quality improvement program, ensuring all interventions are measured for effectiveness and efficiency, complete an annual review and update of the program, and write the annual plan. Prepare the organization for quality and performance improvement review, survey, and accreditation processes by external monitoring agencies, such as Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), CMS, and NCQA.

- In collaboration with executive leadership, oversee the administration of PHC's pay-for-performance programs.

- Direct performance improvement activities, including PHC's Performance Improvement Academy, DHCS mandated improvement work, and measure improvement and engagement activities done within the PHC provider network and service region.

- Oversee PHC's provider level quality data visualization and analysis program, the Partnership Quality Dashboard.

- Assure optimization of monitoring systems for collection and reporting of HEDIS and other quality measures.

- Ensure the Facility Site Review/Medical Record Review process and outcomes meet all regulatory and accreditation requirements. Demonstrate results are coordinated with peer review and credentialing processes.

Quality Improvement, Analytics, and Project Management: Joined as a manager and re-classified as an associate director in January 2016. Promoted February 2019, as Director of Quality and Performance Improvement, accountable for northern region efforts in quality measurement and improvement programs, analytics, and project management.

- Lead regional team in administering project management and performance improvement methodologies to ensure effective outcomes, partnerships, sustainability, and growth.

- Direct data collection and analyses, including medical record retrieval, to support quality performance reporting to the State, provider pay-for-performance programs, and regional improvements with local providers and community stakeholders.

- Responsible for work and staffing plans. Administer a $2.3 million operational budget.

BloodCenter of Wisconsin (*now* Versiti), Milwaukee, Wisconsin **July 2009 – July 2015**
A non-profit, healthcare organization committed to extending life and health by supplying blood to over 50 hospitals, conducting 70,000 diagnostic tests per year, recovering organs and tissues across SE WI, and leading research in innovative treatments for blood diseases and disorders.

Quality Support Services: As the Manager of Quality Management Systems, led cross-functional teams in simplifying, standardizing, and sustaining quality systems to reflect best practices in blood banking, medical device, and pharmaceutical industries.

- Administered all corporate computer systems used to demonstrate compliance to quality requirements in training/competency, error management, corrective/preventive action, audit, document control, and record retention.
- Led the successful implementation of the organization's first Learning Management System (LMS) in 2012. Integrated corporate-level training and job-specific competencies for laboratory, blood collection and corporate roles - approximately 1000 employees.

- Maintained corporate quality management systems plan, corresponding policies and

procedures, and fulfilled data analysis requests during onsite audits/inspections. Assessors included FDA, CMS, national accrediting bodies, and numerous state licensing boards.

- Achieved significant cycle time and waste reductions through cross-functional, continuous improvement activities in document control, record retention, training, and error management systems. Exceeded cost savings targets each year.

- Led integration of corporate quality systems upon acquisition of the Wisconsin Donor Network (OPO) and Wisconsin Tissue Bank in 2010. Developed and managed activities over a multi-year integration-plan involving corporate QA/RA, OPO nursing, and tissue bank recovery staff.

GE Healthcare, Milwaukee, Wisconsin **August 2007 - June 2009**
A General Electric Company providing a range of products, services, and expertise in medical imaging and information technologies, medical diagnostics, and patient monitoring systems.

Imaging Sub-Systems Quality Assurance: As a QA leader, responsible for leading implementation of a global quality initiative at five manufacturing sites worldwide.

- Successfully led implementation of global quality (QMS) initiative at Milwaukee manufacturing site in 2007-08. Assessed progress vs. global quality plan, conducted gap analyses, led gap closure activities, and executed training plans.

- Instrumental in coordination of global quality (QMS) initiative at two manufacturing sites in India. Served as key liaison between QA Site Managers and corporate QA team to troubleshoot systemic gaps and training issues.

- Led team at new manufacturing site in New York to implement GEHC global quality plan, obtain ISO 13485 certification, and FDA registration.

The Prairie School, Racine, Wisconsin **2002 to 2007 (Part-time)**
An independent, child-centered, college-preparatory day school, whose mission is to educate children, develop their individual talents, interests, and abilities.

Mathematics and Science Departments: As a faculty member, instructed pre-algebra, algebra, geometry, and science students in grades 6-10. Co-developed and taught an introductory algebra class for struggling middle school students.

Gyrus ACMI Corporation, Racine, Wisconsin **2005-06 (Part/Full-time), 2001-02 (Full-time)**
An industry-leading manufacturer of minimally invasive surgical instruments used in urology, gynecology, and laparoscopy.

Quality Assurance: As a quality engineer, responsible for supporting disposable and durable product lines manufactured and repaired at Racine plant. Supervised 8-10 Quality Control techs.

- Facilitated resolution of supplier and manufacturing related quality issues by working directly with raw component suppliers and manufacturing personnel.

- Developed Process Master Validation plans for disposable and durable product lines transferred from Wisconsin to Mexico and Minnesota in 2006.

- Reviewed complaint investigations completed by manufacturing engineers for proper root cause analysis and corrective actions.

Kimberly-Clark Corporation, Neenah, Wisconsin **1998 - 2001**
A multi-billion dollar global consumer products company with core businesses in personal care, health care, and tissue.

Child-Care Business Support: Responsible for implementing nonwoven qualifications, cost savings initiatives, quality improvements, and development to commercialization scale-ups.

Adult Care Research: Responsible for product development contributions and related competitive product analysis for incontinence products.

Amy Turnipseed

[redacted]

Accomplished Healthcare Executive with over 15 years of experience providing strategic vision and leadership in the health care delivery system. Currently responsible for the operations and executive management of five departments at Partnership HealthPlan of California, a Medicaid plan serving approximately 900,000 members in 24 counties.

Professional Experience

Partnership HealthPlan of California (PHC), Fairfield, CA

Chief Strategy and Government Affairs Officer	September 2021 - *Present*
Senior Director of External and Regulatory Affairs	February 2017- September 2021
Director of Policy and Program Development	July 2014- February 2017

- Executive team member, reporting directly to the CEO and Board of Commissioners since 2014
- Served as the Compliance Officer from 2017 to 2023, reporting to the full Board on compliance with federal and state regulations. Leads the development and maintenance of PHC's Compliance Plan and annual Risk Analysis
- Responsible for directly reporting to the Board of a variety of key initiatives, government affairs, and all areas of compliance
- Responsible for the executive oversight of five PHC operating departments including: Regulatory Affairs and Compliance, Communications, Legal, Network Services, and Project Management/Operational Excellence
- Develops the health plan's Strategic Plan and leads the Strategic Planning Committee, a subcommittee of the Board
- Leads PHC's California Advancing and Innovating Medi-Cal (CalAIM) implementation including:
    - Strategic planning to manage multi-year implementation of CalAIM initiatives
    - Leading cross-departmental operations for successful execution and operationalization of the new Enhanced Care Management benefit and Community Supports services. Departments include: Health Services, Provider Relations, Member Services, Claims, Configuration and Quality;
    - Representing PHC at state-level meetings with Department of Health Care Services (DHCS);
    - Meeting with county leaders and their local partners to collaborate on CalAIM;
    - Leading education sessions with county partners, providers, community-based organizations, and stakeholders on multiple aspects of implementation; and
    - Developing the Incentive Payment Program grants structure, a mechanism to financially support local organizations to develop CalAIM capacity and infrastructure
- Directly oversees the implementation of new benefits, program expansions, and regulatory changes, requiring cross-departmental management and participation including for: CalAIM, Whole Child Model transition, program eligibility expansions, 2024 DHCS Medi-Cal contract., and managed care model changes
- Leads the strategic efforts, planning and implementation for the expansion of PHC's county organized health system model (known as single plan model) into 10 additional counties in Northern California (Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama and Yuba) expected in 2024.
- Conduct implementation planning for new requirements for Duals Special Needs Plan (DSNP)
- Establishes and maintains productive relationships with key staff at DHCS and other regulatory agencies including the Department of Managed Care, Office of Inspector General, and Centers for Medicare & Medicaid Services (CMS)
- Oversees PHC's external community and government relations, including managing and monitoring of trade associations, outreach and legislative strategy and reporting directly to the Board
- Responsible for analysis and making recommendations on major policy and budgetary changes that may impact plan and updating the Board accordingly
- Responsible for the strategic development and contracting of PHC's provider network in consideration of market conditions and competitive activities

- Actively participate on behalf of PHC in various community and advocacy forums including meetings with our associations, regulators, legislative representatives, and provider partners and advise business leaders on positioning and engagement methods

Harbage Consulting, Sacramento, CA — October 2011- June 2014
Senior Consultant

- Advised and worked closely with senior management at DHCS on a multitude of complex initiatives, including the Coordinated Care Initiative (CCI). The CCI was launched by the state of California to provide better coordinated care to people with both Medicare and Medi-Cal
- Reported to the Director at DHCS on the progress of CCI
- Facilitated meetings between DHCS and health plan leaders on implementation of CCI
- Managed progress of projects and execution throughout DHCS, requiring coordination across numerous departments and external stakeholders
- Facilitated communication between DHCS and CMS on the CCI
- Coordinated information flow to a statewide communications team, as well as organizing large events with over 300 attendees.
- Represented DHCS at meetings with stakeholders, including advocacy organizations.

Office of the Secretary of Education, Sacramento, CA
Senior Communications Director — August 2010- February 2011
Policy Analyst — May 2009- February 2011

- Served as liaison between the Secretary of Education and the public, including communicating directly with media
- Developed communication strategy on education issues for the Governor and Secretary focusing on higher education issues and the California Master Plan
- Researched and tracked state and federal legislative bills and policy initiatives regarding higher education

Goddard Claussen, Sacramento, CA — August 2006- January 2009
Account Coordinator

- Coordinated qualitative and quantitative research programs for tax reform, water policy, healthcare, transportation and political reform
- Developed messaging and outreach materials for numerous ballot initiatives and issue advocacy campaigns

Leadership/Achievements

Association for Community Affiliated Plans (ACAP) — Washington D.C.
Leadership Academy, 2020-2021

Local Health Plans of California (LHPC) — Sacramento, CA
Compliance Officers Committee, Co-Chair, 2019- current

Education

University of Southern California, 2010 — Los Angeles, CA
Master of Public Administration

Gonzaga University, 2006, *cum laude* — Spokane, WA
Bachelor of Arts, Political Science
Bachelor of Arts, History

Danielle Ogren

[redacted]

Accomplished Healthcare Leader with over 15 years' experience in Medi-Cal Managed Care. Results-oriented, decisive leader with the ability to balance strategic decisions and financial stewardship with a hands on approach. Engaging communicator and relationship builder with proven success in improving regulatory compliance while spearheading improvements to ensure quality healthcare delivery for over 895,000 members in 24 Northern California counties. Excel in dynamic, demanding environments while remaining pragmatic and focused. Highly engaged leader with expertise in Compliance and team development with passion for the vision. *Core strengths include:*

- Compliance and Regulatory Affairs
- Culture Development and Refinement
- Health Care Operations
- Risk Management
- Contract Negotiations
- Team Building and Motivation
- Issue Analysis and Resolution
- Program Development

Professional Experience

Partnership HealthPlan of California, Fairfield, CA

Sr. Director of Regulatory Affairs and Contracting	May 2024-Present
Director of Compliance and Regulatory Affairs	September 2023-May 2024
Director of Regulatory Affairs and Program Development	May 2022- August 2023
Associate Director of Compliance and Program Strategy	October 2021-May 2022

- Leadership team member, reporting directly to the Chief Strategy and Government Affairs Officer, CEO and, Board of Commissioners
- Serves as Compliance and Privacy Officer, minimizing risk by ensuring development of policies, procedures and ensuring full compliance with federal and state regulations including Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH) Act, and other rules as applicable. Immediately addressed issues though training and corrective actions.
- Responsible for conducting risk analyses, oversees PHC audits, and manages Fraud, Waste, and Abuse (FWA) and HIPAA Program and privacy reporting.
- Responsible for directly reporting to the Board of Commissioners on a variety of key initiatives, and areas of compliance.
- Facilitates Fraud Waste and Abuse and Physical, Administrative, Technical Safeguards, and Delegation Oversight Review committees, subcommittees of Compliance Committee
- Establishes and maintains productive relationships with key staff at the Department of Health Care Services (DHCS) and other regulatory agencies including the Department of Managed Care (DMHC), Office of Inspector General (OIG), Department of Justice (DOJ) and Centers for Medicare & Medicaid Services (CMS)
- Cultivated relationships with Federal Agencies serving as an expert witness as requested
- Responsible for ensuring compliance program incorporates critical compliance elements as identified by the U.S. Department of Health and Human Services (HHS), OIG, Code of Federal Regulations (CFR) related to Medicaid program integrity requirements, and DHCS. Responsibilities include:
  - Development and review of policies and procedures
  - Lead development and implementation of compliance training and education programs for all key stakeholders
  - Development of annual compliance risk assessment and internal work plans to monitor progress
  - Development of monitoring and audit work plan including internal, external, subcontractor, delegate audits. Ensure timely and accurate regulatory reporting, responses, and corrective actions.

    - Provider participation status review and background checks
    - Investigations and remediation
    - FWA detection and prevention
- Responsible for oversight of implementation of new benefits and regulatory changes, requiring cross-departmental participation. Programs include: CalAIM and 2024 DHCS Medi-Cal contract.
- Responsible for the operations and management of Regulatory Affairs and Compliance (RAC) and Legal Affairs and Provider Contracting Departments
- Responsible for the oversight of annual regulatory audits
- Responsible for analysis of major policy/regulatory changes that may impact plan, with particular attention to potential state and federal changes affecting Medi-Cal
- Responsible for drafting PHC's provider network templates in consideration of regulatory requirements. Participate in negotiations.

Associate Director of Cost Efficiency	October 2020- October 2021
Senior Manager of Cost Efficiency	December 2017- October 2020
Cost Avoidance Manager	December 2015-December 2017
Finance Contracting Analyst	July 2013-December 2015

- Leadership team member, reporting directly to the Chief Financial Officer (CFO) and Finance Committee
- Provided strategic support to legal for contract language related to the development and/or modification of contract templates to ensure compliance with all regulatory requirements and health plan initiatives
- Established and developed analytic reporting to Compliance Officer and Director of Legal Affairs related to fraud, waste, abuse and provider payment disputes
- Responsible for the oversight of compliance with network provider agreement provisions and reported outcomes, developed corrective action plans and ensured remediation of cited deficiencies to Compliance Officer.
- Cultivated relationships with DHCS including Capitated Rates Development Division and other state and federal regulatory agencies
- Developed and oversaw operational functions for recoveries, reinsurance, coordination of benefits, third party liability and overpayments
- Responsible for process improvement opportunities, recommendations and implementation of changes to maximize efficiency and quality of analytic work
- Completed an extensive analysis comparing PHC's healthcare spend to the Medi-Cal provider manual, resulting in significant configuration and contracting changes, which was positively received by the CFO and subsequently the PHC Board of Supervisors
- Responsible for contract fiscal negotiations for large network, all provider types
- Responsible for all value based provider rate development including new and innovative approaches to contracting using current and alternative reimbursement methodologies
- Provided CFO with rate development analytics and budgetary impact analysis
- Responsible for providing strategic direction to the Chief Financial Officer (CFO) and other C-Level Executives for rate development of innovative programs
- Ensures overall performance of network provider contracts aligns with quality and incentive programs
- Maintains knowledge of market rates in the service area
- Support CFO in completion, oversight and analysis of Supplemental Rate Development (SDR) and Rate Development Templates (RDT) to Department of Health Care Services (DHCS)
- Responsible for the Private Hospital Directed Payment and Enhanced Payment Program reconciliation and submission with network providers to DHCS
- Provide analysis and review of the annual health care cost budget, month end statements, and actual to budget variances
- Lead and managed the Cost Efficiency team to support PHC's strategic goal of fiscal stewardship and compliance

Certifications/Leadership

Certificate of Health Care Compliance (CHC): 2022

Local Health Plans of California (LHPC) — Sacramento, CA
Compliance Officers Committee, Chair, 2022- current

Affiliations

Health Care Compliance Association (HCCA) Member and Certified Health Care Compliance (CHC) Member

Education

University of California Davis — Davis, CA
Bachelor of Science

JEFFREY J. DEVIDO, M.D., M.T.S.

JDEVIDO@PARTNERSHIPHP.ORG

[redacted]

OVERVIEW

Specialist in mental health and addiction treatment. Administrative oversight of mental health and addiction treatment systems of care within Medicaid program in Northern California.

BOARD CERTIFICATIONS/LICENSURE

Adult Psychiatry
Addiction Psychiatry
Addiction Medicine
Active CA Medical Licensure

EXPERIENCE

CHIEF, ADDICTION SERVICES, MARIN COUNTY, CA, HHS
2016 - present
Responsible for grant management (over $4 million) aimed at expansion of SUD treatment system of care for Medicaid beneficiaries. Medical Director of co-occurring SMI-SUD outpatient clinic. System of care clinical education.

BEHAVIORAL HEALTH CLINICAL DIRECTOR, PARTNERSHIP HEALTHPLAN OF CA
2017 - present
Medical Director of DMC-ODS regional model SUD treatment system of care (7 counties). Quality management oversight and program expansion of/innovation in non-specialty mental health treatment system of care (24 counties). System of care education.

ASSISTANT CLINICAL PROFESSOR—VOLUNTEER; DEPT OF PSYCHIATRY AND BEHAVIORAL SCIENCES; WEILL INSTITUTE FOR NEUROSCIENCES AND UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
Full time consultation-liaison psychiatrist 2013-2016. Resident supervision and resident/fellow/medical student supervision/education.

EDUCATION

B.S. CHEMISTRY WITH SPECIALIZATION IN BIOCHEMISTRY
University of Virginia, 2000

MASTERS IN THEOLOGICAL STUDIES
Harvard Divinity School, 2003

MEDICAL DOCTOR
Columbia University College of Physicians and Surgeons, 2008

ADULT PSYCHIATRY RESIDENCY
Massachusetts General and McLean Hospitals, Harvard University, 2012

ADDICTION PSYCHIATRY FELLOWSHIP
Partners Health, Harvard University, 2013

Senior Director of Behavioral Health

Mark Bontrager

EDUCATION AND LICENSES

2011 Stanford Graduate School of Business, Executive Program for Nonprofit Leaders (EPNL)
2002 Indiana University School of Law, Doctor of Jurisprudence degree (J.D.)
1995 Indiana University School of Social Work, Master of Social Work degree (M.S.W.)
1993 Goshen College, Bachelor of Arts degree in Psychology (B.A.)
State Bar of Indiana, admitted 2002, Currently Inactive
Licensed Clinical Social Worker (LCSW), State of California 2006, State of Indiana 1997
Certified Healthcare Privacy Compliance (CHPC), Certified Healthcare Compliance (CHC)

PROFESSIONAL EXPERIENCE

Sr. Director of Behavioral Health **2021/Present**
Partnership HealthPlan of CA, Fairfield, California

- Oversee mental health and substance use disorder services for managed care plan
- Serve on the Executive Team for the managed care plan
- Represent the plan on external committees and stakeholder groups
- Support new programs and benefit implementations as needed and directed

Director of Regulatory Affairs & Program Development **2018/2021**
Partnership HealthPlan of CA, Fairfield, California

- Oversee Regulatory Affairs and Compliance department for managed care plan
- Serve as Privacy Officer for the health plan
- Manage staff in Regulatory Affairs and Compliance
- Support new programs and benefit implementations as needed and directed
- Participate in annual risk assessment, audits and the creation of compliance plan
- Participate as a member of the Operations and Emergency Response Teams

Executive Director **2007/2018**
Aldea Children & Family Services, Napa, California

- Oversaw operations for an agency of 160 staff and annual budget over $12 million
- Worked in conjunction with Board of Directors on mission and strategic planning
- Set organizational goals and objectives each year
- Led Development staff on fundraising, grant writing and strategy
- Created partnerships with public and private entities to better serve clients
- Managed senior program staff and administrative staff, setting annual goals
- Oversaw the purchase of properties and other assets
- Provided oversight to the CFO and fiscal operations of the agency
- Collaborated with other agencies in service development and implementation
- Identified new public and private funding opportunities for the agency and partners
- Participated in community-wide committees and advisory groups

- Oversaw the expansion of programming, services and staffing
- Participated in a successful $2 million dollar capital campaign
- Obtained National Accreditation

Deputy Director **2005/2007**
Aldea Children & Family Services, Napa, California

- Managed program directors overseeing eight programs
- Oversaw fiscal operations and agency Controller
- Developed new programs utilizing existing infrastructure
- Worked towards greater integration of programming and services
- Directed senior management in overall agency operations
- Directed mental health and child welfare service lines for the agency
- Developed contracts and expanded existing contracts for services
- Worked closely with local government to partner on specific projects
- Participated in Finance and Development Committees of the Board
- Partnered with Executive Director in planning and execution of services

Attorney **2002/2006**
Private Practice, Indianapolis, Indiana

- Represented clients in adoption and special education matters
- Conducted custody evaluations as directed by the court
- Performed mediations for parties in dispute
- Successfully advocated and passed laws promoting adoption from foster care
- Provided trainings to public social service / child welfare agencies
- Consulted with school districts over special education issues
- Represented clients in family law matters

Program Manager / Therapist / Social Worker **1996/2003**
The Villages of Indiana, Inc., Indianapolis, Indiana

- Used organizational skills to assist in establishing a residential program
- Conducted interviews and trained direct care staff in behavior management
- Directed staff meetings and weekly clinical team meetings
- Gave presentations to community groups to garner support
- Provided individual and family therapy with clients
- Completed foster care / adoption home studies
- Managed program staff of twelve members
- Created policy and procedures for program operations

Vitae

BOARD/COMMITTEE MEMBERSHIPS

Governors Appointment to Mental Health Services Act Oversight & Accountability Commission (2021 – Present)
Governors Appointment to Children's Justice Act Task Force (2015 – 2018)
Solano County Children's Alliance Executive Committee (2013 – 2018)
Napa County Child Abuse Prevention Council Steering Committee Member (2008 – 2018)
Foster Family-based Treatment Association (FFTA) (2010 – 2012)
Napa County Children's Health Initiative Board Member – Treasurer (2007 – 2012)
Napa Valley Coalition of Non-Profits Behavioral Health Committee – Co-Chair (2008 – 2010)
Napa County Workforce Investment Board Member – Vice Chair (2005 – 2010, 2015 - present)
Pacific Union College Social Work Advisory Board Member (2006 – 2009)
Napa County Mental Health Services Act – PEI Advisory Board Member (2007 – 2009)
Adoption in Child Time, Inc. Board Member (2003 – 2009)
Indiana Juvenile Justice Task Force, Inc. (2004 – 2006)

PUBLICATIONS & TRAININGS PROVIDED

Bontrager, Mark & Peter Kenny (2004). Foster Parent Journal. School Datebooks Publication, Lafayette, Indiana.

Kenny, Peter & Mark Bontrager (2004). Adopting a Foster Child. ACT Publications, Rensselaer, Indiana.

Bontrager, Mark & Jim Kenny (July/August 2004 issue). "Pseudo-Bonding and Other Myths." *Foster Families Today*. Louis & Company Publishing, Windsor, Colorado.

Bontrager, Mark & Jim Kenny (May/June 2004 issue). "Appellate Courts Choose Bonding." *Foster Families Today*. Louis & Company Publishing, Windsor, Colorado.

Bontrager, Mark (2003). "New Tax Credits a Boon to Parents Adopting Special Needs Kids." ACT ONE. 5 (1), pg. 3.

Bontrager, Mark (2003). "Do I Have to be Rich to Adopt?" ACT ONE. 5 (2), 2-3.

"Legal Issues for Mental Health Professionals: Responding to Requests for Disclosures, What does HIPAA Allow?" (Training 3 hours of continuing education credit, 2009)

Professional/Educational/Volunteer Experience

University of California at Berkeley Haas School of Management – Executive training programs: Leading for Performance, Leader as Coach, Leadership Training
Victim/Offender Mediator, Certified Civil Mediator state of Indiana (2002)
Court Appointed Special Advocate (CASA)
North American Council on Adoptable Children: Indiana State Subsidy Representative (2004)

Director of Health Equity

MOHAMED ALIEU JALLOH, PHARM.D.

[redacted]

CURRENT EMPLOYMENT

2023-Present **HEALTH EQUITY OFFICER (DIRECTOR OF HEALTH EQUITY)**
Partnership Health Plan of California, Fairfield, CA

2016-Present **ASSISTANT PROFESSOR IN CLINICAL SCIENCES**
Touro University California College of Pharmacy, Vallejo, CA
- Lecture at least 25+ hours of pharmacotherapy lecture material in family medicine, evidence based medicine, health equity, and digital health-related topics each year
- Over 92% of 120+ students rated " very agreed" or "agreed" that my lectures are presented in a clear and understandable manner

2018-Present **GUEST LECTURER**
Stanford University College of Medicine, Stanford, CA
- Lecture at least 6+ hours of pharmacotherapy lecture material in family medicine topics each year
- Over 95% of 50+ students rated lectures "excellent" or "very good"

2020-2021 **PER-DIEM COVID-19 VACCINATION PHARMACIST**
CVS Pharmacy, Vallejo, CA

2016-2021 **SPOKESMAN FOR THE AMERICAN PHARMACISTS ASSOCIATION (APhA)**
American Pharmacists Association | Washington, DC
- Quoted and interviewed by 20+ leading journalists from *Time Magazine*, *WebMD*, *Men's Health*, *Washington Post*, *NPR*, *AccuWeather*, and *USA Today*

2014-2016 **PER-DIEM COMMUNITY PHARMACIST**
Walgreens | Omaha, NE

HONORS AND AWARDS

2021	Touro University College of Pharmacy "Clinical Professor of the Year" Award Winner
2021	Touro University College of Pharmacy "Most Engaging Professor of the Year" Award Winner
2019	Touro University College of Pharmacy "Most Entertaining Professor of the Year" Award Winner
2019	Touro University College of Pharmacy "IPhO Preceptor of the Year" Award Winner
2018	The Doctors Company **and** Napa Valley Community Foundation Second Responder Recognition
2018	ASHP CEO National Courageous Service Award Winner
2014	Natural Medicines Comprehensive Database Recognition Award Winner
2013	Walgreens National Diversity Scholarship Recipient
2013	Wilkes Multicultural Global Scholar and Citizen Award Winner
2012	Who's Who Among Students in American Universities and Colleges

EDUCATION

2008- 2014	**DOCTOR OF PHARMACY (PHARM.D.)** *Pharmacy Spanish Concentration Certificate* Wilkes University, Nesbitt School of Pharmacy, Wilkes-Barre, PA
2014- 2016	**GRADUATE CERTIFICATE IN CLINICAL AND TRANSLATIONAL SCIENCES (BIOSTATISTICS)** Creighton University School of Medicine, Omaha, NE

INTERNATIONAL EDUCATION

	SPANISH LANGUAGE
Summer 2012	University of Malaga, Malaga, Spain
Summer 2011	Colegio Mayor Mara, Madrid, Spain

LICENSURES AND BOARD CERTIFICATIONS

Licenses	**PHARMACIST**
Expires 2025	California License#: RPH76770
Expires 2024	Nebraska License#: 14659
Certifications	
Expires 2026	**BOARD CERTIFIED PHARMACOTHERAPY SPECIALIST (BCPS)** Board of Pharmacy Specialties, # 3160131

CERTIFICATES

Certificates	
Jan 2022	**DIVERSITY, HEALTH EQUITY, INCLUSION, AND ANTI-RACISM** American Association of Colleges of Pharmacy (AACP)
Jan 2021	**BASIC LIFE SUPPORT (BLS) PROVIDER** ACLS Certification Institute
Apr 2019	**PHARMACY-BASED TRAVEL HEALTH SERVICES** American Pharmacists Association, Washington, DC
Mar 2017	**LIFESTYLE AND WELLNESS COACH** National Diabetes Prevention Program (DPP) Vallejo, CA
Jun 2016	**MEDICATION THERAPY MANAGEMENT** American Pharmacists Association, Washington, DC
Jun 2016	**EVIDENCE-BASED PRACTICE** Creighton University School of Pharmacy & Health Professions, Omaha, NE
May 2015	**TEACHING CERTIFICATE PROGRAM FOR PHARMACY RESIDENTS** Creighton University School of Pharmacy & Health Professions, Omaha, NE

May 2013 **PHARMACY BASED IMMUNIZATION DELIVERY**
American Pharmacists Association, Washington, DC

POST-DOCTORAL TRAINING

Jul 2014-Jun 2016 **DRUG INFORMATION AND EVIDENCE BASED MEDICINE RESEARCH FELLOWSHIP**
Center for Drug Information & Evidence-Based Practice
Creighton University, Omaha, NE
Program Preceptor(s): Darren Hein, PharmD; Zara Risoldi-Cochrane, PharmD, MS; Amy Wilson, PharmD

- Provided pharmacotherapeutic recommendations in a medication therapy management center and volunteer ambulatory care and acute care clinic.
- Managed an academic drug information consultation service that provides over 1000 clinical consultation annually to health care professionals.
- Supervised over 50+ Pharm.D. advanced pharmacy practice experience (APPE) rotation students during an academic drug information consultation service and medication therapy management (MTM) center.
- Provided regional and national medication policy and P&T support for Catholic Health Initiatives (CHI), PharMerica, and McKesson.
- Provided medical content and editorial expertise for Medscape and Healthline.com.
- Served as an investigator and co-investigator on 3+ research projects.

TEACHING EXPERIENCE

Fall 2016 to Present **STANFORD UNIVERSITY SCHOOL OF MEDICINE**
Didactic Lectures

- Men's Health (BPH and ED) (2 hours)
- Headache and Migraines (2 hours)
- Sexually Transmitted Diseases and HIV (2 Hours)
- Osteoarthritis Management (2 hours)

Fall 2016 to Present **TOURO UNIVERSITY CALIFORNIA COLLEGE OF PHARMACY PROGRAM**
Didactic Lectures

- Introduction to Drug Information (3 hours)
- Drug Literature Evaluation (3 hours)
- Reviewing and Applying Systematic Reviews and Meta-Analyses (1.5 hours)
- Ophthalmic, Otic, and Oral Agents Part 1 (3 hours)
- Constipation and Diarrhea Management (3 hours)
- Atopic Dermatitis and Contact Dermatitis Management (3 hours)
- Medication Therapy Management and Reimbursement (3 hours)
- Osteoarthritis Management (3 hours)
- Gout (3 hours)
- Headache and Migraines (3 hours)
- Men's Health (BPH and ED) (3 hours)
- Travel Health (8 hours)

Clinical Rotations Teaching/Experiential Teaching

- Ambulatory Care Rotation (1 PGY1 resident and 2 students every 6 weeks)

CREIGHTON UNIVERSITY SCHOOL OF PHARMACY AND HEALTH PROFESSIONALS

Fall 2014 to Spring 2016

Didactic Lectures

- PHA 458 Literature Evaluation and Evidence Based Practice (15 hour)
- PHA 469 Case Studies and Case Discussion (15 Hours)
- PHA 319 Pharmaceutics Skills Lab (8 hours)

Clinical Rotations Teaching/Experiential Teaching

- PHA 515, Drug Information Rotation (8 students every 5 weeks)
- PHA 534, Medication Therapy Management (MTM) (2 students every 5 weeks)
- PHA 528, Dominican Republic International Medical Mission (2 students every 4 weeks)

GRANT WRITING AND CONSULTANT EXPERIENCE

Contracts

Jul 2014-present **PROJECT MANAGER OR CONTRIBUTOR**

- Provided key project management for Mckesson, PharMerica, and Healthline.com that resulted in over $2000 in billable services.

Grants Submitted

Sep 2021 **Children's Book Intervention to Address Parent Knowledge and Motivation in Childhood Vaccinations: A Cross-Sectional Study** Touro University California, Vallejo, CA

- $2,326.16 (Funded)

May 2021 **Barber Motivation for Conducting Mental Health Screening In African American Barbershops: A Cross-Sectional Study**
Touro University California, Vallejo, CA

- $2, 000 (Funded)

Feb 2015 **"ASSESSING DRUG INFORMATION NEEDS OF RURAL NEBRASKA PHARMACISTS"**
Nebraska Pharmacists Association, Lincoln, NE

- $2, 500.00 (Not Funded)

PUBLICATIONS

Peer-Reviewed Journals

Sep 2022 ***Jalloh MA***, Stompanato J, Nguyen JQ, Barnett MJ, Ip EJ, Doroudgar S. Barber Motivation for Conducting Mental Health Screening and Receiving Mental Health Education in Barbershops That Primarily Serve African Americans: a Cross-sectional Study. *J Racial Ethn Health Disparities*. 2022;10.1007/s40615-022-01420-5.

May 2022 ***Jalloh MA,*** Chung K, Doroudgar S. Severity of visual hallucinations worsened with lisinopril despite receiving sedative hypnotic therapy or antipsychotic therapy: First case report. *Res Social Adm Pharm*. 2022;18(11):4009-4011.

Mar 2020 ***Jalloh MA,*** Barnett M, Ip EJ. Men's Health Related Magazines—what they recommend and the evidence to support their recommendations: A retrospective study. *Am J Mens Health.* 2020 May-Jun; 14(3): 1557988320936900

Mar 2020 ***Jalloh MA.*** Esketamine (Spravato) for Treatment-Resistant Depression. *Am Fam Physician*. 2020 Mar 15;101(6):339-340.

May 2018	***Jalloh MA***, Doroudgar S, Ip EJ. What is the impact of the 2017 cochrane systematic review and meta-analysis that evaluated the use of PCSK9 inhibitors for lowering cardiovascular disease and mortality? Expert Opin Pharmacother. 2018 May;19(7):739-741.
May 2016	***Jalloh MA***, Gregory PJ, Hein DJ, Risoldi-Cochrane Z, Rodriguez A. Dietary supplement interactions with antiretrovirals: A systematic review. *Int J STD AIDS*. 2017;28(1):4-15.
May 2016	Gregory PJ, Bird AS, Hein DJ, Abe A, Risoldi-Cochrane Z, ***Jalloh MA***, Wilson AF. Assessment of the value of an academic drug information service to the healthcare community. *J Am Pharm Assoc* [Currently in review]
May 2015	Schreck Bird A, Gregory PJ, ***Jalloh MA***, Risoldi Cochrane Z, Hein DJ. Probiotics for the Treatment of Infantile Colic: A Systematic Review. *J Pharm Pract*. 2016. [Epub ahead of print].
May 2015	Gregory PJ, ***Jalloh MA***, Abe AM, Hu J, Hein D. Characterization of Complementary and Alternative Medicine-Related Consultations in an Academic Drug Information Service. *J Pharm Pract*. 2015. [Epub ahead of print].
Continued Education	
	Jalloh M. Itching to Find a Solution: The Community Pharmacist's Role in Ocular Allergy Treatment. https://www.powerpak.com/course/preamble/121944

PRESENTATIONS

Invited Podium Presentations	**ADDRESSING VACCINE HESITANCY (VH) AND HEALTH DISPARITIES IN MINORITY COMMUNITIES: ALTERNATIVE APPROACHES AND LEVERAGING COMMUNITY PARTNERSHIPS**
March 2023	2023 NACCHO Preparedness Summit Conference, Atlanta, GA
March 2019	**"COORDINATING WITH PHARMACIES DURING STATE AND NATIONAL EMERGENCIES"** 2019 NACCHO Preparedness Summit Conference, St. Louis, MO
May 2018	**"PRESCRIBING MEDICATION RELATED APPS"** California Pharmacists Association (CPhA) Western Pharmacy Exchange Conference, San Diego, CA
May 2015	**"ARE RECOMMENDATIONS IN MENS HEALTH-RELATED MAGAZINES TRULY EVIDENCE-BASED: A RETROSPECTIVE STUDY-PRELIMINARY RESULTS"** Midwestern Pharmacy Residency Conference, Omaha, NE
Dec 2014	**"GOOGLE POWER SEARCHING FOR PHARMACISTS: HOW TO APPLY THE HIDDEN TOOLS OF GOOGLE FOR DRUG INFORMATION"** American Society of Health System Pharmacists (ASHP) Midyear, Orlando, FL
Leadership Related	
Nov 2013	**"A #SCRIPT FOR SOCIAL MEDIA"** Audience: 600+ APhA-ASP Region 1 & 2 Midyear Meeting attendees, Washington, DC

LEADERSHIP AND PROFESSIONAL SERVICE

University

Jul 2022- Present	**CHAIR-FACULTY DEVELOPMENT COMMITTEE** Touro University California College of Pharmacy
Aug 2019- Jul 2022	**CHAIR-ADMISSIONS COMMITTEE** Touro University California College of Pharmacy
Aug 2019- Jul 2022	**COP MEMBER-ENROLLMENT MANAGEMENT COMMITTEE** Touro University California College of Pharmacy
Aug 2019- Jul 2022	**COP MEMBER-ENROLLMENT LEADERSHIP COMMITTEE** Touro University California College of Pharmacy
Health Plan/PBM	
	VOTING MEMBER OF P&T COMMITTEE Partnership Health Plan
Editorial Advisory Board	
	EDITORIAL ADVISORY BOARD MEMBER
Mar 2018- Present	*Drug Topics: Voice of the Pharmacist* Modern Medicine Network
May 2018-Present	*British Medical Journal (BMJ) Evidence Based Medicine*
Mar 2015-Mar 2016	*Transitions* American Pharmacists Association- New Practitioner Network
Mar 2012-Mar 2014	*Student Pharmacist Magazine,* American Pharmacists Association-Academy of Student Pharmacists
Peer Reviewer	
	MEDICAL JOURNALS
May 2020-Present	*American Journal of Men's Health*
Jan 2018-Present	*British Medical Journal (BMJ) Evidence Based Medicine*
Oct 2014- Present	*Journal of Medical Internet Research*
Oct 2014-Present	*Journal of Evidence-Based Complementary and Alternative Health*
National Student Leadership	
Jul 2013-Aug 2014	**NATIONAL STUDENT ADVISORY COMMITTEE MEMBER-AT-LARGE** American College of Clinical Pharmacy (ACCP)
Jun2013-Aug 2014	**NATIONAL LIAISON TO REGION I** Phi Lambda Sigma (PLS) Pharmacy Leadership Society
Mar 2013-Mar 2014	**NATIONAL STANDING COMMITTEE MEMBER OF COMMUNICATIONS** American Pharmacists Association-Academy of Student Pharmacists
Mar 2013-Mar 2014	**NATIONAL STRATEGIC PLANNING COMMITTEE** American Pharmacists Association-Academy of Student Pharmacists

EXPERT COMMENTARY EXPERIENCE

Director of Population Health Management

DeLorean Ruffin, DrPH, MPH

Education

- **Doctor of Public Health (DrPH)** – Health Education and Promotion, Loma Linda University (2022)
- **Master of Public Health (MPH)** – Argosy University (2016)
- **Bachelor of Science Biology** – Barry University (2013)

Core Competencies

- Program Monitoring & Evaluation
- Data Synthesis/Decision Making
- Strategic Leadership and Planning
- Grant and Budget Management
- Cross-Functional Leadership
- Program and Policy Development
- Organizational Learning Advocacy
- Resource Allocation Strategy
- Change Management
- Good Clinical Practices
- Project Management
- Stakeholder Communication
- Population Health Management

Technical Competencies

- MS Office Suites, Visio, Statistical Analysis Software (SAS), SPSS, Proficiency in Process Mapping, Six Sigma & Lean
- PowerBI Dashboards, Tableau
- Qualitative Data Analysis-NViVO, EDC (Veeva)
- EMR (Epic, eCW, Athena)
- Salesforce (CalConnect)
- Cloud Based Repository

Professional Affiliates

- Black Doctoral Network (BDN), Member, Conference Workshop Presenter **2020-Present**
- American Public Health Association Member, Peer Reviewer (HIV/AIDS, MCH) **2019-Present**
- Society of Public Health Education Member, **2019-Present**
- Institute of Health Care Improvement (IHI), Member, **2021-Present**
- CA Primary Care Association (CPCA), Member, **2021-Present**

Additional Work Experience

- Clinical Research Coordinator-

Summary of Qualifications:

Dynamic and results-driven Population Health Management executive with over 10 years of experience in strategic healthcare leadership. Proven track record of developing and implementing comprehensive population health strategies that drive quality patient outcomes and operational excellence. Adept at leveraging data analytics to inform decision-making and improve health equity across diverse patient populations. Skilled in fostering cross-functional collaboration and building strategic partnerships with community organizations to enhance care delivery and access. Demonstrated success in maintaining and achieving HPA and HEA NCQA accreditation and maintaining regulatory compliance with CMS, DHCS, and CDPH standards.

Professional Experience

Partnership HealthPlan of California — April 2024 – Present
Director of Population Health Management — **40 hours/week**

Key Responsibilities and Achievements:

- Spearheaded data-driven Population Health Management strategies, collaborating closely with the Health Analytics team to leverage data for measurable improvements in patient health outcomes and real-time program adjustments.
- Developed innovative, patient-centered interventions to address care gaps and health equity issues in Solano County, partnering with the Director of Health Equity to create sustainable activities with tangible impact on patient outcomes.
- Implemented proactive approach to community engagement by strategically utilizing Community Health Liaisons to transform the department's participation from reactive to strategic, aligning activities with organizational goals and community partnerships.
- Led comprehensive reviews of Population Health Management Program Description and Evaluation, ensuring high-quality work and timely project completion to drive better member outcomes.
- Fostered strong interdepartmental collaboration and positive team dynamics, setting a tone of accountability and professionalism while building key partnerships with internal and external stakeholders.

Accomplishments and Impact:

- Spearheaded the development of innovative, patient-centered interventions for Solano County, addressing critical care gaps and health equity issues, resulting in a comprehensive suite of sustainable activities poised to make a tangible difference in patient outcomes.

West Oakland Health Council (now Baywell Health) — August 2021 – March 2024
Director Of Research, Evaluation, and Community Health — **40 hours/week**

Key Responsibilities and Achievements:
As the driving force behind West Oakland Health's strategic endeavors in community health, research, and evaluation, my role encompasses steering the organization's direction in population health management. I am deeply engaged in crafting and implementing research strategies, enhancing quality improvement initiatives, and leading community health programs, all while ensuring alignment with the requirements and regulations set forth by CMS, DHCS, NCQA, CDPH, and other regulatory bodies.

- Spearhead West Oakland Health's strategic initiatives in community health, research, and evaluation, aligning with CMS, DHCS, NCQA, and CDPH regulations.
- Ensure regulatory compliance (TJC, NCQA-PCMH, HRSA-UDS, FTCA) and actively participate in certification and audit processes.
- Cultivate strategic partnerships with community organizations and stakeholders to enhance population health management activities.
- Develop innovative programs for specialized patient populations, improving quality, health equity, and patient outcomes leveraging continuous quality improvement methodologies and tools (PDSA, Lean Six Sigma, and DMAIC.)

PMI Health, Atlanta, GA | June 2014- Aug. 2016, 2 years, 2 months

- Analyze large datasets using quantitative and qualitative methods to drive quality outcomes and evaluation.
- Oversee grant applications and direct funds toward key quality improvement, prevention, and treatment initiatives.

Accomplishments and Impact:

- Advanced from Director of Quality Assurance, implementing population health management tactics that reduced service delivery disparities by 50% within six months.
- Led development of strategic objectives supporting quality improvement initiatives while ensuring compliance with federal and state regulations.
- Expanded leadership role from managing three data analysts to overseeing four key departments: WIC, Community Health, and Maternal Child Health.

Contra Costa County Health Services, Concord, CA — November 2020 - August 2021
PUBLIC HEALTH PROGRAM MANAGER — 40 Hours/week

Key Responsibilities and Achievements:

- Developed, coordinated, and implemented, evidenced-based audience-centric health education programs across a range of county and state health education, prevention, or public health services programs inclusive of non-clinical sites, residential care facilities, and co-leads state level quality strategy for Community of Practice (CoP) sessions.
- Built, fostered, and maintained collaborative partnerships to strengthen resources available for extending the reach of CCHS awareness and education programs and broad-based education initiatives to improve public health in the communities serviced.
- Delivered culturally competent communications leveraging specialty techniques, and methods to provide data and educational public health information and strategic communication plans inclusive of reports, presentations, fact sheets, articles for publication, and responses to individuals or groups to improve overall health literacy.
- Monitored action items within the organization focused on PMO efficiency and ensured timely responses, and appropriate progress to remedy problems that required interim and long-term solutions.
- Consolidated data and research information for presentation to executive leadership and other facility leadership and staff for use in the planning, development, and operation of new and existing managed care programs
- Provided subject matter expertise in response to day-to-day business issues; researched applicable subject matter practices; and remained aware of latest epidemiological disease management learning agendas.

Accomplishments and Impact:

- Created public health messaging and content and coordinated website maintenance, engaging over 5000 views that led to program sustainability and additional state funding for site management to reconcile and resolve budgetary matters.
- Managed external client facing relationships and partners with corporate and regional business areas advised undergraduate and graduate epidemiology interns and delegated tasks that supported the goals of the COVID-19 Vaccination Program staff and volunteers.

Interface Children & Family Services, Camarillo, CA — December 2020 – April 2021
EVALUATION MANAGER — 40 Hours/week

Key Responsibilities and Achievements:

- Successfully built and maintained systems and programs to assess and increase the impact of ICFS core program areas including justice services; domestic violence; mental health; human trafficking; runaway and homeless youth; early child and family development; and child abuse prevention.
- Ensured program sustainability by working collaboratively with Program Coordinators to obtain $1.5 Million in grant funding. Developed and tracked sound initiative goals and objectives ensuring partner engagement and commitment to agency objectives utilizing business intelligence tools for trauma-informed Mental and Behavioral Health programs.
- Led designing, developing, and executing critical complex projects supporting system migration, change control, and archival activities for data management systems.
- Extracted and compiled data from databases using query language to generate reports and presentations on collected data, interpreting the data, and drawing conclusions.

- Collaborated with Justice Services teams to facilitate performance improvement activities for quality of care, process improvement, regulatory compliance, and patient experience using evidence-based tools, techniques, and methodologies.
- Leveraged business intelligence tools to analyze reports and create solutions that would maximize the financial performance of the business unit.

Accomplishments and Impact:

- Successfully awarded $1.5 Million in grant funding (Medically Assisted Treatment (MAT), Phoenix Project, CCVI) following thorough evaluation and leadership recommendations for improvements to technology that would enhance continuous monitoring and compliance of privacy data and mature the management governance, practices, processes, and tools used.
- Leveraged business intelligence tools to analyze reports and create solutions that would maximize the financial performance of the business unit which led to generating agency and departmental fact sheet through Power BI.
- Developed roadmap for the modernization of processes, policies, and systems and other technological advancements with implementable milestones and sustainable outcomes. This included authoring proposals, reviews, and ratings of RFP from competing vendors, and final selection processes.

IQVIA (contracted), Long Beach, CA — June 2020 – November 2020
Clinical Research Coordinator — 40 Hours/week
Key Responsibilities and Achievements:

- Worked closely with the Director of Operations at Long Beach Clinical Trials site with collection and tracking of critical study documents, including preparation and approval of essential document packages.
- Facilitated successfully completed 3 eTMF reviews, including data management utilizing EDC for clinical trials to ensure compliance with study protocols and IRB, GCP, ICH, and FDA regulations and guidelines.
- Day- to-day data management and administration for 3 clinical studies simultaneously.
- Participated in the selection of Contract Research Organizations (CROs) for small budget sponsored clinical investigation.

Accomplishments and Impact:

- Provided strategic oversight to the Clinical Operations Director in our vendor and CRO relationships and provides clinical input into their governance committees.
- Reviewed start-up documentation, including site initiation, interim monitoring, and close-out materials.
- Conducted subject recruitment, eligibility screenings, informed consent (1678), and outpatient logistics to ensure accurate study tracking metrics, including study milestones, site/subject payments, vendor relations, etc.

Good Samaritan Health Center, Atlanta, GA — August 2016 – August 2018
Health Outcomes Manager — 40 Hours/week
Key Responsibilities and Achievements:

- Instrumental in identifying steps necessary to effectively communicate with outside organizations such as IPA's, health plans, and government agencies to serve as an internal SME for relevant programs and tracking performances, including HRSA Site Visit Protocol, HEDIS, PCMH, UDS, MU, FTCA, and Joint Commission guidelines.
- Fulfil research requests using inferential statistical techniques to interpret data from various sources such as surveys, automated reports, online programs, and published literature.
- Optimized administrative OPX budget and accelerated productivity of operations team following the execution of successful cost analysis and gaining sponsor approval and stakeholder buy-in for my recommendation to replace the outdated dental EHR with a cloud-based system.
- Provided strategic and practical support to develop, submit and maintain large-scale sponsored research projects and enhance community impact.
- Change agent and project management partner for the transformation and inaugural rollout of grant writing for QI/QA-related funding opportunities.
- Managed grants administration activities including development and management of contracts and subcontracts and ongoing post-award compliance matters by introducing the practice and coordination of PDSA Cycles.

Accomplishments and Impact:

- Successfully championed at-risk health programs, leading to NCQA accreditation by spearheading the development of the PCMH (Patient-Centered Medical Home) care delivery model within a healthcare facility of 45-50-personnel.
- Oversaw the re-branding of several CBO partners with social media content creation.
- Successfully developed and executed a pilot program aimed at revising an outdated QI/QA program, work plan, and annual evaluation process.
- Fostered a high-performance culture by motivating teams and developing member relationships and engagement.

Professional References

Professional, Academic, or Personal References
Available Upon Request

this page left blank

Quality and Performance Improvement Program Description

September 2025
MPQD1001

Program Approval

	08/20/2025

Robert Moore, MD MPH MBA
Quality/Utilization Advisory Committee (Q/UAC) Chairperson *Date Approved*

	09/10/2025

Angela Brennan, DO
Physician Advisory Committee (PAC) Chairperson *Date Approved*

	10/22/2025

Kim Tangermann
Board of Commissioners Chairperson *Date Approved*

TABLE OF CONTENTS

Program Purpose and Goals	4
Scope of Quality and Performance Improvement Program	5
Authority and Responsibility	6
Approach to Quality and Performance Improvement	17
Cultural Competency	40
Communication Systems	40
Delegation	42
Sanctions	42
Annual Quality Improvement Work Plan	42
Review by Outside Licensing Agencies or Accrediting Bodies	42
Annual Quality Improvement Program Evaluation	43
Statement of Confidentiality	43
Statement of Conflict of Interest	44
Appendix A	
Standing Staff Members of Partnership HealthPlan of California's Quality Improvement Committees	46
Appendix B	
Partnership HealthPlan Strategic Quality Plan: Achieving Five-Star Quality	59
Appendix C	
Pathway to Excellence: Partnership HealthPlan of California's Framework for Continuous Learning	72
Appendix D	
Resumes for Key Leadership Roles Accountable for Implementing and Maintaining the QI/PI Program	103

Program Purpose and Goals

Partnership HealthPlan of California's (Partnership) Quality and Performance Improvement (QI/PI) program provides a series of systematic processes to monitor and evaluate the quality of clinical care and health care service delivery to all Partnership members. This includes an organized framework to:

- Review activities and identify opportunities to improve the quality of health care services provided
- Promote efficient and effective use of health plan financial resources
- Promote and improve health equity
- Strike a balance between compliance with and performance on regulatory standards
- Partner with internal and external stakeholders to support performance improvement
- Improve health outcomes of our members

The QI/PI program promotes consistency in assessing and improving the quality of the full scope of health care services while providing a mechanism to:

- Ensure integration with current community and population health priorities, standards, and goals that impact the health of the Partnership member population
- Ensure alignment with DHCS' Comprehensive Quality Strategy Report
- Identify and act on opportunities to improve care and service
- Identify overuse, underuse, and misuse of health care services
- Identify and act on opportunities to improve processes to ensure member safety
- Identify and act on opportunities to address disparities in health access and outcomes
- Address potential or tangible quality issues
- Review trends that suggest variations in the process or outcomes of care

The QI/PI program adheres to the following goals to improve the quality and effectiveness of clinical care and service to Partnership members:

- Improve the health of the populations Partnership serves
- Enhance the member care experience
- Support the delivery of high-quality clinical care
- Reduce disparities in health access and outcomes
- Ensure member safety
- Measure and encourage appropriate use of clinical resources
- Strengthen a culture of continuous quality improvement within the Partnership network

The QI/PI program accomplishes these goals by:

- Systematically monitoring and evaluating service and care provided
- Continuously improving our data and approach to analytics to validate care outcomes
- Actively pursuing opportunities for improvement in areas that are relevant and important to Partnership members' health
- Implementing strong interventions when opportunities for performance improvement are identified
- Addressing overall member experience by improving provider access and member awareness of the health plan's role and responsibilities
- Promoting a culture of learning and improvement through a framework called Pathway to Excellence: Partnership's Framework for Continuous Learning (P2E)

These goals align with Partnership's mission: To help our members and the communities we serve be healthy.

Applying the model of a learning organization, the measurement and analysis of selected indicators and professionally recognized standards of practice underpin the evaluation of QI/PI activities. The objectives of the program are to:

- Engage providers, members, and community stakeholders to improve quality metrics through identifying opportunities for improvement and acting on opportunities that have the greatest impact on member care. These actions are driven by rigorous data analysis, whenever possible, and through a collaborative atmosphere where new ideas can be explored and tested to enhance learning.
- Improve member experience through enhanced primary care provider (PCP) access.
- Strengthen the data and analytics infrastructure through the development of foundational systems and processes for evaluation of results and decision-making.
- Achieve and maintain pertinent National Committee for Quality Assurance (NCQA) accreditations while ensuring compliance with contractual quality requirements, state and federal quality regulations, evidence-based standards of care, and standards of selected accrediting bodies.
- Equip PCPs to provide recommended high-quality care through provision of information, technical assistance, improvement tools, and financial incentives.
- Optimize value-based programs through measure research and incorporation of best practices.

The objectives, scope, organization, and mechanisms for overseeing effectiveness of monitoring, evaluation, and problem-solving activities in the QI/PI program are assessed and revised at least annually.

Scope of Quality and Performance Improvement Program

The scope of the QI/PI program includes the quality of clinical care and of service for all members. The program presently covers a Medi-Cal (the name for Medicaid in California) product line and includes the anticipated integration of a Dual Eligible Special Needs Plan (D-SNP), Partnership Advantage, in 2027. This is specifically defined as an Exclusively Aligned Enrollment (EAE) D-SNP. Partnership aims to become a Medicare Medi-Cal Health Plan, joining other managed care plans across California, in offering members eligible for both Medi-Cal and Medicare the opportunity for one plan to manage all of their benefits, including care coordination and other wraparound services.

The monitoring and evaluation of clinical issues reflects the population served by Partnership without regard to age group, disease category, or risk status. In partnership with other Partnership departments, the QI/PI program encompasses all aspects of medical care including:

- Diagnoses and procedures with a wide variation in cost or utilization patterns
- Identifying overuse, underuse and misuse of health care services and prescription medications
- Identifying and addressing racial/ethnic and other disparities in health care delivery or outcomes
- Identifying and addressing access or quality issues related to behavioral health services through delegated contracts
- Promoting cultural and linguistic competence of Partnership staff and network practice sites and providers
- Member Experience Outcomes
- Facility Site Reviews and ongoing monitoring to assess compliance with patient safety standards
- Ambulatory medical records review
- An assessment of physical accessibility of outpatient providers for seniors and persons with disabilities
- Preventive health care guideline compliance
- Chronic and acute care clinical practice guideline (CPG) compliance
- Continuity and coordination of care between PCPs and specialists, different levels of care, PCPs and other provider types, and PCPs and Behavioral Health Practitioners (through the Care Coordination department)
- Accessibility and quality of primary, specialty, and behavioral health care
- Member grievances (through the Grievance & Appeals department)
- Investigation and resolution of Potential Quality Issues (PQIs)
- Provider satisfaction (through the Provider Relations department)
- Provider credentialing (through the Provider Relations department)
- Supporting clinics in achieving patient centered health homes

The QI/PI program encompasses monitoring and evaluation of care and service in the following settings:

- Acute hospital services
- Ambulatory care, including preventive health care, perinatal care, chronic disease management, and family planning
- Emergency and urgent care services
- Behavioral health services* (mental health and substance use disorder)
- Ancillary care services including but not limited to: home health care, skilled nursing care, subacute care, pharmacy, medical supplies, durable medical equipment (DME), therapy services, laboratory, vision, and radiology services
- Long term care placements in skilled nursing facilities, subacute care facilities, and intermediate care facilities.
- Wellness and Recovery Program

Refer to the Approach to Quality and Performance Improvement section for more information on Behavioral Health Services

Authority and Responsibility

Board of Commissioners

The Board of Commissioners on Medical Care (the Commission) promotes, supports, and has ultimate accountability, authority, and responsibility for a comprehensive and integrated QI/PI program. The Commission is ultimately accountable for the quality of care and services provided to members. The Commission has delegated direct supervision, coordination, and oversight of the QI/PI program to the Physician Advisory Committee (PAC), which serves as the main Quality Improvement committee. PAC is supported by two other quality committees – the Quality and Utilization Advisory Committee (Q/UAC) and the Internal Quality Improvement Committee (IQI), which are described in more detail below. The county Boards of Supervisors for each geographic area appoints members of the Commission, which include representatives from the community, including consumers, businesses, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health departments. The Commission meets six times per year.

The purpose of the Commission is to arrange for the provision of health care services to qualifying individuals, as well as other purposes set forth in the enabling ordinances established by the respective counties.

Key Roles

The following leadership roles carry authority and responsibility to ensure the QI/PI Program is fully implemented and maintained. The qualifications of staff presently fulfilling these roles are detailed in Appendix D which includes documented evidence corresponding to that collected annually on behalf of DHCS. Given the personal details included, this appendix is not posted publicly.

Chief Executive Officer

The Partnership Chief Executive Officer's (CEO) primary roles in quality management and improvement are multifaceted. The CEO maintains a working knowledge of the clinical and service issues targeted for improvement and provides overall organizational leadership and direction in these efforts. In addition, the CEO identifies new and emerging opportunities to strengthen accountability among both internal teams and external partners in driving quality and performance improvement. They are actively involved in the prioritization and oversight of quality improvement activities across the organization and ensure that the necessary resources are available to support the successful implementation of the approved QI/PI program.

Chief Operating Officer

The Chief Operating Officer (COO) provides strategic leadership and guidance in all health plan operations. The COO has purview over the Member Services, Provider Relations, Claims, Configuration, Grievance and

Appeals, Transportation and the Regional Leadership departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The COO's level of involvement fulfills the need for executive support and accountability for data quality improvements, and interdepartmental support for quality improvement interventions and initiatives.

Chief Health Services Officer
The Chief Health Services Officer (CHSO) works closely with leaders in Utilization Management to provide accountability for delegates to meet necessary NCQA accreditation requirements and provide strategic leadership and guidance in the review and revision of provider contracts to ensure QI reporting requirements and value-based program contingencies are met. The CHSO also has purview over the Care Coordination, Utilization Management, Enhanced Health Services, Behavioral Health and Health Equity departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The CHSO's level of involvement fulfills the need for executive support and accountability for improvements with data quality AND coordination of activities between QI and these departments**.** This role collaborates with the Chief Medical Officer and members of PAC, Q/UAC, and IQI in matters involving quality of care, clinical, and medical procedures.

Chief Medical Officer
The Chief Medical Officer (CMO), with the assistance of the members of PAC, Q/UAC, and IQI, as well as the other medical directors of Partnership, is responsible for providing professional judgment regarding matters of quality of care, peer review, clinical, and medical procedures. The CMO is the chair of IQI and Q/UAC and has significant involvement in all QI/PI, Pharmacy, and Health Services activities as well as providing oversight to these programs on a day-to-day basis. The CMO is a Medical Doctor (MD) or Doctor of Osteopathy (DO) with an unrestricted license in the State of California.

Medical Director for Quality
Assists CMO by providing physician support for varying activities within the QI/PI department, including Performance Improvement, Member Safety, Peer Review, and the Quality Incentive Programs, as well as assists with utilization management review activities. This role also serves as management oversight for the Member Safety teams within the QI/PI department.

Medical Director of Medicare Services
This role provides physician leadership in preparation for implementing the Medicare Dual Special Needs Plan (D-SNP). This medical director works closely with the CMO and QI/PI Department to develop policy, strategy, and tactical activities with Medicare leads designated in departments across the organization. As D-SNP is implemented, this role will provide medical leadership for Partnership's Medicare activities, including utilization management, quality, care coordination, pharmacy, grievances, and compliance activities. Also assists CMO, as requested, in supporting broader needs to oversee appropriateness and quality of care delivered through Partnership and for the cost-effective utilization of services.

Senior Director of Quality and Performance Improvement
This role works collaboratively with the CMO to define strategy, develop programs and services, and to evaluate the effectiveness of the QI/PI Program. Together with the QI management team, including the Medical Director for Quality, provides oversight of Facility Site Reviews, investigation of potential quality issues, compliance with NCQA standards, HEDIS® and other performance measure data collection and performance reporting, value-based payment programs (QIPs), performance improvement initiatives and programs, external and internal QI training, provider education on the QIPs and HEDIS®, grant application and grant management. This role works to foster greater cross collaboration of QI staff and strategic involvement of other departments to support the execution of tactics defined and maintained under Partnership's 5-Star Quality Strategy.

Chief Strategy & Government Affairs Officer
The Chief Strategy and Government Affairs Officer (CSGAO) reports to the Chief Executive Officer and is a peer to the other executive team members. The CSGAO leads the overall strategic direction of the HealthPlan in consultation with the CEO and Governing Board. This position is responsible for the operations and executive management of Regulatory Affairs and Compliance (RAC); Communications, Legal, Network Services, and Project Management/Operational Excellence (PMO) departments. This position also oversees our Medicare Duals Special Needs Plan (D-SNP) program.

Senior Director of Regulatory Affairs & Contracting
This position serves as Partnership's Compliance Officer, working to ensure the HealthPlan's ongoing compliance with all applicable federal, state, local, and administrative agency statutory and regulatory requirements. Furthermore, this position serves as Partnership's Fraud Prevention Officer and Privacy Officer; is a subject matter expert in fraud and privacy and is responsible for promoting the prevention, detection, and deterrence of fraud and privacy risks while ensuring PHC complies with all state and federal privacy and fraud laws.

Behavioral Health Clinical Director
The Behavioral Health Clinical Director holds an MD/DO, PhD or PsyD credential. With the assistance of the Behavioral Health team, this individual is responsible for providing professional judgment regarding matters of quality of care, peer review, and clinical policies and procedures through oversight of Partnership activities in the areas of mental health and substance use disorder services as provided by Partnership's delegated behavioral health providers.

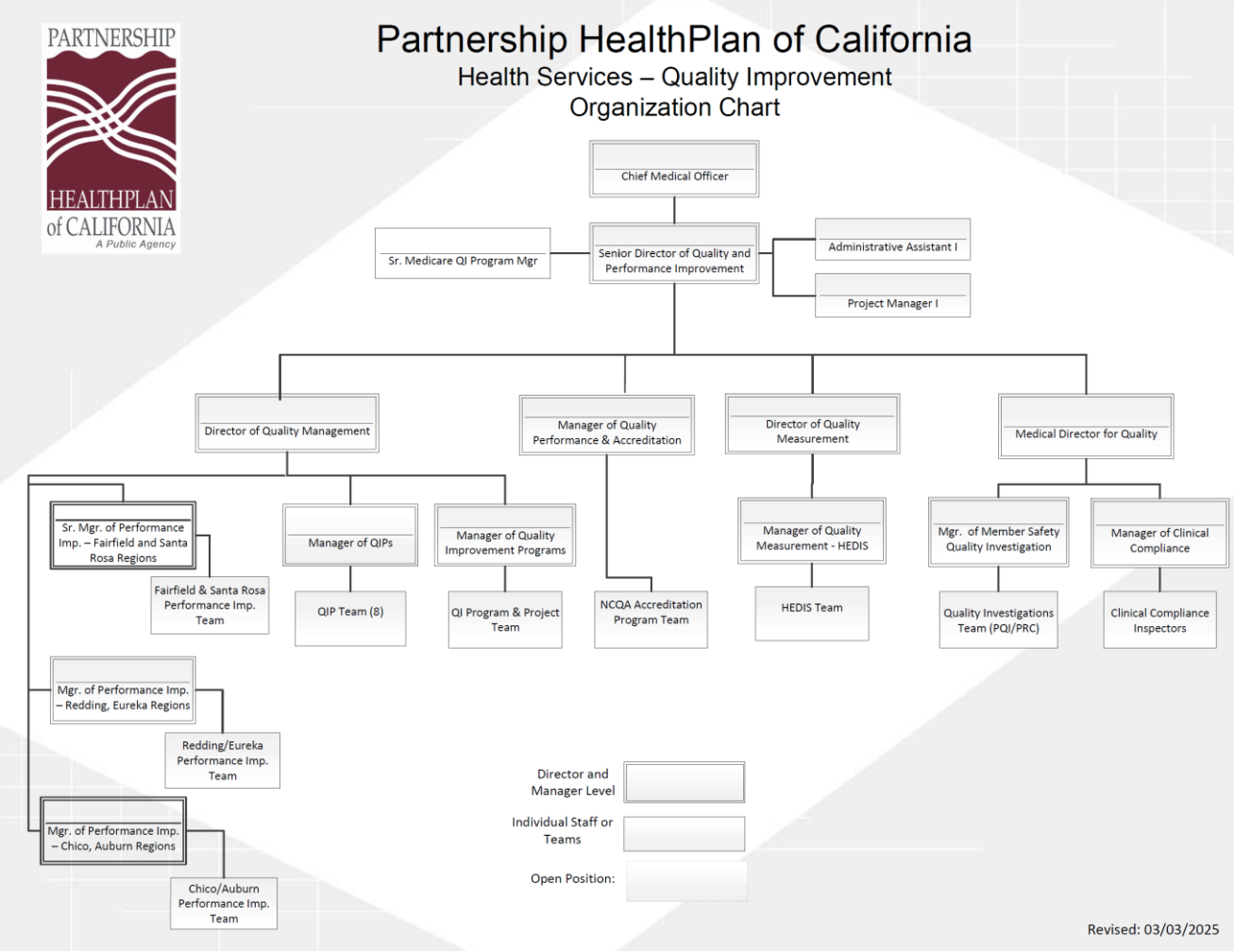
Senior Director of Behavioral Health
Under the direction of the Chief Health Services Officer (CHSO), the Senior Director of Behavioral Health leads the Behavioral Health team to oversee the operations and delegated functions of Partnership's mental health and substance use disorder services. Partnership's annual audit of Carelon Behavioral Health stipulates that the organization produces evidence that Behavioral Health Specialists at the level of PhD and/or MD are on their QI Committee or teams that report to their QI Committee. Carelon meets this standard.

Director of Health Equity (Health Equity Officer)
The Director of Health Equity serves as the Health Equity Officer (HEO) for Partnership. In collaboration with Partnership leaders, the Director of Health Equity leads the development and implementation of strategies that advance diversity, equity, and inclusion across the organization. This role drives systemic change to enhance representation and cultivates programs that foster a culture of belonging. It also promotes awareness of health inequities within our membership and guides the creation of actionable plans to address them. Key responsibilities include identifying opportunities to track, analyze, and reduce disparities in care, with a focus on the varied cultural, linguistic, economic, educational, and health needs of our communities and workforce. In collaboration with the CMO, oversees the Quality Improvement and Health Equity Transformation Program (QIHETP) program operations and assists in the development and coordination of QIHETP policies and procedures.

Director of Population Health Management
The Director of Population Health Management works collaboratively with leaders across the organization, to execute the organization's Population Health Management strategy. This role provides oversight, strategic direction, and support for related initiatives, including those essential to improving quality measure performance and member experience. This role offers guidance and ensures alignment with health care policies, financing, accreditation requirements, and regulations to drive optimal health outcomes for members.

Program Staff

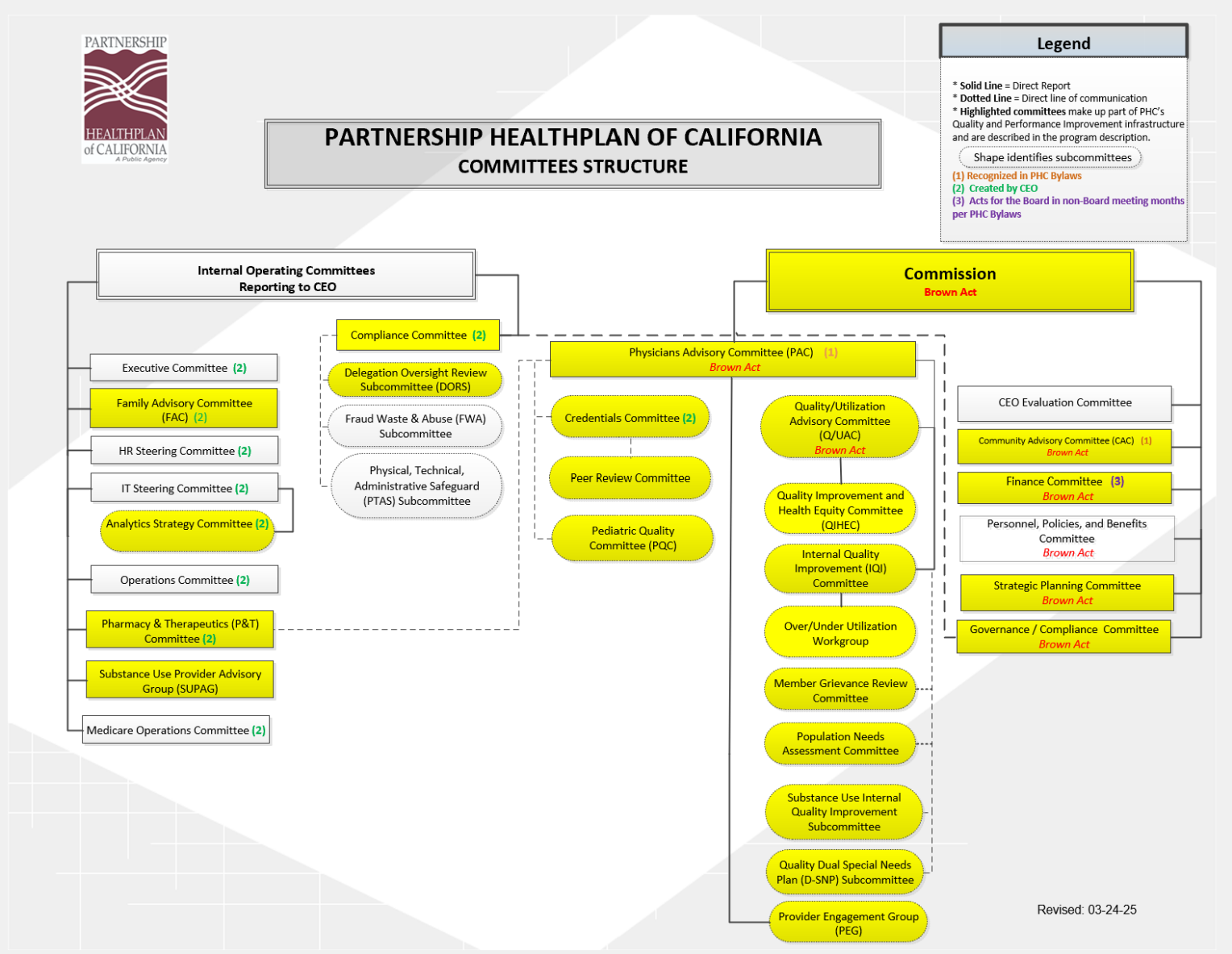
Partnership QI/PI program leadership and corresponding teams are outlined in the organizational chart below.



The QI/PI department is structured to provide governance over the QI program and corresponding work plan. Under the guidance of the CMO, the Senior Director of Quality and Performance Improvement and respective directors in QI/PI lead the department in the execution of QI/PI activities outlined in the QI Program Description and QI Work Plan. The department ensures the primary activities related to performance improvement, adherence to regulatory requirements, and the quality and safety of clinical care to optimize members' experience with Partnership are completed through ongoing engagement and the provision of interdisciplinary support to all areas within Partnership.

Committee Functions

Partnership has developed a robust committee structure to support the breadth and depth of multiple facets of QI/PI regulatory requirements and activities. There are several internal operating committees that report to the CEO and a number of external facing committees, principally PAC and four others that report directly to the Board of Commissioners. Certain committees must adhere to state regulations, including the Brown Act, which provides stipulations for making meetings available to the public. The diagram below describes how committees are organized and the reporting structures. This is followed by a narrative briefly describing each committee, in alphabetical order, essential to the Quality and Performance Improvement infrastructure.



Analytics Steering Committee
The Analytics Steering Committee (ASC) is a multidisciplinary forum with representatives from Claims, QI/PI, Office of the CMO, Health Services, Members Services, Behavioral Health, Strategy and Government Affairs, Provider Relations, Finance, and IT. The ASC is part of the Analytics Center of Excellence (ACE), an enterprise-wide virtual framework that functions to promote and coordinate data analytics efforts to generate information, knowledge and wisdom to improve health outcomes, enhance the member experience of care, and reduce or maintain the cost of care by optimizing utilization of data, technology and staff.

The ASC meets every other month throughout the year with the following foci:

- Act as an advocate for data analytics initiatives and projects across the wider organization
- Provide oversight and guidance for Partnership's data analytics projects across all regions
- Provide recommendations based on data analysis and strategic planning
- Inform and advise the Data Governance Council (DGC) on relevant analytic initiatives and cooperates with the DGC to ensure alignment with overall data strategy
- Review and monitor policies to guide data analytics throughout Partnership
- Promote and foster data analytics, data interpretation, and data sharing to improve the utility of data for planning and decision-making, especially related to current issues, initiatives, and integrated problem-solving. (Analytics Champion)
- Establish project goals for the ACE as well as determine how success will be measured
- Act as final authority for resolving issues or disputes on analytics prioritization and needs
- Identify and advise on minimizing project and business risks
- Establish subcommittees as required to facilitate the work of the committee

Compliance Committee
The Compliance Committee, chaired by the Compliance Officer, is an internal committee and has general responsibility to oversee Partnership's compliance and ethics programs. The purpose of the Committee is to oversee Partnership's implementation of compliance programs, policies and procedures that are designed to respond to the various compliance and regulatory risks facing the company; provide an avenue of communication among management, those persons responsible for the internal compliance function, and the Commission; and perform any other duties as directed by the Commission or the CEO.

Community Advisory Committee (CAC)
The Community Advisory Committee (CAC) is composed of Partnership members, advocates and stakeholders who represent the diversity and geographic areas of Partnership's membership including hard-to-reach populations. The CAC is a liaison group between our members and Partnership, advocating for members by ensuring that the health plan is responsive to the health care and information needs of all members. Additionally, the CAC provides Partnership members with a forum to discuss common issues of interest and importance, while creating a supportive and informative environment. The CAC meets quarterly, reviews and makes recommendations regarding quality improvement activities, provides feedback on quality and health equity initiatives, and serves in the capacity of a focus group. Three CAC members are selected to serve on the Partnership Board to provide member input and report back to the CAC.

Credentials Committee
The Partnership CMO, or designee, chairs the Credentials Committee. Committee members include a minimum of five contracted network practitioners. The committee meets monthly, excluding July and December. The functions of the Credentials Committee are to:

- Participate in and make recommendations regarding the structure and process for the credentialing and re-credentialing of providers and licensed practitioners
- Participate in the development, implementation, and annual review of related policies and procedures
- Review and approve Partnership staff recommendations for credentialing of practitioners who meet criteria
- Review and approve Partnership staff recommendations for credentialing of practitioners who do not meet exception criteria

- Review qualifications and circumstantial details for contracted practitioners who meet exception criteria and make credentialing decisions
- Review and evaluate the qualifications of each practitioner seeking re-credentialing as a contracted provider at least every three years and assure compliance with established criteria
- Review ongoing sanctions monthly and member complaints quarterly for each practitioner
- Verify that each provider in the network meets credentialing requirements, including implementation of and adherence to any corrective action plans (CAPs) to meet standards
- Decisions regarding provider credentialing and re-credentialing
- Develop disciplinary or sanction actions of practitioners
- Provide oversight of any delegated credentialing activities

Summary information of credentialing activities is presented to the PAC and to the Partnership Board of Commissioners at regularly scheduled meetings.

Delegation Oversight Review Subcommittee (DORS)
The Delegation Oversight Review Subcommittee (DORS) comprises representatives from operational departments that have oversight responsibility wherein Partnership has assigned authority to an external entity (delegated entity) to perform on its behalf. DORS meets no less than four times per year and is responsible for overseeing agreements and responsibilities between Partnership and its delegated entities. The Subcommittee is tasked with overseeing that delegates are compliant with all applicable state and federal regulations, contractual obligations, and accreditation requirements.

Family Advisory Committee (FAC)
The Family Advisory Committee (FAC) is a member advisory group to the CEO and staff of Partnership. The FAC provides a forum for parents, guardians and caregivers of children with CCS conditions to discuss common issues of interest and importance, to create a supportive and informative networking environment and to advocate for members by ensuring that Partnership is responsive to the diversity of health care needs for all members. Minutes from FAC meetings are reviewed by the PQC.

The FAC membership is comprised of representatives throughout Partnership's geographic service areas who advocate for CCS-eligible children of diverse cultures, ethnicities, genders, ages and disabilities. Meetings are held at least four (4) times per year with the option for additional meetings as needed.

The mission of FAC is to leverage the Whole Child Model (WCM) to enhance the quality of how CCS beneficiaries – and their families – experience care.

Finance Committee
The Board of Commissioners authorizes the Finance Committee to act on matters of urgency when the Board does not meet. Items approved by the Finance Committee are ratified by the full Board at a subsequent full Board meeting. The Finance Committee is comprised of an appointed group of members from the Board, which encompasses representation from across Partnership's entire service region. The Finance Committee meets monthly.

The Finance Committee has the following authority:
- Review and make recommendations on the annual budget
- Review and make recommendations on financial policy
- Review major capital expenditures
- Monitor the financial status of the organization and overall leadership for better management in alliance with the executive team and other Partnership staff

The Committee also advises the Board of Commissioners on the fiscal impact of any changes pertaining to value-based programs as related to:

- Payment structure
- Annual budget
- Prioritizing programs

Governance and Compliance Subcommittee

The Governance and Compliance Committee is a subcommittee of the Commission, has the fiduciary responsibility to oversee Partnership's regulatory Compliance Program, and shall ensure the establishment and maintenance of an effective compliance and ethics program by assuring compliance activities are reasonably designed, implemented, and generally effective in preventing and detecting risks or compliance violations. The subcommittee meets quarterly.

Internal Quality Improvement (IQI) Committee

An internal Partnership committee comprised of appropriate Partnership department directors and staff, the Internal Quality Improvement (IQI) Committee tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation. The IQI Committee meets monthly, at least ten (10) times per year, with the option to add additional meetings if needed, to review policies, procedures, and QI activities. The Partnership CMO (chair of the committee), Director of Health Equity, Medical Director for Quality, Manager, Member Safety - Quality Investigations and Health Services leadership as described for Q/UAC attend IQI Committee meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. Multidisciplinary improvement teams may be designated to complete analysis and intervention recommendations for quality improvement issues and activities. Evaluations and recommendations put forward at IQI represent strategies used in local entity engagement to address deficiencies in performance measures for members 21 years of age or less. The IQI Committee serves to integrate quality activities organization-wide, which are then reported to Q/UAC and PAC.

Member Grievance Review Committee (MGRC)

The Member Grievance Review Committee (MGRC) represents a multidisciplinary oversight forum with representatives from Claims, QI/PI, Office of the CMO, Pharmacy, Care Coordination, Utilization Management, Population Health, Member Services, Provider Relations, RAC, Behavioral Health, Enhanced Health Services, and Transportation Services to track and trend Grievances, Appeals, Exempt Grievances, and State Hearing cases. It serves as a collaborative work group to discuss complex cases or improvement opportunities with the following key focus areas: quality improvements, clinical oversight, operational excellence, member experience, and regulatory compliance. Findings may be presented in the Q/UAC, IQI, CAC, Delegation Oversight Review Subcommittee (DORS), and/or Substance Use Internal Quality Improvement Subcommittee (SUIQI) meeting. MGRC is held on a quarterly basis.

Over/Under Utilization Workgroup

The Over/Under Utilization Workgroup is an internal Partnership committee that evaluates services that may be over-or under-utilized compared to optimal utilization. The Over/Under Utilization Workgroup meets quarterly. Its goals are to use the results of the analysis to drive quality improvement activities, accuracy of data collection and analysis, and the most cost-effective use of resources. A designated Partnership Medical Director chairs the committee, and the Health Analytics department supports it. Representatives from Health Services (e.g. Pharmacy, Population Health, Health Equity, Quality Improvement, and Utilization Management), Compliance, Member Services, Operational Excellence/Project Management Office (Op-Ex/PMO), Provider Relations, and Claims also attend. A summary of activity from the committee is annually reported to IQI and Q/UAC, (as part of the Utilization Management Grand analysis) and Partnership's Compliance Committee.

Pediatric Quality Committee (PQC)

The Pediatric Quality Committee (PQC) is the clinical advisory committee for the Whole Child Model (WCM) program. The PQC meets at least four (4) times per year with the option for additional meetings if needed.

The membership of PQC includes the Partnership Whole Child Model Medical Director (Chairperson), CMO (Vice Chairperson), Chief Health Services Officer (CHSO), Pharmacy Director, at least four California Children

Services (CCS) paneled clinician providers, CCS Medical Directors designated by each Partnership County, and Nurse Director or Manager as designated by each County CCS program. Other health plan staff and outside experts may make special or periodic reports to the committee or may attend selected meetings by invitation from the committee chair or designee.

Peer Review Committee (PRC)
The Peer Review Committee (PRC) membership includes external practitioners representing PCPs, board certified specialists and non-physician medical practitioners (NPMP), which include nurse practitioners, physician assistants, certified nurse midwives, and licensed midwives. The Partnership CMO Regional and Associate Medical Directors are also voting members of the PRC. Partnership's RN Quality Investigators and the Manager of Member Safety - Quality Investigations support the Committee. Partnership's Medical Director for Quality, CMO, or other designated Partnership Medical Director chairs the committee. NPMP may vote to rate providers and/or systems only in areas in which they possess subject matter expertise. All committee members are eligible to vote on issues brought before the committee. The committee meets at least quarterly and on an as needed basis. Peer Review functions are to:

- Review potential and actual quality issues and provider/member complaints and appeals related to quality of care
- Make recommendations for Corrective Action Plans (CAP) and practitioner discipline or sanctions to the Credentials Committee
- Make recommendations on improvements to systems of care based on specific occurrences

Physician Advisory Committee (PAC)
The Physician Advisory Committee (PAC) monitors and evaluates all Health Services activities and is directly accountable to the Board of Commissioners for the oversight of the QI/PI program. PAC meets at least ten (10) times a year. Voting membership includes external PCPs, board certified high-volume specialists and non-physician clinicians. A voting provider member of the committee chairs PAC. The Partnership CEO, COO, Chief Financial Officer (CFO), CMO, Medical Director for Quality, Regional Medical Director(s), Behavioral Health Clinical Director, and leadership from the following departments including; QI/PI, Provider Relations, Care Coordination, Utilization Management, Network Services, and Pharmacy attend PAC meetings regularly. Other Partnership staff attend on an adhoc basis to provide expertise on specific agenda items. PAC oversees the activities of Q/UAC and other quality- related committees and reports QI/PI activities to the Board of Commissioners.

Pharmacy and Therapeutics (P&T) Committee
The Pharmacy and Therapeutics (P&T) Committee is comprised of Partnership staff and network practitioners including pharmacists, PCPs, and specialists, including behavioral health. The Chief Medical Officer (CMO) or Pharmacy Director (when designated by the CMO) chairs the P&T. The committee makes decisions and recommendations on development and review of the medical benefit drug formulary, pharmacy policies and procedures, new drugs, and drug approval criteria. The P&T meets quarterly, providing regular activity reports and recommendations to PAC, the approval authority for P&T related activities. The P&T Committee also serves as Partnership's Drug Utilization Review (DUR) Board. Partnership's DUR Board conducts retrospective analysis on drug utilization to identify patterns of fraud, waste, and abuse or inappropriate or medically unnecessary care. In addition, the DUR Board makes recommendations for education programs and bulletins to improve drug safety and therapeutic outcomes.

Provider Engagement Group (PEG)
Meetings are held quarterly. This group will include network staff and vary based on subject matter. The purpose of PEG is to educate and update the network about new Partnership programs, benefits, and/or changes mandated by DHCS or Partnership. The Plan staff will target specific network invitees depending upon subject matter to be presented or discussed. Targeted provider audience and invitees include clinic managers, supervisors and other mid-management staff. Minutes of the meetings will be presented to PAC.

Population Needs Assessment Committee (PNA)
The Population Needs Assessment Committee (PNA) is an internal committee serving as a multi-departmental decision-making body whose goal is to carry out the DHCS mandate to meaningfully participate in each Local Health Jurisdiction's (LHJs) Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). The PNA Committee meetings occur on a bi-monthly basis to review requests from the counties, and general progress towards shared work on the CHA/CHIP collaborative in Partnership's service areas, including the approval and implementation of the shared SMART (Specific, Measurable, Attainable, Relevant, Time-Bound) goals between Partnership and each of the LHJs in Partnership's service. This committee also meets annually to review and make recommendations for the Population Needs Assessment (PNA) used to fulfill NCQA requirements. The PNA Committee activities and recommendations will be shared with the Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC) and Partnership's Board of Commissioners.

Quality Improvement and Health Equity Committee (QIHEC)
The Quality Improvement and Health Equity Committee (QIHEC) meets bimonthly analyzing and evaluating the results of Health Equity related Quality Improvement activities. This includes annual review of the results of performance measures, utilization data, consumer satisfaction surveys, grievance and appeal data, and findings and activities of other Partnership specific committees (e.g., Community Advisory Committee, Population Needs Assessment Committee, etc.). This committee shall also be responsible for instituting actions to address health-equity performance deficiencies, including policy recommendations, and ensuring appropriate measurement and follow-up of identified performance deficiencies.

The QIHEC provides recommendations to Q/UAC. Q/UAC provides recommendations to PAC.

Partnership Members of the QIHEC include (but are not limited to): CMO, Director of Health Equity, Director of Grievance and Appeals, COO, Director of Communications, Director of Health Analytics, Senior Director of Quality and Performance Improvement, Director(s) of Care Coordination, Director(s) of Utilization Management, Director(s) of Population Health, Senior Health Educator, Chief Health Services Officer (CHSO), Director of Pharmacy Services, Regional Medical Director(s), Associate Medical Director(s), Senior Provider Relations Representative Manager, and Senior Director of Member Services. In addition, a broad range of network providers (e.g. Hospitals, Clinics, County Partners, Subcontractors, Downstream Subcontractors, and Members will be solicited to actively participate in the QIHEC.

Quality/Utilization Advisory Committee (Q/UAC)
The Quality/Utilization Advisory Committee (Q/UAC) is responsible to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. This responsibility includes providing significant input on the QI Program Description, Annual Evaluation and Work Plan. Q/UAC voting membership includes consumer representative(s) and external clinicians who represent hospitals, medical groups, and practice sites in geographic sections of Partnership's service area. Physician and non-physician clinician members also serve on the Peer Review Committee. The Partnership CMO (chair of the committee), Behavioral Health Clinical Director, Director of Health Equity, Medical Director for Quality, Manager of Member Safety - Quality Investigations, and leadership from the Health Services departments (e.g. QI/PI, Utilization Management, Care Coordination, Pharmacy, Population Health, Health Equity, Enhanced Health Services, Grievance and Appeals, and Provider Relations departments attend Q/UAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The committee meets monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to PAC and at least quarterly to the Commission.

Activities include but are not limited to:
- Review and approve the QI/PI Program Description, Program Evaluation and Work Plan annually
- Review and approve standardized utilization review criteria and protocols
- Approve and ensure implementation of evidence-based guidelines and policies of medical practice including preventive, chronic care, and behavioral health initiatives

- Analyze summary data and make recommendations for action plans for quality improvement activities
- Assure that appropriate follow-up activities occur for all CAPs and QI/PI activities
- Provide oversight of delegated QI activities except for credentialing activities, which the Credentials Committee reviews

Strategic Planning Committee
The Strategic Planning Committee advises the Board of Commissioners and the CEO on long-range strategic issues affecting Partnership. This committee is appointed by the Board of Commissioners and is comprised of some Board of Commissioners' members and other leaders from the community who are not members of the Board. This committee meets on a quarterly basis.

Substance Use Internal Quality Improvement Subcommittee (SUIQI)
A committee comprised of appropriate Partnership and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for Partnership's substance use disorder services oversight. The Substance Use Internal Quality Improvement Subcommittee (SUIQI) meets at least quarterly. Activities and progress are reported to IQI. This also includes review of:

- Utilization management retroactive and appeals review
- Inter-rater reliability for peer review and utilization management
- Quality of service, quality of facility, and grievances and appeals
- Investigation of potential over-use, under-use, and misuse of services
- Policies related to provision of substance use disorder services

Members of the committee include the Behavioral Health Clinical Director, Senior Director of Behavioral Health, Senior Manager of Behavioral Health, CMO, and representatives from Provider Relations, Member Services, Claims, Compliance, Behavioral Health, and Quality Improvement departments.

Substance Use Services Provider Advisory Group (SUPAG)
The Substance Use Services Provider Advisory Group (SUPAG) monitors Partnership substance use disorder services treatment activities. The committee will meet at least four times per year. Membership includes licensed and certified substance use disorder service providers and clinicians and others involved in substance use disorder care. The Committee also includes county substance use disorder services administration representatives.

Note: Meeting frequency indicated with each committee is subject to change based on business needs.

Membership in committees is voluntary and open to all who meet the minimum criteria and who are willing to serve. When positions become available, Partnership looks for committee members who reflect the diversity of our communities. Partnership continually evaluates key diversity factors (including, but not limited to: race, ethnicity, language, gender identity, sexual orientation, disability status, etc.) to ensure that committee membership reflects Partnership's membership and provides diverse views. The committee chair will make a good faith effort to review and verbally report (to committee members) key membership demographic information after the publication of the Partnership community reports when a position becomes available, annually. As opportunities present, special efforts will be made to invite candidates who reflect such attributes to continually encourage diversity within committees.

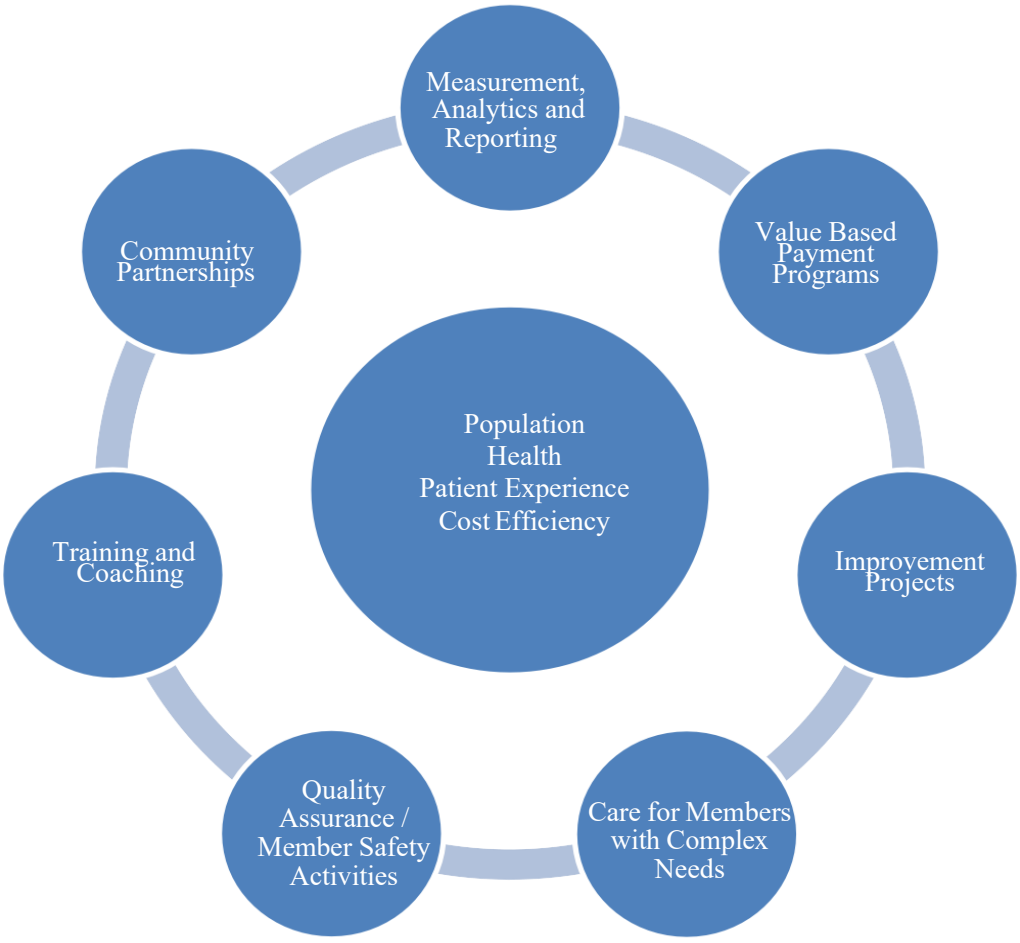
As a tool for evaluating meaningful improvements in DEI and for preparing for Health Equity Accreditation, Partnership will distribute a DEI Survey on an annual basis to assess the diversity of key committees starting in 2024. The annual DEI Survey will allow committee members to provide feedback on improving the diversity, equity, and inclusion within their respective committee. Certain committees are more involved in the decisions for services regarding member experience and clinical care, and therefore such key committees will be prioritized in assessing their respective DEI compositions and opinions. The key committees identified to receive the DEI Survey in 2024 were Q/UAC, PAC, P&T, CAC, PRC, and QIHEC. Committee members will be provided with updated Partnership membership demographic data to compare with the makeup of the organization itself. This information will be utilized to identify at least one (1) opportunity to improve the DEI of key committees.

Approach to Quality and Performance Improvement

Partnership's Quality and Performance Improvement program focuses on simultaneous pursuit of the Institute for HealthCare Improvement (IHI) Quintuple Aim – population health, patient experience, cost efficiency, workforce well-being and advancing health equity – via seven primary levers:

- Measurement, Analytics and Reporting
- Value Based Payment Programs
- Improvement Projects
- Care for Members with Complex Needs
- Quality Assurance and Member Safety Activities
- Training and Coaching
- Community Partnerships

In addition to the Triple Aim (population health, patient experience and cost efficiency), Partnership is committed to pursuing the fourth aim of achieving workforce well-being. This aim ensures providers across our network have adequate resources to provide high-quality care to our members. Additionally, Partnership is dedicated to pursuing a fifth aim of achieving equitable health for all of our members. This aim supports an increased understanding of social determinants of health and working to address disparities that impact the quality and sufficiency of health care provided to Partnership members.



Mental Health Services:
Since January 1, 2014, Partnership has provided mental health services for those with mild to moderate treatment needs, pursuant to the Plan's Medi-Cal contract with the State of California. This mandate is detailed in the California Department of Health Care Services (DHCS) All Plan Letter 22-006 (Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services) issued April 8, 2022. Partnership delegates the administration of these services to Carelon Behavioral Health, formerly known as Beacon Health Options, in all 24 counties served by Partnership. By the start of 2026, Partnership will no longer delegate member-facing responsibilities to Carelon Behavioral Health, including its member access line, grievances & appeals, and care coordination functions. The exact scope and timing of de-delegation is pending finalization in early 2025-2026.

DHCS assigns Specialty Mental Health Services for mental health conditions deemed to be moderate to severe in terms of level of impairment (also referred to as serious and persistent mental health conditions or SMI) to County Mental Health Plans (MHPs). These include all conditions that meet the medical necessity criteria pursuant to the DHCS Behavioral Health Information Notice (BHIN) 21-073, issued December 10, 2021.

Mental health QI management and improvement activities are delegated in part by Partnership to Carelon Behavioral Health. Partnership oversight of these delegated QI functions is achieved through: 1) annual and ad hoc audits, 2) semi-annual review of QI reports produced by these entities, and 3) discussion of quality management and development of quality improvement projects, (e.g., improved PCP referral forms, review and monitor quality issues related to neuropsychological testing, additional reports related to QI, and access standards).

Wellness and Recovery Program:
On July 1, 2020, Partnership and seven counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) implemented the "Wellness and Recovery" program, a regional substance use disorder services program. As Partnership does for other services, this program description includes the planned structure of quality and performance improvement activities Partnership uses for the overall program.

The quality infrastructure of the Wellness and Recovery Program is designed to help achieve one of the key goals of the program: the integration of substance use disorder services with the existing physical and mental health service delivery system. It reflects the incorporation of the county-focused quality structure outlined in the state and federal Organized Delivery System (ODS) waiver requirements into the strong, foundational quality structure of Partnership.

Measurement, Analytics and Reporting
The QI/PI department collects data annually on clinical indicators for Medi-Cal through the Health Effectiveness Data & Information Set (HEDIS®) program. DHCS and NCQA Accreditation are two governing entities that mandate HEDIS® annual reporting. NCQA is the governing entity at the national level, whereas DHCS is the governing entity at the CA State level.

DHCS and NCQA select sets of clinical quality measures that are sourced directly from the NCQA measure library and/or Center for Medicare & Medicaid Services (CMS) measure library in which managed care plans are required to report. The DHCS and NCQA clinical quality measure sets also identify measures requiring stratification by race/ethnicity and language per NCQA's designated categorizations.

Partnership annually conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, which measures member experience in the last six months across a set of standard questions. In addition, Partnership cooperates with the CAHPS® survey conducted annually by DHCS for its Medi-Cal population. The CAHPS® survey results, combined with the final rate performance of the HEDIS® clinical quality measures are calculated by NCQA to provide Partnership's overall Medicaid Health Plan Star Rating. Partnership participates in compliance audits for HEDIS® and CAHPS® with the state-contracted External Quality Review Organization (EQRO) and Partnership's contracted audit firms to ensure that survey results and measure rate calculations are in accordance with NCQA and CMS specifications. Utilizing an NCQA certified software vendor, Partnership calculates and reports the performance, including health equity-based stratifications, as required by NCQA and

DHCS at the reporting unit level. Separately, Partnership reports CAHPS® survey results at the plan-wide level, and HEDIS® measure performance results at the reporting unit level for its fully delegated subcontractors. Partnership works with the EQRO to report audited results per due dates defined by NCQA and DHCS annually. Partnership utilizes DHCS' EQRO File Transfer Protocol (FTP) website when sending communications containing patient-level data, as required per the direction of the EQRO during the annual performance measure validation audit.

Once submitted to NCQA and DHCS, Partnership further evaluates its performance, and that of its fully delegated subcontractors, versus the NCQA National and DHCS established Quality and Health Equity Performance measure benchmarks. The resulting Annual HEDIS® Performance Summary includes analysis of whether or not Partnership, including its fully delegated subcontractors, met or exceeded the NCQA National and DHCS established benchmarks. Currently DHCS defines high performance level (HPL) for a measure in the Managed Care Accountability Set (MCAS) as being above the 90th percentile of all Medicaid Health Plans nationwide, as promulgated by NCQA. DHCS defines the minimum performance level (MPL) on MCAS measures as being the *average* (median) score of Medicaid Managed Care plans nationally (i.e. the 50th percentile), as promulgated by NCQA. Managed care plans are required to exceed the MPL on MCAS measures, as determined by DHCS. Partnership must conduct additional quality improvement and health equity improvement projects when DHCS established MPLs are not met, per DHCS mandate in the DHCS Quality Improvement and Health Equity Framework Policy Guide. In reporting units where DHCS defined minimum performance levels (MPLs) and health disparity reduction targets were not met, the QI program and Quality Improvement and Health Equity Transformation Program (QIHETP) teams collaborate to present recommended action plans centered around performance improvement to IQI and Q/UAC. Partnership also reviews and acts on items identified through periodic reports made available through DHCS, including but not limited to: the Technical Report, Health Disparities Report, Preventive Services Report, and Focus Studies. Partnership responds timely to DHCS actions that may include subsequent focused studies, ongoing technical assistance from the EQRO, financial sanctions, administrative sanctions, and/or Corrective Actions in cases where below MPL performance is reported.

Aside from compliance audits for HEDIS® and CAHPS®, Partnership also conducts annual Encounter Data Validation (EDV) studies, at the direction of the state-contracted EQRO. The goal of this annual study is to evaluate DHCS' encounter data completeness and accuracy through a review of medical records for a specified 12-month study period. The study is focused on a member population continuously enrolled to Partnership during the specified study period with at least one professional visit during the study period. The EQRO selects a random sample of members from which Partnership procures corresponding medical records via provider outreach, submitting the records timely using a process defined annually by the EQRO. Partnership responds timely to actions identified through the EQRO and DHCS in the resulting Encounter Data Validation Report.

Analytics support for the QI program is primarily provided by staff in the Finance, Information Technology (IT), and Quality and Performance Improvement departments. Health analytics including population assessment, case management member stratification, and monitoring of utilization patterns is conducted by the Director of Health Analytics and Health Analytics Analysts who are part of the Finance department. Data Analysts in the QI and IT departments also work collaboratively with Health Analytics to support the following work:

- Partnership Pay-for-Performance Programs (also known as Quality Incentive Programs or QIPs)
- Sourcing and integration of data for HEDIS® annual and monthly reporting
- Monthly reconciliation of QIP data that is used to support tools for providers to monitor their performance, at a site and organization level, on quality metrics and services
- Partnership Quality Dashboard (PQD) front end development and maintenance of this provider-facing HEDIS® and QIP performance monitoring tool
- Development and execution of data collection plans that identify baseline performance and capture the impact of performance improvement interventions
- Analysis of performance data to identify areas for improvement, including creating dashboards and reports to actively measure targeted processes and performance changes over time
- Provision of actionable recommendations and informing stakeholders of the impact of key decisions based on final measure performance data

The Health Analytics team also includes more senior analytics roles, including Data Scientists and Senior Health Data Analysts, who conduct statistical comparisons and analysis when stratifying member level data and corresponding quality outcomes is needed to inform the design and decision-making in quality improvement interventions.

In addition to HEDIS® and CAHPS®, summary results from access studies, grievances, Initial Health Appointments (IHA), facility site and medical record reviews, PQIs, targeted improvement projects, performance improvement activities (including practice facilitation and other quality capacity building activities) are presented to IQI and physician committees at least annually. Measure performance trends are reviewed more regularly through a monthly project and during improvement team meetings. Partnership completes a robust, comprehensive evaluation annually for major programs and quality improvement projects and initiatives.

At the organizational level, the Executive Team and Board of Commissioners review a comprehensive dashboard including metrics across the organization every six months. Each year, the executive team sets organization-wide priorities. A board advisory group on Quality meets three to four times annually to provide feedback and advice on strategic quality issues.

Performance results are shared with external and internal stakeholders through data reports and data presentations given at quality committee meetings, medical director meetings, conferences, provider site visits, webinars, and community meetings.

Through Partnership's value-based programs, providers receive reports showing their performance against established thresholds and Partnership network averages (and/or across peer groups) at least annually, but this information is available on a monthly basis for providers participating in certain QIPs. The Primary Care Provider Quality Incentive Program (PCP QIP) provides PCPs aggregate and member-level data through two interactive online tools: eReports and PQD. eReports refreshes twice a week and allows PCPs to identify those members with gaps in preventive and chronic disease care in support of compliance on the PCP QIP's clinical measures. It also allows PCPs to upload additional data to support measure-specific numerator compliance or exclusion criteria. PQD is a Tableau-based online data visualization and analytics tool that supports analysis of Partnership's HEDIS® and PCP QIP performance data.

Substance Use Disorder - focused performance improvement projects are managed by Partnership and administered centrally. The SUIQI reviews data at least annually from eligibility, claims, encounter, and provider data to analyze adherence to protocols and identification of those in need of services; timely access measures; initial and engagement of clients into treatment; fidelity to American Society for Addiction Medicine (ASAM) requirements; and outcome and recovery data. The SUIQI aligns their efforts, where possible, with the EQRO evaluation processes and support their evaluation criteria.

In addition, review of the substance use disorder service system and its integration into overall Plan services are incorporated into the ongoing Partnership measurement and reporting programs. This includes summary results from access studies, grievances, IHAs, facility site and medical record reviews, PQIs, targeted improvement projects, and training activities. These are presented to SUIQI on an ongoing basis and reported to SUPAG, IQI, Q/UAC, and PAC at least annually. Substance use disorder services performance reports are also shared at various meetings, trainings, and webinars and community meetings.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Program

The Agency for Healthcare Research and Quality (AHRQ), in collaboration with the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA), governs the administration of the CAHPS® survey through a nationally recognized set of standard and survey design principles.

As an NCQA accredited health plan, Partnership is required to contract with a certified NCQA survey vendor to administer the annual regulated CAHPS® survey. These survey results capture accurate and complete information about Partnership's member-reported experiences with their health care and provide insights to the quality of care delivered across the Primary Care Provider (PCP) network.

Partnership includes both adult and child populations in its CAHPS® survey sampling. The data collected informs our assessment of service delivery and helps identify areas for improvement to enhance member satisfaction and health outcomes. CAHPS® results are integrated into ongoing quality improvement efforts, supporting targeted interventions and performance monitoring.

Partnership generates the CAHPS® sample frames, obtains auditor approval, and coordinates with the certified survey vendor to ensure compliance with state and federal survey administration requirements.

For additional CAHPS® program inter-department dependencies related to DHCS and NCQA accreditation requirements, please reference the following sections in this document.

- Measure, Analytics and Reporting
- NCQA Accreditation Program Management

Program Scope

The CAHPS® Program team oversees the annual survey cycle from implementation through completion. Program oversight includes vendor management and contracting with a certified NCQA® survey vendor.

Additionally, the CAHPS® program team provides oversight for CAHPS Score Improvement goal development and implementation, supported by inter-department collaboration with the QI HEDIS® and NCQA Accreditation Team, as well as the external department partners including Administration, Communications, Grievance and Appeals, Health Services, HR/Workforce Development, Member Services, OpEx/PMO, Population Health and Transportation.

Survey Results

The contracted NCQA-certified survey vendor conducts a comprehensive analysis of CAHPS® survey results, comparing current-year respondent rates and measure performance to year-over-year results. HEDIS® benchmarks, and nationally derived Medicaid benchmarks through NCQA's Quality Compass®. This analysis provides critical insight into member experiences and highlights trends in care delivery and satisfaction.

Performance is assessed across a core set of CAHPS® measures, including the following rating and composite domains:

Rating Measures	Composite Measures
Rating of Health Care	Coordination of Care
Rating of Health Plan	Customer Service
Rating of Personal Doctor	Ease of Filling Out Forms
Rating of Specialist	How Well Doctors Communicate
	Getting Care Quickly
	Getting Needed Care

These measures support Partnerships broader quality improvement goals by identifying strengths and opportunities to improve member experience, access and communication across the provider network and plan services.

Health Plan Rating

The CAHPS® results are an important component of the NCQA 5-star Health Plan Rating (HPR). As an NCQA Accredited Health Plan, Partnership is required to submit and publicly post the annual CAHPS® scores for one or both survey populations.

The HPR is calculated using a weighted methodology that combines HEDIS® clinical performance measures with CAHPS® survey results. In reporting year 2024, Partnership earned an NCQA HPR of 3.5 Stars, based on submission of the adult survey population.

Current CAHPS® scores across both the adult and child populations highlight significant opportunities for improvement. To address this, the QI CAHPS® Program Charter guides cross departmental efforts and collaboration with the provider network to drive meaningful improvements and increase star ratings across all survey populations.

Value Based Payment Programs

Partnership has value-based programs in the areas of primary care, hospital care, specialty care, palliative care, perinatal care, behavioral health, and enhanced care management. These value-based programs align with Partnership's organizational mission to help our members and the communities we serve be healthy. Partnership uses nine (9) guiding principles to build and strengthen its provider network through value-based program management that promotes the delivery of high-quality, affordable, and equitable care to our members.

1. Pay for outcomes, exceptional performance, and improvement
2. Offer sizeable incentives
3. Actionable Measures
4. Feasible data collections
5. Collaboration with providers
6. Simplicity in the number of measures
7. Comprehensive measure set
8. Align measures that are meaningful
9. Stable measures

The aforementioned guidelines and design of these programs assures no payments are made directly or indirectly to providers as an inducement to reduce or limit Medically Necessary Covered Services to members, per 42 CFR sections 438.3(i) and 438.10(f)(3). Additionally, these value-based programs and corresponding financial payments comply with the requirements of APL 19-005. All financial incentive programs, per contract requirements, are reported in the form, manner, and frequency specified by DHCS. Partnership utilizes its value-based programs to compensate its network providers in ways that assure provider accountability for both quality outcomes and total cost of care across the populations served. The same approach will be utilized as alternative payment models are introduced to network providers. Partnership monitors quality performance under these value-based programs and alternative payment models and responds timely, within 90 calendar days, to any DHCS requested reporting. Additionally, on an annual basis, Partnership reports on its network payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) framework categories. Partnership supports the delivery of effective primary care and integrated care through the emergence and use of alternative payment models. In evaluating the effectiveness of primary care, Partnership fulfills DHCS required reporting that reflects its investment in primary care service delivery and promotion of primary care delivery through alternative payment models.

Primary Care Provider Quality Incentive Program (PCP QIP)

This program provides financial incentives, data reporting, and technical assistance to PCPs to improve key domains of quality: clinical care, patient experience, access and operations, and resource use. PAC reviews and approves proposed clinical measures selected for the PCP QIP. A group of providers and administrators across counties and practice types recommend measures for the PCP QIP each year in QIP Advisory Group. Following the QIP Advisory Group's recommendations and internal discussions with various Partnership department stakeholders, the draft measures are released to the Partnership provider network during a public comment period. Feedback from the public comment period is shared with the QIP Advisory Group and at internal stakeholder meetings, at which time measure recommendations are forwarded to PAC for review and approval. The measures and detailed specifications can be found on the Partnership website.

Hospital Quality Incentive Program (HQIP)

The HQIP, established in 2012, is a pay-for-performance program for invited hospitals serving Medi-Cal members in the Partnership network. The goal of the HQIP is to improve the quality of care provided to members by offering participating hospitals substantial financial incentives in exchange for meeting selected performance targets.

Participants report on measures across the following measurement domains: advance care planning, clinical quality, operations and efficiency, patient safety, and patient experience. To support improving coordination of care after discharge and increase support for patient self-management, the HQIP includes a 7-Day Follow-Up measure for all Partnership adult members admitted to the hospital. Like the PCP QIP, Partnership collaborates with hospital partners and internal Partnership department stakeholders to design the program, and PAC reviews and approves the measures selected. The measures and detailed specifications can be found on the Partnership website.

Palliative Care Quality Incentive Program (PC QIP)
All Partnership contracted Intensive Outpatient Palliative Care provider sites are automatically enrolled in the PC QIP. Providers may earn incentives from the program based on care provided to members who have serious illnesses and have an approved intensive outpatient palliative care treatment authorization request (TAR) on file. Partnership has designed the PC QIP, which offers significant financial incentives to support and improve the access to and quality of palliative care provided by Partnership's contracted palliative care providers. The program also incentivizes the completion of POLST (Physician Order for Life-Sustaining Treatment) for these members and for actively participating in a data collection system addressing quality assessments reviewed against established quality thresholds.

Perinatal Quality Incentive Program (QIP)
The Perinatal QIP provides financial incentives to participate in the Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers providing quality and timely prenatal and postpartum care to Partnership members. Participation is by invitation and requires signing a Letter of Agreement. For this incentive program, a simple and meaningful measurement set has been developed and currently includes the following measures: Prenatal Immunization Status, Timely Prenatal Care, Timely Postpartum Care, and Electronic Clinical Data System (ECDS). The current ECDS measure reflects Partnership's efforts to partner with an approved HEDIS data aggregator. These efforts contributed to the success of this measure and have positively impacted Partnership's HEDIS® rates and other QIPs who share this measure in their measurement set.

Behavioral Health Quality Incentive Program (QIP)
The Plan's delegated mental health administrator, Carelon Behavioral Health, manages the quality incentive program for the network. The Behavioral Health QIP is administered through the Carelon Behavioral Health network and focuses on measurement-based care by utilizing member screenings over time in participating practices to inform clinical interventions and measure results. The QIP for substance use disorder services focuses on a provider's ability to address members with co-occurring substance use disorder and mental health needs.

Enhanced Care Management (ECM) Quality Incentive Program (QIP)
The ECM Program is a Medi-Cal benefit that replaces the current Whole Person Care (WPC) Pilot and Intensive Outpatient Care Management (IOPCM) activities. As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the objective of ECM is to motivate, modify, and improve the health outcomes of seven identified groups of individuals by standardizing a set of care management services and interventions, then build upon the positive outcomes from those programs. Participants are incentivized for the timely reporting of enrolled members in ECM benefits as the basis for determining the incentive pool amounts for the quality measures. The four quality measures include: Care Plan and Release of Information Upload into PointClickCare, PHQ-9 Depression Screening, Blood Pressure Screening, and timely Review of ED/Admission Notifications.

Improvement Projects
Partnership considers a number of factors to determine where and how to focus its improvement efforts. The Managed Care Accountability Set (MCAS), a subset of HEDIS® measures for which DHCS holds Managed Care Plans accountable; a subset of HEDIS® measures which carry weight for NCQA health plan accreditation; and most recently the advent of CMS, DHCS and Model of Care measures aligned with the D-SNP, are prioritized by QI. In addition, QI prioritizes recommendations from the QIHEC's annual evaluation of quality measure performance data. These recommendations are focused on addressing health-equity performance deficiencies and ensuring appropriate equity-focused interventions are identified to reduce health disparities in alignment with the requirements of the NCQA health equity accreditation and per DHCS mandates.

Additional criteria for selection include:

- Meaningful clinical or service areas to both providers and members
- Measures where improvement projects would impact large populations of members
- Over or underutilization of services
- Clinical or service areas where provider variation in practice is greatest
- Clinical or service areas that present opportunities to address health inequities

Data sources used to determine focus areas include:

- Annual, monthly, and year-to-date performance on HEDIS® measures
- Performance on Partnership's pay-for-performance measures that provide financial incentives to provider organizations to drive improvement, including data on disparities based on factors such as race and ethnicity, preferred language, and zip codes
- CMS Administrative Data
- CAHPS® and other Member Satisfaction surveys
- Grievances and appeals
- Facility site and medical record review results
- IHA rates
- Utilization data
- County level and/or public health data
- Clinical data derived from Health Information Exchange (HIE) with providers

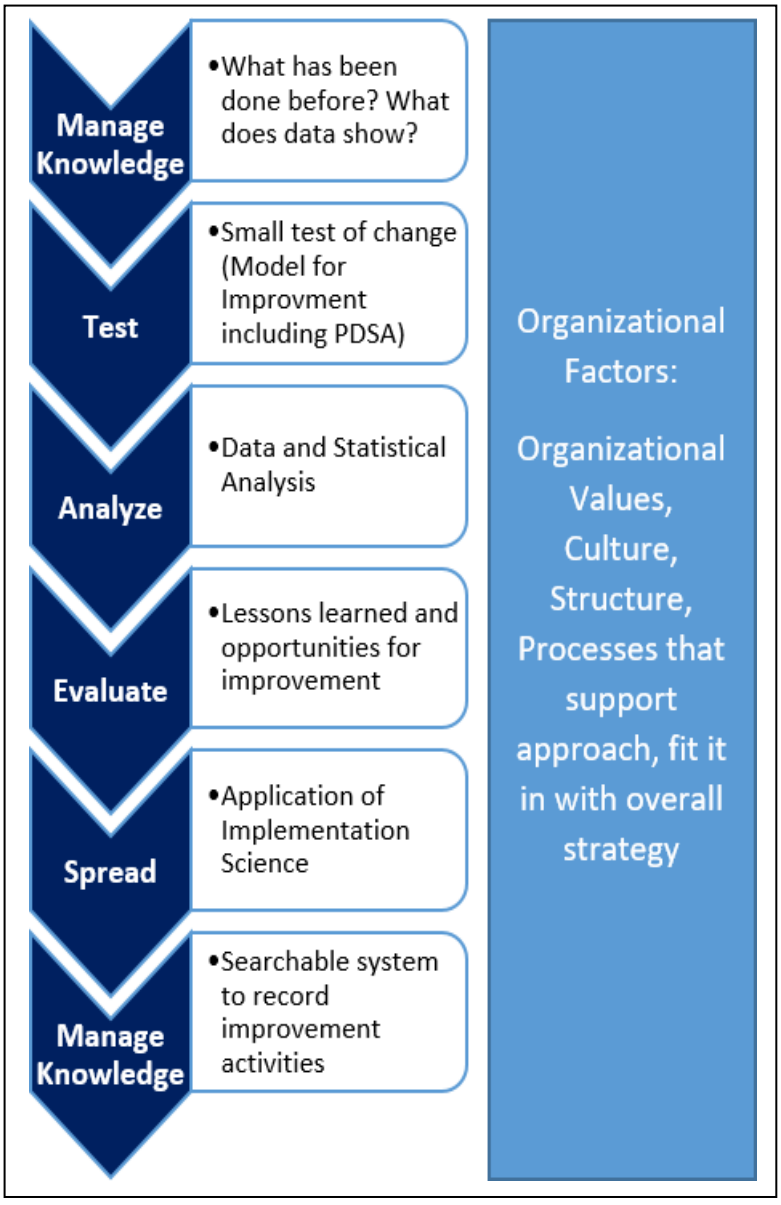
Based on the department that will lead an improvement effort, its leadership and management propose focus areas and projects with guidance from their executive sponsor, other members of the executive leadership team, medical directors, other departments and key stakeholders. For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the QIHETP team supports ongoing QI efforts in the identification of potential quality or equity of care issues, and improvement of HEDIS® quality measures in context with social determinants of health. For member-facing improvement efforts, CAC and other member focus groups are often consulted.

The QI/PI department is often the lead for many improvement efforts, particularly those that are mandated or due to poor performance on the Managed Care Accountability Set (MCAS), which are the set of measures that Department of Health Care Services (DHCS) selects for annual reporting by Medi-Cal managed care health plans. This can include mandated improvement efforts to meet disparity reduction targets for specific populations and/or measures as identified by DHCS. Partnership participates in DHCS mandated statewide collaborations and initiatives focused on improving quality and equity of care for its members. Partnership designates staff to attend, at a minimum, quarterly regional collaborative meetings, including those designated as in-person. The QI/PI department also takes the lead on mandated Performance Improvement Projects (PIPs) that are assigned by DHCS. On an ongoing basis, Partnership is required to complete a minimum of two PIPs per Centers for Medicare & Medicaid Services' (CMS) mandates. PIPs are led by the QI/PI program based on criteria defined by DHCS and overseen by the EQRO, and include at least annual status reports to DHCS. The involvement of fully delegated subcontractors is considered in both mandated short-term improvement projects (Plan-Do-Study-Act) and the PIPs. Once the objective and scope of improvement projects are approved, an improvement team is formed with a lead or project manager and individuals who are involved in the improvement effort. Current year performance priorities are outlined in Partnership's QI Program Work Plan.

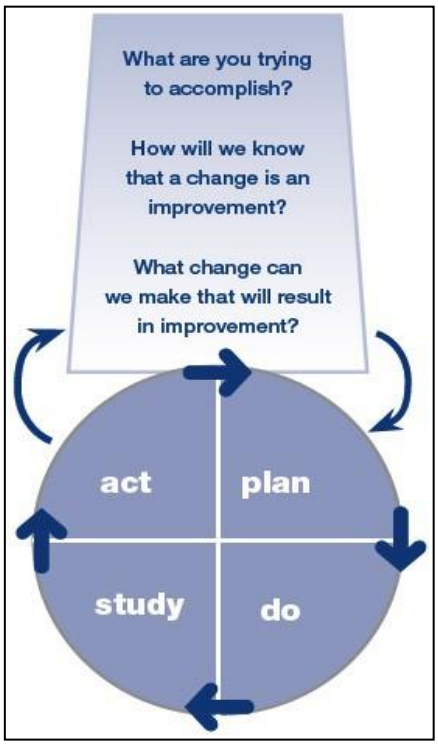
For 2024-2025 Partnership has set metrics for success which includes NCQA Health Plan Ranking (HPR) targets. Partnership has formed, in recent years, measure-family-focused workgroups to better coordinate service and performance across the organization and to raise Partnership's overall quality measure performance. This effort is referred to as Quality Measure Score Improvement (QMSI) and consists of cross-functional workgroups led by Quality staff with support from Medical Directors and includes representation from across the organization, including: Care Coordination, Claims, Health Education, Office of the CMO, Pharmacy, Population Health, Provider Relations and Regional Leadership. Each workgroup is focused on measure performance analysis,

identification of measure focus priorities and efforts needed to close performance gaps. QMSI workgroup areas include pediatrics, chronic diseases, , behavioral health, women's health and perinatal care, and elder care. Together these workgroups will identify opportunities and barriers to be addressed to improve care outcomes for members and increase HPR.

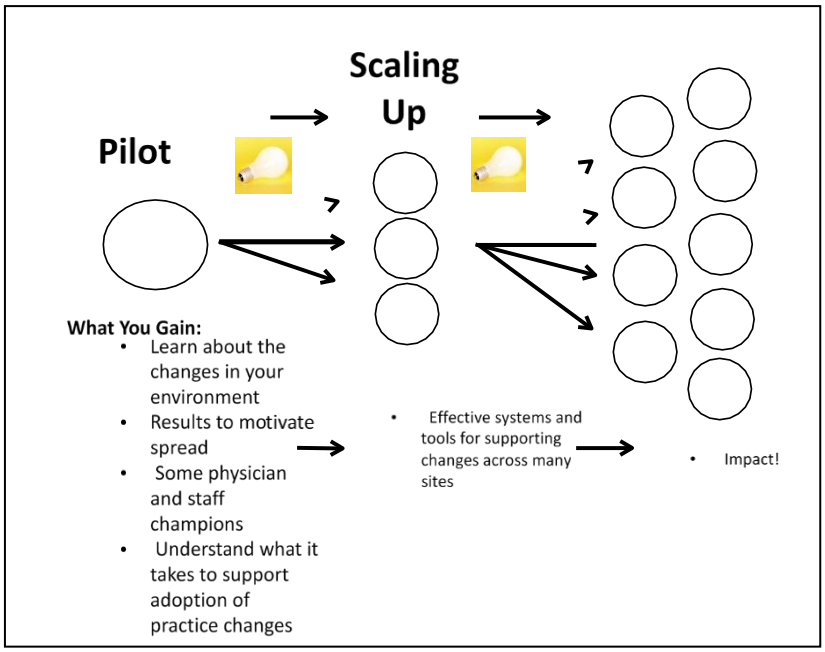
Partnership has developed the Pathway to Excellence (P2E) framework for improvement activities. This framework includes six major components as noted below:



This framework includes several performance improvement methodologies including small tests of change using the Model for Improvement and the Plan-Do-Study-Act (PDSA) cycle, optimizing spread through the application of implementation science with robust project management infrastructure to guide strategic improvement initiatives and targeted improvement projects. Appendix C has a detailed description of the P2E framework.



Partnership supports spreading effective interventions within and across sites and regions as more is known about the problem, resources, and infrastructure needed to support the change on a larger scale. Within provider organizations and throughout Partnership's provider network, spread is challenging and highly dependent on provider organizations' leadership, culture, and quality improvement infrastructure to do this effectively. The figure below outlines this approach.



A list of current year improvement projects and outcomes are available in Partnership's QI Program Work Plan and annual QI Evaluation, respectively.

Care for Members with Complex Needs (CCM)
CCM is a voluntary program that provides tailored interventions aimed at improving the member's self-management of their health; and increasing the appropriate usage of health and medical resources while reducing the inappropriate utilization of health care resources. These goals are achieved by working with the member/caregiver and the member's interdisciplinary care team to:

- Educate about the member's benefits with managed care and how to use available resources
- Identify and help with understanding of member's medical condition(s)
- Support and encourage self-management skills to promote and optimize the member's personal health goals and well-being
- Coordinate necessary health care services and
- Refer to appropriate medical or social community resources when applicable

Please see the Care Coordination program description for further information regarding the populations targeted and the specific interventions used for Partnership members.

Quality Assurance and Member Safety Activities
Quality Assurance and Member Safety activities include investigation of PQIs; facility site and medical record reviews; assessing the level of physical accessibility of provider sites including specialists and ancillary providers that serve a high volume of seniors and persons with disabilities; and monitoring IHA rates.

Member safety activities are governed in large part by DHCS directives. To stay aware of updates and guidance on conducting member safety activities, Partnership maintains a multi-department system to monitor and implement regulatory guidance, including but not limited to All Plan Letters (APLs) and contract amendments, like those that inform the QI program. APLs are also available and searchable by all staff via the DHCS website.

Potential Quality Issues (PQI) and Peer Review
A PQI is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists. A quality issue is defined as a confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process. The PQI investigation and Peer Review process provide a systematic method for the identification, reporting, and processing of a PQI to determine opportunities for improvement in the provision of care and services to Partnership members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity.

PQIs are identified through the systematic review of a variety of data sources, including but not limited to:

- Information gathered through concurrent, prospective, and retrospective utilization review
- Referrals from any Health Plan staff
- Facility Site Reviews
- Claims and encounter data
- Pharmacy utilization data
- HEDIS® medical record review process
- Medical record reviews/audits
- Grievances and Appeals
- Ancillary providers/vendors/delegates such as Carelon, VSP, etc.
- Provider sentinel/adverse events such as provider preventable conditions that are reported as required by the State

All cases are initially reviewed by an RN Quality Investigator and then forwarded to the CMO or Medical Director for Quality in accordance with Policy MPQP1016. Medical records and other supporting documentation are collected, and where issues are identified, the provider of concern may be given an opportunity to respond. The CMO/Medical Director for Quality review includes assessment of, but is not limited to, appropriate level of care, appropriate tests, therapy and treatment, technical expertise, referral, consultation, timeliness, and adequate documentation.

The RN Quality Investigators, pharmacist representative, and identified Medical Directors review potential quality issue cases at PQI rounds. Severity ratings are designated to identify "Practitioner performance," "System issues," or both. Sometimes, multiple provider performance issues or system issues are identified in the same case and rated accordingly. Upon determination by a Medical Director that a case requires review by the Peer Review Committee, the RN Quality Investigator prepares the PQI case file for Peer Review (see MPQP1053 for the Peer Review Committee policy). The Peer Review Committee reviews concerns and complaints about the quality of care and services provided to Partnerships' members and makes recommendations for actions to prevent reoccurrences of the identified issues. The Committee also reviews sentinel conditions identified as having quality concerns. Cases with significant concerns are communicated to the Credentials Committee at the recommendation of the Peer Review Committee.

Annual reports are presented to IQI and Q/UAC showing trends related to referral patterns and quality of care concerns. A monthly report is presented to the CMO and Medical Director for Quality which includes cases open, closed, referrals, and pending PRC review.

Pharmacy Department Patient Safety Initiatives

Partnership has a number of activities in place to ensure medication safety and adherence for Partnership members. These activities include:

- *Managing Pain Safely (MPS)*. Pharmacy leads an ongoing multi-year initiative to promote the safe use of opioids.
- The Pharmacy Department uses Medi-Cal Rx Contractor pharmacy data to monitor opioid prescribing and utilization against opioid-related HEDIS® measures: HDO (high dose opioids), POD (opioid use 31 days), UOP (multiple prescribers/pharmacies), and BZD/Opioid concurrent use.
- The Pharmacy Department monitors and evaluates naloxone prescriptions to help promote access and utilization to improve patient safety.
- The Pharmacy Department reviews and analyzes drug utilization to identify high-risk members taking antipsychotic and opioid medications and provides interventions against identified risks.
- The Pharmacy Department monitors antipsychotic pharmacy claims to identify suboptimal medication regimens and adherence for members taking antipsychotic medications. Interventions aim to address and reduce risk for metabolic syndrome induced by antipsychotic medications.
- *Smoking Cessation*. In collaboration with Care Coordination, Partnership offers smoking cessation counseling services to members who indicate "yes" on the Health Risk Assessment (HRA) question, "Would you like help quitting?" Functions include provider outreach, educating members on medication adherence to tobacco cessation products, and assisting with enrollment in the California Smokers Helpline program.
- *Latent Tuberculosis Therapy (LTBI) Monitoring*. LTBI 12 dose monitoring to ensure patients receive appropriate therapy and interact with providers and county public health departments to ensure completion of therapy and identify patients that may have fallen out of therapy.

Site Reviews

Partnership conducts Site Reviews that include a review of the physical site, medical records, and a review that evaluates accessibility for Seniors and Persons with Disabilities (SPDs). Site Reviews are conducted for primary care, OB/GYN, palliative care, substance use disorder services providers, non-accredited sites, mobile/street medicine, and private duty nurses. With the Sunset of Comprehensive Perinatal Service Program (CPSP), Partnership now conducts Site Reviews on all OB providers up to every three years. Partnership is awaiting an official OB tool and/or APL and further guidance on this topic from DHCS. The internal and external quality improvement committees review the results from the Site Reviews, Initial Health Appointments (IHAs), and Physical Accessibility Review Survey (PARS) Results at least annually. Results from Site Reviews are reported to the DHCS twice per year. The Credentials Committee is notified when Site Reviews are completed.

Initial Health Appointments (IHA)

In January 2023, DHCS issued APL 22-030 which changed the name of Initial Health Assessment to the Initial Health Appointment (IHA) and discontinued the requirement of a Staying Healthy Assessment (SHA) questionnaire to be

completed by the member and reviewed by the Primary Care Physician (PCP) annually. The Staying Healthy Assessment (SHA) was replaced by the Member Risk Assessment.

The Initial Health Appointment must be completed within 120 days of enrollment to the health plan or within 120 days of assignment to a primary care provider (whichever is most recent). The visit must be conducted in the primary care setting and be provided in a way that is culturally and linguistically appropriate for the member.

Partnership collaborates with network practitioners and providers to improve IHA compliance by:

- Identifying areas where training is needed
- Identifying and sharing best practices
- Seeking input from network practitioners about systems Partnership can put in place to improve IHA compliance
- Providing technical assistance, resource materials, and training in areas where indicated
- Reminding providers monthly to review their list of newly assigned members and track outreach attempts to the members
- Publishing provider and member facing newsletter articles
- The Site Review Team offers 1:1 educational training with sites about IHA requirements at every site review exit interview. The Partnership Billing Guide and information on IHA are provided during the site review exit interview process.
- Sending monthly mailers along with address labels for newly enrolled members so providers can reach out to members and schedule an IHA appointment
- Clinical Operational meetings are designed to collaborate between both parties (Partnership and Facility) on procedures and operations to ensure patient quality of care and outcome. Partnership uses this opportunity to present on IHA, Blood Lead testing, and offers additional education on Site Review.

CHDP Training Replacement with Sunset effective 7/1/2024

Under the CalAIM initiative, DHCS has transitioned the Child Health and Disability Prevention Program (CHDP) effective July 1,2024 to Partnership. This transition aligns with the desire to streamline efforts and consolidate care responsibilities, for members 21 years of age and younger.

The Inspections Team now offers training on all CHDP topics and is reviewed during the Site Review process. Training topics include Audiometric, Vision, BMI, Dental Fluoride Varnish Application and Preventative Care, which covers immunizations, CAIR, and blood lead screening. Training courses are offered through a live WebEx session, or they are available online. Once training is completed, a certificate of completion is sent to the site and is valid for 3 years.

Quality Improvement Coaching and Training Support

The Performance Improvement (PI) team offers a variety of coaching and training opportunities to clinicians, administrators and staff to gain quality improvement expertise and to learn from peers. Each initiative prepares provider sites to optimize population health, enhance their patients' experiences of care, promote provider and care team satisfaction, and foster a culture of continuous quality improvement.

Provider Tiering and Enhanced Provider Engagement: In 2022, Partnership began strategic planning to expand provider engagement to engage a wider group of provider organizations (PO's) in building their capacity for quality improvement work. Using the previous year's PCP QIP clinical measure scores, provider organizations are organized into tiers, with coaching programs designed to align with the priorities and needs of the respective organizations.

2025-26 provider tiers and respective coaching opportunities are:

- Tier 1 PO's (< 33% of clinical points earned in previous year's PCP QIP): Strong candidates for participating in the Modified PCP QIP, coupled with a Needs Assessment and ongoing improvement coaching
- Tier 2 PO's (33-79% of clinical points earned in previous year's PCP QIP): Practice Coaching, JLI's, improvement pilot or PIP partnership on established MCAS measures

- Tier 3 PO's (>80% of clinical points earned in previous year's PCP QIP): Voices from the Field, innovation pilots on emerging measures
- PO's at any tier: Regional meetings, Improvement Academy trainings

Modified PCP QIP: The Modified QIP is a simplified set of measures given to Provider Organizations with low PCP QIP Scores. Providers are evaluated annually to determine participation. Thresholds for participation are reevaluated and adjusted annually, according to need and available coaching resources.

Needs Assessment and Relationship Building: The Needs Assessment is the initial step for provider organizations assigned to the Modified PCP QIP or who are at risk of placement in it in the following measurement year. Members of the provider organization's leadership team will complete an in-person Needs Assessment with a member of the PI team. The Needs Assessment is a modified version of the Building Blocks of Primary Care Assessment (BBPCA), a tool developed by the UCSF Center for Excellence in Primary Care and is designed to identify an organization's strengths and improvement opportunities within their quality program. Alternatively, a provider organization can complete a Population Health Management Capabilities Assessment Tool (PhmCAT), a tool published by DHCS as part of their Equity Practice Transformation initiative. The PhmCAT tool is also based on the BBPCA tool, and contains additional questions on health equity, behavioral health, and social health strengths and improvement opportunities within the organization. Completed PhmCAT tools are reviewed in detail with a member of the PI team.

Completing the Needs Assessment allows the provider organization to assess themselves and fosters relationship building with Partnership; it also provides a framework for prioritizing improvement opportunities and committing to activities to build their quality infrastructure and organization-wide culture of quality.

Once the provider organization has chosen areas for improvement, Partnership will offer support through various means including: providing coaching, training opportunities, grant application opportunities and resources, and connecting with outside resources.

Practice Coaching: In 2020, Partnership initially began offering practice facilitation, a narrower set of coaching tools and support, to PCP organizations with large member assignments and some existing quality infrastructure that had opportunity for improvements in clinical performance. Partnership expanded and broadened support via practice coaching, to meet the evolving needs of the network as it transitioned through the COVID-19 public health emergency. The coaching format is now offered to provider organizations that score between 33-79% of clinical points on their PCP QIP.

Practice coaches assist primary care practices in the application of evidence-based best practices to quality improvement activities. Working alongside organizational quality teams, the practice coach provides guidance and resources to facilitate system-level changes. The practice coach provides a framework for translating evidence-based research into practice by building relationships, improving communication, and facilitating change.

The following are areas where Partnership practice coaches offer support:

- Provide guidance on inter-disciplinary project team formation and collaboration for QI projects
- Project management – provide guidance and tools on framing and managing QI projects
- QI project development and use of QI tools, methodologies, and best practices
- Provide data analytics training and support
- Provide guidance on change management aspects of QI project
- Coach provider organizations on adopting a culture of quality and advancing quality improvement efforts throughout the organization

Partnership Improvement Academy

The Partnership Improvement Academy encompasses different types of training to support and educate provider organizations about quality improvement. Trainings are added, adjusted, or abandoned based on the needs of the network and are evaluated regularly for opportunities to improve.

ABCs of QI: This program is a one-day in-person training designed to teach healthcare organizations the basic principles of quality improvement including developing aim statements, measures, and change ideas; how to use data and run charts, and testing change ideas on a small scale. The program is offered regionally, several times per year, to meet the needs of the expanding network.

Improving Measure Outcomes: These trainings are 1-1.5-hour webinar learning sessions offering CME/CE and cover the PCP QIP measures

The objectives of the learning sessions are:

- Overview of clinical measure specifications and threshold definitions
- Present documentation recommendations/highlights to maximize measure adherence
- Review regional performance data on clinical measures, including data that show disparities by race and ethnicity
- Review best and promising practices to close gaps in care
- Showcase Voices from the Field, high-performing providers who present their best practices for closing care gaps
- Overview of performance improvement strategies and tools

The target audience is clinicians, practice managers, quality improvement team, and staff who are responsible for participating and leading quality improvement efforts within their organization.

Northern Region Consortia & Partnership Northern Region QI Collaboration: This partnering occurs formally on an annual basis via a written scope of work agreement under which they jointly promote and support QI capacity building in the clinic setting through trainings, improvement advising, peer-to-peer sharing, and conducting annual clinic profiles/assessments. The Northern Consortia membership is comprised of Federally Qualified Health Centers (FQHCs) in the Partnership Northeast, Northwest, East, and Southwest Regions and represent the largest PCP organizations, in terms of assigned member volume. Partnership benefits from the peer network forums the consortia leaders have established amongst its members' QI leadership and CMOs. The QI Peer Network and CMO Peer Network meet every other month, including longer in-person meetings on a biannual basis. Within these peer networks, Partnership is invited to share measure level education, guidance, and technical assistance on the application of performance improvement tools and methods. These interactions occur either as part of recurring peer network meetings or separate webinar offerings targeting peer network members.

Clinically Led HEDIS® Measure Education: HEDIS® Measure Education is also incorporated into provider interactions with Partnership's Member Safety Team. Partnership Member Safety nurses have unique opportunities through their Site Review visits to build rapport with PCP clinical leadership and staff. During the completion of the medical record review portion of Site Reviews, Partnership nurses incorporate measure education and corresponding medical record-keeping best practices during their reviews with providers.

Pharmacy Academic Detailing: Partnership's Pharmacy Department offers provider organizations detailed analysis of their patient's adherence to medication for a number of chronic conditions, to identify opportunities to improve medication management of their condition. Topics covered in Academic Detailing sessions include:

- Increasing prescriber and pharmacist knowledge of the HEDIS® measures for diabetes, hypertension and asthma, Medi-Cal Rx formulary, and proper documentation of diabetes, hypertension, cardiovascular disease, asthma and other diagnoses (e.g., ADHD)
- Analysis of provider organization's pharmacy fill data and measure compliance to highlight prescribing and refill best practices
- Increasing member knowledge and engagement in chronic disease management

Substance Use Disorder Services Support and Training

The Partnership DMC-ODS (Drug Medi-Cal Organized Delivery System) Regional Model program provides clinicians, administrators and staff with quality improvement expertise. Sites are supported so as to encourage integrated care across the Partnership system, to optimize population health, enhance their patients' experiences of care, promote provider and careteam satisfaction, and foster a culture of continuous quality improvement.

Trainings provided on a regular basis include American Society for Addiction Medicine (ASAM) criteria and application.

Partnership provides a range of support and services to contracted Drug Medi-Cal Providers. These include:

- Training and technical assistance to help providers improve services and clinical documentation and regulatory compliance
- Conduct regularly scheduled chart compliance reviews, offering guidance and written feedback focused on quality improvement of services
- Provision of resources such as sample forms, audit instruments and other tools that would help providers develop effective systems of quality records management
- Responding to technical questions related to regulations or practices
- Communication with providers and other agencies in order to better understand and interpret program regulations and to address treatment needs
- Responding to grievance and appeals from Partnership members or other concerned individuals in the areas of access, quality, billing, critical incidents or client rights

Community Partnerships

In many cases, the quality improvement efforts that have the biggest impacts on the health of members involve significant community collaboration and coalitions with local entities. Local entities are crucial partners in developing strategies for Partnership to address deficiencies in performance measures. Local entities in Partnership's communities engaged in this collaboration include: county health departments (including public health officers), the four consortia that serve FQHCs in Partnership's community, law enforcement, schools, and various Community Based Organizations (CBOs) or nonprofit agencies. Many providers in Partnership's network provide health care services to Partnership's members and are also partners in larger community-level interventions. This includes primary care physicians, FQHCs, Rural Health Centers, Indian Health Service Health Centers, hospitals, long-term care facilities, specialist physicians, hospice agencies, and community pharmacies. Community partnerships can take place on various levels, from engaging with partners and networking, to actively participating in or convening larger groups to drive change and further large-scale initiatives.

Partnership's participation in community partnerships can be in one of five roles: Leader, Convener, Participant, Funder, and Advocate. Multiple job positions within Partnership attend meetings with various partners and stakeholders and take on one of these roles depending on their scope of knowledge and decision-making authority.

Some current major initiatives involving community partnerships with local entities include:

1. Mental Health Integration
2. Improving Access to Specialty Care Services
3. Regional Approach to Treating Substance Use Disorder
4. Integrating Medical Records through HIEs
5. Implementing CalAIM including establishing partnerships within each county Partnership serves
6. Improving preventive care quality outcomes for members less than 21 years of age
7. Community Health Assessment & Community Health Improvement Plan (CHA/CHIP) collaboration
8. Population Health Community Engagement

To further elaborate on the community partnerships, the table below highlights a few examples of current and ongoing initiatives, specific to mental health integration and treating substance use disorder:

Community Activities		
Wellness and Recovery	**Mental Health**	**Other Initiatives**
Collaboration with local hospitals to integrate Community Health Workers within emergency departments to provide warm handoffs to substance use disorder service providers.	Collaborating with counties and Sac Valley Medshare to improve data solution through a single source.	Multi-Payer Fee Schedule – participating with school districts to provide school-linked behavioral health services.
Shasta County Substance Abuse	Collaborating with counties to provide	Conduct monthly Learning

Community Activities		
Wellness and Recovery	**Mental Health**	**Other Initiatives**
Coalition	resources and support for clients diagnosed with an eating disorder.	Collaborative with our school partners around behavioral health service delivery.
Humboldt County Drug Medi-Cal Huddle	Engaging with non-contracted providers to provide alternate solutions for services to clients with an eating disorder.	Meet quarterly with all county Child Welfare Partners to review utilization, coordination of care and discuss services.
Drug Safe Solano Substance Use Coalition	Streamlining processes internally to offer an option for Partnership to take the "lead" on eating disorder cases where county capacity is lacking.	Meet quarterly with all First Five partners to review utilization, coordination of care and discuss services.
Meet quarterly with all county Behavioral Health partners to review SUD referrals, coordination of care and discuss services.	Streamlining processes internally with other departments for coordinating care for eating disorders and other mental health conditions.	
	Coordinating with other departments to improve reporting measures related to mental health and eating disorders.	
	Meet quarterly with all county Mental Health Plan partners to review utilization, coordination of care and discuss services.	

Member Input

Members are also crucial partners in informing strategies and interventions Partnership pursues to address deficiencies in performance measures and reduce health disparities. Member input is obtained from member outreach events, member experience surveys, member focus and engagement groups, member grievance and appeals data, CAC feedback, FAC feedback, PCP/specialist access and availability data, Member Services telephone access reports, member suggestions, and member requests for PCP transfers. Consumers are also represented on the Q/UAC and Partnership Board of Commissioners. Member feedback on Health Equity-related interventions is encouraged and requested in our Health Equity playbook, which emphasizes the importance of outreaching and gaining insight from those who are actually experiencing the disparities. Provider organizations are also encouraged to employ similar playbook tactics to improve care within their practices. Various workgroups meet to review the data collected at least quarterly and the workgroups recommend areas for improvement and action plans. These are presented and monitored by IQI. Performance on HEDIS® measures and progress made in other QI activities are shared with Partnership's members through the Q/UAC, CAC, FAC, and member newsletter.

Physician and Other Clinician Input

Through Partnership's committee structure, clinicians provide input on the quality improvement program including focus areas, strategies to improve care and service, and effective ways for measuring performance in projects. In addition, clinician input is provided on various projects such as the pay-for-performance programs for primary care, specialtycare, and hospitals. Partnership holds "provider comment periods" where physicians and their staff can provide input on priorities for these programs. Across all work, Partnership solicits input on priorities and interventions through committee meetings and other meetings with provider practices and clinic consortiums.

Population Health Community Engagement and Partnerships

The Population Health Management (PHM) department participates in continuous community engagement and outreach, including community partner collaboration. PHM attends various in-person community outreach events and works to build trust among members within each community, as well as community partners. Attendance at community events is imperative for strengthening the relationship between Partnership and external stakeholders.

Outreach at these events includes promotion of well-child visits, timely prenatal care and postpartum visits, adult wellness care, and general education about Partnership benefits. Partnership's regional liaisons and leaders in various departments actively participate in both internal and external workgroups to share information and reduce duplication of effort. Through collaborative meetings, these staff members identify community resources that may benefit Partnership members and share these resources with the organization to promote integration into program offerings that meet member needs. Programs within the community or offered through providers may include:

- Enhanced Case Management (ECM)
- Community Supports
- Regional Center participation
- Behavioral Health and Wellness & Recovery services
- Eating Disorder treatment
- Outpatient palliative care
- Other community programs such as WIC, support groups, community collaboratives, etc.

Furthermore, in alignment with DHCS' Population Health Management Policy Guide and 2024 Contract, Partnership works collaboratively with Local Health Jurisdictions (LHJ), hospitals, community providers, other payers, community-based organizations, member representatives, and other community stakeholders on each county's CHA and CHIP report. This collaborative work has replaced DHCS' historically mandated Population Needs Assessment. Together with these agencies, Partnership works with community stakeholders to prioritize local needs and agree upon a shared plan of action to keep the communities and members it serves be healthy.

See MCND 9001 for further details of Population Health Management's community engagement.

Population Health Management Strategies

Since 2017, Partnership has made significant inroads in establishing practices to lay the foundations for creating a Population Health Management (PHM) program. In February 2020, Partnership established the Population Health department. The Population Health, QI/PI, and Health Equity departments and teams conduct coordinated work to support the objectives of quality and equitable care and services for Partnership members through the following activities:

- Provision of guidance and updates on the NCQA standards related to PHM
- Participation in creating and executing QI and Health Equity initiatives that address identified health disparities andopportunities for member engagement/strategic program development
- Assistance in evaluation of initiatives, state-mandated work and performance improvement projects to determine the effectiveness of developed PHM programs
- Review and analysis of HEDIS® measure performance to help determine necessary targeted interventions to improve member health outcomes and well-being
- Development of broad-based member outreach strategies designed to engage members and direct them to their PCP
- Review and periodic revision to value-based programs to ensure they are supporting providers in their attempts to complete recommended missing services for members
- Execution of Partnership Improvement Academy workshops and training programs, as needed
- Local community stakeholder engagement, including support of local LHJ's Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) processes

Population Health, QI/PI, and Health Equity reside within Health Services. The Population Health and QI/PI departments report up to the CMO and the Health Equity department reports up to the CHSO. The Population Health department maintains a series of documents similar to those maintained by the QI/PI department including the Population Needs Assessment (PNA), Population Health Management Strategy and Program Description, the Population Health Work Plan, and the Segmentation Report, which are then presented at IQI, Q/UAC and PAC. Of note, the Population Needs Assessment is first reviewed by the internal Population Needs Assessment Committee prior to being reviewed by the remainder of the committees, including several additional committees beyond what are listed above. The Population Health Department also oversees the writing and

implementation of the Health Equity Cultural and Linguistic (C&L) Trilogy documents consisting of the C&L/QIHETP workplan, the C&L Program Evaluation, and the C&L Program description; all three of these documents are also reviewed and approved by IQI, Q/UAC, and PAC; they are also reviewed by QIHEC. Each department is led by a director that has a standing meeting time to discuss shared and separate work priorities to further support alignment of activities and optimal outcomes.

See the Population Health Management Strategy and Program Description, (MCND9001) and the C&L Program Description (MCND9002) for further details.

NCQA Accreditation Program Management

Partnership strives to improve the health status of members and their care experience to become one of the highest quality health plans in California. The NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA) support Partnership's vision, mission, and strategic goals and fulfill Partnership's contractual obligations with DHCS.

Partnership is an NCQA Health Plan accredited organization as of January 2021, having successfully achieved renewal as of December 2023. HPA

- Provides a framework to guide our operational and quality improvement activities.
- Provides a nationally recognized standard and definition for a high-quality health plan, performance against which will allow Partnership to compare ourselves objectively against other high-quality plans.
- Offers the only widely available health plan assessment that bases results on clinical performance (HEDIS®) and member experience (CAHPS®).

Partnership is on a journey to obtain NCQA HEA. HEA focuses on the foundation of health equity work. HEA

- Builds an internal culture that supports the organization's external health equity work.
- Collects data that helps the organization create and offer language services and provider networks mindful of individuals' cultural and linguistic needs.
- Identifies opportunities to reduce health inequities, improve care and member experience.

Program objectives are outlined separately for HPA and HEA:

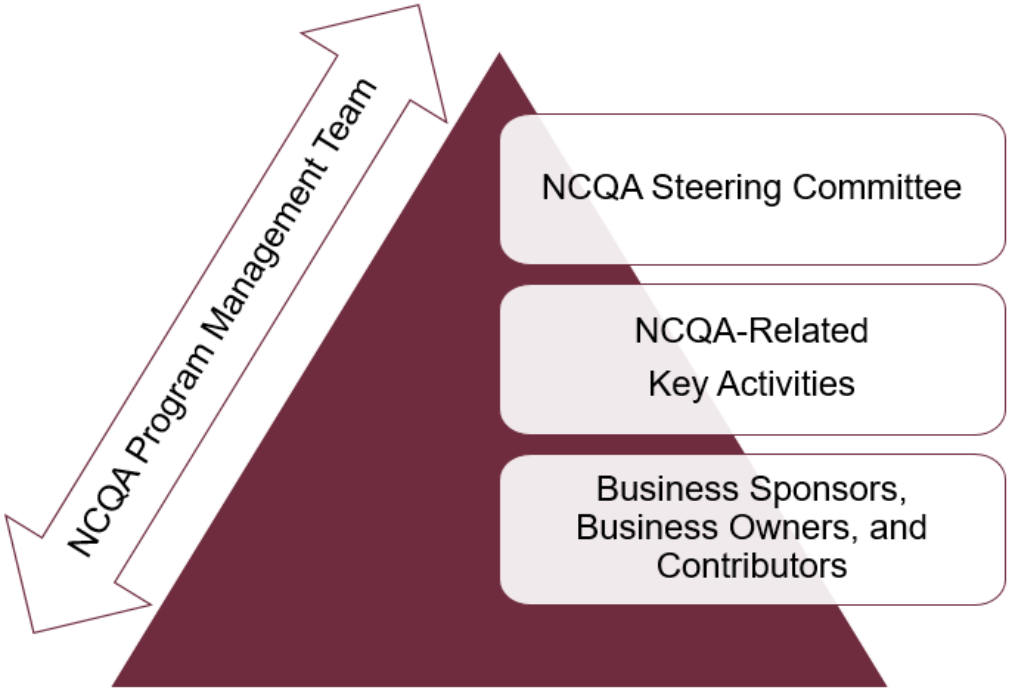
<u>Health Plan Accreditation</u>

- Maintain compliance of all NCQA Health Plan Accreditation (HPA) Standards and Guidelines, following the 2026 Standards and Guidelines, Triannual Policy Updates and Monthly FAQs.
- Monitor plan-wide compliance of HPA requirements through Renewal Survey.
- Successfully submit Partnership's Renewal Survey on September 22, 2026.
- Obtain the renewal of Accredited status by December 2026.

<u>Health Equity Accreditation</u>

- Develop knowledge and build readiness for Initial Survey.
- Monitor plan-wide compliance of HEA requirements for Initial Survey.
- Successfully submit Partnership's Initial Survey on June 17, 2025.
- Obtain the Accredited status by September 2025.

The NCQA Accreditation Program is managed via a tiered approach. A description of each tier is provided to define roles and responsibilities for each level of the program's governance.



- NCQA Program Management Team
  - Leads and coordinates efforts across each level of NCQA governance.
  - Manages the plan-wide NCQA Accreditation process, specifically:
    - Updates and maintains ownership of NCQA requirements through a plan-wide project work plan.
    - Updates and maintains the plan-wide evidence submission library, a list of required documents that are used to demonstrate compliance.
    - Identifies data needs and reports completion/approval dates through a grand analysis report schedule.
    - Coordinates a plan-wide mock survey with the NCQA consultant.
    - Reviews and assesses the Standards and Guidelines, coordinates any follow-up questions based on NCQA tri-annual policy updates and monthly FAQs.
  - Provides advisory support and guidance across NCQA Accreditation processes, standards/requirements, and HEDIS® and CAHPS® reporting, as needed.
  - Maintains and updates the NCQA compliance dashboard to evaluate progress.
  - Monitors and reports program status, escalates risks/barriers in a timely fashion.
  - Recommends changes to new and/or existing business practices to support and sustain program structure.
  - Facilitates the NCQA Steering Committee.
  - Serves as liaison with Business Owners across the health plan and as the primary liaison to NCQA,our consultant, and Medicaid health plans.
- NCQA Steering Committee
  - Leads NCQA Accreditation efforts by defining Partnership's NCQA program vision and purpose, and provides overall strategic direction.
  - Monitors and reviews program progress relative to goals, timelines and metrics.
  - Champions NCQA Accreditation readiness across the organization.
  - Resolves program conflicts and disputes, reconciling differences of opinion and approach.
  - Evaluates and approves major program components including program timelines, resource allocations, budget, risk management strategies, and program management/governance practices.
- NCQA-Related Key Activities
  - Standards are assigned to departments where the Business Owners reside.
  - Activities take place over the fiscal year to ensure compliance is maintained for all HPA and HEA Standards and Guidelines.
  - All Business Owners are required to complete the key activities to maintain compliance of all assigned

NCQA Standards and Guidelines.

- Business Sponsor
  - Holds a Partnership leadership position and is usually from the same department as the Business Owner. This person has formal authority/ownership for assigned requirements based on business practices.
  - Supports the Business Owner in achieving compliance and addressing any obstacles or barriers to the work and escalates project risks if needed. Escalation will include, but is not limited to, identifying needs for additional communication with stakeholders from regional counterparts, contributors, operational leadership, and the NCQA Steering Committee.
- Business Owner
  - Manages and/or executes the day-to-day work in order to achieve and maintain compliance of the assigned NCQArequirements.
  - Maintains deep subject matter expertise across the requirements, which includes reviewing and addressing changes to NCQA standards timely.
  - Collaborates and coordinates activities and deliverables with the contributors. Collaboration will include, but is not limited to, communicating the project's timeline, scope of work, roles and responsibilities.
  - Tracks and reports progress toward compliance with the requirements.
  - Provides periodic updates, at least quarterly, to the NCQA Program Management Team and contributor(s). Updates will include, but are not limited to, progress updates, risks and/or barriers, and staffing changes.
  - Raises issues to the Business Sponsor should challenges occur.
  - Primary contact for evidence preparation and responsible for all submissions.
- Contributor
  - A staff member outside of the Business Owner's department who holds subject matter expertise related to the assigned NCQA requirement(s).
  - Collaborates actively with the Business Owner to ensure successful completion of NCQA-related tasks. This includes, but is not limited to, providing expertise, data, policies, documents, and/or work deliverables timely to meet NCQA Standards.
  - Notifies the Business Owner and the NCQA Program Management Team of any staffing changes.

As part of the NCQA HPA process, Partnership reports HEDIS® and CAHPS® annual results to NCQA in June of each year. Evaluation of HEDIS® and CAHPS® performance is separate from Standards and Guidelines scoring. NCQA assesses Medicaid Health Plan quality based on various clinical measures, including preventive services to keep members healthy and treatments in response to illnesses and chronic diseases. NCQA also evaluates a Health Plan based on customer satisfaction. In September 2024, Partnership earned a Health Plan Rating (HPR) of 3.5 stars.

Partnership's next HPA reaccreditation survey, or Renewal Survey, is scheduled for September 22, 2026. The table below summarizes key HPA survey dates, as well as HEDIS® and CAHPS® reporting and scoring requirements.

HPA Survey Option	Partnership Survey Status	HEDIS®/CAHPS® Reporting and Health Plan Rating (HPR) Scoring
Renewal	December 2023: Reaccreditation Status received September 22, 2026: Next Renewal Survey submission date November 9-10, 2026: Two-day HPA file review audit December 2026 (targeted): Health Plan Accredited	Annual HEDIS®/CAHPS® reporting (MY 2024) in June 2025 and annual HPR scoring in September 2025.

At the time of preparing the QI Program Description, Partnership is positioned to obtain Health Equity (HE) Initial Survey Accreditation in September 2025, to fulfill the January 1, 2026 DHCS mandated timeline. Partnership will continue its process of sustaining compliance with the HEA Standards and Guidelines throughout the fiscal year. All key stakeholders are required to review NCQA changes and clarifications, including the Triannual Policy Updates and Monthly FAQs, and initiate revisions, as needed, in alignment with NCQA's expectations and look-back period.

Cultural Competency

Partnership is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible beneficiaries. The Health Education, Cultural and Linguistic (HEC&L) team regularly assesses and documents member cultural and linguistic needs to determine whether covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. The HEC&L team also ensures that all cultural and linguistic services are provided in an appropriate manner.

Currently, the Population Health department is responsible for the operations of the Health Education, Cultural and Linguistic Services Program. Additionally, CAC and FAC provide recommendations on the development and implementation of culturally and linguistically accessible services.

Partnership's policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. Partnership has systems and processes to:

- Assess, identify, and track linguistic capability of bilingual employees
- Identify and track linguistic capability of contracted staff in medical and non-medical settings
- Collect data on cultural, ethnic, racial and linguistic needs and prepare biennial analysis to ensure Partnership and its providers deliver services that meet the needs of Partnership's culturally diverse population
- Conduct a PNA and disparity assessment every year to: identify member health needs and health disparities to promote health equity; evaluate Health Education, C&L and QI activities and available resources to address identified concerns; and implement targeted strategies for Health Education, C&L and QI programs and services. Please see the PNA for detailed findings and the related Action Plans.
- Collaborate with the Director of Health Equity to provide cultural competence, sensitivity, and diversity training to staff, providers and relevant delegates per recommendations from the 24-016 All Plan Letter

Partnership monitors and evaluates the effectiveness of cultural and linguistic services by reviewing and responding to:

- CAHPS® Survey data
- Member grievance and appeals
- Reports of utilization of interpreter services by language
- Provider assessments and Site Reviews
- Disparities in HEDIS® data

See the Cultural and Linguistic Program Description (MCND9002) and Quality Improvement and Health Equity Transformation Program Description (MCED6001) for additional details.

Communication Systems

Partnership communicates its QI/PI program activities internally and externally through the following mechanisms:

Internal Communications

- Monthly QI/PI department meetings to provide program and project updates, department priorities and identify critical issues and plans of action

- QI/PI directors and managers communicate more frequently with their respective teams and individual staff throughout each month. This is accomplished via meetings, huddles, and email communications.
- The QI/PI leadership team meets monthly with the Senior Director of QI/PI to assure timely organizational updates, consistent messaging and prioritization across the QI/PI department. The CMO attends when available or gives input through regular 1:1s with the Senior Director of QI/PI and Medical Director for Quality.
- Recurring meetings with PR, Regional leadership, and Population Health to provide information on key QI/PI projects and other updates on QI programs
- Recurring Health Services Department Leadership Committee meetings to share information regarding improvement activities within the Health Services department
- 5 Star Room QI/PI key information and performance displays in Fairfield and Redding offices
- Department SharePoint pages
- Written department updates provided to all department heads and senior leadership as part of monthly Operations meeting hosted by the COO
- Partnership's internal website PHC4ME
- Quality Measure Score Improvement initiative and corresponding cross-functional workgroups categorized and focused by clinical measure domain
- NCQA Newsletter

External Communications

- Quarterly CAC meetings to provider updates on pertinent activities and allow committee members to provide input on initiatives, program design and evaluation
- FAC meetings that occur at least four times per year to share information and solicit input on topics and initiatives that impact CCS members
- Standing Consortia meetings to solicit input from providers
- Regional medical director/quality meetings
- QIP Advisory Groups to solicit input on value-based programs
- Periodic feedback from providers via "provider comment periods" on performance metrics and QIP measures
- Quarterly input on QI programs and proposed initiatives via the Board Advisory Group
- Monthly QI/ PI update document that summarizes activities for the QI department and is included in IQI andQ/UAC meeting packets
- Texting campaigns related to closure of quality gaps, relationship building, as well as health education are sent via Partnership's texting platform.
- Partnership makes ad-hoc updates as needed and conducts bi-annual audits to ensure QI project and program information on the website remains accurate and up to date.
- Member newsletters released two times per year that include articles covering preventive health and QI/PI projects
- Quarterly Provider Newsletters that include articles specific to QI/ PI in the designated "Quality Corner" section of the document
- Outbound and inbound calls and communication fielded by the Member Services department
- Care Coordination calls with members
- Population Health member outcall projects and campaigns
- Monthly external QI newsletters that describe activities and training resources related to improving quality of care
- Conferences, trainings, onsite meetings, webinars to share best practices across regions
- ePrompts member level reminders about HEDIS® related preventive health services incorporated into Partnership's Call Center system, Provider Online Services system, and online Member Portal

Delegation

Delegated activities to contracted providers are reviewed and approved at least annually by DORS, IQI, Credentials and Q/UAC committees. A delegation agreement, including a detailed list of activities delegated and reporting requirements, is signed by both the delegate and Partnership. Partnership delegates QI for behavioral health to Carelon Behavioral Health.

- Reporting quality improvement activities and analyses to Partnership on a quarterly or semi-annual basis is done for delegated QI activities
- Evaluation includes a review of both the processes applied in carrying out delegated activities, and the outcome achieved toward quality improvement in accordance with the respective policy(ies) and agreement governing the delegated responsibility
- The DORS, IQI, Credentials, and Q/UAC committees review evaluations and make recommendations regarding opportunities for improvement and continuation of delegated functions
- Partnership QI/PI staff communicates feedback from the DORS, IQI, and Q/UAC to contract providers andincorporates improvement activities initiated in the annual QI/PI work plan

Review by Outside Licensing Agencies or Accrediting Bodies

Medi-Cal is a federal and state-funded program and CMS has delegated administration of the state program to the California DHCS. CMS permission is required in order for the state to delegate program administration to Partnership. The State must document the cost-effectiveness of the program and provide assurance that program beneficiaries are not negatively impacted by this delegation. Partnership operations, including the QI/PI program, are audited annually by DHCS.

Partnership submits periodic compliance reports to DHCS and undergoes periodic compliance audits. Opportunities for improvement identified through all compliance or regulatory audits are addressed by multidisciplinary teams and corrective action plan development. Implementation of CAPs and other interventions aimed at addressing opportunitiesfor improvement are reported to the IQI and Q/UAC. Partnership maintains a compliance plan that includes monitoring and reporting of fraud, waste, and abuse. The Partnership Compliance Committee consists of representatives of each department including QI/PI.

Sanctions

Sanctions may be imposed on Partnership by an established regulatory agency or purchaser due to failure to meet quality metrics or benchmarks, fulfill data quality and reporting requirements, or meet Corrective Action Plan (CAP) requirements. In any of these cases, a quality review team will collaborate and recommend action plans needed beyond those already established through the annual QI Trilogy and organizational goal-setting processes Resulting action plans will be presented for review and approval by the CEO, COO, CMO, Chief Health Services Officer, and Senior Director of Quality and Performance Improvement. Action plans and progress reports are shared with Q/UAC.

Annual Quality Improvement Work Plan

The QI/ PI Annual Work Plan is used to track progress on key QI activities and initiatives throughout the year. The document outlines major activities for the QI/PI department and organization as a whole that advance quality and performance improvement. The QI/PI Work Plan supports the comprehensive annual evaluation and planning process that includes the annual review and revision of the QI/PI program.

Approved annually by the Q/UAC, PAC, and Board of Commissioners, the QI/PI Annual Work Plan indicates planned QI activities and objectives, timelines, and accountable person for each activity. It includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service, and member experience. The annual evaluation of the QI/PI program is also listed as a specific activity on the QI/PI Work Plan. Goals and associated deliverables are included in the work plan and progress tracked at the level of deliverables. Forms for providing status updates are sent to staff one month in advance of the semi-

annual and annual update deadlines to be completed by work plan contributors.

The work plan also includes information on issues that were previously identified. Updates on the monitoring of these issues is provided semi-annually, when work plan contributors provide status updates on whether deliverables driving goals are complete, on track, delayed or require additional explanation. These issues are tracked in a separate worksheet within the work plan.

Annual Quality Improvement Program Evaluation

The overall effectiveness of the QI/PI program is evaluated in writing annually by IQI and Q/UAC and is approvedby Q/UAC, PAC, and the Commission. The QI Program Evaluation includes:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
- Trending of data on key measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis and evaluation of distinct programs, initiatives and QI-related work as well as the overall effectiveness of the QI/PI program and of its progress toward influencing network-wide safe clinical practices. The summary of effectiveness also addresses the adequacy of the organizational resources involved in the QI/PI program.
- The annual QI Work Plan goals and associated deliverables are informed by the QI Evaluation. The evaluation provides summations and analysis of many of the key activities outlined in the accompanying work plan. In turn, if there are opportunities for improvement identified in the evaluation of prior year initiatives and work conducted to support the goals of the quality improvement program, these opportunities are translated into goals with actionable deliverables for the next year's work plan. The results in the QI Evaluation, particularly those tied to the need to revisit allocated resources, for committees, standing programs and other related activity are assessed, and if changes are deemed necessary, they are reflected in the QI/PI program in the subsequent year.
- The annual QI Work Plan goals and associate deliverables informed by the Model of Care and the performance improvement efforts aligned with the D-SNP program, specifically those associated with CMS and DHCS-specific quality metrics.

The following are separate evaluations and not included in the QI Program Evaluation:

- Evaluation of the Cultural and Linguistic Program activities
- Evaluation of Utilization Management and Care Coordination activities
- Evaluation of the Population Health program
- A comprehensive evaluation of member grievance and appeals
- Evaluation of the Quality Improvement and Health Equity Program and corresponding work plan activities, as defined in the program description for the Quality Improvement and Health Equity Transformation Program (QIHETP)

A summary of the QI Program Evaluation, including a description of the program, is provided to members or practitioners upon request.

Statement of Confidentiality

Confidentiality of provider and member information is ensured at all times in the performance of QI/PI program activities through enforcement of the following:

- All members of the Q/UAC and Credentials Committee are required to sign a confidentiality statement that is maintained and securely stored in the respective QI or Provider Relations files.
- All QI/PI and Utilization Management documents are restricted solely to authorized Health Services department staff, members of the PAC, Q/UAC, PRC, and Credentials Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to, Peer Review and Credentials meeting

minutes and agendas, QI and Peer Review reports and findings, PQI and QI files, Utilization Management reports, or any correspondence or memos relating to confidential issues where the name of a provider or member is included.

- Confidential peer review documents that are protected by California Evidence Code §1157 are designated "Confidential – Protected by CA Evidence Code 1157."
- Confidential documents are stored in locked file cabinets or restricted network folders with access limited to authorized persons only.
- Confidential documents are destroyed by shredding.
- Partnership has designated a Privacy Officer responsible to oversee compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal privacy laws.

- Partnership maintains administrative structure, reporting procedures, due diligence procedures, training programs and other methods to ensure effective compliance in use and disclosure of members' Protected Health Information (PHI).

Statement of Conflict of Interest

Any individual personally involved in the care and/or service provided to a member or an event or finding undergoing quality evaluation cannot vote or render a decision regarding the appropriateness of such care. All members of the Q/UAC and Credentials Committee are required to review and sign a conflict-of-interest statement, agreeing to abide by its terms.

Revision Date(s): January 2000, March 2002, (QD100101) October 2002, September 2004, May 2006, (MPQD1001) May 2007, April 2008, May 2009, October 2009 *(re-signed)*, May 2010, April 2012, March 2013, March 2014, March 2015, March 2016, March 2017, November 2017, *October 2018, February 2019 *(Amended)*, September 2019 *(Amended);* September 2020; September 2021; September 2022; September 2023, September 2024

*Effective October 2018, Approval Date reflects the month in which the Physician Advisory Committee reviewed and approved.

Appendix A: Quality and Performance Improvement Program Description
Standing Staff Members of Partnership QI Committees

(Does not include external physician or consumer membership;
see committee description for those details)

Partnership Analytics Steering Committee Standing Members	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Director of Health Equity
Provider Relations	Senior Director of Provider Relations
Claims	Senior Director of Claims
Finance	Chief Financial Officer
	Deputy Chief Financial Officer
	Director of Health Analytics
	Senior Director of Financial Planning and Analysis
Information Technology	Chief Information Officer
	Senior Director of Enterprise Information Management
	Director of Data Warehouse
	Director of Data Governance
Behavioral Health	Senior Director of Behavioral Health
Administration	Chief Strategy & Government Affairs Officer
Member Services	Director of Member Services

Partnership Board Meeting Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Director of Regulatory Affairs and Program Development
	Behavioral Health Services Administrator
	Regional Directors
	Associate Director of Communications and Public Affairs
	Assistant Board Clerk / Executive Assistant to the CEO
	Board Clerk
Claims	Director of Claims
Finance	Chief Financial Officer
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Director of Care Coordination Operations (NR)
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Director of Health Equity
Human Resources	Chief Human Resources Officer
Information Technology	Chief Information Officer
Member Services	Director of Member Services
Provider Relations	Senior Director of Provider Relations

Partnership Compliance Committee Standing Staff Invites *Note: Partnership Staff are not committee members;* *attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Senior Director of Regulatory Affairs & Contracting
	Senior Director of Behavioral Health
Claims	Senior Director of Claims
	Director of Claims
Configuration	Director of Configuration
Finance	Chief Financial Officer
	Director of Internal Audit (Finance)
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Chief Health Services Officer
	Director of Pharmacy Services
	Manager Quality Assurance and Patient Safety
	Senior Director of Care Management
Human Resources	Chief Human Resources Officer
Information Technology	Chief Information Officer
Member Services	Director of Member Services
	Senior Director of Member Services
	Director of Grievances and Appeals
Network Services	Director of Network Services
Project Management/ Operational Excellence	Director of Operational Excellence and Program/Project Management Office

Partnership Community Advisory Committee (CAC) Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Senior Director of Behavioral Health
	Regional Director(s)
	Regional Manager(s)
	Manager of Communications
	Program Manager I, Communications
	Communications Specialist
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Regional Medical Director(s)
	Chief Health Services Officer
	Director of Health Equity
	Associate Director of Population Health
	Manager of Population Health
	Senior Health Educator
	Health Educator
Member Services	Senior Director of Member Services and Grievance
	Director of Member Services
	Associate Director of Member Services
	Manager of Member Services
	Member Service Representative
	CAC Coordinator
	Administrative Assistant(s) of Member Services
Grievance & Appeals	Director of Grievance and Appeals
	Supervisor of Grievance and Appeals

Partnership Credentials Committee Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Regional Medical Director(s)
	Associate Medical Director(s)
	Medical Director for Quality
Provider Relations	Senior Director of Provider Relations
	Associate Director of Provider Relations
	Senior Manager of Systems Team and Credentialing
	Credentialing Supervisor
	Credentialing Specialist(s)

Partnership Delegation Oversight Review Sub-Committee Standing Members	
Department Represented	**Position Title**
Administration	Sr. Director of Regulatory Affairs and Program Development
	Compliance Program Manager
	Project Coordinator
	Supervisor of Program Integrity
	Associate Director of Operational Excellence and Program/Project Management Office
	Senior Manager of Regulatory Affairs
	Behavioral Health Services Administrator
	Director of Grievance and Appeals
	Compliance Auditor
Claims	Director of Claims
Finance	Sr. Manager of Business Decisions and Analysis
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Director of Pharmacy Services
	Sr. Director of Care Coordination
	Director of Population Health
	Director of Utilization Management
	Manager, Member Safety-Quality Investigations
	Medical Director
	Director of Enhanced Health Services
	Director of Transportation
	Director of Quality Improvement
	Supervisor of Health Education
Member Services	Sr. Director of Member Services
Project Management/Operational Excellence	Associate Director of Operational Excellence and Program/Project Management Office
Provider Relations	Senior Director of Provider Relations
	Director of Provider Relations
Network Services	Director of Network Services

Partnership Family Advisory Committee (FAC) Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Director of Care Coordination
	Associate Director of Care Coordination
	Chief Health Services Officer
	Senior Health Educator
	Manager of Grievance and Appeals
	Senior Director of Care Management

Partnership Finance Committee Standing Members	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Health Services Officer
	Chief Strategy and Government Affairs Officer
	Senior Director of Behavioral Health
	Northern Region Executive Director (ad hoc)
Finance	Chief Financial Officer
	Deputy Chief Financial Officer
	Senior Director of Accounting/Controller

Partnership Finance Committee Standing Members	
	Senior Director of Fiscal Policy and Strategy
	Senior Director of Financial Analysis
	Director of Internal Audit
	Director of Facilities
Human Resources	Senior Director of Human Resources (ad hoc)
Information Technology	Chief Information Officer
Provider Relations	Senior Director of Provider Relations

Partnership Governance and Compliance Subcommittee	
Department Represented	**Position Title**
PHC Governance & Compliance Committee Standing Staff Invites	Chief Strategy & Government Affairs Officer
	Director of Regulatory Affairs and Program Development
	Chief Executive Officer
	Chief Operating Officer
	Chief Information Officer
	Chief Financial Officer
	Chief Medical Officer (optional)
	Board Clerk
Five (5) members from the Board of Commissioners, with at least one board member representing each of the geographic regions.	

Partnership Internal Quality Improvement (IQI) Committee Standing Members	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Regional Manager(s)
	Compliance Manager of Grievance and Appeals
Configuration	Configuration Department Leadership
Finance	Director of Health Analytics
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer – Committee Chair
	Behavioral Health Clinical Director
	Medical Director for Quality – Committee Vice Chair
	Medical Director for Medicare Services
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Behavioral Health Clinical Director
	Senior Director of Behavioral Health
	Director of Health Equity
	Director of Quality Management
	Director of Population Health
	Directory of Pharmacy Services
	Director of Care Coordination
	Director of Utilization Management
	Director of Enhanced Health Services
	Associate Director(s) of Utilization Management
	Associate Director of Population Health
	Manager of Care Coordination Regulatory Performance

Partnership Internal Quality Improvement (IQI) Committee Standing Members	
Department Represented	**Position Title**
	Manager Member Safety – Quality Investigations
	Manager of Clinical Compliance – Quality Inspections
	Senior Director of Care Management
	Senior Health Educator
	Associate Medical Director(s)
	Regional Medical Director(s)
	Utilization Management Policy Analyst
Member Services	Senior Director of Member Services & Grievance
Provider Relations/Network Services	Senior Director of Provider Relations
	Director of Network Services

Partnership Member Grievance Review Committee (MGRC) Standing Members	
Department Represented	**Position Title**
Administration (e.g. Regulatory Affairs & Compliance, Network Services, and Legal Affairs)	Regional Director
	Chief Operating Officer
	Legal Analyst
	Senior Manager of Regulatory Affairs & Compliance
	Program Manager II
Grievance & Appeals	Director of Grievance & Appeals
	Grievance & Appeals Compliance Manager
	Manager of Grievance & Appeals
	Senior Grievance & Appeals Nurse Specialist
	Senior Manager of Behavioral Health
Behavioral Health	Senior Manager of Behavioral Health
Claims	Director of Claims
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Chief Health Services Officer
	Medical Director of Quality
	Director of Pharmacy Services
	Senior Clinical Pharmacist
	Director of Care Coordination
	Director of Care Coordination Operations
	Director of Utilization Management Strategies
	Manager, Member Safety - Quality Investigations
	Program Manager II, Quality Improvement
	Health Equity Officer
	Culture & Linguistics Liaison
	Manager of Population Health
Member Services	Senior Director of Member Services
	Director of Member Services
Provider Relations	Senior Director of Provider Relations
	Senior Manager of Provider Relations Representative
	Senior Program Manager
	Lead PR Representative
	Supervisor of Education Specialist Team
	Senior Provider Relations Representative
Transportation Services	Director of Transportation Services
	Associate Director of Transportation Services
	Manager of Transportation Programs

Partnership Over/Under Utilization Workgroup Standing Members	
Department Represented	**Position Title**
Administration	Regulatory Affairs Manager
	Regulatory Affairs Specialist
	Senior Director of Northern Region
	Director of Operational Excellence and Program/Project Management Office
Claims	Director of Claims (SR)
Finance	Associate Director of Health Data Analytics
	Senior Manager of Cost Efficiency
	Senior Health Data Analyst
	Manager of Health Analytics
	Project Manager II
	Cost Avoidance Manager
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Chief Health Services Officer
	Medical Director
	Behavioral Health Clinical Director
	Director of Care Coordination Operations (NR)
	Associate Director(s) of Utilization Management
	Director of Pharmacy Services
	Senior Director of Quality and Performance Improvement
	Director of Health Equity
	Associate Director of Housing and Incentive Programs
	Associate Director of Care Coordination
	Director of Population Health
	Director of Utilization Management Strategies
	Director of Pharmacy Services
	Regional Supervisor of Utilization Management
	Director of Quality Management
	Senior Manager of Population Health
	Manager of Performance Improvement
	Manager of Clinical Pharmacy
	Manager of Quality Incentive Programs
	Manager of Care Coordination
	Program Manager
Information Technology	Director of Enterprise Information Management
Provider Relations	Senior Director of Provider Relations
	Senior Provider Relations Representative Manager
	Senior Manager of Provider Relations Representatives
	Senior Manager of Provider Network Education and Credentialing
	Manager of Provider Relations Representatives (SR)
	Manager of Provider Relations Representatives (NR)
	Program Manager
	Senior Provider Relations Representative
	Provider Relations Representative

Partnership Pediatric Quality Committee (PQC) Standing Staff Invites *Note: Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Medical Director
	Chief Medical Officer
	Director of Health Equity
	Senior Director of Care Management
	Chief Health Services Officer
	Director of Pharmacy Services
	Director of Care Coordination

Partnership Peer Review Committee Standing Staff Invites *Note: Non-Medical Director Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Medical Director for Quality
	Manager, Member Safety-Quality Investigations
	Supervisor of Member Safety-Quality Investigations
	Quality Investigator, Member Safety
	Project Coordinator, Member Safety-Quality Investigations
	Manager, Clinical Compliance Inspections Team
	Supervisor, Clinical Quality and Member Safety-Quality Inspections
	Clinical Compliance Inspectors, Clinical Quality and Member Safety-Quality Inspections
	Chief Health Services Officer
	Director of Health Equity
	Regional Medical Director(s)
	Associate Medical Director(s)
	Director of Pharmacy Services or Designated Pharmacist
	Behavioral Health Clinical Director

Partnership Pharmacy & Therapeutics (P&T) Committee Standing Staff Invites *Note: Partnership Staff are voting committee members; attendance is not mandatory nor is adelegate required* **P&T invitees, not standing PNT committee members*	
Department Represented	**Position Title**
Health Services	Chief Medical Officer
	Director of Pharmacy Services
	Clinical Pharmacist(s)
	Sr. Clinical Pharmacist(s)
	Behavioral Health Clinical Director
	Regional Medical Director(s)
	Associate Medical Director(s)
	Chief of Health Services Officer
	Pharmacy Operations Supervisor

Partnership Physician Advisory Committee (PAC) Standing Staff Invites *Note: Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Behavioral Health Clinical Director
Finance	Chief Financial Officer
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Population Health, and Care Coordination)	Chief Medical Officer
	Medical Director for Medicare Services
	Senior Director of Quality and Performance Improvement
	Chief Health Services Officer
	Director of Pharmacy Services
	Associate Director(s) of Utilization Management
	Director of Health Equity
	Director of Population Health
	Medical Director for Quality
	Senior Director of Care Management
	Regional Medical Director(s)
Provider Relations	Senior Director of Provider Relations
Network Services	Director of Network Services

Partnership Population Needs Assessment (PNA) Committee	
Department Represented	**Position Title**
Population Health	Director of Population Health
	Associate Director of Population Health
	Manager of Population Health
Administration	Regional Director (South)
	Regional Director (Northeast)
	Regional Director (East)
	Regional Manager (North)
	Chief Medical Officer
	Chief Operating Officer
Behavioral Health	Senior Director of Behavioral Health
Health Equity	Director of Health Equity
Health Services	Chief Health Services Officer
Office of CMO	Medical Director (South)
	Medical Director (Northeast)
	Medical Director (East)
	Medical Director (North)
OpEx/PMO	Director of OpEx/PMO
	Senior Manager of OpEx/PMO
Transportation Services	Director of Transportation Services
Utilization Management	Associate Director of Housing & Incentive Programs
Quality Improvement	Senior Director of Quality and Performance
	Director of Quality Management

Partnership Provider Engagement Group (PEG) Standing Members	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Regional Medical Director
Provider Relations	Senior Director of Provider Relations
	Director of Member Services and Provider Relations SR Manager of Provider Relations Representatives Manager of PR Representatives, SR and NR

Partnership Quality Improvement and Health Equity (QIHEC) Committee Standing Members	
Department Represented	**Position Title**
Administration	Director of Grievance and Appeals
	Chief Operating Officer
	Associate Director of Communications
Finance	Director of Health Analytics
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Director of Health Equity
	Senior Director of Quality and Performance Improvement
	Medical Director for Quality
	Director(s) of Care Coordination
	Director(s) of Utilization Management
	Director(s) of Population Health
	Senior Health Educator
	Chief Health Services Officer
	Director of Pharmacy Services
	Regional Medical Director(s)
	Associate Medical Director(s)
Provider Relations	Senior Provider Relations Representative Manager
Members Services	Senior Director Member Services

Partnership Quality/Utilization Advisory (Q/UAC) Committee Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Associate Director of Grievance and Appeals
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordinationand Population Health)	Chief Medical Officer – Committee Chair
	Medical Director for Quality – Committee Vice Chair
	Medical Director for Medicare Services
	Behavioral Health Clinical Director
	Regional and Associate Medical Director(s)
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Director of Health Equity
	Director of Population Health Management
	Director of Enhanced Health Services
	Director(s) and Associate Director(s) of Utilization Management
	Director(s) and Associate Director(s) of Care Coordination
	Director of Pharmacy Services
	Manager, Member Safety Quality Investigation
	Manager of Clinical Compliance – Quality Inspections
Provider Relations	Senior Health Educator
	Senior Provider Relations Rep Manager

Partnership Strategic Planning Committee Standing Staff Invites *Note: Partnership Staff are not committee voting members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Behavioral Health Services Administrator
	Regional Directors
	Senior Director of Regulatory Affairs and Contracting
	Director of Communications and Government Affairs
	Policy Analyst
Finance	Chief Financial Officer
	Director of Financial Planning and Analysis
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Director of Health Equity
Information Technology	Chief Information Officer

Partnership Substance Use Internal Quality Improvement Subcommittee Standing Members	
Department Represented	**Position Title**
Administration	Senior Director of Behavioral Health
	Behavioral Health Clinical Director
	Senior Manager of Behavioral Health
	Program Manager, Behavioral Health
	Director of Grievance and Appeals
	Regional Director
	Grievance and Appeals Compliance Manager
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Behavioral Health Clinical Specialist
	Manager of Member Safety – Site Inspections
Claims	Customer Service Manager (NR)
Compliance	Director of Regulatory Affairs and Program Development
Member Services	Supervisor of Member Services
Provider Relations / Network Services	Senior Director of Provider Relations
	Provider Relations Representative (NR & SR)
	Senior Manager of Network Education and Credentialing Manager of Provider Relations Representatives (NR & SR)

Partnership Substance Use Services Provider Advisory Group Standing Members	
Department Represented	**Position Title**
Administration	Senior Director of Behavioral Health
	Behavioral Health Clinical Director
	Program Manager, Behavioral Health
	Senior Manager of Behavioral Health
	Grievance and Appeals Compliance Manager

Appendix B: Quality and Performance Improvement Program Description
Partnership HealthPlan Strategic Quality Plan: Achieving Five-Star Quality

2020-2025
Introduction

In 2017, Partnership HealthPlan of California (Partnership) created a HEDIS® measure score improvement strategic plan, directed at dramatically improving HEDIS® scores by sub-region. Two imperatives have led us to a major revision of this plan. First, the HEDIS® score improvement strategic plan did not address thelink between the member experience and overall quality. Second, Partnership is on the road to NCQA accreditation, which includes a number of standards outside the patient experience and clinical quality scores and defines many activities throughout the organization that impact both.

The purpose of this 2020 update to the strategic plan is to clearly articulate the long and short-term initiatives Partnership will engage in over the next five years to achieve 5-star NCQA Health Insurance Plan Rating status. NCQA accreditation is the gold standard for measuring performance of health plans in the United States. Full accreditation by NCQA categorizes overall health plan performance from zero to five stars, analogous to the Medicare Stars rating system. A 5-star rating is the highest possible score achieved by just 2 of 171 Medicaid plans nationally in 2019; a score of 4-star or above is considered above average, achieved by 40 health plans nationally.

This document serves as a communication tool for Partnership leadership and staff, Board members, providers and other stakeholders and lays a solid foundation from which an operational plan will be created.

This Five-Star Strategic Plan is an elaboration of the first focus area of Partnership's organizational Strategic Plan: to ensure high quality health care to all our members. This strategic plan also aligns with Partnership's vision - to be the most highly regarded Health Plan in California - and its mission, which transcends service to our members to include the greater community, "To help our members, and the communities we serve, be healthy."

Improving quality not only has intrinsic benefits to our members, but it carries intangible benefits to the organization and the community. When quality improvement activities are aligned with the "quadruple aim" of better health, lower cost, better care and caring for the providers, it assists with making the overall health care system function more effectively and efficiently. A focus on quality also improves the reputation of Partnership in the state, allowing further innovation and influence among state-wide stakeholders.Finally, the principles of quality improvement can influence the organization to more efficiently execute on operational priorities not directly related to quality.

Lastly, in 2019, DHCS moved aggressively towards the use of larger scale health plan sanctions for performance on measures that are below average performance. This places additional financial pressure on Partnership to improve quality measure results within our network.

Organizational Values Supporting Quality

To achieve 5-star quality, Partnership must have an organizational culture of quality which is nurtured by the executive leadership team and Board of Commissioners. Core to this culture are these organizational values (from our organizational strategic plan), with aphorisms reflecting these values.

- Partnerships: Fostering strong partnerships with members, providers, and community leaders to collectively improve health outcomes. "Putting our members first."

- Overall focus on Quality: Focusing on continuous quality improvement in every aspect of the organization and in collaboration with our partners. "Doing the right thing right, the first time andevery time."
- Integrity: Set a standard of professionalism, integrity, and accountability. "Striving for perfection, but embracing the opportunity to learn from imperfection. Excellence is achievable!"
- Innovation: Striving to be innovative and seeking creative solutions. "Willingness to challenge the status quo and insist on change when needed."

In addition, the Partnership leadership team has several conceptual frameworks focused on quality:

- Balancing Compliance and Performance: Balancing rigid attention to regulatory requirements with flexibility and innovation needed to drive improvement. "Not all change is improvement, but all improvement requires change."
- Promoting Health Equity: Ensuring an organizational culture that recognizes the diverse backgrounds of our employees and supports the institution of practices that consider social determinants of health, the impacts of implicit bias and the provision of fair and judicious healthcare and services to meet the broad-based needs of our members. "Everyone has a fair and just opportunity to be as healthy as possible."
- Becoming a Learning Health Plan. "Making decisions based on rigorous data analysis wheneverpossible (instead of based on hope or wishful thinking)." "Creating an atmosphere where new ideas can be explored and where strong, independent teams can test these ideas."

The term "Learning Health Plan" is new in this strategic plan, although many associated tactics are not new. More background and explanation is presented next.

Learning Health Plan

A common underlying theme in most Quality Improvement frameworks is that organizations and teams must embrace continuous learning to achieve their highest potential. Tom Nolan, one of the creators of theModel for Improvement, said "What are the necessary and sufficient conditions for improvement in large systems? **Will, ideas and execution!"**

Donald Berwick describes what will, ideas, and execution means:
"Providing **will** refers to the tasks of fostering discomfort with the status quo and attractiveness for the as-yet-unrealized future. Providing **ideas** means assuring access to alternative designs and ideas worth testing,as opposed to continuing legacy systems. And **execution** was his term for embedding *learning* activities and change in the day-to-day work of everyone, beginning with leaders." -Milbank Quarterly, August, 2019

The Partnership Executive Team and Board are committed to making a profound and deep link between the necessities of using a learning health plan framework to best serve our members and our communities.

The fundamental tenets of a Learning Health Plan are:

1. Using the scientific method to optimize implementation of quality improvement initiatives
   a. Building on prior research/experiences
   b. Rigorous and widespread testing of change on a small scale (using the model for improvement framework)
   c. Tracking of information gleaned from small tests of change so others can retrieve this information and build upon it.
   d. Use of control groups (where appropriate)
   e. Careful data and statistical analysis

f. Using a combination of classic project management methodology with the ConsolidatedFramework for Advancing Implementation Science[1] to have a systematic effective approach to program implementation and building internal expertise in these approaches.

2. Having the leadership and staff to support this approach
   a. Communicate effectively about quality and change, through a mixture of data and stories. "No data without a story, no story without data."

A Learning Health Plan avoids widespread implementations of any unproven projects, without measurement of what the outcome is, performing weak or no evaluation of the project, and continuing theproject without knowing if it is effective. While such projects are often related to regulatory mandates, gathering data on their effectiveness or lack thereof can provide valuable evidence for advocating policy change.

Without using the term "learning organization" or "learning health plan," Partnership has been building the infrastructure and leadership to include most of these elements. For example, creating a Project Management/Operational Excellence Department and Team, creating a Health Analytics Team, doing internal trainings through the Learning Management System and external trainings, conducting efficient but meaningful Return on Investment analyses of several programs, and developing a system of storing lessons learned in small tests of change in the quality department are all examples.

By identifying the elements of a strong learning health organization and standardizing our communicationaround the core principles, we will solidify the cultural values around being a Learning Health Plan.

Process of Developing 5-Star Strategic Plan

Leaders in the Quality Improvement (QI) Department created this strategic plan with input from Partnership leadership and staff via the HEDIS® Score Improvement team and the Analytics, Care Coordination, Population Health, Information Technology (IT), Member Services, Pharmacy and QI departments.

The scope of this strategic plan is rooted in the emerging field of population health management. Population health management, in the context of a health plan, requires assessment and analysis of member needs, stratifying the population into risk tiers and defining segments for targeted interventions. Once population segments are identified, the health plan engages available resources to improve the health and wellbeing of the plan's assigned membership on both an individual and aggregate level. This is distinct from approaching population health with a public health approach –which would encompass coordinated and multi-sector efforts to improve the quality of health for an entire community or communities— an approach which is beyond the scope of this strategic plan.

The Quality Improvement department will lead the implementation of this strategic plan, collaboratively and in partnership with other departments and providers, respecting capacities and competing priorities.

Evaluation

Partnership is committed to testing new approaches and scaling up when new approaches are successful. The QI department will lead efforts to support processes and systems for learning and monitoring progress on the implementation of the NCQA 5-Star Strategic Initiative Plan, and sharing evaluations with Partnership leaders and our community partners.

---

[1] Keith, R.E., Crosson, J.C., O'Malley, A.S. *et al.* Using the Consolidated Framework for Implementation Research (CFIR) to produce actionable findings: a rapid-cycle evaluation approach to improving implementation. *Implementation Sci* **12,** 15 (2017)

Environmental Factors

The following strengths and weaknesses within the organization and opportunities and threats external to the organization were taken into consideration when drafting this strategic plan.

Strengths	Weaknesses
• NCQA Interim Accreditation status attainted - many standards (notably the Population Health Management standards) directly support improved HEDIS® scores. • Significant programming and ability to offer technical assistance to bolster primary care capacity for quality and clinical improvement • Robust pay-for-performance program and commitment to value-based processes. • Supportive data systems including eReports and Partnership Quality Dashboard • Increasing cross-department collaboration • Strong HEDIS® Medical Record ReviewProject processes • New member portal building an infrastructure to outreach to members • Growing internal analytic capacity and standardized data sets support population health analysis • Recent assignment of largest direct member categories to PCPs so that PCP QIP applies	• Competing priorities: major system implementations, multiple goal teams, efforts to comply with NCQA standards, new benefits, new regulatory mandates • Many databases still not integrated or standardized • Data governance processes not deeply institutionalized • Preventive or coordination services Partnership offers are not widely understood or utilized by members • Member input not deeply integrated into member-facing improvement efforts • Limited Partnership experience in outreaching to members to close HEDIS® gaps • Collaboration across Partnership departments sometimes not prioritized over core departmental work. • Confined "single views" of member; gaps in care not visible across health plan data systems • Regional disparities in access and health risk factors
External Opportunities	**External Threats**
• NCQA First Survey Accreditation (11/2020) – roadmap to becoming higher quality plan • Provider network and communities support improved clinical performance and are willing to partner (e.g., Joint Leadership Initiative) • Provider partner bright spots with best practices and excellent quality scores • Pilot programs to enable greater accuracy of member contact information. • Preparation for MediCare Duals Special Needs Plan (D-SNP) • MCHC for all: Enhanced Care Management and In Lieu of Services proposals • Aligned Proposition 56 incentive funding	• Judicial threats to the Affordable Care Act (risk aversion) • Lethargic CMS response to DHCS proposals impact scope and speed of DHCS policy changes • Changing regulatory environment with increasing risk of financial sanctions and other penalties • Proposed changes to public charge policy (decreased enrollment) • Primary care site staff turnover (providers, nurses, medical assistants) • Member access to PCPs for care • PCP capacity for outreach • PPS providers (provider primary care for over 75% of members): PPS system reimburses based on volume, not services provided (removes some options for incentivizing quality activities) • Natural disasters and power outages • Pharmacy Carve Out

HEDIS® Score Improvement Aim Statement

The Partnership Five Star Quality Strategic Plan Aims to achieve the following:

1. A weighted average of all accountable DHCS MCAS measures >50th percentile (in year 1) with yearly improvement afterwards in three years, all individual measures performance will be above the 50th percentile.
2. ≥25th percentile in all adult and pediatric CAHPS® measures year 1; with yearly improvement afterwards
3. 80% of applicable points earned in each standard category of NCQA accreditation standards, including Must Pass elements

These are ambitious goals and will require a significant amount of investment, collaboration, and focus. The Managed Care Accountability Set (MCAS) will grow from 19 measures for measurement year (MY) 2018 to 36 for MY 2020. With the new MCAS measures, the minimum performance level increased from the 25th to the 50th national Medicaid percentile.

See Appendix E for HEDIS® performance in measurement year 2018.

Focus Areas, Goals and Objectives

This strategic plan is centered on five key focus areas: 1) Engaging Clinical Practices 2) Engaging Members 3) Data Infrastructure 4) Accreditation Standards and 5) Access. Specific activities, timelines, resources, and evaluation benchmarks will be developed in an operational plan. See Appendix A for a visual depiction(process map) of Partnership's Achieving Five-Star Quality focus areas and goals.

Focus Area 1: Primary Care Practice Ability to Deliver High Quality Health Care

Partnership recognizes the critical role PCPs play in improving clinical quality performance, as well as optimizing utilization, maximizing access to care and enhancing the patient experience. A central theme within this focus area is to better equip PCPs to provide recommended high quality care through provision of information, technical assistance, improvement tools and financial incentives.

Focus Area 1: PCP Delivery of High Quality Care

Goals	Objectives
A. Supply Actionable Care Gap Data to PCPs	•Optimize: eReports •Optimize: Partnership Quality Dashboard (PQD) •Study: Integrate ePrompts into Provider OnlineServices •Expand: Unblinded quality data sharing •Promote: Electronic Health Record (EHR) workflow optimization, including integration with CAIR
B. Technical Assistance to Support Provider QI Capacity	•Optimize: Mandated PDSA/PIPs/Site Reviews/Prop56 •Expand: Technical assistance offerings, provider education and coaching for large and medium sizedpractices •Sustain: General QI training: ABCs of QI •Adapt: Measure-specific trainings and webinars •Evaluate: PCP leadership development •Study: Partnership leverage for promoting health equity through providers
C. Optimize Pay for Performance Programs	•Optimize: PCP QIP •Optimize: Perinatal QIP •Optimize: Hospital QIP

Focus Area 2: Partnership Engaging Members to Improve Quality Metrics

There is a significant opportunity for Partnership to expand direct-to-member engagement activities to improve MCAS and HEDIS® scores. The goals within this focus area will require Partnership to take on new initiatives and/or expand current initiatives that provide actionable data to Partnership staff, leverage contacts with members through in-reach and outreach, and increase Partnership's presence in communities. Direct health plan contact with members complements the outreach conducted by providers. Partnership Network providers are diverse in size, staffing and resources and may be limited in outreach capabilities for a variety reasons, including competing priorities or absence of supportive technology or workflows. In other instances, members are not assigned to or directly managed by a PCP (e.g., direct members) or the member may have considerablemovement across PCPs during the HEDIS® measurement year.

Focus Area 2: Partnership Engaging Members to Improve Quality

Goals	Objectives
A. Supply Actionable Care Gap Data to Partnership Staff and Members	•Integrate: Prompts into Essette •Integrate: ePrompts into Call Center •Integrate: ePrompts into Member Portal
B. Increase Partnership Member-Engagement Capacity	•Pilot: Reminders into Care Coordination workflow •Study: Integration of reminders into Member Services workflow •Expand: Train Partnership staff on targeted qualitymeasures •Study: New and updated member incentives •Increase: Member input into engagement process •Expand: Partnership Outbound engagement activities •Develop: Digital Engagement Solutions
C. Other Strategies for Member Engagement	•Test: Leverage Community Health Workers/CareManagers on Quality Measures •Study: ED and inpatient settings •Test: Outreach to direct members •Expand: Outreach through identification and participation in grassroots community activities

Focus Area 3: Data, Analytics, and Knowledge Management

A critical element to improving MCAS and HEDIS® quality scores lies in Partnership's ability to strengthen data and analytics infrastructure. Additionally, in order to function under the Learning Health Plan framework, foundational systems and processes need to be developed and established to strengthen how data and improvement study results are evaluated and used in decision-making to further optimize the rate of qualityimprovement. Four goals will help improve the organization's infrastructure needed to support and assessprimary care and member interventions.

Focus Area 3: Data, Analytics, and Knowledge Management

Goals	Objectives
A. Actionable CareGap Data to PCPs, Partnership staff and members	• Objectives in Focus Area 1, Goal 1 • Objectives in Focus Area 2, Goal 2 • Expand: Pilots on improving member contact information • Align: Health education tools on Member Portal with quality measures
B. Data Quality, Timely Access and Completeness	• Optimize: Configuration of new core claims system • Implement: Provider Master Data Management • Expand: Data Dictionaries • Operationalize: Data Stewardship Program • Expand: Health Information Exchange (HIE) • Expand: Clinical Data Repository (CDR) • Operationalize: Partnership Data Governance structure
C. Supportive Analytics	• Expand: Well-constructed Data Marts • Build: Comprehensive member data (Member 360) • Optimize: Analysis and presentation of annual quality measure results • Optimize: Leverage rolling-year monthly HEDIS® data • Integrate: Equity analysis with improvement activities
D. Learning HealthPlan Framework	• Expand: Knowledge Management infrastructure • Develop: Standardized scientific approach to small tests of change • Study: Standardized approach to scaling up/implementation

Focus Area 4: Achieving Health Plan NCQA Accreditation

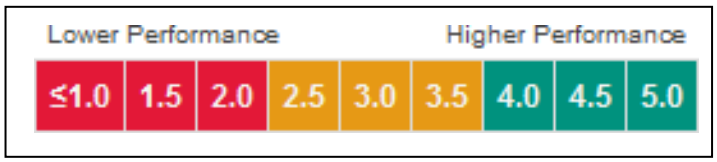
The provision of high quality healthcare to our members is fundamental to Partnership's vision and mission. Wewant to be one of the highest quality health plans in California. NCQA Health Plan Accreditation supportsthis goal by:

- Providing a framework to guide our operational and quality improvement activities. (Many of the activities outlined in the standards are best practices that should be pursued regardlessof our accreditation goals.)
- Providing a nationally-recognized standard and definition for a high quality health plan, performance against which will allow Partnership to compare ourselves objectively against other high quality plans.
- Offering the only widely-available health plan assessment that bases results on clinical performance (HEDIS®) and member experience (CAHPS®).

In the summer of 2019, Partnership received formal Interim Accreditation Status, receiving 50 out of 50 total possible points. Interim Accreditation ensures organizations have a basic structure in place to meet expectations for consumer protection and quality improvement. Interim Accreditation status indicates a strong position and readiness of an organization to move forward with formal First Survey Accreditation, which covers the full scope of the standards and requirements, including HEDIS® and CAHPS® reporting.

First Survey Accreditation is planned for late 2020-early 2021. As noted earlier, two years after that the HEDIS® and CAHPS® scores will be integrated to give a star rating from 0 to 5.

5-Star Scale



As part of the process for setting appropriate goals and areas of focus, the NCQA Project Management Team reviews the accreditation scoring methodology on an annual basis to appropriately apply updates, changes or modifications. Broadly, here are the categories in which we have extracted as areas of focus,which are resource intensive and have significant cross-departmental impact, expressed as goals:

Focus Area 4: Achieving NCQA Accreditation

Goals	Objectives
A. Pass all "MustPass" Elements	• Optimize: Internal file review • Optimize: Delegated file review • Optimize: Delegates following NCQA Standards • Align: Department Goals
B. Strengthen "Grand Analysis" Improvement Activities	• Optimize: Utilization Management • Improve: Member Experience • Optimize: Network Adequacy and Availability • Implement: Population Health Management • Implement: Continuity and Coordinationof Care • Non-Behavioral • Behavioral
C. Prepare for Medicare	• Measure: Baseline MediCare HEDIS®Measures • Address: MediCare HEDIS® Gaps • Evaluate: MediCare incentive programoptions for patients and providers • Plan: Support for overall quality oversight

Focus Area 5: Improving Member Experience through Improved PCP Access

Background: In the 2019 Partnership CAHPS® survey, the areas below the 25th percentile for adult and children werealmost exclusively in the area of perceived access to services. Since the CAHPS® survey will account for about one-third of our accreditation score and is also slated to become an MCAS measure, it is imperative that Partnership explore additional activities to improve PCP access. While the access composite scores in CAHPS® include questions related to specialty access, only PCP access will be included in Focus Area 5. Activities related to increasing specialty access will be covered in the Access and Availability Grand Analysis required as part of NCQA accreditation.

From July-October, 2019 multiple stakeholders[2] were asked to give feedback and suggestions for increasing access to PCPs in the Partnership service area.

> The 54 ideas that were generated were categorized by the degree of control the Clinical Practice has overthe factor, the degree of control the Health Plan has over the factor, as well as a categorization of the cost, effort and effectiveness of each suggestion. See Appendix D for the details.

Prioritization Process:
We eliminated those suggested interventions that were high cost (3-4) and low estimated effectiveness (1). Additional changes were made, based on feedback from Executive Committee. This leads to these 17 objectives, grouped into four goals.

[2] Nine Joint Leadership Initiatives, Physicians Advisory Committee, Strategic Planning Committee, Medical Directors of Partnership, Board Advisory Group on Quality, Executive Committee at Partnership, Operations Committee at Partnership

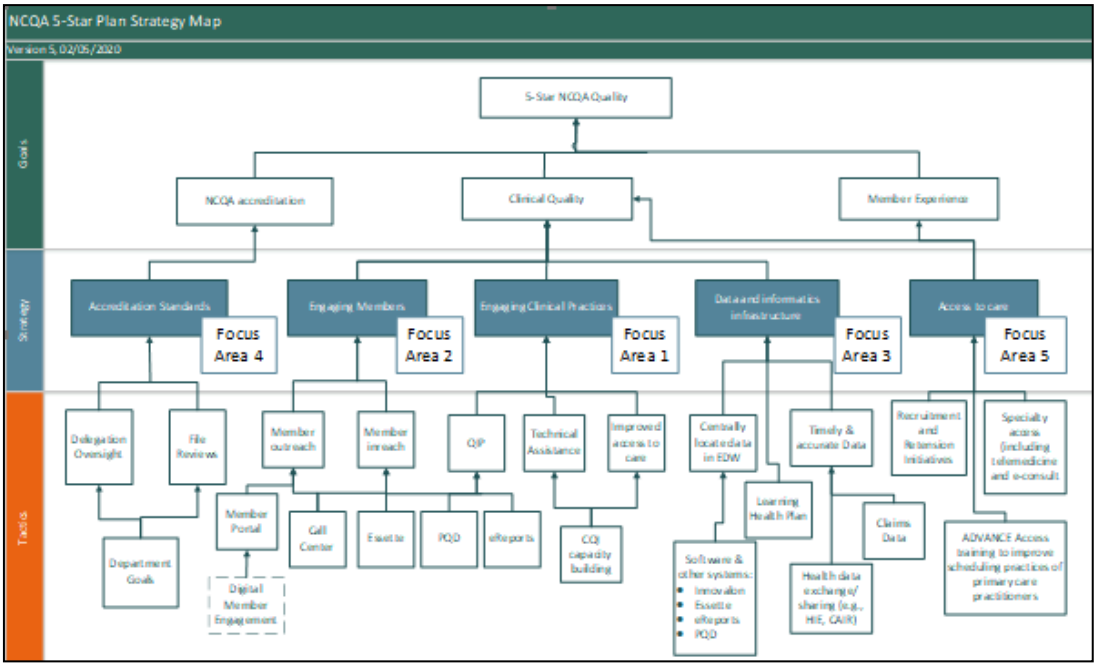
Focus Area 5: Improving Member Experience through PCP Access

Goals	Objectives
A. Recruitment	•Implement: Marketing to Residents within Partnership region •Implement: Marketing to Residents outside Partnership region •Implement: Marketing to out-of-state primary care Residents originally from Partnership counties •Explore: Support partner job search •Study: Support J-1 visa process
B. Retention	•Test: Optimize HPSA scores in shortage areas •Implement: Support providers in completing application/processfor loan repayment •Study: Increase PCP organization reimbursement for sites with greatest challenge via adjustment of PCP-QIP by recruitment difficulty factor •Study: Coordination among local agencies providing supplemental dollars for loan repayment, signing bonus, etc. •Implement: Advocacy for new and larger loan repaymentprograms by state/federal government. •Test: Vetted Locum Tenens providers to provide vacationcoverage •Planning: Proposal for structure for providing social support to providers
C. Alternative Access Options	•Implement: Promoting the leveraging Phone/Video visits toincrease access •Implement: On demand video visits for urgent care •Promote: Advanced Access methodology
D. Learning	•Implement: Exit Interviews of Clinicians leaving the region •Implement: Interview practices that are very successful inrecruiting strong staff

Conclusion

This Partnership Strategic Plan for Achieving Five Star Quality provides a roadmap for using the overall structureand framework of NCQA, modified by requirements of DHCS, to substantially improve quality and ultimately achieve a 5-star rating by NCQA by 2025.

Appendix A: Partnership Strategic Quality Plan



Pathway to Excellence

Partnership Framework for Continuous Learning

Final Workgroup Report June, 2021

Workgroup Members:
Robert Moore, MD MPH
Mark Netherda, MD
Erika Robinson
Nancy Steffen
Caron Lee
James Devan
Naresh Vemparala
Farashta Zainal

From Quality Measure Score Improvement Team Goal #4:

SMART goal #6:

Partnership's transformation as a Learning Health Plan: Define a framework/plan for expanding knowledge management infrastructure relative to best practices in quality measure improvement and operationalizing standardized approaches to small tests of change through scaling and wide-spread implementation.

Milestones:

Final report presented to the executive HEDIS® Measure Score Improvement team by June 30, 2021

Table of Contents

Executive Summary 71
Framework Development 74
Original Pathway to Excellence Whitepaper and Plan (2021) 75
Continuous Learning as a Quality Framework 75
- Roots in Partnership Culture 75
- Definitions of Learning 76
- Learning Organization and Quality Improvement 76

Pathway to Excellence Framework Overview 78
Knowledge Management 81
- Background Concepts 81
- Categories of Knowledge 82
- Essentials of Strategic Knowledge Management 82
  - Strategic Initiatives to Bridge Gaps 83
  - Information Technology Resources for Knowledge Management 84
  - Supportive Leadership Activities for Knowledge Management 85

Small Tests of Change 85
- Framework Options 85
- Considerations when Planning a Pilot/Small Test of Change 87

Data and Statistical Analysis 89
- Analytics Strategic Plan 89
  - Project Purpose/Business Justification 89
  - Structure of Analytics Strategic Planning 91

Standards for Evaluation 92
Optimizing Spread: Application of Implementation Science 92
Organizational Factors 95
- Plan for Nurturing Organizational Culture 95

Plan for Maturing the Framework 97
- Overall Plan 97
- Year 2 Activities 97

Bibliography 98

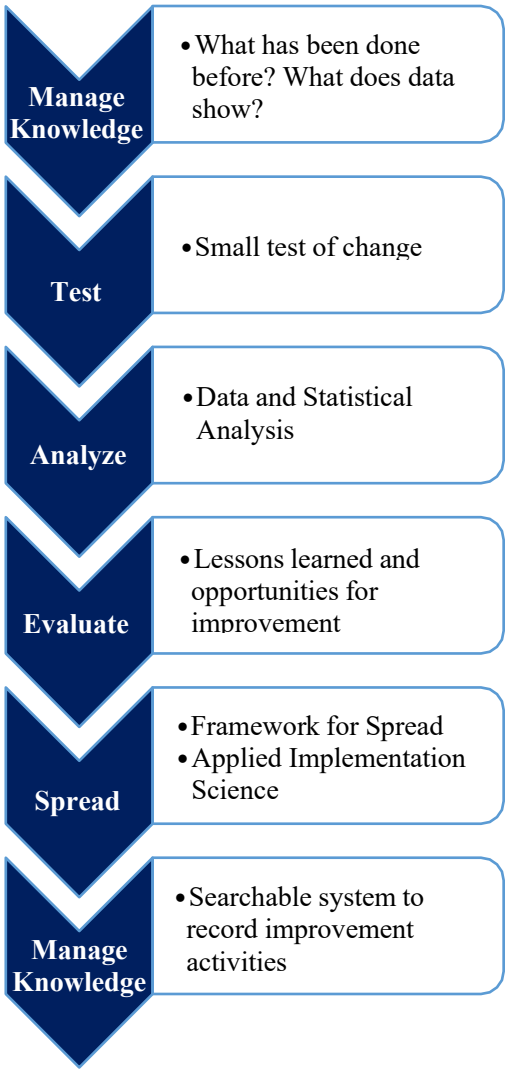
Executive Summary

For years, Partnership's QI Program Description (and DHCS itself) has highlighted the Model for Improvement, whichincludes the well-known PDSA (Plan-Do-Study-Act) cycle as a guiding framework for improving the quality of health are of our members. Yet, as we accumulated positive experience with many small tests of change, Partnership'soverall health plan ranking (comparing a subset of HEDIS® scores with the scores of other health plans) was improving slowly. Recent reports on relative performance on Pediatric Health measures has highlighted lower performance in Partnership's northern regions, which could have an impact Partnership's success with absorbing additional rural counties. While small tests of change (PDSAs) are a key framework in improvement activities, they are not sufficient to achieve larger scale long lasting improvement.

Partnership updated its 5-star Strategic Plan in 2020, and is executing a comprehensive tactical plan related to this plan. A central goal was NCQA accreditation, achieved in January 2021. HEDIS® scores for measurement year 2021 will be the baseline year for rating the health plan on NCQA's 5-star HEDIS® scoring. The COVID pandemic and the Health Edge core claims processing implementation have had a notable negative impact on energy that can be spent by Partnership and our providers on improving health care quality measures. As we move into late 2021 and 2022, we must be ready to re-energize our provider network to improve clinical outcomes.

In 1990, Peter Senge outlined the components of what he called a "learning organization," in his book *The Fifth Discipline: The Art and Practice of the Learning Organization*. The highest performing organizations are the strongest learning organizations, he argues, and they have specific disciplines that characterize being a learning organization. About a decade ago, the term "learning organization" was expropriated by a variety of Health Care Organizations to become a "learning health system." Different organizations and authors had different ideas of what the "system" was, ranging from a geographic system to an integrated delivery system to the entirehealth care delivery system in the United States.

Over the past year, a workgroup of Partnership's HEDIS® score improvement team explored how these concepts of a "learning organization" and a "learning health care system" could be applied to a health plan. The resulting framework is composed of five elements, shown in the diagram below (knowledge management has a role at the beginning and end of the process, so is presented twice):



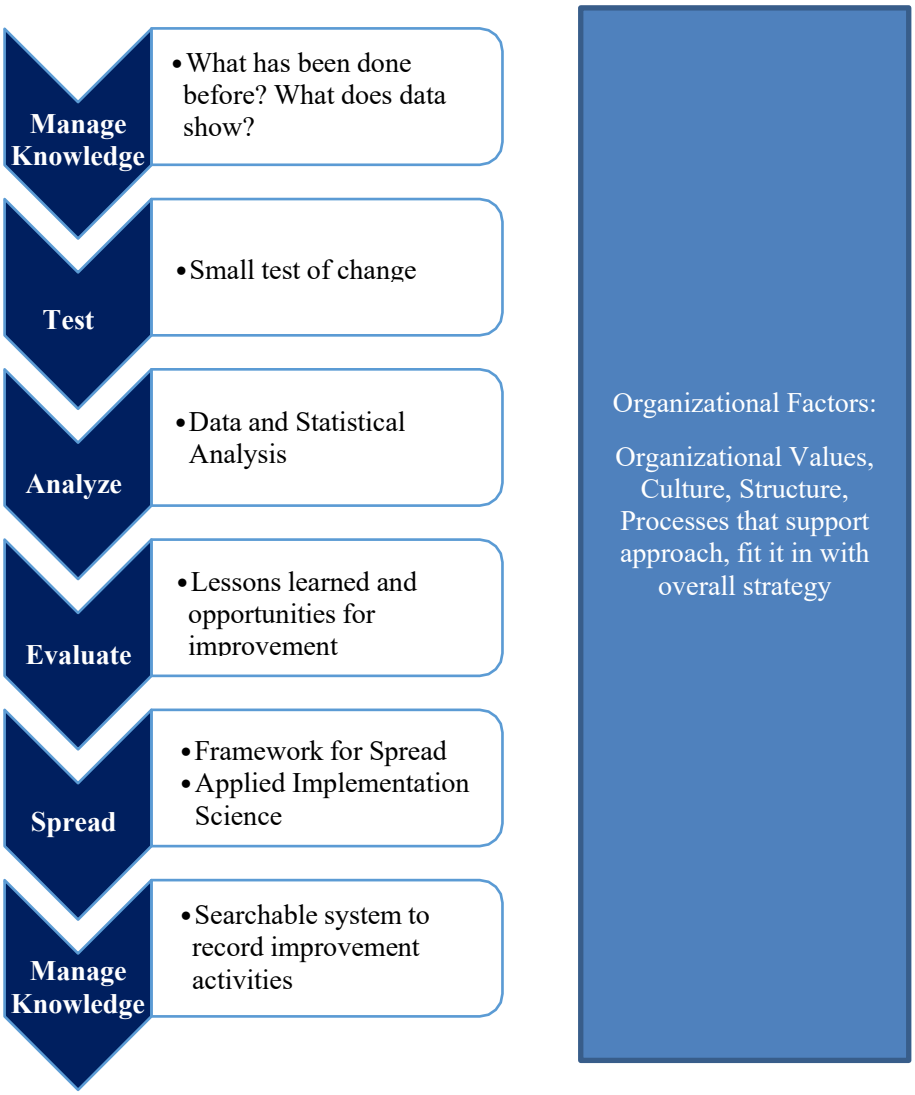
This document provides an overview of each of these key elements, including current activities at Partnership as well as a summary of the academic literature on each topic. Next, several leadership activities and overarching activities are described as critical elements to optimize the successful use of these five elements. We end with a plan for further developing our framework in the 2021-2022 fiscal year and beyond. We believe that adoption of this framework will provide critical support for our NCQA stars status, and contribute to our vision, to be themost highly regarded health plan in California.

A detailed description of the Pathway to Excellence framework can be found after the 2022 update activities section below.

2022 Update and Activities Related to the Pathway to Excellence Framework

Background:

Traditional QI frameworks are missing several key components essential for optimal testing of new ideas and implementation of successful tests. In 2020 to 2021, Partnership researched frameworks and ideas that were missing from traditional QI frameworks into one overarching framework, called the Pathway to Excellence. Major components are summarized here:



A detailed white paper with references is available on Partnership's internal website (Partnership4Me), along with a number of recorded presentations on each of the topics above.

Activities of 2022-23

During 2022, Partnership steadily worked on rolling out the Pathway to Excellence (P2E) Framework, building on an implementation plan created in 2021. Major activities of 2022 and planned activities for 2023 are listed here:

1. Creating in internal website to make P2E materials easily available to Partnership staff.
2. Formal presentations on each of the major topics:
   a. Overall Pathway to Excellence Framework, including coverage of theory of knowledge and learning.
   b. Knowledge Management
   c. Small Tests of Change
   d. Data and Statistical Analysis, including a sub presentation on Using the Data We Have (Health analytics and Data Governance work to continue into 2023).
   e. Evaluation methods
   f. Using Applied Implementation Science to Optimize Spread of Tested Ideas
3. These presentations were given internally:
   a. Operations Leaders

b. Medical Directors
c. Health Services Directors and Managers
d. Recorded for others to review (new staff, new leaders, etc.)
e. Board Quality Advisory Workgroup

4. Externally, the overall framework was adapted and presented to:
   a. Partnership's Hospital Quality Symposium
   b. The California Hospital Quality Council's annual Quality Forum
   c. Additional forums planned for 2023: CPCA Quality meeting in March.
5. Incorporating the major principles of the P2E framework in thinking about our everyday work. (Will continue in 2023)
6. Special focus on Strategic Knowledge Management (KM) Activities (all ongoing, continuing in 2023)
   a. Shared Drive Cleanup by HS departments
   b. SharePoint site cleanup
   c. Use of One-Note for Knowledge Management
   d. Master list of abbreviations updated and posted to SharePoint
   e. Principles for updating external website for KM created.
   f. Use of PowerDMS for Knowledge Management (Plan to implement after fall 2023)
   g. Microsoft 365 and its role in updating KM infrastructure (including external website). Planned for 2023.
   h. IT backup of KM materials on shared drive (2023 topic)

Framework Development

The Pathway to Excellence: Partnership's Framework for Continuous Learning was developed by a workgroup of the HEDIS® Score Improvement Goal Group. The workgroup met monthly to discuss and flesh out different aspectsof this framework and to systematically review the academic literature related to the different elements. A review of pre-existing activities that contribute to these elements was tabulated. Interviews of external organizations working on this framework were initiated, and will continue as our understanding of the framework elements expands.

Original Pathway to Excellence Whitepaper and Plan (2021)

Initially, the workgroup was named "Learning Health Plan" as an extension of the "Learning Health System" concept, but with feedback from the executive team and Partnership's board advisory committee on quality, the framework is renamed "Pathway to Excellence: Partnership's Framework for Continuous Learning."

Workgroup Members:

Robert Moore, MD MPH
Mark Netherda, MD
Erika Robinson
Nancy Steffen
Caron Lee
James Devan
Naresh Vemparala
Farashta Zainal

The workgroup developed this document, an annotated bibliography, several PowerPoint presentations summarizing the key concepts, and notes summarizing the monthly meetings.

Continuous Learning as a Quality Framework

Roots in Partnership Culture

The Mindset of Continuous Learning is rooted in Partnership's organizational culture.
Several of Partnership's organizational values (listed on the Partnership website) support different aspects of quality:

1. Partnerships: Fostering strong partnerships with members, providers, and community leaders to collectively improve health outcomes. "Putting our members first."
2. Overall focus on Quality: Focusing on continuous quality improvement in every aspect of the organization and in collaboration with our partners. "Doing the right thing right, the first time and every time. Excellence is achievable! Striving for perfection, but embracing the opportunity to learn from imperfection."
3. Integrity: Set a standard of professionalism, integrity, and accountability. "Willingness to challenge the status quo, and insist on change when needed."
4. Innovation: Seeking creative solutions. Apply knowledge in new ways.

In addition, two key organizational principles specifically support aspects of being a learning organization:

1. Balancing Compliance and Performance: Balancing rigid attention to regulatory requirements with flexibility and innovation needed to drive improvement. "Not all change is improvement, but all improvement requires change."
2. Continuous Learning: "Making decisions based on rigorous data analysis whenever possible (instead of based on hope or wishful thinking)." "Creating an atmosphere where new ideas can be explored and where strong, independent teams can test these ideas"

The mindset of continuous learning can be expressed in these three credos:

1. We are all very proud of Partnership, the work we do and the systems we have developed. Nonetheless, werecognize that we as individuals and as a company can do better.
2. We strive as individuals to be curious and continuously learn.
3. We also strive as an organization to learn and grow.

While these are organization-wide values, this document will focus on the applications of continuous learning to our work to support our strategic goal of becoming a 5-Star NCQA recognized health plan. This includes work related to improving quality and performance in these Partnership departments: quality, pharmacy, care coordination, utilization management, health analytics, and population health. Of note, some parallel activities in Partnership's operational departments are being organized by the OpEx/PMO department.

Organizational leadership activities are critical for applying this work. This includes ensuring that activities are related to organizational priorities, that staff are supported and motivated, that staff work well cross-departmentally, and that the overall organizational culture is supported.

Knowing is not enough; we must apply. Willing is not enough; we must do.
- Johann Wolfgang von Goethe

Definitions of Learning

Two useful definitions of learning are:
Learning (noun):

1. Process of acquiring information, knowledge or understanding/wisdom
2. The process by which (tacit) knowledge is *created* through the transformation of experience

Note that these definitions are very different from the concept of Machine Learning, a form of Artificial Intelligence (AI), defined as the use and development of computer systems able to learn and adapt without following explicit instructions. We will *not* be addressing machine learning in this report.

Another important distinction is the difference between Learning, Innovation, and Invention. In contrast to learning, innovation and invention are defined as follows:

Innovation (noun): The creation, development, *and implementation* of a new product, process or service, withthe aim of improving efficiency, effectiveness or competitive advantage.

Invention (noun): brand new concept or idea which may not be completely defined/fleshed out/proven.

Learning Organization and Quality Improvement

The idea of a learning organization was defined and popularized in Peter Senge's 1990 book, *The Fifth Discipline: the Art and Practice of the Learning Organization*. His definition of a

Learning Organization (noun): An organization that facilitates the learning of its members and continuously transforms itself.

In the book, Senge details the Five Disciplines of a Learning Organization:

1. Personal Mastery
2. Mental Models
3. Shared Vision
4. Team Learning
5. Systems Thinking

In this context, learning is used as an adjective, modifying organization.

Early reference to the importance of learning in Quality Improvement work also uses learning as an adjective, modifying activities. This is summarized by Don Berwick's analysis of a quote by Tom Nolan, the creator ofthe Model for Improvement:

> "What are necessary and sufficient conditions for improvement in large systems? **Will, ideas, andexecution**!"
>
> - Tom Nolan, creator of the Model for Improvement
>
> "Providing **will** refers to the tasks of fostering discomfort with the status quo and attractiveness for theas-yet-unrealized future. Providing **ideas** means assuring access to alternative designs and ideas worthtesting, as opposed to continuing legacy systems. And **execution** was (Nolan's) term for embedding *learning* activities and change in the day-to-day work of everyone, beginning with leaders."
>
> - Don Berwick, founder of the Institute for Healthcare Improvement

Learning Health System: Another use of learning as an adjective is Learning Health System, first used by the National Institute of Medicine in 2007, to mean that evidence based medicine would be applied reliably throughout the health care delivery system:

> "A learning healthcare system is designed to generate and apply the best evidence for the collaborative healthcare choices of each patient and provider; to drive the process of discovery as a natural outgrowthof patient care; and to ensure innovation, quality, safety, and value in health care."

Evidence based medicine is given a broader definition:

> "to the greatest extent possible, the decisions that shape the health and health care of Americans—by patients, providers, payers, and policy makers alike—will be grounded on a reliable evidence base, willaccount appropriately for individual variation in patient needs, and will support the generation of new insights on clinical effectiveness."

Immediately after this, a subsequent explanation drives back to "information from clinical experience" andclinical effectiveness of interventions.

The Institute of Medicine considers learning as building a knowledge base and translation of this knowledge regularly in the course of patient care.

In the decade that followed, the term learning health system was used in many different senses, depending onhow the author thought about the word "system":

1. U.S. Healthcare Delivery **System**
2. Academic Medical Center as a **System**
3. **System** of translating research into practice
4. Integrated Healthcare Delivery **System**
5. Local or Regional Healthcare Eco-**system**
6. Data Management or Health Information Exchange **System**

We bring this diversity of views to your attention so the reader will be aware that this term is fraught, not tochoose one concept of a Learning Health System over another.

What does the Pathway to Excellence look like?

1. Decisions and conclusions are based on rigorous data analysis whenever possible (instead of based on hope or wishful thinking), while creating an atmosphere where new ideas can be explored.
2. Within this framework, strong independent teams test these ideas, quantitative and qualitative evaluation is performed, knowledge gained is organized for future retrieval, and successful practices are spread effectively.

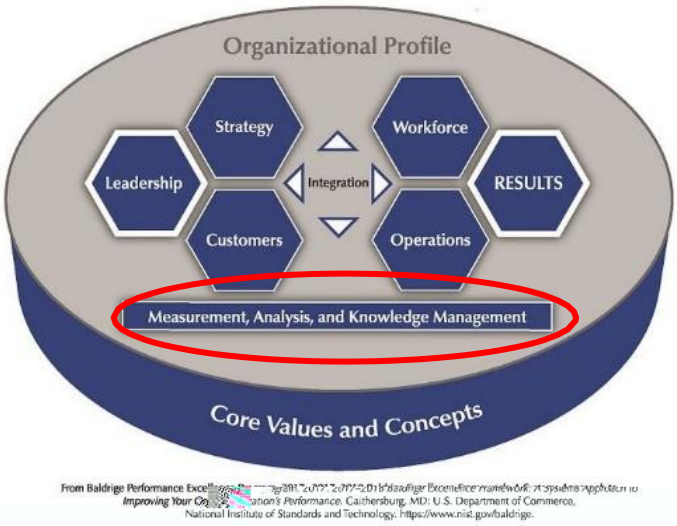
How does this work fit in with other Quality Frameworks?

The Pathway to Excellence Framework shares some themes with two other major quality frameworks: The National Baldrige Award for Quality criteria and the Shingo Model of lean management.

Baldrige Criteria: Four of underpinnings of the Baldrige criteria relate to the *Pathway to Excellence* Framework:

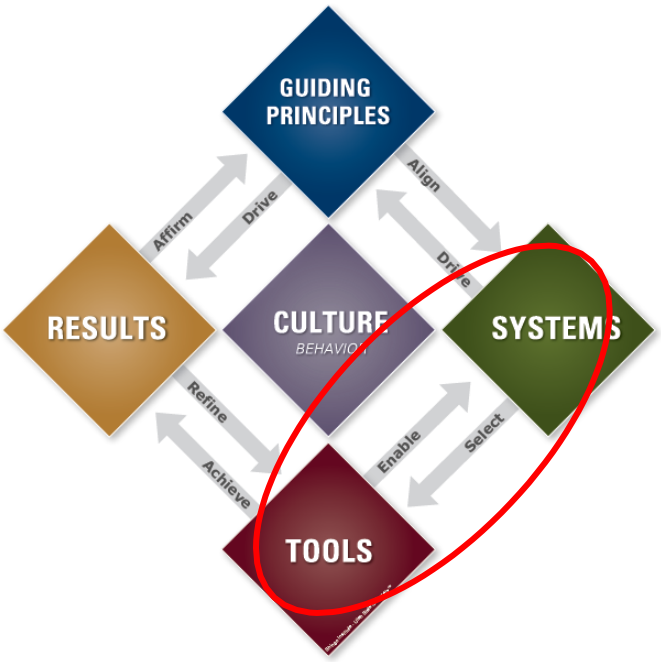
1. Organizational learning
2. Focus on Success and Innovation
3. Management by Fact
4. Delivering Value and Results.

The Organizational Profile of the Baldrige Criteria are shown on the figure below. Of special note, the overarching concepts of measurement, analysis and knowledge management identify three of the elements shared with the *Pathway to Excellence* framework. Also shared is the idea that organizational core values andconcepts underpin the effectiveness of the quality framework.



From Baldrige Performance Excellence Program. 2017-2018 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance. Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology. https://www.nist.gov/baldrige.

Shingo Model: The **Shingo model** of operational excellence asserts that successful organizational transformation occurs when leaders understand and take personal responsibility for architecting a deep and abiding culture of continuous improvement. Leaders lead culture; nurturing the organizational culture is at thecenter of the model. The Shingo Model includes an improvement system, improvement tools, a work system and a management system. While the Shingo model focuses on Purpose, Process, and People, the learning framework described in this paper at Partnership focuses on Process. Process values/principles/behaviours include: continuous improvement, seeking perfection, embracing scientific thinking, and focusing on the process.



Partnership Strategic Plan: The Pathway to Excellence framework will be applied to the first area of emphasis in thecurrent Partnership strategic plan (see below): Access to High Quality Care.

Pathway to Excellence Framework:

After consolidating our information on the Pathway to Excellence Framework, we can summarize this Partnership Framework for Continuous Learning as:

1. Using the scientific method to optimize implementation of quality improvement initiatives
   - Learn from the past: Building on prior research/experiences
   - Small Tests of Change: Rigorous and widespread testing of change on a small scale (using themodel for improvement framework)

- Knowledge Management: Tracking of information gleaned from small tests of change so otherscan retrieve this information and build upon it.
- Careful data and statistical analysis with use of control groups, where appropriate
- Implementation and Spread: Using a combination of classic project management methodologywith the Consolidated Framework for Advancing Implementation Science while having the leadership and staff to support this approach

2. Communicate effectively about quality and change, through a mixture of data and stories. "Nodata without a story, no story without data."

The following sections will summarize each element in greater detail.

Knowledge Management

Background Concepts

Knowledge Management as a field of study has a rather limited literature in relation to health care. There are several journals (including The Journal of Knowledge Management Practice and the Journal of Knowledge Management) and a few books that focus on this area (one is *Strategic Knowledge Management: Driving Business Results by Making Tacit Knowledge Explicit* by Arun Hariharan published in 2015).

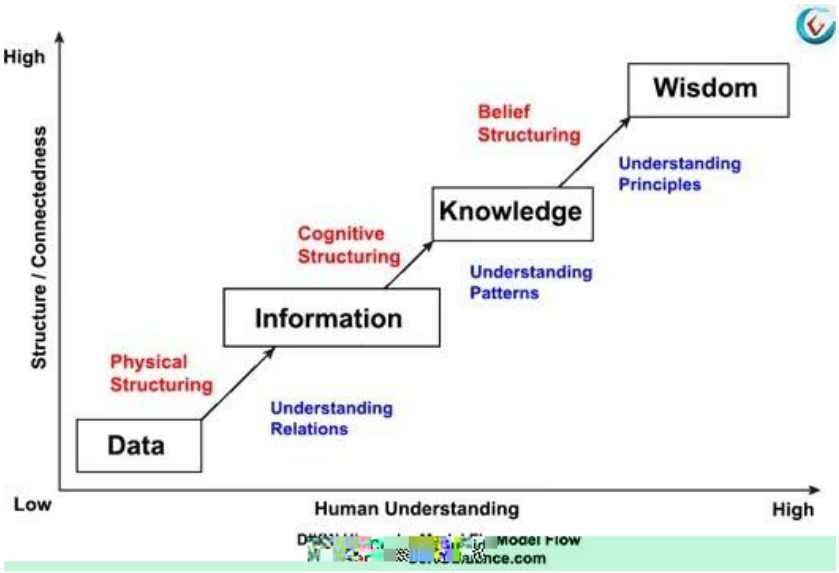
We begin with a brief overview of definitions and philosophy of knowledge.

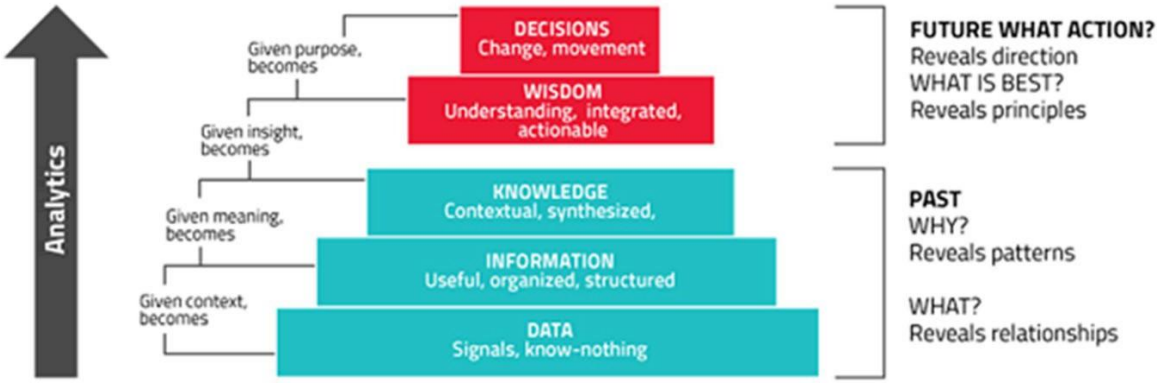
Definitions: Two useful definitions of knowledge are:

1. True belief or understanding of the relations which things and ideas bear to each other and to themselves (Originally from Greek philosophers)
2. Processed information (see below)

DIKW Framework: A key conceptual framework for related knowledge and learning is the Data Information Knowledge Wisdom (or DIKW) Framework, illustrated both as a graph and a pyramid, below. Each level is part of a hierarchy:

a. Data, which is physically structured and related to make
b. Information, which is cognitively structured and pattern recognition to make
c. Knowledge, which with belief structuring and principle definition makes
d. Wisdom, which can be used to prospectively make decisions about future courses of action.





Categories of Knowledge

Categories of Knowledge within an organization can be divided us as follows:

- Individual knowledge: within the brain of an individual, based on their experience, learning or analysis = ***tacit knowledge.*** This tacit knowledge may be possessed by an **expert within** an organization, or by a known **outside expert** who is consulted when needed.
- Individual knowledge: written down or recorded for reference by one person = ***explicit individual knowledge.*** Converting tacit knowledge to explicit knowledge is a central goal in the field of knowledge management.
- Group knowledge: written, recorded or programmed processed information for use by multiple individuals in an organization = ***explicit group knowledge.*** Explicit group knowledge may be derived from either internal sources or from systematic review of external sources. Explicit knowledge is storedin some sort of **knowledge base**, written down on paper or in an electronic format.

Essentials of Strategic Knowledge Management

The overall aim of Knowledge Management is to ensure that knowledge that is relevant to the business, fromany source internal or external, is available at the right place at the right time to enable the right person in thecompany to make the right decisions and implement them so they you achieve the organization's strategic business objectives.

There are three core goals of Knowledge Management

a. Easy and effective application of knowledge/reuse of knowledge. "Use the knowledge you have available."
b. Avoid reinventing knowledge (instead: build on prior knowledge). Don't "reinvent the wheel"
c. Create new knowledge. Apply what has been learned previously to try out new ideas/processes, and measure how well they work.

To robustly apply the principles of Knowledge Management to an organizations two levels of analysis and workmust be conducted:

1. Organizing knowledge and filling gaps (every few years, strategic work)
   a. Identify knowledge capabilities critical to business success (start with 3-5 processes)
   b. Identify a knowledge champion and community of experts for each process to ownknowledge repository of that process.
   c. Conduct knowledge inventory and infrastructure inventory to describe knowledge assetsand map knowledge, divided into internal, external, explicit and tacit. Research should include customer, data, business, market and regulatory framework
   d. Identify knowledge gaps and infrastructure gaps
   e. Define **strategic initiatives to bridge gaps**

2. Applying knowledge to spread or generate new knowledge (ongoing tactical activity)
   a. Storing, vetting, categorizing and transmitting knowledge
   b. Implementing initiatives using knowledge (AKA knowledge translation)
   c. Measuring business results (against benchmarks along with non KM based interventions)

Strategic Initiatives to Bridge Gaps

Broadly, there are three major **categories** of Strategic Knowledge Management Activities:

1. Organizing Explicit Knowledge
2. Organizing Tacit Knowledge
3. Application of existing Knowledge

Major activities in each category are described:

Organizing Explicit Knowledge:

1. Develop a process for gathering knowledge systematically from external sources
2. Develop a standard process for knowledge contribution
   a. Succinct high level summary
   b. Best practices funnel/vetting
3. Establish standardized processes for content management
4. Establish documentation standards for best practices/case studies/lessons learned when project fails

Organizing Tacit Knowledge:

1. Establish communities of practice with knowledge manager (AKA moderator)
2. Organize and define subject matter experts, with the best mechanism to consult them
   a. Pull: mechanism to look for expert in the topic at hand and reaching out to them for input.
   b. Push: experts reach out with information (newsletters, articles, emails etc.)
   c. Combination of Push-Pull: intermediary for contact with experts

Application of Existing Knowledge:

1. Systematic mine knowledge (pull)
a. Gathering information from high performers in a structured way.
b. Review current operational data daily: what needs to be done today? "Use the data we have"
2. Content dissemination (push) (Don't leave it to "chance or choice")
a. Knowledge sharing seminars
b. Publication/dissemination of best practices (newsletter, email)
3. Develop "closed loop processes" to ensure regular review of knowledge for possibility of spread.
4. Determine scope for process for spreading: small scale vs. company-wide
5. Ensure a process is developed for capturing result of knowledge replication/spread, including new knowledge.

Examples of strategic initiatives to bridge gaps that may be selected include:

a. Implementing supportive technology tools
b. Formation of communities of practice
c. Sharing best practices, case studies, lessons learned, both internal and external.
d. Define processes for knowledge sharing (contribution) and knowledge reuse (implementation)
e. HR activities to change culture
f. Corporate learning programs
g. Creating access to experts
ii. Hiring
iii. Consulting
iv. Trainers

Information Technology Resources for Knowledge Management

Features: Here are some features of knowledge management that need IT support:

1. Tools for collaboration and communication between team members
2. Mechanism for storing list of experts with areas of expertise
3. Potential support for other Knowledge Management processes
4. Support of leadership activities promoting Knowledge Management
5. Managing the programs selected to be the organization's **Knowledge Base**: Storing internal and external explicit knowledge contribution, with ability to search and find easily, as well as push certaincontent. This includes knowledge replication and business results.

Contents: Information to be organized within the Knowledge Base includes:

1. Best practices
2. Case Studies
3. Lessons learned
4. Standard documented processes
5. QI projects
6. Innovative ideas
7. FAQs
8. Internal benchmarking
9. e-learning modules
10. Other training material
11. External reports on markets, customers, competitors, regulatory environment, technology trends.

A review of Partnership IT tools that are currently used for some sort of Knowledge Management (and which could beleveraged to better manage additional knowledge) include:

1. Shared drives (baseline data, many other documents)
2. Outlook: email
3. SharePoint: Partnership4Me (document organization)
4. Public Website posting of knowledge for sharing with external partners
5. Microsoft office tools: Excel, Word, PowerPoint, Visio
6. Workfront: has review process and project management functions.
7. PowerDMS: review process for submitted documents. Note that PMO has selected this to be used for capturing end of project write-ups.
8. Prezi (entire 360-degree view)

Supportive Leadership Activities for Knowledge Management

Three key elements of a supportive leadership culture are

1. Sharing of ideas (Interpersonal relationships, professional trust)
2. Willingness to build on others' ideas
3. Giving credit for origination of knowledge

Some techniques that can included to achieve these are:

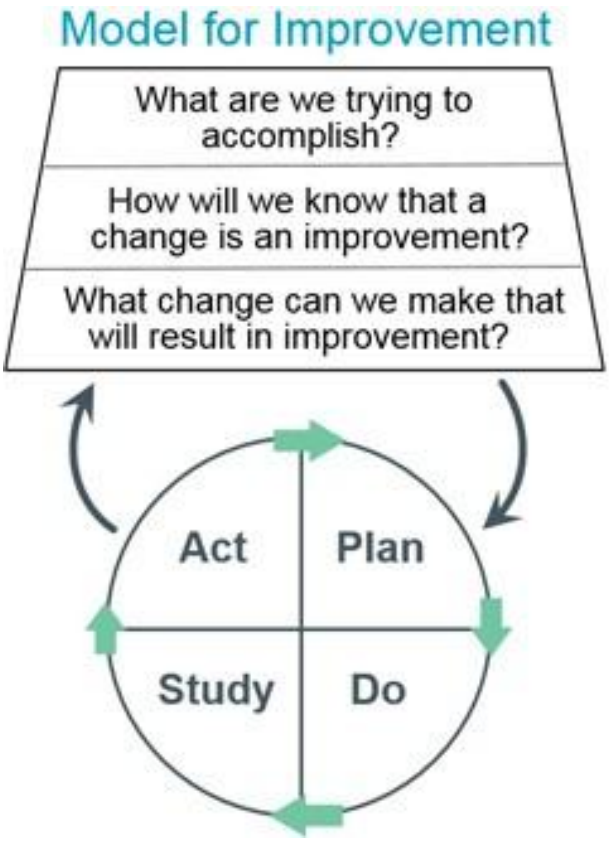
1. Link Knowledge Management to formal recognition (awards), incentives and/or performance evaluation system
2. Capturing measured results: process and outcome measures
3. Capturing and spreading narratives/survey results
4. Senior leadership attention to Knowledge Management and inclusion in strategic planning and organizational dashboards.
5. Designating resources to maintain/curate Knowledge Base over time to assure ease of access andlocation at the right place/time

Small Tests of Change

Framework Options

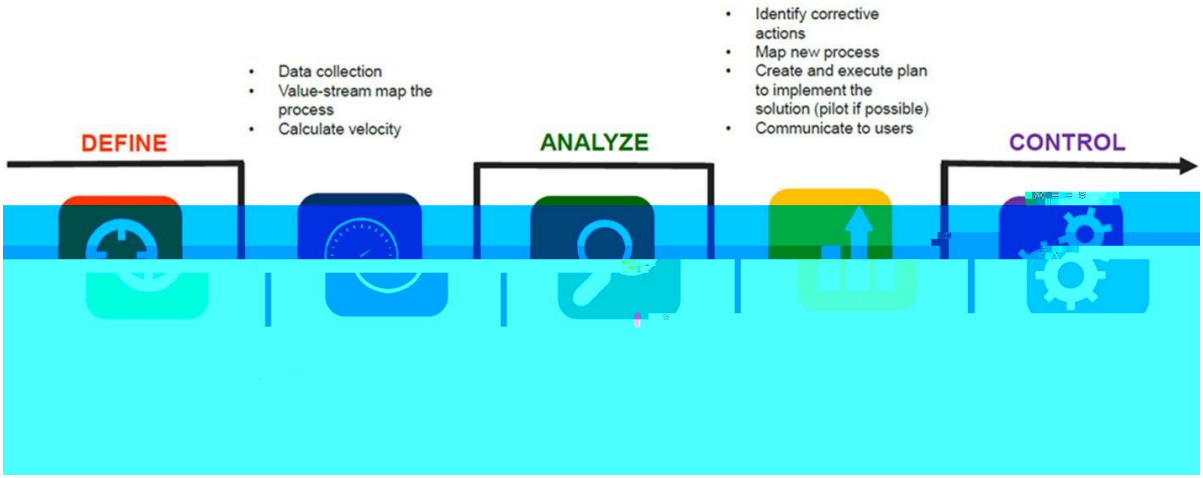
Broadly, when considering a small test of change, we start with a problem and a process.

The model for improvement (includes the PDSA cycle is a problem oriented small test of change: In the Partnership run training *ABCs of QI*, the focus is on the basic concepts of Quality Improvement using the Model for Improvement. The Model for Improvement represents a focus on quality improvement, as opposed to using DMAIC or Lean Six sigma for process optimization or Agile for IT implementations that include doing tests of change.

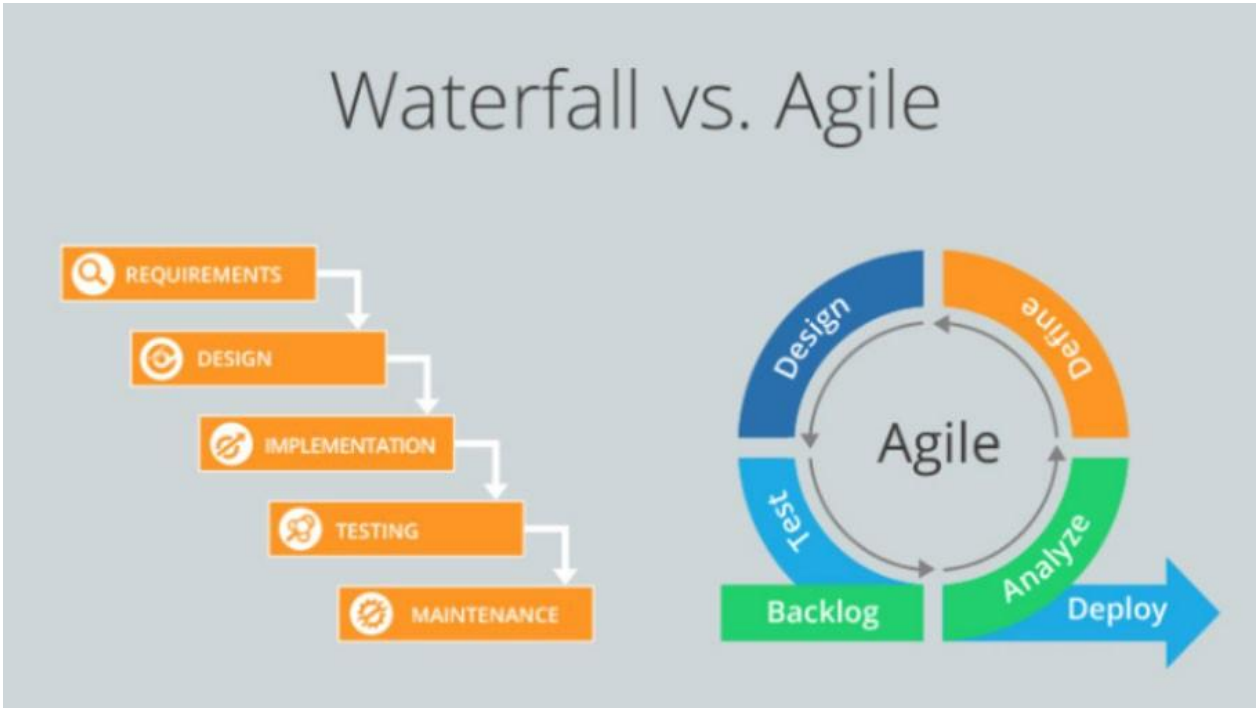


For reference only, we briefly describe DMAIC and Agile; they are not the focus of this document.

Define, Measure, Analyze, Improve, and Control (DMAIC) is a standard process, which often includesapplication of lean/six sigma principles, for process oriented change and optimization.



Agile is a method of implementation that combines pilots/tests with scaled implementation, and is contrasted with the Waterfall method of implementation:



Considerations when Planning a Pilot/Small Test of Change

What size test? Is a test of change big enough for outcome to have meaning? There are three factors to consider: *cost of failure, confidence in intervention, resistance to change* as shown in the following graphic:

Are We Ready to Implement?

Appropriate Scope for a PDSA Cycle

Current Situation		Staff/Clinicians Readiness to Make Change: Resistant	Indifferent	Ready
Low Confidence that change idea will lead to Improvement	Cost of failure large	Very Small Scale Test	Very Small Scale Test	Very Small Scale Test
	Cost of failure small	Very Small Scale Test	Very Small Scale Test	Small Scale Test
High Confidence that change idea will lead to Improvement	Cost of failure large	Very Small Scale Test	Small Scale Test	Large Scale Test
	Cost of failure small	Small Scale Test	Large Scale Test	Implement

The Improvement Guide, Second Edition, Jossey-Bass, April, 2009

API 4

Here are other key factors to consider when designing a pilot in a way that will inform future implementation/scale-up activities. (Al-Ubaydli, List, & Suskind, 2019):

1. Do the research/pilot results scale to larger markets and settings?
2. When we scale the intervention to broader and larger populations, should we expect the same level of efficacy that we observed in the small-scale setting?
3. If not, what are the important threats to scalability? (Al-Ubaydli, List, & Suskind, 2019)
   a. Statistically underpowered (sample size needed)
   b. Difference in population
   c. Negative economies of scale
   d. Program structure difficult to scale
   e. Dosage of intervention will be less with larger scale
   f. Incentives will be different with larger scale
   g. Inputs (staffing training for example) will be different between pilot and spread
   h. Scaling likely to cause substitution effect that wasn't present in pilot
4. What can the researcher do from the beginning of their scholarly pursuit to ensure eventualscalability?

Data and Statistical Analysis

Analytics Strategic Plan

Partnership is has begun the process of building on a Strategic Data Plan to develop a Strategic Analytics Plan. A Charter has been created and initial work has begun, but the need to convert current analytic reports to draw data from Health Edge, and to validate these mappings, has led to this strategic analytic process to be put on hold.

The charter outlines many excellent definitions, aims and purposes, and so is extracted here:

Project Purpose/Business Justification

Definitions of Data and Analytics

Raw Data: discrete pieces of information that flow into the organization

Processed Data: organized and consolidated raw data, the result of which is more easily manipulated through analysis to generate information.

Data Literacy: Competencies to promote the ability to read, understand, create and communicate data as information.

Data Information Knowledge Wisdom Pyramid: A hierarchy of class of models for representing functional relationships between data, information, knowledge and wisdom

Analytics: Systematic computational analysis of data or statistics, used for the discovery, interpretation and communication of meaningful patterns in data.

Project Purpose

To create a framework for an enterprise-wide analytics strategy to achieve the following value/advantage:

- To be more efficient in how we analyze data, eliminating redundancies, and optimizing teams
- To be confident in the processed data we use and share
- To prioritize and evaluate processed data/analytics project needs efficiently and ensure capacity
- To be prepared to respond to processed data/analytics requests in urgent situations
- To make processed data management and analytics processes more transparent
- To standardize quality assurance, presentation, and documentation of processed data products
- To streamline intake processed data and analytics requests
- To conduct data analysis and program evaluations using sound scientific methods
- To make processed data available for self-service review and analysis by different business units
- To develop innovative solutions for systematic data discovery of opportunities, gaps, or risks thatwould improve financial and/or health outcomes
- To operationalize advanced analytics (prediction models, machine learning, time series, statisticaltesting, data mining, etc.)

Aim Statement
In a 5-year period, to develop an enterprise-wide framework to maximize use of data to generate information, knowledge and wisdom to improve health outcomes, enhance the member experience of care,and reduce or maintain the cost of care by optimizing utilization of resources, including data, technology and staff. The focus of the effort include: • Define analytic needs for the business • Strengthen or develop policies and procedures for prioritization, management, access, and documentation of processed data products • Review existing data architecture and identify opportunities to optimize structure • Expand self-service analytics tools • Operationalize/integrate advanced analytics • Increase data literacy
Scope
Draft: **In scope:** any data project that involves data analysis or the creation of a report or a specialized dataset to be used for regulatory reporting, operations, or measuring performance, either for financial or health care purposes. **Not in scope:** projects involved in acquiring, processing, or warehousing raw data from main sources (DHCS, providers, other)
Deliverables
Outcome 1: Identify an analytics governance body Outcome 2: Decide on an analytics team structure and role definitions Outcome 3: Develop standards for data products Outcome 4: Develop a comprehensive strategic plan for the next 5 years

Structure of Analytics Strategic Planning

Data Governance Council • Final decision making body in the data governance structure • Sets overall direction on health analytics strategy and initiatives • Advises and empowers the Analytics Strategy Committee to implement an enterprise-wide analytics program
Analytics Strategy Committee • Prioritizes and communicates efforts between Data Governance Council, workgroups and stakeholders • Ensures the analytics strategy efforts align with the priorities from the Data Governance Council • Provides recommendations (including resource allocation recommendations) to the Data Governance Council • Sponsors, approves and manages plans that support analytics strategy efforts and projects • Forms work groups and defines their scope, based on area of expertise and responsibility

The Pathway to Excellence Workgroup identified a number of specific opportunities in the data and analytics realm that would be part of the Framework for Continuous Learning:

Partnership should consider documenting and standardizing:

1. Review of **commonly used variables** used in outcomes analysis: sources of bias/confounding; how variables are inter-related
2. Description of **data currently available** for retrospective analysis
3. Major **types of statistical analysis** that applies to health plan level work.
4. Selecting **appropriate test for statistical significance**.
5. **Presentation of data**: best practices/Partnership standards in presentation of data

Partnership should standardize and train staff on the process of taking a data need and formulate a data request withjustification. Four key purposes of reporting on data:

1. Looking for trends and outliers. Trends over time, by year, month. Standard stratification approaches include: Geography, Provider site (and parent organization if PCP), Race/Ethnicity, Aidcode, Homeless status, Presence of major mental health disorder. Results should be shared by number and percentage of total (rates); Ideally with Tableau dashboard.
2. Evaluating the impact of a specified intervention (may be part of rough evaluation or formal evaluation). Report using data from data warehouse or other sources, with citation of data sources clearly indicated.
3. Define a detailed list of either members or sub-population for a particular intervention (the requester should be able to define planned intervention, as this determines the fields of the output). Depending on nature of date needed, raw or aggregate data can be generated from pharmacy, claims configuration (Essette), Claims or Finance.
4. Define a list of providers for a particular intervention (the requester should be able to define planned intervention, as this determines the fields of the output).

What are the data and analytic areas do we need to build internal expertise?

1. Communicating analysis to our provider partners, in a way that is not too complex.
2. More advanced database skills, programming (python, R), google colab

For what areas should we seek outside help?

1. Biostatistics/epidemiology
2. Data scientist (study design)
3. Economics/social science to determine methodologies, creative randomization or alternatives
4. Advanced database and programming expertise

Standards for Evaluation

General approach to Evaluation. We should systematically plan evaluation and analytic approach ahead of time and then iteratively. Some questions to answer:

1. Is it possible to prove something?
2. How scientifically sound is the evaluation? What size of intervention is needed?
3. Since the evaluation plan impacts study design, how will the study change?

On a regular basis in reviewing scientific literature we need to seek out and save evaluation methods done by others researchers, for possible future use. This knowledge should be managed logically.

What are major areas of evaluation methods, which Partnership should consider document and standardize?

1. Options for **randomization**, with explanation of factors to consider in choosing one (include ABtesting as option)
2. Options for **control groups**, with explanation of factors to consider in choosing one
3. Description of **ethical framework**: when is consent needed; when an Institutional Review Boardreview is needed (is publication planned).
4. **Standard template for study design**, including: problem analysis, strategy to manage change, proposed interventions, target population, definition of outcomes and potential unintended consequences, baseline outcome rate, anticipated observations/week, unit of randomization, blinding,and implementation of the randomization strategy
5. **List of options for study design** (See Horwitz reference for options)
6. **Overall evaluation framework** options to consider, with explanation of factors to consider inchoosing one.

Optimizing Spread: Application of Implementation Science

Overview: (Dubner, 2020) gives a definition of Implementation Science: Definition of ImplementationScience:

> *It's the study of how programs get implemented into practice and how the quality of that implementation may affect how well that program works or doesn't work.*

Factors to consider, at least once, when making the decision to do a large scale implementation based on resultsof a successful pilot.

The Consolidated Framework on Implementation (Damschroder, et al., 2009) is a Social science construct that seeks to organize the theoretical frameworks and factors that influence the success of an implementation. For a *larger* implementation, it is probably worth spending some time going through the list to consider strategies for improving the success of this particular implementation. For smaller implementations, it is rarely very helpful.In addition, (Al-Ubaydli, List, & Suskind, 2019) notes these reasons for failure of pilots to spread successfully:

1. Spillover and administration quality impacts direct treatment effects.
2. The participant(s) being unrepresentative of the population in terms of direct treatment effect.
3. The statistical estimation error.
4. Economies/diseconomies of scale in participation costs.
5. The participant(s) being unrepresentative of the population in terms of participation cost. (really asubset of number 2)
6. Economies/diseconomies of scale in implementation costs. (4 and 6 go together).

The Science of Using Science: Towards an Understanding of the Threats to Scaling Experiments (Al-Ubaydli, List, & Suskind, 2019) is a more practical consideration of this topic. Some highlights:

1. Consider the myriad of factors that lead results of pilots to not be generalizable with spread, when designing the pilot or small test of change. Initial backward induction to understand, up-front, potential problems with scaling; think like a policy maker when doing the initial study. ("What could possibly go wrong") (See section on PDSA for a list of these)

2. Due to these characteristics of pilots, which make generalizability problematic, the following are recommended:
   a. More precise statistical summaries of the pilots to assess if they actually worked
   b. More frequent replication before attempting spread: If goal is demonstrating 95% confidencethat small scale pilots will scale, may need about 4 independent studies to show the same thingto overcome the possibility of these biases being present.

3. Once decision to spread has been made: the following are recommended to <u>increase chance of success/fidelity:</u>
   a. Detailing the core elements or "non-negotiables" of the intervention
   b. Ensure the facilitators/project managers/staff understand the "whys" or the mechanism behind the intervention effect.
   c. Look for technology to standardize processes and to check fidelity: Upload data of spread sites in a way that can do fidelity testing as data entered. (see Dubner, below)
   d. Original scientist or pilot person also should play an important role in actual role out of program
   e. Carefully measuring program efficacy when program is scaled: (generation of new knowledge.)

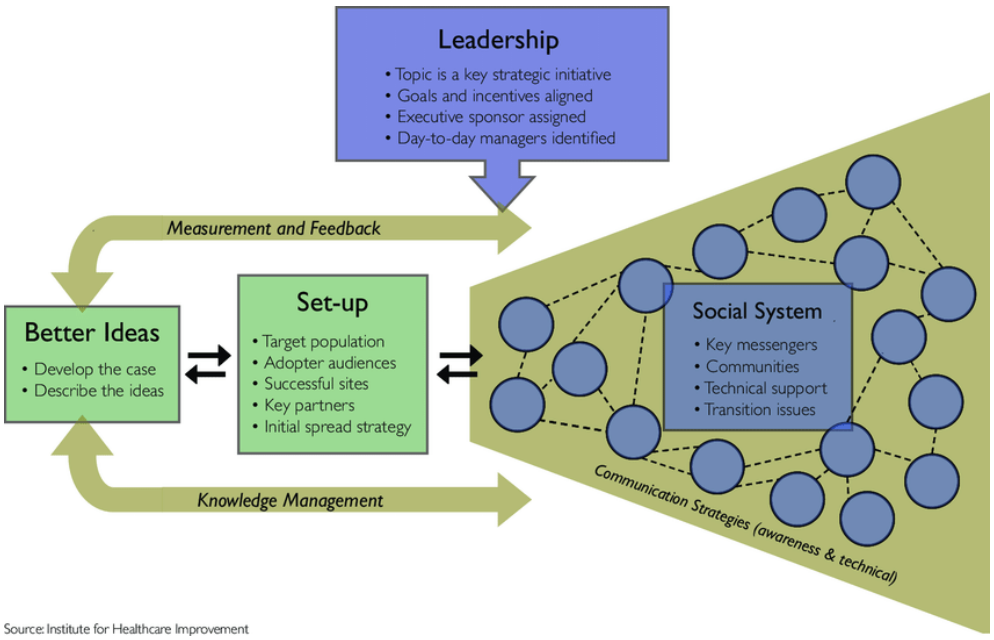
<u>Why spread fails</u>: (Dubner, 2020) summarizes the main five reasons spread/implementation fails:

1. Evidence not there to support scaling in first place
2. Wrong people were studied in the pilot compared to the larger population.
3. Wrong situation was used: voltage drop with change of situation: avoid by preserving "fidelity" oforiginal test. One solution: Upload data of spread sites in a way that can do fidelity testing as dataentered.
4. (Infrastructure/Delivery system of spread very different from system of academic testing.)
5. Need to look at both the supply and demand for the intervention

<u>Elements of successful transitions from projects to programs</u> (Savinsky & Stadelhofer, 2011?) describeselements of successful spread with important pitfalls to avoid.

1. Solidify leadership support
2. Understand current state
3. Define future state
4. Confirm and monitor operational metrics
5. Enlist expertise and appoint a transition leader
6. Engage affected personnel
7. Determine staffing
8. Develop team charters
9. Create and execute transition plans
10. Establish post-transition processes for documentation and evaluation

Framework for Spread (from the Improvement Guide):



Other factors to integrate (from workgroup discussion):

1. For implementations, standard should be a transparency of timeline and milestones
2. Ideally, there would be agreement of what constitutes thorough analysis of animplementation/spread.
3. To manage knowledge of optimal implementations, Partnership should capture examples of case studies towrite up to document best practices in spread, for example: birthday club, Palliative care, MPS, IOPCM
4. Future examples where framework will be helpful include implementation of ECM and Collective Medical Technology's Collective Plan.

Partnership approach to Scale-up and Implementation (Sustainability)

Current Status: Project Review Board (PRB) is the major mechanism for larger, multidepartment projects, for prioritization, estimation of resources and scope. Many, but not all major implementations go through PRB; the trend has been to ensure all do. Considerations: Project management approach, but not always done equally rigorously for every project. Implementations need to be integrated with department and organizational goals. As project becomes a program, there is a transition to Program Management approach to blending into other existing operations—this involves a different skill set than project management.

Organizational Factors

Organizational Factors:
Organizational Values, Culture, Structure, Processes that support approach, fit it in withoverall strategy

In addition to the organization factors listed under the Knowledge Management section, above, the workgroup collected other leadership and organizational activities that would we needed to support the success of the Pathway to Excellence framework.

1. **Nurture Values**: Current Status: Link to communication channels and other activities. Leadersmentoring and demonstrating them. Developing staff expertise. Supportive organizational and management culture. (See separate document)
2. **Systematically review the work we are currently doing,** categorizing by need for knowledge documentation, evaluation, nature of the work, budget, relationship to regulation/quality
3. **Promulgate a Partnership approach** to systematically consider each tactic.

Another view of overall organization framework to support continuous learning activities is from (Bellin Health Case Study, 2015):

1. Cascading structure of Planning, with the 120-day planning cycle forming the core timeline.
   a. 100 days of work, 20 days of evaluating results from last cycle, planning and prioritizing activities/plans for the next cycle. Steps:
      ii. Diagnostic Journey
      iii. Prioritization and Focus
      iv. Organizing the Work
      v. Work Period
      vi. Recalibration
   b. Major systems feeding into this process:
      i. Information gathering: marketing, customer service, strategic analysis, strategicplanning
      ii. System of production/optimization
      iii. System of measurement
      iv. System of improvement
      v. Managed Spread of successful improvements
      vi. System of evaluation
      vii. Building expertise/capturing knowledge (Improvement IQ)
      viii. Strategy room documenting all aspects of this system

Plan for Nurturing Organizational Culture

The workgroup crafted a plan to support supporting the organizational culture towards the principles of the Pathway to Excellence. It is presented here:

What to Share more widely and regularly to promote culture: Key Concepts (see draft PowerPoint)

- Overarching statements of values
- 5 key steps (skip the leadership step for presenting to organization)
- Brief Description of each step

- Key sayings/slogans to represent key ideas in each step: what to do and what not do to
- Use stories to illustrate

Sharing Knowledge about P2E:

- Presentations (Internal and potentially external)
  - Topics:
    - Overview of elements of P2E
    - Knowledge Management
    - Data Analysis/Statistics/Evaluation
    - Small tests of change/scaling up
  - Presentation to leadership teams; record for future.
- Showcased examples
  - Internal: capture, publish, publicize
  - External: lessons learned, capture information
- Smaller Key Message
  - Derived from Larger Presentation
- Slogans
  - Start with those already identified
  - Potential graphics associated with some?

Marketing Paths: Needs timeline and work plan

- Milestones
  - New name selected
  - Plan completed
  - Playbook draft/update
  - Presentations given/saved
  - Awards (Internal and external)
  - External presentations
- Internal communications paths; especially good for smaller key message and slogan
  - Emails
  - Partnership4me
  - Office Hours/VEB
  - Campaign
  - IQI, EQMSI, Ops, Exec
- Durable materials that use name of initiative
  - Trivets
  - Graphics
- Calendar to drip out the slogans etc.
- External communication paths, once core presentation refined
  - PAC
  - Board
  - Board Quality Committee
  - Strategic Planning
  - Clinic Consortia
  - CIN
  - CHCF Leadership
  - CAHP

- LHPC Medical Directors
- State quality convening 2022
- Poster presentation at IHI

Building Leadership Understanding and Commitment

- Incorporate into HS leadership meeting
- After leaders learn about aspects of the LHP, have them give talks to staff

Building Front Line Staff Understanding and Commitment

- LMS training
- Sample Interview questions for staff interviews that demonstrate LHP and ask about traits that would support it
- QI department training (NR and SR)
- Involving staff with aspects of Pathway to Excellence activities that are interesting and outside theirusual work
- Other department trainings/engagement: PMO, pharmacy, medical directors
- Awards for demonstrating aspects of P2E: examples
  - Best graphical presentation of data
  - Evaluation of the year
  - Best case study write-up
  - PDSA of the year
  - Spread process of the year (most likely to be sustained)
  - Project manager of the year
  - Analyst of the year
  - Best meeting facilitator of the year

Plan for Maturing the Framework

Overall Plan

Components of this Framework for Continuous Learning will be divided up and additional detailed documentation based on the recommendation in this document will be generated each year for the next severalyears.
In particular, the work of the Health Analytics Strategy Workgroup will resume in 2022, and may move beyondthe initial focus on analytics to tackle some of the data standardization and evaluation template needs describedabove.

Year 2 Activities

The current plan for activities in year 2 of the Pathway to Excellence are:

1. To spread key concepts in this framework to leadership within the Health Services leadershipteam.
2. To focus on the Knowledge Management section to develop a Strategic Knowledge Management plan and associated action plan, by June 30, 2022. A special area of focus withinthis work will be on regularly reviewing and using data we already have access to.

These will be incorporated into the Quality Measure Score Improvement team goal.

Bibliography

Al-Ubaydli, O., List, J. A., & Suskind, D. (2019). The Science of Using Science: Towards an Understanding ofthe Threats to Scaling Experiments. *National Bureau of Economic Research, Inc. Working Papers.* National Bureau of Economic Research. Retrieved from https://ideas.repec.org/p/feb/artefa/00670.htmlBellin

Health Case Study. (2015).

Berwick, D. M. (1996, March 9). A primer on leading the improvement of systems. *BMJ, 312*, 619-622.

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009, August 7). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science, 4*(50). Retrieved from https://doi.org/10.1186/1748-5908-4-50

Dubner, S. (2020, February 12). Policymaking Is Not a Science (Yet). *Episode 405*. Retrieved from https://freakonomics.com/podcast/scalability/

Etheredge, L. M. (2007, January 26). A Rapid-Learning Health System. *Health Affairs*, w107-w118. Finkelstein, A.

(2020, April 16). A Strategy for Improving U.S. Health Care Delivery -- Conducting More Randomized, Controlled Trials. *New England Journal of Medicine, 382*(16), 1485-1488.

Firestone, J. M., & McElroy, M. W. (2003, November). *Corporate Epistemology: Competing Philosophies of Truth in Business and How They Influence Knowledge Management.* Retrieved from MKCI.org: https://www.kmci.org/media/Corporate_Epistemology.pdf

Hariharan, A. (2015). The Strategic Knowledge Management Handbook.

Horwitz, L. I., Kuznetsova, M., & Jones, S. A. (2019, September 19). Creating a Learning Health System through Rapid-Cycle, Randomized Testing. *New England Journal of Medicine, 381*(12), 1175-1179.

Institute of Medicine. (2007). The Learning Healthcare System: Workshop Summary. Washington D.C.: The National Academies Press.

Keith, R. E., Crosson, J. C., O'Malley, A. S., Cromp, D., & Taylor, E. F. (2017). *Using the Consolidated Framework for Implementation Research (CFIR) to produce actionable findings: a rapid-cycle evaluation approach to improving implementation.* Retrieved from Implementation Science Open Access 12:15: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5303301/

OpEx/PMO. (2020). DMAIC Process.

Platt, J. E., Wienroth, M., & Raj, M. (2020). An Analysis of the Learning Health System in Its First Decade in Practice: Scoping Review. *Journal of Medical Internet Research*, e17026.

Savinsky, C., & Stadelhofer, A. (2011?). Best practices for a smooth project-to-operations transition.

Simon, G. E., Platt, R., & Hernandez, A. F. (2020, April 16). Evidence from Pragmatic Trials during Routine Care -- Slouching toward a Learning Health System. *New England Journal of Medicine, 382*(16), 1488-1491.

Smoyer, W. E., Embi, P. J., & Moffatt-Bruce, S. (2016, December 20). Creating Local Learning Health Systems. *JAMA, 316*(23), 2481-2482.

Venkataramani, A. S., Underhill, K., & Volpp, K. G. (2020, January 7). Moving Toward Evidence-Based Policy: The Value of Randomization for Program and Policy Implementation. *JAMA, 323*(1), 21-22.

Weaver, P. (2010). Understanding programs and projects--oh, there's a difference! *PMI Global Congress 2010--Asia Pacific.* Melbourne, Victoria, Australia: Newtown Square, PA: Project Management Institute.

Annotated Bibliography Available on Request

Appendix D: Resumes for Key Leadership Roles Accountable for Implementing and Maintaining the QI/PI Program

The order of resumes corresponds to the sequence of key roles outlined in the Authority and Responsibility section of this document.

Chief Executive Officer

Sonja Bjork, JD

[redacted]

Medi-Cal Health Plan Senior Executive

Experienced and mission-driven Medi-Cal managed care Chief Executive Officer with excellent leadership, analytical and strategic planning skills. Engaging communicator and relationship builder with experience in geographic expansion to new service areas. Demonstrated record of success in complex provider contract negotiations. Supportive and hands-on leadership style with ability to motivate teams in achieving organizational excellence, including implementation of new benefits and initiatives that improve services for providers and members.

Areas of Expertise

- Strategic Planning & Execution
- Team Leadership & Development
- Organizational Design & Restructuring
- Budgeting & Fiscal Management
- Contracting & Negotiations
- Medi-Cal Policy Analysis & Implementation
- Employee Engagement
- Community Emergency Response

Select Career Highlights

- Selected as a commissioner on the national Medicaid and CHIP Payment and Access Commission (MACPAC), a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Service and states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP).
- Led expansion of health plan service area to multiple northern California counties. This included organizing network readiness requirements, memoranda of understanding with various agencies and providing expertise on required county board of supervisor enabling ordinances. Established additional regional offices and staffing models to ensure local presence and excellent customer service.
- Led operational departments in obtaining NCQA (National Committee for Quality Assurance) accreditation that required extensive policy and procedure development, reorganization of workflows and support of internal mock audits.
- Successfully implemented numerous Medi-Cal benefits and programs such as CalAIM enhanced case management and community supports, community-based adult services, autism and behavioral health services, including network development through community and provider outreach; oversaw internal operational readiness efforts such as claims configuration, member communication and provider education efforts.

Career Experience

Partnership HealthPlan of California
Chief Executive Officer
2023-Present

- Lead service area expansions, most recently adding ten counties to the health plan, resulting in a 38% increase in membership
- Ensures appropriate staffing levels to meet operational requirements, including a recent increase of almost 30%, while maintaining company culture and achieving a 92% overall employee satisfaction rate
- Guides strategic planning with stakeholders, including the Board of Commissioners, consumers and employees
- Oversees development of $5.9 billion annual budget
- Develops and maintains strong community partnerships in support of the health plan mission
- Identifies opportunities for new approaches to benefit administration
- Supports evaluation and adoption of new technologies to improve efficiency and service
- Lead focused initiatives to address health disparities identified through data analytics and support efforts to attain NCQA Health Equity Accreditation

Partnership HealthPlan of California
Deputy CEO/Chief Operating Officer
2022-2023
Chief Operating Officer
2015-2022

Executive management of multiple operational departments including claims, member services, grievance & appeals, health services (health equity, utilization management, care coordination and population health), provider relations, project management office, configuration department and multiple regional offices within a Medi-Cal managed care health plan.

- Oversight of multiple regional offices to assess and support local needs, community involvement and responsive service
- Led operational departments in establishing and maintaining performance standards to ensure DHCS contract compliance and excellent service to all stakeholders
- Worked with department heads to develop and implement annual administrative budget proposals
- Developed, sponsored and evaluated organizational and departmental goals in support of PHC's mission and vision
- Supported achievement & maintenance of NCQA Accreditation
- Developed and promoted health equity initiatives
- Supported & engaged with Plan's very active Consumer and Physician Advisory Committees
- Led provider recruitment and workforce development program, with focus on rural California
- Managed major benefit implementations within operational departments
- Served as liaison to consortia of Federally Qualified Health Centers, Tribal & Rural Health Centers
- Led health plan's Community Emergency Response Team, whose actions work to eliminate or reduce disruptions to accessibility of health care services to members in community-wide emergencies such as wildfires, flooding, planned public safety power shut-offs and the ongoing COVID-19 pandemic

Partnership HealthPlan of California
Deputy Chief Operating Officer
2014-2015

- Led implementation of new benefits, including coverage of mild to moderate mental health services
- Operationalized the transition of autism services from regional centers to PHC
- Led development of organization's multi-year strategic plan
- Led transition of low income health program (LIHP) into coverage through PHC Medi-Cal managed care
- Coordinated with stakeholders to support establishment of PACE in rural northern California
- Served as liaison to multiple community organizations in strategic grant award program

Partnership HealthPlan of California
Director of Policy & Program Development
Manager of Business Development
2011-2014

- Coordinated and evaluated multiple Requests for Proposals/Requests for Information for outsourcing opportunities
- Managed and implemented Medi-Cal Coverage Expansions for the health plan under the Affordable Care Act which included:

    1) Transition of indigent adults to Medi-Cal (Low Income Health Plan)
    2) Newly eligible to Medi-Cal under the Affordable Care Act
    3) Healthy Families – transition of children from subscriber-based coverage into Medi-Cal

- Led expansion of PHC to eight new rural northern California counties – PHC planning & developing team, educational activities and outreach in the northern region
- Managed the Intergovernmental Transfers (IGTs) process with multiple counties and district hospitals to bring matching federal Medicaid funds to our local communities
- Implemented Community Based Adult Services (CBAS) into Medi-Cal Managed Care

Stahnke & Associates Legal Services for Children
Attorney 2000-2010

As a Certified Child Welfare Specialist, provided high quality legal representation to children in abuse and neglect cases.

- Conducted trials involving complex legal and medical issues
- Performed legal research and analysis in preparing motions, trial briefs and writs of appeal
- Served on steering committee to develop and implement the Dependency Drug Court program which has improved access to substance abuse treatment and services for parents of dependent children
- Provided training to staff members, foster youth, foster parents and agency representatives on local implementation of state legislation affecting dependent children
- Served on advisory committees for various county initiatives including: Team Decision Making; Heart Gallery; Permanent Connections for Foster Youth

Solano Partnership HealthPlan (now Partnership HealthPlan of California)
Grievance Coordinator
1994-2000

Coordinated health plan response to member issues and complaints in order to address member concerns in a fair and timely manner:

- Worked closely with Member Services Director to develop and implement policies and procedures
- Prepared issue briefs and represented health plan at administrative hearings
- Established and facilitated the Consumer Advisory Committee whereby health plan members could provide input and feedback on various aspects of health plan operations
- Analyzed NCQA standards and requirements and ensured member grievance system compliance during mock audits
- Liaison with local legal aid advocacy groups to ensure smooth transition from traditional Medicaid program to managed care environment
- Represented the health plan on the Solano Community Services Task Force
- Served on the State Steering Committee of the California Connections Project

Solano County Legal Assistance
Staff Attorney 1993-1994

Legal services agency serving low-income residents of Solano County in the areas of housing, health care and government benefits. Received foundation grant funding to provide legal representation and advocacy to ensure low-income children's access to health care in Solano County.

- Represented low-income clients at administrative hearings on Medi-Cal and other public benefits issues
- Served on the steering committee of the Community Services Task Force on Managed Care to address health care access issues under the county's new Medi-Cal Managed Care Plan
- Created and coordinated distribution of Medi-Cal outreach material to pregnant teens in order to improve access and utilization of prenatal care services
- Supervised legal interns in providing advocacy to clients in the areas of domestic violence, housing and public benefits
- Served on the National Youth Law Center Statewide Youth/health Advocates Committee

Educational Background

Juris Doctorate
UC Berkeley School of Law, University of California, Berkeley

Bachelor of Arts, Sociology – Concentration in Analysis & Research (CARR)
University of Wisconsin, Madison

Professional & Personal Accomplishments

Commissioner – Medicaid and CHIP Payment and Access Commission (MACPAC) – Appointment Term; 2022-2025

Local Health Plans of California – Member and past chair of COO Committee (2015-present)

Volunteer, Soccer Without Borders – Oakland program for newcomer immigrant and refugee youth (2013-Present)

Statewide CAHP & County Behavioral Health Workgroup (2014)

Child Abuse Prevention Council Practitioner of the Year (2007)

National Association of Child Counsel- Child Welfare Law Specialist (certified in 2006)

Board Member & Board Chairperson, Solano Diversified Services (2006-2010)

Court Appointed Special Advocates (CASA) (2005-2010) Board Member

Solano County Women Lawyers (2000-2010)

Wendi Davis

Qualifications Summary

- *Dynamic healthcare leader offering 25+ years' comprehensive achievements with non-profit, rural, and integrated healthcare delivery and payer systems.*
- *Expertise in institutional, professional, LTC, Rehab, and Behavioral Health payment regulations and requirements, as well as Medi-Cal Managed Care and EDI technology.*
- *Proven ability to manage various specialties such as Admissions, Health Information Management, Care Coordination & Utilization Review, Physician Credentialing, Claim Adjudication, and Contract Negotiating.*
- *Exceptional strategic planning skills and a history of generating multimillion dollar improvements for multiple Northern California healthcare delivery systems while overseeing operations.*
- *Recognized for ability to incorporate innovative management techniques that result in exceptional employee engagement and retention rates, as well as cultivating strong collaborative relationships with government agencies, public officials and community groups.*

Professional Experience

Partnership Health Plan of California, Redding, CA Nov 2013-Present

Chief Operations Officer June 12, 2023 to present

Responsible for the oversight of operations and executive management of the Claims, Member Services, Configuration, Grievance and Appeals, Transportation, and the Regional Leadership Team. This position provides leadership in organizing the HealthPlan's operations, interdepartmental communication, and participates in goal setting and strategic organizational planning in the development of new business lines and programs.

- Oversight of the HealthPlan's operational departments and regional offices as described above to insure efficient and high quality administration of Medi-Cal Managed Care for 24 counties.
- Works with department directors to establish department goals, improve operational effectiveness, implement work plans and making corrective actions as needed.
- Oversee the provider network and contractual agreements including reimbursement and services.
- Monitors departments' performance and production through comprehensive reporting and progress against goals.
- Provides leadership in interdepartmental projects involving department operations to ensure quality outcomes. Participates in new business planning and program development.
- Participates with counterparts at local health plans throughout California.

Northern Region Executive Director July, 2017 to June, 2023

Oversee the operations of the Partnership HealthPlan of California's Northern Region. Represent the HealthPlan with community agencies, providers and elected officials. Manage staff in Redding and Eureka offices. Work with Plan leadership to assure awareness of the Region's needs and issues; work with Regional staff and communities to promote the interests and values of Partnership HealthPlan within the Region. The Northern Region employees over 175 staff, and provides support and services for the seven northern counties which account for approximately 175,000 members. Establish long range, strategic direction of the Northern Region and ensures departmental goals and objectives support that direction. Establish performance indicators, operating goals, process improvement initiatives, productivity improvements, and cost reduction programs that consistently improved production and quality, as well as provider and member satisfaction. Participate in community healthcare collaborative committees, and improvement projects.

Selected Achievements:

- *Successfully built and established a full service claims processing team and call center.*
- *Developed and implemented a Provider Scorecard program, providing quarterly claims, denial and payment data to providers resulting in a 21% decrease in denials.*
- *99.6% of all claims are processed within 30 days, and maintaining a 98.6% accuracy rate.*

Claims Director *Nov, 2013 to July, 2017*

Directed overall operations for Claims and Customer Service departments in the Northern Region. Established performance indicators, operating goals, process improvement initiatives, productivity improvements, and cost reduction programs that consistently improved production and quality, as well as provider and member satisfaction. Participates in community healthcare collaborative committees, and improvement projects.

Selected Achievements:

- *Successfully built and established a full service claims processing team and call center.*
- *Implemented a paperless work flow system, instituted real time inventory monitoring.*
- *Developed and implemented a Provider Scorecard program, providing quarterly claims, denial and payment data to providers resulting in a 21% decrease in denials.*
- *99.6% of all claims are processed within 30 days, and maintaining a 98.6% accuracy rate.*

Adventist Health System, Santa Rosa, CA Oct 2012-Nov 2013

Regional Executive Director, Revenue Cycle

Responsibility for the Revenue Cycle and workflows region-wide, including Scheduling, Pre-Registration, Insurance Verification, Financial Counseling, Health Information Management, Case Management, Billing and Collections and Customer Service for 4 acute hospitals(including 1 Critical Access facility), 58 Clinics, and 1 Behavioral Health Facility. This includes the centralized pre-registration center as well as the patient access functions at all facilities in the Northern Cal Network, as well as the Centralized Billing Office.

Selected Achievements

- *Increased clean claim rate from 56% to 92%, and decreased denials by 40%.*
- *Consolidated 4 Local Business Offices into one Central Office, while increasing the percent of accounts financially cleared from less than 50% to nearly 90% at all four sites.*
- *50+ Patient Access professionals obtained their CRCR certification through HFMA.*

Kaiser Permanente, Oakland, CA Aug 2007-Oct 2012

Nor Cal Exec Regional Director, Revenue Cycle (June 2010-Oct 2012)

Accountable for the accurate and compliant generation of over 2 million external claims annually, which equated to $2 Billion+ dollars a year for the Nor Cal Revenue Cycle. Outpatient and Physician visits exceeded 25 million encounters and inpatient stay days totaled 900,000 in 2011. Oversight and accountable for the management and ongoing remediation of Epic Resolute Systems, as well as ePremis Billing Systems. Partnered with KP Technology teams for various upgrades and enhancements.

The scope of responsibility included both professional and health system billing, as well as integration with Admissions/Registration, Physician Groups, Health Information Management, Professional Coding, Revenue Integrity, Case Management and Charge Capture. Claims were generated for 21 Acute Hospitals, 175+ clinics, Home Care and Hospice Services as well as professional claims for over 6300 physicians, representing all specialties.

Selected Achievements

- *Consolidated 21 Local Business Offices into one Central Office, and initiated Epic WQ's for all professional billing edits, while* simultaneously decreasing AR backlog by 45 Days.
- *Increased claim accuracy to 92% from a previous level of 47%.*
- *Collaborated with Union and labor leaders to establish productivity and accuracy standards for all staff*
- *Introduced process improvements in Case Management and Patient Financial Assistance to decrease Medi-Cal TAR denials by 83%.*

National Associate Vice President, Revenue Cycle Back End Processes (October 2007-June 2010)

Oversee the processes and procedures for billing and follow-up for Kaiser's 8 national regions. Develop the architecture and functional requirements for the national standard operating model for the back end functions of the revenue cycle, while assisting the local regions with regional projects and initiatives.

Selected Achievements

- *Led the design of the operating model for the BCR project (Billing/Collections HIM and Case Management Re-engineering), and successfully implemented the program in 6 regions.*
- *Co-Sponsored the development and implementation of NEVI-National Eligibility Verification Initiative (Integrated Insurance Verification) which resulted in a 31% decrease in claim rejections.*
- *Assisted in the coordinating and disbursement of $19 million in grant dollars given to aid in the support and expansion of 35+* federally qualified health centers (FQHCs) and 11 free clinics. This work increased and improved access to care for over 75,000 vulnerable and underserved individuals.

Catholic Healthcare West, North State Service Area, Redding, *CA* June 2003 - Aug 2007

Regional Exec Director of Revenue Cycle and Admissions

Manage and direct the Central Business Office and Admissions, for Catholic Healthcare West's North State Region. The Region includes three acute care facilities, 8 clinics, 3 rural health clinics, ground and air life support service, Home Care and Hospice and a SNF.

Selected Achievements

- *Gross AR days from 74 to 58, while decreasing bad debt from 3.2% to 1.5%, and increasing net revenue.*
- *Integrated insurance verification, and an ABN system, to enhance and expand the Pre-Registration System, while initiating an upfront cash collection process and collecting over 1.5 million in 2005.*
- *Increased patient and employee satisfaction scores to 5 star levels.*
- *Awarded the No. 1 CBO in CHW for percent over goal for cash collections in 2004 and 2005.*

Education

Masters of HealthCare Administration: *St. Joseph's College of Maine*
Bachelors of Science: *California State University, Chico 1992*
CHAM Certified-*Certified HealthCare Admissions Manager 2002*
QHC/RHC (Clinical Documentation, Billing and Coding Training) Certification *CPCA 2011*

Professional Associations/Awards

Healthcare Financial Management Association: *Affiliate,1997-Present*
CAHAM ~ Carl Satterfield Statewide Award of Professional Excellence: *1999*
California Association of HealthCare Admissions Management: Served as President, *2003-2012*

KATHERINE BARRESI, RN, BSN, PHN, NE-BC, CCM

Chief Health Services Officer
[redacted] • [redacted] • [redacted]

Healthcare Leadership Executive

Dynamic, results-driven healthcare leader with over a decade of executive experience in driving operational excellence and strategic growth within diverse healthcare settings, including managed care, case management, population health, and utilization management. Expert in policy development, cross-functional collaboration, and program transformation with a proven record of success at Partnership HealthPlan of California, impacting the lives of over 900,000 Northern California residents through sustainable health initiatives.

Qualifications

Executive Management: Oversight of multiple departments with 500+ budgeted employees across 6 regional offices, specializing in operational efficiency and interdepartmental alignment.

Regulatory & Compliance Expertise: In-depth knowledge of government sponsored health programs and standards, accreditation requirements, and healthcare policy for managed care.

Population Health & Case Management: Proven track record in directing programs across acute, outpatient, and community settings to enhance patient outcomes.

Data Analytics: Skilled in utilizing analytics for cost optimization and operational insights, supporting quality patient care and fiscal accountability.

Health Equity & Policy Development: Deep expertise in implementing initiatives addressing health disparities and inequities, social determinants of health and collaborating with non-traditional community-based groups.

Leadership & Mentorship: Adept at team building, talent development, and fostering a collaborative culture across diverse teams and stakeholders.

Experience

Partnership Health Plan of California — Fairfield, CA
Chief Health Services Officer — 10/2023 - Present

- Proudly served as a member of the Executive Team for Medicaid managed care plan that provided services and care to over 24 counties in Northern California.
- Responsible for the operational management and leadership for the following Health Services departments: Utilization Management (UM), Care Coordination (CC), Population Health Management (PHM), Health Equity, Behavioral Health, and CalAIM initiatives.
- Provided strategic leadership in organizing the health plan's operations, interdepartmental communication, and organizational goal planning and strategic direction.
- Served as a statewide expert on CalAIM and other various assorted initiatives related to government health care programs to promote solutions for health policy, population management, and clinical quality outcomes.

Partnership Health Plan of California — Fairfield, CA
Senior Director Health Services — 01/2023 - 10/2023

- Clinical and strategic leadership to assigned departments including planning, execution, growth and compliance of various benefits and services
- Dyad to Chief Medical Officer and associated Medical Directors at the Health Plan
- Responsible for providing direction to leaders in areas of health plan compliance and regulatory guidelines related to operations
- Created operational analytics to increase efficiencies, revenue optimization, and cost containment maintaining patient-centric quality expectations
- Change agent for transformation of services and benefits under CalAIM including Enhanced Care Management, Community Supports, Population Health Management, Health Equity, Housing and Homelessness Incentive Program and various other associated initiatives

Experience

Partnership Health Plan of California
Fairfield, CA

Director Care Coordination
02/2020 - 01/2023

- Responsible for the performance, quality and oversight of the various case management programs and services including Complex Case Management, Transitions of Care, California Children's Services Whole Child Model and other associated interventions
- Owned complex business and clinical proposals with executive communication and lead enterprise wide execution; requiring interdepartmental and external resources and teams
- Fostered a culture of collaboration and quality with external community partners and stakeholder to address shared goals and community needs

Partnership Health Plan of California
Fairfield, CA

Associate Director Care Coordination
06/2013 - 02/2020

- Responsible for day-to-day oversight for the operations and implementation of various case management programs and services in the Care Coordination Dept
- Worked collaboratively with others across the organization aligned the appropriate resources to maximize efficiencies and achieve goals
- Proactively identified potential gaps and enacted solutions to decrease organizational and operational risk
- Supported and monitored efforts to enhance staff support and training

Education

Sonoma State University
Sonoma CA

Bachelors of science nursing
01/2012 - 01/2013

- G.p.a. 3.66
- Juliana Johnson Memorial Scholarship Recipient
- Alliance Health Care Scholarship Recipient

Napa Valley College
Napa, CA

Associates degree in nursing
01/2010 - 01/2012

- Degree with honrs
- Nursing Class President
- 160 Nursing Preceptorship hours in Labor and Delivery
- Napa Valley College Foundation Scholarship Recipient
- Bra n Track Nursing Scholarship Recipient
- Elise M. Tarner Memorial Scholarship Recipient
- Geri Glover Scholarship Recipient
- Grant's Fund Scholarship Recipient

Active Licensures & Certifications

Registered Nurse (RN): License #825562 - California Board of Registered Nursing

Public Health Nurse (PHN): License #86817 - California Board of Nursing

Certified Case Manager (CCM): Certification #4215211 - Commission for Case Management

Certification Nurse Executive – Board Certified (NE-BC): Certification #2022003530 - American Nurses Association

Key Competencies

Managed Care Operations · Case Management · Public Speaking · Nursing · Program Development · Population Health Management · HEDIS · Leadership · Policy Analysis · Health Equity · Quality · Change Management · Public Health Nursing · Government Sponsored Health Programs · Regulatory Compliance · Finance · Employee Relations · Vendor Management · Utilization Management · Community Engagement · Team Development · NCQA · Data Technologies · Health Analytics

Volunteering

Registered Nurse (RN)

Napa County Medical Reserve Corps 2020 - Present

Registrant in the county's Disaster Healthcare Volunteers Program (DHV) to provide healthcare needs or supports, on a volunteer basis, during disasters and other emergencies.

Robert Moore, MD, MPH, MBA, FAAFP

Work Address
Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534

Education

2014-17	Western Governors University Master's Degree in Business Administration (MBA) Healthcare Management, February, 2017
1986-92	University of California San Francisco School of Medicine: Doctor of Medicine (MD), May, 1992
1989-90	Columbia University, New York City School of Public Health, Division of Tropical Medicine Master's Degree in Public Health (MPH), February, 1991
1982-86	University of California Berkeley Bachelor of Arts in Biochemistry, May, 1986

Internship and Residency

1992-95	Family Medicine Residency Program Ventura County Medical Center

Post-graduate training

2007-2009	UCSF Center for Health Professionals: California Health Care Foundation Health Care leadership Fellowship, Cohort VII
2003-2008	Harvard School of Public Health, Boston Managing Ambulatory Care: A Program for Physicians in California Community Health Centers (Initial course: 2003, Alumni courses: 2004-2008)
2002	Intermountain Health Care, Salt Lake City Advanced Training Program in Health Care Delivery Improvement
2001	American Academy of Family Physicians, Kansas City Fundamentals of Management Course
2000	University of California, Davis Telemedicine Learning Center Training

Professional Experience and Training

2011-2024	Chief Medical Officer, Partnership HealthPlan of California. Includes professional oversight of grievances and appeals, quality, pharmacy, credentialing, health equity, care coordination, utilization management, behavioral health. Member of executive leadership team, with input on other aspects of health plan operations (claims, member services, provider relations, health analytics, IT, finance, HR). Active participation in Local Health Plans of California (co-facilitator of Medical Directors group) and the Association of Community Affiliated Plans. Advised the California Department of Health Services on assorted health policies.
1995-2023	Family Physician, Ole Health, Napa, California. Outpatient only since 2018.
1995-2018	Active on Medical Staff of Queen of the Valley Hospital, Napa, California
1998-2011	Medical Director, Community Health Clinic Ole (now Ole Health), Napa, California
2006-2011	Chief Medical Officer, Redwood Community Health Coalition (now Aliados Health)
2011	Chief Medical Officer, Redwood Community Health Network
2007-2008	Medical Director, Healthy Moms and Babies (now Ole Health Perinatal Services)
1995-2007	Private Practice in Obstetrics, Napa, CA
1994-99	Emergency Room Physician, Valley Emergency Physicians, several California sites
1994-95	Ventura Urgent Care, Physician
1993-95	Ventura County Emergency Department, Physician

Community Activities

2017-2024	Touro University Community Advisory Council, Member
2013-2020	Steering Committee, Honoring Choices Napa Valley
2013-2024	Board of Directors, Coalition of Compassionate Care for California
2012-2019	Board of Directors, Migrant Clinicians Network
2008-2023	Member of California Improvement Network, a program of the California Healthcare Foundation
2018-2024	Board of Directors, Sac Valley Med Share, a community health information exchange in northern California
2012-2018	Board of Directors, Connect HealthCare, a health information exchange in northern California. Served as Chair and Treasurer.
2009-2011	Chair of the Standardized Measures Group of the Tools for Quality Program, Tides Foundation and California Primary Care Association
2008-2011	Adjunct Assistant Professor of Family Practice, Touro University College of Osteopathic Medicine
2005-2017	Board of Directors, Western Clinicians Network
2009-2012	Medical Advisor to Board of Directors, Clinica Verde, Boaco, Nicaragua
2008-2009	Chair of Clinician's Committee, California Primary Care Association
2007-2008	Chair of Steering Committee, Accelerating Quality Improvement through Collaboration (California Primary Care Association program funded by California Health Care Foundation)
1996-2011	Teaching of Medical Students, Nurse Practitioner Students, Physician Assistant Students, Undergraduate Students at Community Health Clinic Olé
2012-2023	Teaching of Public Health Students at Partnership HealthPlan
1998-2007	Member of Board of Directors, Healthy Moms and Babies, Perinatal service provider

	for low-income women in Napa County (Served as Vice President, Secretary, Treasurer and currently President)
1998-2011	Member, Physician Advisory Committee, Partnership Health Plan of California
2003-2014	Chair of Community Health Committee of the Napa County Medical Society
1995-2003	Volunteer team physician for Napa and Vintage High School football teams
1999-2000	Member, Napa County Online Health Data Exchange Consortium

Research and Publications

2019	Chibber K, Tobey R, Moore R, and Rojasova S. Medicaid Managed Care Plan and Health Centers Advancing Value-Based Payment and Care. Robert Wood Johnson Foundation State Network Blog, November 2019.
2018	Liao J, Hodlofski A, Moore R, Navathe A. Partnership HealthPlan of California: Addressing Opioid Overuse with Behavioral Design Principles. Journal of Delivery Science and Innovation. Volume 6, Issue 1, March 2018, Pages 95-98.
2017	Barnato AE, Moore R, Moore CG, Kohatsu ND, Sudore RL. Financial incentives to increase advance care planning among Medicaid beneficiaries: Lessons learned from two pragmatic randomized trials. Journal of Pain and Symptom Management. Volume 54, Issue 1, July 2017, Pages 85-95.
2017	"EConsult Implementation Success Depends on Workflow" Health Affairs Letter, published March 13, 2017.
2013	"The Placebo Effect: the most powerful treatment we have." Marin Medicine 60 (1): 17-20
2012	"Conflicting national guidelines for mammography result in longer time intervals in between mammograms" Poster Presentation; 2012 Annual Meeting of APHA, Maria Fuchs, Robert Moore
2010	"Using Health Information Technology to Improve Quality" Information Bulletin #15, June 2010. Health Center Controlled Networks Series, National Association of Community Health Centers. Robert Moore, Fred Rachman, Michael Lardiere.
2008	"Cost Effective and Consistent TB screening and LTBI Care" Poster Presentation at Institute for Healthcare Improvement annual meeting, December 10, 2008 in Nashville, TN. Robert Moore, Carlos Avina.
2006	"Group treatment program of LTBI provides more efficient, higher quality care at a Community Health Clinic." Poster presentation at California TB Controllers Association Meeting, May 11, 2006. Luz Hernandez, Juan Martinez, and Robert Moore.
1991	"Chronic maternal morbidity in developing countries: data synthesis and policy suggestions." Presented at the 119th Annual Meeting of the American Public Health Association, Atlanta, Georgia, November 12, 1991.
1989-90	Laboratory investigations on the life cycle of *Trichinella spiralis*. Principle investigator: D. Despommier, Columbia University.
1985-86	"Identifying mutations in duplicated functions in *Saccharomyces cerevisiae*: Recessive mutations in HMG-CoA Reductase Genes," by Michael Basson, Robert Moore, Jules O'Rear and Jasper Rine. Genetics **117**:645-655 (December, 1987).

Professional Affiliations

1. American Academy of Family Physicians and California Association of Family Physicians, member since 1992
2. California Medical Association member since 1986
3. Napa Solano Medical Society member since 1995

Certification

October 2005	Fellow, American Academy of Family Physicians (FAAFP)
July 1995	Board Certified, American Board of Family Physicians; renewed 2002, 2009 and 2019
July 1993	Diplomate, National Board of Medical Examiners

Current Certification in Basic Life Support, Advanced Life Support in Obstetrics

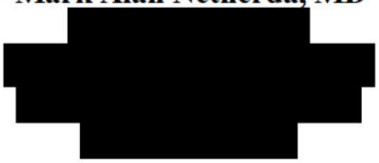
Honors and Awards

2011	Napa Hispanic Network Recognition for Contributions to the Community
2009	California Primary Care Association Hero Award
2008	Lifetime Achievement Award – Napa County Hispanic Network
2006	Values in Action Award for Justice – Queen of the Valley Hospital
2005	Award for Justice – Queen of the Valley Hospital Foundation
2000	Nominee-Values in Action Award for Service and Justice – Queen of the Valley Hospital
1998	Outstanding Physician of the Year – Napa County Medical Society
1997	Health Professional of the Year – Napa County Chamber of Commerce
1997	Nominee-Values in Action Award for Dignity – Queen of the Valley Hospital
1996	Recognition for service to America's underserved – National Health Service Corps
1986-92	Regents Scholar, University of California San Francisco
1986	Certificate of Distinction, University of California Berkeley -For Academic Excellence
1986	Departmental Citation, Biochemistry, University of California Berkeley -Outstanding Graduating Biochemistry Major
1986	Elected Phi Beta Kappa
1985	Robert Gordon and Ida W. Sproul Award, University of California Berkeley -Outstanding Scholarship, Leadership, and Service
1984	Elected to Order of the Golden Bear, University of California Berkeley

Other

Fluent in Spanish

Mark Alan Netherda, MD



CURRENT POSITIONS:
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Medical Director for Quality 06/01/2022 - present
Associate Medical Director for Quality 08/01/2018 – 5/30/2022
Regional Medical Director for Solano and Yolo Counties 09/28/15 – 07/31/2018
Start date: 09/28/2015
4665 Business Center Drive
Fairfield, CA 94534
(707)863-4510

BOARD CERTIFICATION:
American Board of Family Medicine 1991, recertification 1998, 2005, 2012, currently in process

EDUCATION:
Pacific AIDS Education and Training Center
Designate "Key Physician" to be trained in educating and training other healthcare professionals in caring for people infected with HIV. 1992 – 1993

University of California, San Francisco – Fresno
San Joaquin Valley Medical Education Program, Department of Family Medicine
Valley Medical Center, Fresno, CA
Internship 1988 – 1989, Residency 1989 – 1991

George Washington University, School of Medicine and Health Sciences
Washington, DC
Degree – Doctor of Medicine 1988

Stanford University
Stanford, CA
Degrees – Master of Science, Biological Sciences 1984
Bachelor of Science, Biological Sciences 1983

EMPLOYMENT EXPERIENCE:
KAISER PERMANENTE
Family Medicine Primary Care Physician December 3, 2012 - September 7, 2015
401 Bicentennial Way
Santa Rosa, CA 95403
(707)393-4000

COUNTY OF SONOMA
Interim Public Health Officer May 2010 – April 2012
Interim Division Director May 2010 – February 2011
Department of Health Services
625 5th Street
Santa Rosa, CA 95404
(707) 565-4599

WEST COUNTY HEALTH CENTERS
Clinical Consultant providing HCV and HIV care. July 1999 – Aug 2011
6800 Palm Avenue
Sebastopol, CA
(707) 824-9333

COUNTY OF SONOMA
Deputy Public Health Officer
Department of Health Services
July 2008 – May 2010
April 2012 – December 2012
625 5th Street
Santa Rosa, CA 95404
(707) 565-4599

COUNTY OF SONOMA CENTER FOR HIV PREVENTION AND CARE
HIV Primary Care Physician. August 2007 – July 2008
Medical Director. September 18, 1995 – June 2006
499 Humboldt Street, Suite 104
Santa Rosa, CA 95404
(707) 565-7400

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
Associate Clinical Professor, Dept. of Family Medicine, December 1995 – March 2012
Santa Rosa Campus
3320 Chanate Road
Santa Rosa, CA 95404
(707) 576-4000

INTERNATIONAL TRAINING AND EDUCATION CENTER ON HIV
May 2003 – July 2008
University of Washington
901 Boren Avenue #1100
Seattle, WA 98104-3508
(206) 221-7372

Clinical Consultant and Senior Technical Advisor, US-CDC, Namibia
June 2006 - July 2007

Working with the Namibian Ministry of Health and Social Services and US-CDC to develop, implement and manage training programs for physicians, pharmacists and nurses on the use of antiretroviral medications in the public (government) health sector.

Additional in country projects in Namibia:
May 7 – June 7, 2003.
October 10 – 27, 2003.
May 25 – June 6, 2004.
November 10-20, 2005.

OUTPATIENT IMMUNOLOGY SERVICES
COMMUNITY HOSPITAL OF THE MONTEREY PENINSULA
Private Practice. HIV Primary Care. November 1991 – October 30, 1995
23845 Holman Highway, Suite 318
Monterey, CA 93940
(408) 625-4972

NATIVIDAD FAMILY HEALTH CENTER
NATIVIDAD MEDICAL CENTER OF MONTEREY COUNTY
Family Practice Physician. September 1993 – September 1995
945 Blanco Circle, Suite D
Salinas, CA 93901
(408) 422-7998

CUSTOM HEALTH PROGRAM, COUNTY OF MONTEREY
Medical Director – county employee health insurance program, December 1993 – September 18, 1995
1330 Natividad Road
Salinas, CA 93940

HEALTH FIRST CLINIC
Outpatient urgent care and occupational medicine. July 1993 – September 1993
846 Freedom Boulevard
Watsonville, CA 95076

PRIMUS CLINIC OF THE PRESIDIO OF MONTERY
Outpatient family medicine. August 1992 – August 1993
Monterey, CA Clinic closed.

WALK-IN MEDICAL CLINIC
Urgent care medicine. July 1991 – July 1992
Aptos, CA Clinic closed.

APPOINTMENTS:
North Coast Area AIDS Education Training Center
Sonoma County Academic Foundation for Excellence in Medicine
September 1995 – July 2008

Sonoma County Commission on AIDS
August 1997 – June 2006

Chair, Sonoma County Commission on AIDS
Treatment and Care Committee
August 1997- June 2006

Technical Advisory Committee on Medical Aspects of Marijuana
California Medical Association
January 1997 – December 2000

CURRENT PROFESSIONAL ORGANIZATION MEMBERSHIPS:
Sonoma County Medical Association
California Medical Association

Revised 10/2024

KJ

Kermit Jones

[redacted]
[redacted]
[redacted]
[redacted]

Professional Summary

Medical Director focusing on Medicare line of business, regulatory attorney and Internal Medicine Physician with twenty years of practice experience and expertise in healthcare regulation and policy development

Work History

Partnership In Health - Medical Director of Medicare Services
Fairfield, CA
04/2024 - Current

- Manage multidisciplinary teams to optimize patient care
- Oversee Utilization Management policy development
- Work across departments to implement new Medicare-based lines of business
- Engage healthcare systems and providers on product lines, quality improvement programs and incentive programs
- Participate in Grievance and Appeals hearings, Quality and Utilization, Policy Review and Peer Review Committees
- Participate in contract design for network providers

The Permanente Medical Group, TPMG - Internal Medicine Physician
09/2017 - Current

- Implemented chronic disease management programs for high-risk communities
- Completed over 20,000 distinct clinical encounters
- Healthcare advisor for 2019 U.S. Presidential Campaign

United Health Group, Optum - Medical Director
San Francisco, CA
11/2023 - 03/2024

- Medical Claims Review, Utilization Management and Quality Review

U.S. House Of Representatives - U.S. Congressional Candidate
09/2021 - 11/2022

- Designing most comprehensive healthcare plan of any U.S. Congressional Candidate, available upon request

Skills

- Conversational language skills in Arabic and Hindi
- Experience in statistical modeling in R and using Python for Machine Learning and CNN
- Knowledge and expertise in healthcare regulation, Medicare quality programs and incentives
- Completed Master's Degree level course work in business associations, capital structure and finance

Education

04/2023
Massachusetts Institute of Technology
Cambridge, MA
Machine Learning And Data Science PE Program

05/2012
Columbia University School of International & Public Affairs
New York
M.P.A

05/2005
Duke University
Durham, NC

- Directing largest field operation in California with 20 staff members and 1,000 volunteers reaching 160,000 district residents

Rush University Medical Center - Residency Training, IM Resident
Chicago, Illinois
01/2015 - 01/2017

- Principal Investigator for military veteran's mental health research program for PTSD and other mental health interventions

Hyman, Phelps & McNamara - 2nd Year Associate
Washington, DC
09/2013 - 07/2014

- Drafted legal memos on HIPAA, ERISA, FDA regulations and DOJ-enforcement issues
- Advised large healthcare practices and systems on legal matters, compliance, and risk management

White House - Fellow
Washington, DC
08/2012 - 08/2013

- Senate appointment position for nation's premier mid-career leadership program with dual appointment in White House and Dept of Health and Human Services
- Led White House-level principal meeting on programs to secure veteran's benefits and military to civilian life transition program
- Led study group evaluating performance measures for new NIH institution – NCATS

US Navy - Medical Dept. Head
Camp Pendleton South, CA
04/2007 - 06/2009

- Medical Director of CASEVAC team for USMC 364 Squadron
- Medical Dept Head for joint U.S Marine Battalion of over 3,000 Marines at Camp Pendleton, Ca
- Collaborated with department personnel to coordinate multifaceted solutions to emerging military medicine problems.

National Naval Medical Center - Internal Medicine Intern
01/2005 - 01/2006

- Selected for prestiguous USN Flight Surgeon training program at NAS Pensacola, Florida

---

Affiliations & Select Publications

- Member, State Bar of California 2020
- American Board of Internal Medicine 2017
- Member of American Legion
- Member of the Council on Foreign Relations

M.D., J.D

1997
Georgia Institute of Technology
Atlanta, GA
B.S
magna cum laude

- "Health Is Freedom," Diplomatic Courier, 12/2021
- “Stethoscope Diplomacy in the Middle East,” Foreign Policy, 2/2021
- “Obesity is a major risk factor for dying of COVID-19. We need to take it more seriously,” The Guardian, 6/2020

NANCY L. STEFFEN

[redacted]

Desire a senior leadership role in healthcare operations with emphasis in quality and continuous improvement. Passionate integrator of people, technology, and processes to achieve high quality patient care.

Education

BS Degree in Biomedical Engineering, Minor: Mechanical Engineering
Marquette University, Milwaukee, Wisconsin, 1997-Magna Cum Laude

Certifications

Six Sigma Black Belt – University of Wisconsin-Milwaukee
ASQ Quality Auditor

Summary of Experience

Twenty-seven years of experience leading cross-functional teams in quality assurance, quality improvement, analytics, and enterprise system integrations. Lead administrator of quality management systems and improvement initiatives within managed care, healthcare operations, diagnostic laboratories, and medical device manufacturing settings. Achieve sustainable results by developing effective processes/systems for healthcare teams to deliver value to patients.

Employment History

Partnership HealthPlan of California, Redding, California **July 2015 to present**
A non-profit community based health care organization that contracts with the State to administer Medi-Cal benefits through local care providers to ensure Medi-Cal recipients have access to high-quality comprehensive cost-effective health care. PHC serves over 600,000 people across 14 Northern California counties. Based in PHC's Northern Region.

Quality & Performance Improvement: Promoted May 2022 to Senior Director of Quality and Performance Improvement; responsible for plan-wide leadership of quality and performance improvement programs to substantially improve the quality of care provided to PHC members.

- In collaboration with the Chief Medical Officer (CMO), lead the strategic direction of PHC's quality goals and initiatives, including prioritization of efforts.
- Lead, develop, and coach the Quality staff in hiring, budgeting, training, performance appraisals, goal setting, and resource allocation.
- Oversee PHC's quality improvement program, ensuring all interventions are measured for effectiveness and efficiency, complete an annual review and update of the program, and write the annual plan. Prepare the organization for quality and performance improvement review, survey, and accreditation processes by external monitoring agencies, such as Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), CMS, and NCQA.

- In collaboration with executive leadership, oversee the administration of PHC's pay-for-performance programs.

- Direct performance improvement activities, including PHC's Performance Improvement Academy, DHCS mandated improvement work, and measure improvement and engagement activities done within the PHC provider network and service region.

- Oversee PHC's provider level quality data visualization and analysis program, the Partnership Quality Dashboard.

- Assure optimization of monitoring systems for collection and reporting of HEDIS and other quality measures.

- Ensure the Facility Site Review/Medical Record Review process and outcomes meet all regulatory and accreditation requirements. Demonstrate results are coordinated with peer review and credentialing processes.

Quality Improvement, Analytics, and Project Management: Joined as a manager and re-classified as an associate director in January 2016. Promoted February 2019, as Director of Quality and Performance Improvement, accountable for northern region efforts in quality measurement and improvement programs, analytics, and project management.

- Lead regional team in administering project management and performance improvement methodologies to ensure effective outcomes, partnerships, sustainability, and growth.

- Direct data collection and analyses, including medical record retrieval, to support quality performance reporting to the State, provider pay-for-performance programs, and regional improvements with local providers and community stakeholders.

- Responsible for work and staffing plans. Administer a $2.3 million operational budget.

BloodCenter of Wisconsin (*now* Versiti), Milwaukee, Wisconsin **July 2009 – July 2015**
A non-profit, healthcare organization committed to extending life and health by supplying blood to over 50 hospitals, conducting 70,000 diagnostic tests per year, recovering organs and tissues across SE WI, and leading research in innovative treatments for blood diseases and disorders.

Quality Support Services: As the Manager of Quality Management Systems, led cross-functional teams in simplifying, standardizing, and sustaining quality systems to reflect best practices in blood banking, medical device, and pharmaceutical industries.

- Administered all corporate computer systems used to demonstrate compliance to quality requirements in training/competency, error management, corrective/preventive action, audit, document control, and record retention.
- Led the successful implementation of the organization's first Learning Management System (LMS) in 2012. Integrated corporate-level training and job-specific competencies for laboratory, blood collection and corporate roles - approximately 1000 employees.

- Maintained corporate quality management systems plan, corresponding policies and

procedures, and fulfilled data analysis requests during onsite audits/inspections. Assessors included FDA, CMS, national accrediting bodies, and numerous state licensing boards.

- Achieved significant cycle time and waste reductions through cross-functional, continuous improvement activities in document control, record retention, training, and error management systems. Exceeded cost savings targets each year.

- Led integration of corporate quality systems upon acquisition of the Wisconsin Donor Network (OPO) and Wisconsin Tissue Bank in 2010. Developed and managed activities over a multi-year integration-plan involving corporate QA/RA, OPO nursing, and tissue bank recovery staff.

GE Healthcare, Milwaukee, Wisconsin **August 2007 - June 2009**
A General Electric Company providing a range of products, services, and expertise in medical imaging and information technologies, medical diagnostics, and patient monitoring systems.

Imaging Sub-Systems Quality Assurance: As a QA leader, responsible for leading implementation of a global quality initiative at five manufacturing sites worldwide.

- Successfully led implementation of global quality (QMS) initiative at Milwaukee manufacturing site in 2007-08. Assessed progress vs. global quality plan, conducted gap analyses, led gap closure activities, and executed training plans.

- Instrumental in coordination of global quality (QMS) initiative at two manufacturing sites in India. Served as key liaison between QA Site Managers and corporate QA team to troubleshoot systemic gaps and training issues.

- Led team at new manufacturing site in New York to implement GEHC global quality plan, obtain ISO 13485 certification, and FDA registration.

The Prairie School, Racine, Wisconsin **2002 to 2007 (Part-time)**
An independent, child-centered, college-preparatory day school, whose mission is to educate children, develop their individual talents, interests, and abilities.

Mathematics and Science Departments: As a faculty member, instructed pre-algebra, algebra, geometry, and science students in grades 6-10. Co-developed and taught an introductory algebra class for struggling middle school students.

Gyrus ACMI Corporation, Racine, Wisconsin **2005-06 (Part/Full-time), 2001-02 (Full-time)**
An industry-leading manufacturer of minimally invasive surgical instruments used in urology, gynecology, and laparoscopy.

Quality Assurance: As a quality engineer, responsible for supporting disposable and durable product lines manufactured and repaired at Racine plant. Supervised 8-10 Quality Control techs.

- Facilitated resolution of supplier and manufacturing related quality issues by working directly with raw component suppliers and manufacturing personnel.

- Developed Process Master Validation plans for disposable and durable product lines transferred from Wisconsin to Mexico and Minnesota in 2006.

- Reviewed complaint investigations completed by manufacturing engineers for proper root cause analysis and corrective actions.

Kimberly-Clark Corporation, Neenah, Wisconsin **1998 - 2001**
A multi-billion dollar global consumer products company with core businesses in personal care, health care, and tissue.

Child-Care Business Support: Responsible for implementing nonwoven qualifications, cost savings initiatives, quality improvements, and development to commercialization scale-ups.

Adult Care Research: Responsible for product development contributions and related competitive product analysis for incontinence products.

Amy Turnipseed

[redacted]

Accomplished Healthcare Executive with over 15 years of experience providing strategic vision and leadership in the health care delivery system. Currently responsible for the operations and executive management of five departments at Partnership HealthPlan of California, a Medicaid plan serving approximately 900,000 members in 24 counties.

Professional Experience

Partnership HealthPlan of California (PHC), Fairfield, CA

Chief Strategy and Government Affairs Officer	September 2021 - *Present*
Senior Director of External and Regulatory Affairs	February 2017- September 2021
Director of Policy and Program Development	July 2014- February 2017

- Executive team member, reporting directly to the CEO and Board of Commissioners since 2014
- Served as the Compliance Officer from 2017 to 2023, reporting to the full Board on compliance with federal and state regulations. Leads the development and maintenance of PHC's Compliance Plan and annual Risk Analysis
- Responsible for directly reporting to the Board of a variety of key initiatives, government affairs, and all areas of compliance
- Responsible for the executive oversight of five PHC operating departments including: Regulatory Affairs and Compliance, Communications, Legal, Network Services, and Project Management/Operational Excellence
- Develops the health plan's Strategic Plan and leads the Strategic Planning Committee, a subcommittee of the Board
- Leads PHC's California Advancing and Innovating Medi-Cal (CalAIM) implementation including:
    - Strategic planning to manage multi-year implementation of CalAIM initiatives
    - Leading cross-departmental operations for successful execution and operationalization of the new Enhanced Care Management benefit and Community Supports services. Departments include: Health Services, Provider Relations, Member Services, Claims, Configuration and Quality;
    - Representing PHC at state-level meetings with Department of Health Care Services (DHCS);
    - Meeting with county leaders and their local partners to collaborate on CalAIM;
    - Leading education sessions with county partners, providers, community-based organizations, and stakeholders on multiple aspects of implementation; and
    - Developing the Incentive Payment Program grants structure, a mechanism to financially support local organizations to develop CalAIM capacity and infrastructure
- Directly oversees the implementation of new benefits, program expansions, and regulatory changes, requiring cross-departmental management and participation including for: CalAIM, Whole Child Model transition, program eligibility expansions, 2024 DHCS Medi-Cal contract., and managed care model changes
- Leads the strategic efforts, planning and implementation for the expansion of PHC's county organized health system model (known as single plan model) into 10 additional counties in Northern California (Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama and Yuba) expected in 2024.
- Conduct implementation planning for new requirements for Duals Special Needs Plan (DSNP)
- Establishes and maintains productive relationships with key staff at DHCS and other regulatory agencies including the Department of Managed Care, Office of Inspector General, and Centers for Medicare & Medicaid Services (CMS)
- Oversees PHC's external community and government relations, including managing and monitoring of trade associations, outreach and legislative strategy and reporting directly to the Board
- Responsible for analysis and making recommendations on major policy and budgetary changes that may impact plan and updating the Board accordingly
- Responsible for the strategic development and contracting of PHC's provider network in consideration of market conditions and competitive activities

- Actively participate on behalf of PHC in various community and advocacy forums including meetings with our associations, regulators, legislative representatives, and provider partners and advise business leaders on positioning and engagement methods

Harbage Consulting, Sacramento, CA — October 2011- June 2014
Senior Consultant

- Advised and worked closely with senior management at DHCS on a multitude of complex initiatives, including the Coordinated Care Initiative (CCI). The CCI was launched by the state of California to provide better coordinated care to people with both Medicare and Medi-Cal
- Reported to the Director at DHCS on the progress of CCI
- Facilitated meetings between DHCS and health plan leaders on implementation of CCI
- Managed progress of projects and execution throughout DHCS, requiring coordination across numerous departments and external stakeholders
- Facilitated communication between DHCS and CMS on the CCI
- Coordinated information flow to a statewide communications team, as well as organizing large events with over 300 attendees.
- Represented DHCS at meetings with stakeholders, including advocacy organizations.

Office of the Secretary of Education, Sacramento, CA
Senior Communications Director — August 2010- February 2011
Policy Analyst — May 2009- February 2011

- Served as liaison between the Secretary of Education and the public, including communicating directly with media
- Developed communication strategy on education issues for the Governor and Secretary focusing on higher education issues and the California Master Plan
- Researched and tracked state and federal legislative bills and policy initiatives regarding higher education

Goddard Claussen, Sacramento, CA — August 2006- January 2009
Account Coordinator

- Coordinated qualitative and quantitative research programs for tax reform, water policy, healthcare, transportation and political reform
- Developed messaging and outreach materials for numerous ballot initiatives and issue advocacy campaigns

Leadership/Achievements

Association for Community Affiliated Plans (ACAP) — Washington D.C.
Leadership Academy, 2020-2021

Local Health Plans of California (LHPC) — Sacramento, CA
Compliance Officers Committee, Co-Chair, 2019- current

Education

University of Southern California, 2010 — Los Angeles, CA
Master of Public Administration

Gonzaga University, 2006, *cum laude* — Spokane, WA
Bachelor of Arts, Political Science
Bachelor of Arts, History

Danielle Ogren

[redacted]

Accomplished Healthcare Leader with over 15 years' experience in Medi-Cal Managed Care. Results-oriented, decisive leader with the ability to balance strategic decisions and financial stewardship with a hands on approach. Engaging communicator and relationship builder with proven success in improving regulatory compliance while spearheading improvements to ensure quality healthcare delivery for over 895,000 members in 24 Northern California counties. Excel in dynamic, demanding environments while remaining pragmatic and focused. Highly engaged leader with expertise in Compliance and team development with passion for the vision. *Core strengths include:*

- Compliance and Regulatory Affairs
- Culture Development and Refinement
- Health Care Operations
- Risk Management
- Contract Negotiations
- Team Building and Motivation
- Issue Analysis and Resolution
- Program Development

Professional Experience

Partnership HealthPlan of California, Fairfield, CA

Sr. Director of Regulatory Affairs and Contracting	May 2024-Present
Director of Compliance and Regulatory Affairs	September 2023-May 2024
Director of Regulatory Affairs and Program Development	May 2022- August 2023
Associate Director of Compliance and Program Strategy	October 2021-May 2022

- Leadership team member, reporting directly to the Chief Strategy and Government Affairs Officer, CEO and, Board of Commissioners
- Serves as Compliance and Privacy Officer, minimizing risk by ensuring development of policies, procedures and ensuring full compliance with federal and state regulations including Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH) Act, and other rules as applicable. Immediately addressed issues though training and corrective actions.
- Responsible for conducting risk analyses, oversees PHC audits, and manages Fraud, Waste, and Abuse (FWA) and HIPAA Program and privacy reporting.
- Responsible for directly reporting to the Board of Commissioners on a variety of key initiatives, and areas of compliance.
- Facilitates Fraud Waste and Abuse and Physical, Administrative, Technical Safeguards, and Delegation Oversight Review committees, subcommittees of Compliance Committee
- Establishes and maintains productive relationships with key staff at the Department of Health Care Services (DHCS) and other regulatory agencies including the Department of Managed Care (DMHC), Office of Inspector General (OIG), Department of Justice (DOJ) and Centers for Medicare & Medicaid Services (CMS)
- Cultivated relationships with Federal Agencies serving as an expert witness as requested
- Responsible for ensuring compliance program incorporates critical compliance elements as identified by the U.S. Department of Health and Human Services (HHS), OIG, Code of Federal Regulations (CFR) related to Medicaid program integrity requirements, and DHCS. Responsibilities include:
  - Development and review of policies and procedures
  - Lead development and implementation of compliance training and education programs for all key stakeholders
  - Development of annual compliance risk assessment and internal work plans to monitor progress
  - Development of monitoring and audit work plan including internal, external, subcontractor, delegate audits. Ensure timely and accurate regulatory reporting, responses, and corrective actions.

    - Provider participation status review and background checks
    - Investigations and remediation
    - FWA detection and prevention
- Responsible for oversight of implementation of new benefits and regulatory changes, requiring cross-departmental participation. Programs include: CalAIM and 2024 DHCS Medi-Cal contract.
- Responsible for the operations and management of Regulatory Affairs and Compliance (RAC) and Legal Affairs and Provider Contracting Departments
- Responsible for the oversight of annual regulatory audits
- Responsible for analysis of major policy/regulatory changes that may impact plan, with particular attention to potential state and federal changes affecting Medi-Cal
- Responsible for drafting PHC's provider network templates in consideration of regulatory requirements. Participate in negotiations.

Associate Director of Cost Efficiency	October 2020- October 2021
Senior Manager of Cost Efficiency	December 2017- October 2020
Cost Avoidance Manager	December 2015-December 2017
Finance Contracting Analyst	July 2013-December 2015

- Leadership team member, reporting directly to the Chief Financial Officer (CFO) and Finance Committee
- Provided strategic support to legal for contract language related to the development and/or modification of contract templates to ensure compliance with all regulatory requirements and health plan initiatives
- Established and developed analytic reporting to Compliance Officer and Director of Legal Affairs related to fraud, waste, abuse and provider payment disputes
- Responsible for the oversight of compliance with network provider agreement provisions and reported outcomes, developed corrective action plans and ensured remediation of cited deficiencies to Compliance Officer.
- Cultivated relationships with DHCS including Capitated Rates Development Division and other state and federal regulatory agencies
- Developed and oversaw operational functions for recoveries, reinsurance, coordination of benefits, third party liability and overpayments
- Responsible for process improvement opportunities, recommendations and implementation of changes to maximize efficiency and quality of analytic work
- Completed an extensive analysis comparing PHC's healthcare spend to the Medi-Cal provider manual, resulting in significant configuration and contracting changes, which was positively received by the CFO and subsequently the PHC Board of Supervisors
- Responsible for contract fiscal negotiations for large network, all provider types
- Responsible for all value based provider rate development including new and innovative approaches to contracting using current and alternative reimbursement methodologies
- Provided CFO with rate development analytics and budgetary impact analysis
- Responsible for providing strategic direction to the Chief Financial Officer (CFO) and other C-Level Executives for rate development of innovative programs
- Ensures overall performance of network provider contracts aligns with quality and incentive programs
- Maintains knowledge of market rates in the service area
- Support CFO in completion, oversight and analysis of Supplemental Rate Development (SDR) and Rate Development Templates (RDT) to Department of Health Care Services (DHCS)
- Responsible for the Private Hospital Directed Payment and Enhanced Payment Program reconciliation and submission with network providers to DHCS
- Provide analysis and review of the annual health care cost budget, month end statements, and actual to budget variances
- Lead and managed the Cost Efficiency team to support PHC's strategic goal of fiscal stewardship and compliance

Certifications/Leadership

Certificate of Health Care Compliance (CHC): 2022

Local Health Plans of California (LHPC) — Sacramento, CA
Compliance Officers Committee, Chair, 2022- current

Affiliations

Health Care Compliance Association (HCCA) Member and Certified Health Care Compliance (CHC) Member

Education

University of California Davis — Davis, CA
Bachelor of Science

JEFFREY J. DEVIDO, M.D., M.T.S.

JDEVIDO@PARTNERSHIPHP.ORG

[redacted]

OVERVIEW

Specialist in mental health and addiction treatment. Administrative oversight of mental health and addiction treatment systems of care within Medicaid program in Northern California.

BOARD CERTIFICATIONS/LICENSURE

Adult Psychiatry
Addiction Psychiatry
Addiction Medicine
Active CA Medical Licensure

EXPERIENCE

CHIEF, ADDICTION SERVICES, MARIN COUNTY, CA, HHS
2016 - present
Responsible for grant management (over $4 million) aimed at expansion of SUD treatment system of care for Medicaid beneficiaries. Medical Director of co-occurring SMI-SUD outpatient clinic. System of care clinical education.

BEHAVIORAL HEALTH CLINICAL DIRECTOR, PARTNERSHIP HEALTHPLAN OF CA
2017 - present
Medical Director of DMC-ODS regional model SUD treatment system of care (7 counties). Quality management oversight and program expansion of/innovation in non-specialty mental health treatment system of care (24 counties). System of care education.

ASSISTANT CLINICAL PROFESSOR—VOLUNTEER; DEPT OF PSYCHIATRY AND BEHAVIORAL SCIENCES; WEILL INSTITUTE FOR NEUROSCIENCES AND UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
Full time consultation-liaison psychiatrist 2013-2016. Resident supervision and resident/fellow/medical student supervision/education.

EDUCATION

B.S. CHEMISTRY WITH SPECIALIZATION IN BIOCHEMISTRY
University of Virginia, 2000

MASTERS IN THEOLOGICAL STUDIES
Harvard Divinity School, 2003

MEDICAL DOCTOR
Columbia University College of Physicians and Surgeons, 2008

ADULT PSYCHIATRY RESIDENCY
Massachusetts General and McLean Hospitals, Harvard University, 2012

ADDICTION PSYCHIATRY FELLOWSHIP
Partners Health, Harvard University, 2013

Mark Bontrager

EDUCATION AND LICENSES

2011 Stanford Graduate School of Business, Executive Program for Nonprofit Leaders (EPNL)
2002 Indiana University School of Law, Doctor of Jurisprudence degree (J.D.)
1995 Indiana University School of Social Work, Master of Social Work degree (M.S.W.)
1993 Goshen College, Bachelor of Arts degree in Psychology (B.A.)
State Bar of Indiana, admitted 2002, Currently Inactive
Licensed Clinical Social Worker (LCSW), State of California 2006, State of Indiana 1997
Certified Healthcare Privacy Compliance (CHPC), Certified Healthcare Compliance (CHC)

PROFESSIONAL EXPERIENCE

Sr. Director of Behavioral Health **2021/Present**
Partnership HealthPlan of CA, Fairfield, California

- Oversee mental health and substance use disorder services for managed care plan
- Serve on the Executive Team for the managed care plan
- Represent the plan on external committees and stakeholder groups
- Support new programs and benefit implementations as needed and directed

Director of Regulatory Affairs & Program Development **2018/2021**
Partnership HealthPlan of CA, Fairfield, California

- Oversee Regulatory Affairs and Compliance department for managed care plan
- Serve as Privacy Officer for the health plan
- Manage staff in Regulatory Affairs and Compliance
- Support new programs and benefit implementations as needed and directed
- Participate in annual risk assessment, audits and the creation of compliance plan
- Participate as a member of the Operations and Emergency Response Teams

Executive Director **2007/2018**
Aldea Children & Family Services, Napa, California

- Oversaw operations for an agency of 160 staff and annual budget over $12 million
- Worked in conjunction with Board of Directors on mission and strategic planning
- Set organizational goals and objectives each year
- Led Development staff on fundraising, grant writing and strategy
- Created partnerships with public and private entities to better serve clients
- Managed senior program staff and administrative staff, setting annual goals
- Oversaw the purchase of properties and other assets
- Provided oversight to the CFO and fiscal operations of the agency
- Collaborated with other agencies in service development and implementation
- Identified new public and private funding opportunities for the agency and partners
- Participated in community-wide committees and advisory groups

- Oversaw the expansion of programming, services and staffing
- Participated in a successful $2 million dollar capital campaign
- Obtained National Accreditation

Deputy Director **2005/2007**
Aldea Children & Family Services, Napa, California

- Managed program directors overseeing eight programs
- Oversaw fiscal operations and agency Controller
- Developed new programs utilizing existing infrastructure
- Worked towards greater integration of programming and services
- Directed senior management in overall agency operations
- Directed mental health and child welfare service lines for the agency
- Developed contracts and expanded existing contracts for services
- Worked closely with local government to partner on specific projects
- Participated in Finance and Development Committees of the Board
- Partnered with Executive Director in planning and execution of services

Attorney **2002/2006**
Private Practice, Indianapolis, Indiana

- Represented clients in adoption and special education matters
- Conducted custody evaluations as directed by the court
- Performed mediations for parties in dispute
- Successfully advocated and passed laws promoting adoption from foster care
- Provided trainings to public social service / child welfare agencies
- Consulted with school districts over special education issues
- Represented clients in family law matters

Program Manager / Therapist / Social Worker **1996/2003**
The Villages of Indiana, Inc., Indianapolis, Indiana

- Used organizational skills to assist in establishing a residential program
- Conducted interviews and trained direct care staff in behavior management
- Directed staff meetings and weekly clinical team meetings
- Gave presentations to community groups to garner support
- Provided individual and family therapy with clients
- Completed foster care / adoption home studies
- Managed program staff of twelve members
- Created policy and procedures for program operations

Vitae

BOARD/COMMITTEE MEMBERSHIPS

Governors Appointment to Mental Health Services Act Oversight & Accountability Commission (2021 – Present)
Governors Appointment to Children's Justice Act Task Force (2015 – 2018)
Solano County Children's Alliance Executive Committee (2013 – 2018)
Napa County Child Abuse Prevention Council Steering Committee Member (2008 – 2018)
Foster Family-based Treatment Association (FFTA) (2010 – 2012)
Napa County Children's Health Initiative Board Member – Treasurer (2007 – 2012)
Napa Valley Coalition of Non-Profits Behavioral Health Committee – Co-Chair (2008 – 2010)
Napa County Workforce Investment Board Member – Vice Chair (2005 – 2010, 2015 - present)
Pacific Union College Social Work Advisory Board Member (2006 – 2009)
Napa County Mental Health Services Act – PEI Advisory Board Member (2007 – 2009)
Adoption in Child Time, Inc. Board Member (2003 – 2009)
Indiana Juvenile Justice Task Force, Inc. (2004 – 2006)

PUBLICATIONS & TRAININGS PROVIDED

Bontrager, Mark & Peter Kenny (2004). Foster Parent Journal. School Datebooks Publication, Lafayette, Indiana.

Kenny, Peter & Mark Bontrager (2004). Adopting a Foster Child. ACT Publications, Rensselaer, Indiana.

Bontrager, Mark & Jim Kenny (July/August 2004 issue). "Pseudo-Bonding and Other Myths." *Foster Families Today*. Louis & Company Publishing, Windsor, Colorado.

Bontrager, Mark & Jim Kenny (May/June 2004 issue). "Appellate Courts Choose Bonding." *Foster Families Today*. Louis & Company Publishing, Windsor, Colorado.

Bontrager, Mark (2003). "New Tax Credits a Boon to Parents Adopting Special Needs Kids." ACT ONE. 5 (1), pg. 3.

Bontrager, Mark (2003). "Do I Have to be Rich to Adopt?" ACT ONE. 5 (2), 2-3.

"Legal Issues for Mental Health Professionals: Responding to Requests for Disclosures, What does HIPAA Allow?" (Training 3 hours of continuing education credit, 2009)

Professional/Educational/Volunteer Experience

University of California at Berkeley Haas School of Management – Executive training programs: Leading for Performance, Leader as Coach, Leadership Training
Victim/Offender Mediator, Certified Civil Mediator state of Indiana (2002)
Court Appointed Special Advocate (CASA)
North American Council on Adoptable Children: Indiana State Subsidy Representative (2004)

MOHAMED ALIEU JALLOH, PHARM.D.

[redacted]

CURRENT EMPLOYMENT

2023-Present **HEALTH EQUITY OFFICER (DIRECTOR OF HEALTH EQUITY)**
Partnership Health Plan of California, Fairfield, CA

2016-Present **ASSISTANT PROFESSOR IN CLINICAL SCIENCES**
Touro University California College of Pharmacy, Vallejo, CA
- Lecture at least 25+ hours of pharmacotherapy lecture material in family medicine, evidence based medicine, health equity, and digital health-related topics each year
- Over 92% of 120+ students rated " very agreed" or "agreed" that my lectures are presented in a clear and understandable manner

2018-Present **GUEST LECTURER**
Stanford University College of Medicine, Stanford, CA
- Lecture at least 6+ hours of pharmacotherapy lecture material in family medicine topics each year
- Over 95% of 50+ students rated lectures "excellent" or "very good"

2020-2021 **PER-DIEM COVID-19 VACCINATION PHARMACIST**
CVS Pharmacy, Vallejo, CA

2016-2021 **SPOKESMAN FOR THE AMERICAN PHARMACISTS ASSOCIATION (APhA)**
American Pharmacists Association | Washington, DC
- Quoted and interviewed by 20+ leading journalists from *Time Magazine*, *WebMD*, *Men's Health*, *Washington Post*, *NPR*, *AccuWeather*, and *USA Today*

2014-2016 **PER-DIEM COMMUNITY PHARMACIST**
Walgreens | Omaha, NE

HONORS AND AWARDS

2021	Touro University College of Pharmacy "Clinical Professor of the Year" Award Winner
2021	Touro University College of Pharmacy "Most Engaging Professor of the Year" Award Winner
2019	Touro University College of Pharmacy "Most Entertaining Professor of the Year" Award Winner
2019	Touro University College of Pharmacy "IPhO Preceptor of the Year" Award Winner
2018	The Doctors Company **and** Napa Valley Community Foundation Second Responder Recognition
2018	ASHP CEO National Courageous Service Award Winner
2014	Natural Medicines Comprehensive Database Recognition Award Winner
2013	Walgreens National Diversity Scholarship Recipient
2013	Wilkes Multicultural Global Scholar and Citizen Award Winner
2012	Who's Who Among Students in American Universities and Colleges

EDUCATION

2008- 2014	**DOCTOR OF PHARMACY (PHARM.D.)** *Pharmacy Spanish Concentration Certificate* Wilkes University, Nesbitt School of Pharmacy, Wilkes-Barre, PA
2014- 2016	**GRADUATE CERTIFICATE IN CLINICAL AND TRANSLATIONAL SCIENCES (BIOSTATISTICS)** Creighton University School of Medicine, Omaha, NE

INTERNATIONAL EDUCATION

SPANISH LANGUAGE

Summer 2012	University of Malaga, Malaga, Spain
Summer 2011	Colegio Mayor Mara, Madrid, Spain

LICENSURES AND BOARD CERTIFICATIONS

Licenses	**PHARMACIST**
Expires 2025	California License#: RPH76770
Expires 2024	Nebraska License#: 14659
Certifications	
Expires 2026	**BOARD CERTIFIED PHARMACOTHERAPY SPECIALIST (BCPS)** Board of Pharmacy Specialties, # 3160131

CERTIFICATES

Certificates	
Jan 2022	**DIVERSITY, HEALTH EQUITY, INCLUSION, AND ANTI-RACISM** American Association of Colleges of Pharmacy (AACP)
Jan 2021	**BASIC LIFE SUPPORT (BLS) PROVIDER** ACLS Certification Institute
Apr 2019	**PHARMACY-BASED TRAVEL HEALTH SERVICES** American Pharmacists Association, Washington, DC
Mar 2017	**LIFESTYLE AND WELLNESS COACH** National Diabetes Prevention Program (DPP) Vallejo, CA
Jun 2016	**MEDICATION THERAPY MANAGEMENT** American Pharmacists Association, Washington, DC
Jun 2016	**EVIDENCE-BASED PRACTICE** Creighton University School of Pharmacy & Health Professions, Omaha, NE
May 2015	**TEACHING CERTIFICATE PROGRAM FOR PHARMACY RESIDENTS** Creighton University School of Pharmacy & Health Professions, Omaha, NE

May 2013 **PHARMACY BASED IMMUNIZATION DELIVERY**
American Pharmacists Association, Washington, DC

POST-DOCTORAL TRAINING

Jul 2014-Jun 2016 **DRUG INFORMATION AND EVIDENCE BASED MEDICINE RESEARCH FELLOWSHIP**
Center for Drug Information & Evidence-Based Practice
Creighton University, Omaha, NE
Program Preceptor(s): Darren Hein, PharmD; Zara Risoldi-Cochrane, PharmD, MS; Amy Wilson, PharmD

- Provided pharmacotherapeutic recommendations in a medication therapy management center and volunteer ambulatory care and acute care clinic.
- Managed an academic drug information consultation service that provides over 1000 clinical consultation annually to health care professionals.
- Supervised over 50+ Pharm.D. advanced pharmacy practice experience (APPE) rotation students during an academic drug information consultation service and medication therapy management (MTM) center.
- Provided regional and national medication policy and P&T support for Catholic Health Initiatives (CHI), PharMerica, and McKesson.
- Provided medical content and editorial expertise for Medscape and Healthline.com.
- Served as an investigator and co-investigator on 3+ research projects.

TEACHING EXPERIENCE

Fall 2016 to Present **STANFORD UNIVERSITY SCHOOL OF MEDICINE**
Didactic Lectures

- Men's Health (BPH and ED) (2 hours)
- Headache and Migraines (2 hours)
- Sexually Transmitted Diseases and HIV (2 Hours)
- Osteoarthritis Management (2 hours)

Fall 2016 to Present **TOURO UNIVERSITY CALIFORNIA COLLEGE OF PHARMACY PROGRAM**
Didactic Lectures

- Introduction to Drug Information (3 hours)
- Drug Literature Evaluation (3 hours)
- Reviewing and Applying Systematic Reviews and Meta-Analyses (1.5 hours)
- Ophthalmic, Otic, and Oral Agents Part 1 (3 hours)
- Constipation and Diarrhea Management (3 hours)
- Atopic Dermatitis and Contact Dermatitis Management (3 hours)
- Medication Therapy Management and Reimbursement (3 hours)
- Osteoarthritis Management (3 hours)
- Gout (3 hours)
- Headache and Migraines (3 hours)
- Men's Health (BPH and ED) (3 hours)
- Travel Health (8 hours)

Clinical Rotations Teaching/Experiential Teaching

- Ambulatory Care Rotation (1 PGY1 resident and 2 students every 6 weeks)

CREIGHTON UNIVERSITY SCHOOL OF PHARMACY AND HEALTH PROFESSIONALS

Fall 2014 to Spring 2016

Didactic Lectures

- PHA 458 Literature Evaluation and Evidence Based Practice (15 hour)
- PHA 469 Case Studies and Case Discussion (15 Hours)
- PHA 319 Pharmaceutics Skills Lab (8 hours)

Clinical Rotations Teaching/Experiential Teaching

- PHA 515, Drug Information Rotation (8 students every 5 weeks)
- PHA 534, Medication Therapy Management (MTM) (2 students every 5 weeks)
- PHA 528, Dominican Republic International Medical Mission (2 students every 4 weeks)

GRANT WRITING AND CONSULTANT EXPERIENCE

Contracts

Jul 2014-present **PROJECT MANAGER OR CONTRIBUTOR**

- Provided key project management for Mckesson, PharMerica, and Healthline.com that resulted in over $2000 in billable services.

Grants Submitted

Sep 2021 **Children's Book Intervention to Address Parent Knowledge and Motivation in Childhood Vaccinations: A Cross-Sectional Study** Touro University California, Vallejo, CA

- $2,326.16 (Funded)

May 2021 **Barber Motivation for Conducting Mental Health Screening In African American Barbershops: A Cross-Sectional Study**
Touro University California, Vallejo, CA

- $2, 000 (Funded)

Feb 2015 **"ASSESSING DRUG INFORMATION NEEDS OF RURAL NEBRASKA PHARMACISTS"**
Nebraska Pharmacists Association, Lincoln, NE

- $2, 500.00 (Not Funded)

PUBLICATIONS

Peer-Reviewed Journals

Sep 2022 ***Jalloh MA***, Stompanato J, Nguyen JQ, Barnett MJ, Ip EJ, Doroudgar S. Barber Motivation for Conducting Mental Health Screening and Receiving Mental Health Education in Barbershops That Primarily Serve African Americans: a Cross-sectional Study. *J Racial Ethn Health Disparities*. 2022;10.1007/s40615-022-01420-5.

May 2022 ***Jalloh MA,*** Chung K, Doroudgar S. Severity of visual hallucinations worsened with lisinopril despite receiving sedative hypnotic therapy or antipsychotic therapy: First case report. *Res Social Adm Pharm*. 2022;18(11):4009-4011.

Mar 2020 ***Jalloh MA,*** Barnett M, Ip EJ. Men's Health Related Magazines—what they recommend and the evidence to support their recommendations: A retrospective study. *Am J Mens Health.* 2020 May-Jun; 14(3): 1557988320936900

Mar 2020 ***Jalloh MA.*** Esketamine (Spravato) for Treatment-Resistant Depression. *Am Fam Physician*. 2020 Mar 15;101(6):339-340.

May 2018	***Jalloh MA***, Doroudgar S, Ip EJ. What is the impact of the 2017 cochrane systematic review and meta-analysis that evaluated the use of PCSK9 inhibitors for lowering cardiovascular disease and mortality? Expert Opin Pharmacother. 2018 May;19(7):739-741.
May 2016	***Jalloh MA***, Gregory PJ, Hein DJ, Risoldi-Cochrane Z, Rodriguez A. Dietary supplement interactions with antiretrovirals: A systematic review. *Int J STD AIDS*. 2017;28(1):4-15.
May 2016	Gregory PJ, Bird AS, Hein DJ, Abe A, Risoldi-Cochrane Z, ***Jalloh MA***, Wilson AF. Assessment of the value of an academic drug information service to the healthcare community. *J Am Pharm Assoc* [Currently in review]
May 2015	Schreck Bird A, Gregory PJ, ***Jalloh MA***, Risoldi Cochrane Z, Hein DJ. Probiotics for the Treatment of Infantile Colic: A Systematic Review. *J Pharm Pract*. 2016. [Epub ahead of print].
May 2015	Gregory PJ, ***Jalloh MA***, Abe AM, Hu J, Hein D. Characterization of Complementary and Alternative Medicine-Related Consultations in an Academic Drug Information Service. *J Pharm Pract*. 2015. [Epub ahead of print].
Continued Education	
	Jalloh M. Itching to Find a Solution: The Community Pharmacist's Role in Ocular Allergy Treatment. https://www.powerpak.com/course/preamble/121944

PRESENTATIONS

Invited Podium Presentations	**ADDRESSING VACCINE HESITANCY (VH) AND HEALTH DISPARITIES IN MINORITY COMMUNITIES: ALTERNATIVE APPROACHES AND LEVERAGING COMMUNITY PARTNERSHIPS**
March 2023	2023 NACCHO Preparedness Summit Conference, Atlanta, GA
March 2019	**"COORDINATING WITH PHARMACIES DURING STATE AND NATIONAL EMERGENCIES"** 2019 NACCHO Preparedness Summit Conference, St. Louis, MO
May 2018	**"PRESCRIBING MEDICATION RELATED APPS"** California Pharmacists Association (CPhA) Western Pharmacy Exchange Conference, San Diego, CA
May 2015	**"ARE RECOMMENDATIONS IN MENS HEALTH-RELATED MAGAZINES TRULY EVIDENCE-BASED: A RETROSPECTIVE STUDY-PRELIMINARY RESULTS"** Midwestern Pharmacy Residency Conference, Omaha, NE
Dec 2014	**"GOOGLE POWER SEARCHING FOR PHARMACISTS: HOW TO APPLY THE HIDDEN TOOLS OF GOOGLE FOR DRUG INFORMATION"** American Society of Health System Pharmacists (ASHP) Midyear, Orlando, FL
Leadership Related	
Nov 2013	**"A #SCRIPT FOR SOCIAL MEDIA"** Audience: 600+ APhA-ASP Region 1 & 2 Midyear Meeting attendees, Washington, DC

LEADERSHIP AND PROFESSIONAL SERVICE

University

Jul 2022- Present	**CHAIR-FACULTY DEVELOPMENT COMMITTEE** Touro University California College of Pharmacy
Aug 2019- Jul 2022	**CHAIR-ADMISSIONS COMMITTEE** Touro University California College of Pharmacy
Aug 2019- Jul 2022	**COP MEMBER-ENROLLMENT MANAGEMENT COMMITTEE** Touro University California College of Pharmacy
Aug 2019- Jul 2022	**COP MEMBER-ENROLLMENT LEADERSHIP COMMITTEE** Touro University California College of Pharmacy
Health Plan/PBM	
	VOTING MEMBER OF P&T COMMITTEE Partnership Health Plan
Editorial Advisory Board	
	EDITORIAL ADVISORY BOARD MEMBER
Mar 2018- Present	*Drug Topics: Voice of the Pharmacist* Modern Medicine Network
May 2018-Present	*British Medical Journal (BMJ) Evidence Based Medicine*
Mar 2015-Mar 2016	*Transitions* American Pharmacists Association- New Practitioner Network
Mar 2012-Mar 2014	*Student Pharmacist Magazine,* American Pharmacists Association-Academy of Student Pharmacists
Peer Reviewer	
	MEDICAL JOURNALS
May 2020-Present	*American Journal of Men's Health*
Jan 2018-Present	*British Medical Journal (BMJ) Evidence Based Medicine*
Oct 2014- Present	*Journal of Medical Internet Research*
Oct 2014-Present	*Journal of Evidence-Based Complementary and Alternative Health*
National Student Leadership	
Jul 2013-Aug 2014	**NATIONAL STUDENT ADVISORY COMMITTEE MEMBER-AT-LARGE** American College of Clinical Pharmacy (ACCP)
Jun2013-Aug 2014	**NATIONAL LIAISON TO REGION I** Phi Lambda Sigma (PLS) Pharmacy Leadership Society
Mar 2013-Mar 2014	**NATIONAL STANDING COMMITTEE MEMBER OF COMMUNICATIONS** American Pharmacists Association-Academy of Student Pharmacists
Mar 2013-Mar 2014	**NATIONAL STRATEGIC PLANNING COMMITTEE** American Pharmacists Association-Academy of Student Pharmacists

EXPERT COMMENTARY EXPERIENCE

DeLorean Ruffin, DrPH, MPH

Education

- **Doctor of Public Health (DrPH)** – Health Education and Promotion, Loma Linda University (2022)
- **Master of Public Health (MPH)** – Argosy University (2016)
- **Bachelor of Science Biology** – Barry University (2013)

Core Competencies

- Program Monitoring & Evaluation
- Data Synthesis/Decision Making
- Strategic Leadership and Planning
- Grant and Budget Management
- Cross-Functional Leadership
- Program and Policy Development
- Organizational Learning Advocacy
- Resource Allocation Strategy
- Change Management
- Good Clinical Practices
- Project Management
- Stakeholder Communication
- Population Health Management

Technical Competencies

- MS Office Suites, Visio, Statistical Analysis Software (SAS), SPSS, Proficiency in Process Mapping, Six Sigma & Lean
- PowerBI Dashboards, Tableau
- Qualitative Data Analysis-NVivO, EDC (Veeva)
- EMR (Epic, eCW, Athena)
- Salesforce (CalConnect)
- Cloud Based Repository

Professional Affiliates

- Black Doctoral Network (BDN), Member, Conference Workshop Presenter **2020-Present**
- American Public Health Association Member, Peer Reviewer (HIV/AIDS, MCH) **2019-Present**
- Society of Public Health Education Member, **2019-Present**
- Institute of Health Care Improvement (IHI), Member, **2021-Present**
- CA Primary Care Association (CPCA), Member, **2021-Present**

Additional Work Experience

- Clinical Research Coordinator-

Summary of Qualifications:

Dynamic and results-driven Population Health Management executive with over 10 years of experience in strategic healthcare leadership. Proven track record of developing and implementing comprehensive population health strategies that drive quality patient outcomes and operational excellence. Adept at leveraging data analytics to inform decision-making and improve health equity across diverse patient populations. Skilled in fostering cross-functional collaboration and building strategic partnerships with community organizations to enhance care delivery and access. Demonstrated success in maintaining and achieving HPA and HEA NCQA accreditation and maintaining regulatory compliance with CMS, DHCS, and CDPH standards.

Professional Experience

Partnership HealthPlan of California — April 2024 – Present
Director of Population Health Management — **40 hours/week**

Key Responsibilities and Achievements:

- Spearheaded data-driven Population Health Management strategies, collaborating closely with the Health Analytics team to leverage data for measurable improvements in patient health outcomes and real-time program adjustments.
- Developed innovative, patient-centered interventions to address care gaps and health equity issues in Solano County, partnering with the Director of Health Equity to create sustainable activities with tangible impact on patient outcomes.
- Implemented proactive approach to community engagement by strategically utilizing Community Health Liaisons to transform the department's participation from reactive to strategic, aligning activities with organizational goals and community partnerships.
- Led comprehensive reviews of Population Health Management Program Description and Evaluation, ensuring high-quality work and timely project completion to drive better member outcomes.
- Fostered strong interdepartmental collaboration and positive team dynamics, setting a tone of accountability and professionalism while building key partnerships with internal and external stakeholders.

Accomplishments and Impact:

- Spearheaded the development of innovative, patient-centered interventions for Solano County, addressing critical care gaps and health equity issues, resulting in a comprehensive suite of sustainable activities poised to make a tangible difference in patient outcomes.

West Oakland Health Council (now Baywell Health) — August 2021 – March 2024
Director Of Research, Evaluation, and Community Health — **40 hours/week**

Key Responsibilities and Achievements:

As the driving force behind West Oakland Health's strategic endeavors in community health, research, and evaluation, my role encompasses steering the organization's direction in population health management. I am deeply engaged in crafting and implementing research strategies, enhancing quality improvement initiatives, and leading community health programs, all while ensuring alignment with the requirements and regulations set forth by CMS, DHCS, NCQA, CDPH, and other regulatory bodies.

- Spearhead West Oakland Health's strategic initiatives in community health, research, and evaluation, aligning with CMS, DHCS, NCQA, and CDPH regulations.
- Ensure regulatory compliance (TJC, NCQA-PCMH, HRSA-UDS, FTCA) and actively participate in certification and audit processes.
- Cultivate strategic partnerships with community organizations and stakeholders to enhance population health management activities.
- Develop innovative programs for specialized patient populations, improving quality, health equity, and patient outcomes leveraging continuous quality improvement methodologies and tools (PDSA, Lean Six Sigma, and DMAIC.)

PMI Health, Atlanta, GA | June 2014- Aug. 2016, 2 years, 2 months

- Analyze large datasets using quantitative and qualitative methods to drive quality outcomes and evaluation.
- Oversee grant applications and direct funds toward key quality improvement, prevention, and treatment initiatives.

Accomplishments and Impact:

- Advanced from Director of Quality Assurance, implementing population health management tactics that reduced service delivery disparities by 50% within six months.
- Led development of strategic objectives supporting quality improvement initiatives while ensuring compliance with federal and state regulations.
- Expanded leadership role from managing three data analysts to overseeing four key departments: WIC, Community Health, and Maternal Child Health.

Contra Costa County Health Services, Concord, CA — November 2020 - August 2021
PUBLIC HEALTH PROGRAM MANAGER — 40 Hours/week

Key Responsibilities and Achievements:

- Developed, coordinated, and implemented, evidenced-based audience-centric health education programs across a range of county and state health education, prevention, or public health services programs inclusive of non-clinical sites, residential care facilities, and co-leads state level quality strategy for Community of Practice (CoP) sessions.
- Built, fostered, and maintained collaborative partnerships to strengthen resources available for extending the reach of CCHS awareness and education programs and broad-based education initiatives to improve public health in the communities serviced.
- Delivered culturally competent communications leveraging specialty techniques, and methods to provide data and educational public health information and strategic communication plans inclusive of reports, presentations, fact sheets, articles for publication, and responses to individuals or groups to improve overall health literacy.
- Monitored action items within the organization focused on PMO efficiency and ensured timely responses, and appropriate progress to remedy problems that required interim and long-term solutions.
- Consolidated data and research information for presentation to executive leadership and other facility leadership and staff for use in the planning, development, and operation of new and existing managed care programs
- Provided subject matter expertise in response to day-to-day business issues; researched applicable subject matter practices; and remained aware of latest epidemiological disease management learning agendas.

Accomplishments and Impact:

- Created public health messaging and content and coordinated website maintenance, engaging over 5000 views that led to program sustainability and additional state funding for site management to reconcile and resolve budgetary matters.
- Managed external client facing relationships and partners with corporate and regional business areas advised undergraduate and graduate epidemiology interns and delegated tasks that supported the goals of the COVID-19 Vaccination Program staff and volunteers.

Interface Children & Family Services, Camarillo, CA — December 2020 – April 2021
EVALUATION MANAGER — 40 Hours/week

Key Responsibilities and Achievements:

- Successfully built and maintained systems and programs to assess and increase the impact of ICFS core program areas including justice services; domestic violence; mental health; human trafficking; runaway and homeless youth; early child and family development; and child abuse prevention.
- Ensured program sustainability by working collaboratively with Program Coordinators to obtain $1.5 Million in grant funding. Developed and tracked sound initiative goals and objectives ensuring partner engagement and commitment to agency objectives utilizing business intelligence tools for trauma-informed Mental and Behavioral Health programs.
- Led designing, developing, and executing critical complex projects supporting system migration, change control, and archival activities for data management systems.
- Extracted and compiled data from databases using query language to generate reports and presentations on collected data, interpreting the data, and drawing conclusions.

- Collaborated with Justice Services teams to facilitate performance improvement activities for quality of care, process improvement, regulatory compliance, and patient experience using evidence-based tools, techniques, and methodologies.
- Leveraged business intelligence tools to analyze reports and create solutions that would maximize the financial performance of the business unit.

Accomplishments and Impact:

- Successfully awarded $1.5 Million in grant funding (Medically Assisted Treatment (MAT), Phoenix Project, CCVI) following thorough evaluation and leadership recommendations for improvements to technology that would enhance continuous monitoring and compliance of privacy data and mature the management governance, practices, processes, and tools used.
- Leveraged business intelligence tools to analyze reports and create solutions that would maximize the financial performance of the business unit which led to generating agency and departmental fact sheet through Power BI.
- Developed roadmap for the modernization of processes, policies, and systems and other technological advancements with implementable milestones and sustainable outcomes. This included authoring proposals, reviews, and ratings of RFP from competing vendors, and final selection processes.

IQVIA (contracted), Long Beach, CA — June 2020 – November 2020
Clinical Research Coordinator — 40 Hours/week
Key Responsibilities and Achievements:

- Worked closely with the Director of Operations at Long Beach Clinical Trials site with collection and tracking of critical study documents, including preparation and approval of essential document packages.
- Facilitated successfully completed 3 eTMF reviews, including data management utilizing EDC for clinical trials to ensure compliance with study protocols and IRB, GCP, ICH, and FDA regulations and guidelines.
- Day- to-day data management and administration for 3 clinical studies simultaneously.
- Participated in the selection of Contract Research Organizations (CROs) for small budget sponsored clinical investigation.

Accomplishments and Impact:

- Provided strategic oversight to the Clinical Operations Director in our vendor and CRO relationships and provides clinical input into their governance committees.
- Reviewed start-up documentation, including site initiation, interim monitoring, and close-out materials.
- Conducted subject recruitment, eligibility screenings, informed consent (1678), and outpatient logistics to ensure accurate study tracking metrics, including study milestones, site/subject payments, vendor relations, etc.

Good Samaritan Health Center, Atlanta, GA — August 2016 – August 2018
Health Outcomes Manager — 40 Hours/week
Key Responsibilities and Achievements:

- Instrumental in identifying steps necessary to effectively communicate with outside organizations such as IPA's, health plans, and government agencies to serve as an internal SME for relevant programs and tracking performances, including HRSA Site Visit Protocol, HEDIS, PCMH, UDS, MU, FTCA, and Joint Commission guidelines.
- Fulfil research requests using inferential statistical techniques to interpret data from various sources such as surveys, automated reports, online programs, and published literature.
- Optimized administrative OPX budget and accelerated productivity of operations team following the execution of successful cost analysis and gaining sponsor approval and stakeholder buy-in for my recommendation to replace the outdated dental EHR with a cloud-based system.
- Provided strategic and practical support to develop, submit and maintain large-scale sponsored research projects and enhance community impact.
- Change agent and project management partner for the transformation and inaugural rollout of grant writing for QI/QA-related funding opportunities.
- Managed grants administration activities including development and management of contracts and subcontracts and ongoing post-award compliance matters by introducing the practice and coordination of PDSA Cycles.

Accomplishments and Impact:

- Successfully championed at-risk health programs, leading to NCQA accreditation by spearheading the development of the PCMH (Patient-Centered Medical Home) care delivery model within a healthcare facility of 45-50-personnel.
- Oversaw the re-branding of several CBO partners with social media content creation.
- Successfully developed and executed a pilot program aimed at revising an outdated QI/QA program, work plan, and annual evaluation process.
- Fostered a high-performance culture by motivating teams and developing member relationships and engagement.

Professional References

Professional, Academic, or Personal References
Available Upon Request

this page left blank

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
1. QI Program Infrastructure											
1.a.	QI Program Documents	Continued	**Goal #1:** By July 2026, complete draft QI Program Description, QI Work Plan, and QI Evaluation revisions in preparation for August Quality Committee meetings.	**Deliverable #1:** Finalize 2026 - 2027 QI Program Description	10/1/2025	7/30/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.a.				**Deliverable #2:** Finalize 2025 - 2026 QI Work Plan.	10/1/2025	7/30/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.a.				**Deliverable #3:** Finalize 2025 - 2026 QI Evaluation.	10/1/2025	7/30/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.a.				**Deliverable #4:** Complete Draft of 2026 - 2027 QI Work Plan	10/1/2025	7/30/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.b.	Improve Partner Satisfaction	New	**Goal #1**: By November 2025, implement a post-training feedback survey for Trilogy participants to establish a baseline satisfaction score and identify two areas for improvement in future sessions.	**Deliverable #1**: By August 31, 2025: Draft survey questions and finalize with key team input.	6/30/2025	8/31/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.b.				**Deliverable #2**: By September 15, 2025: Pilot the survey with a small group and make revisions as needed.	7/30/2025	9/15/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.b.				**Deliverable #3**: By October 15, 2025: Launch the full survey to all recent Trilogy training participants.	8/1/2025	10/15/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.b.				**Deliverable #4**: By November 15, 2025: Analyze results.	10/30/2025	11/15/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.b.				**Deliverable #5**: By December 15, 2025: Share findings with the team.	11/15/2025	12/15/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
1.c.	Streamline QI Trilogy Document Processes	New	**Goal #1**: By June 30, 2026, partner with at least two stakeholders outside the Trilogy team to observe current workflows and identify two to three actionable improvements aimed at reducing administrative burden and manual work across the program.	**Deliverable #1**: By September 30, 2025: Identify and confirm two (or more) stakeholders to engage with.	7/1/2025	9/30/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.c.				**Deliverable #2**: By November 30, 2025: Schedule and complete observation sessions or process walk-throughs with each stakeholder	9/30/2025	11/30/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.c.				**Deliverable #3**: By January 31, 2026: Analyze findings and map out current pain points or redundancies.	11/30/2025	1/31/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.c.				**Deliverable #4**: By March 31, 2026: Draft a summary of proposed process improvements and share with stakeholders for feedback.	1/31/2026	3/31/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.c.				**Deliverable #5**: By June 30, 2026: Finalize two to three actionable improvement recommendations and develop an implementation plan.	3/31/2026	6/30/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.d.	Enhance QI Trilogy Training Tools	New	**Goal #1**: By June 30, 2026, collaborate with the Training & Development team to revamp the QI Trilogy Training and develop at least two microlearning modules that reinforce key concepts in a more engaging and accessible format.	**Deliverable #1**: By August 30, 2025: Meet with T&D team to define project scope, responsibilities, and timeline.	6/30/2025	8/30/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.d.				**Deliverable #2**: By October 15, 2025: Gather and review current training materials; identify areas needing updates or replacement.	8/30/2025	10/15/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.d.				**Deliverable #3**: By December 31, 2025: Draft new or revised content and storyboard two microlearning modules.	10/15/2025	12/31/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.d.				**Deliverable #4**: By February 28, 2026: Complete development of microlearning modules and test internally.	12/31/2025	2/28/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.d.				**Deliverable #5**: By March 31, 2026: Launch updated training and modules; collect initial user feedback.	2/28/2026	3/31/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
1.e.	Physician Advisory Committee (PAC) Oversight of QI Program	New	**Goal #1:** By June 30, 2026, Ensure PAC oversight of Partnership's QI Program through semi-annual monitoring of the QI Work Plan	**Deliverable #1:** By September 30, 2024 QI Trilogy Documents to be reviewed for approval by PAC in September 2024, post-review of other Quality committees to include but not limited to: * FY 2024-25 - Work Plan * FY 2024-25 - Program Descriptions * FY 2023-24- QI Program Evaluation	9/10/2025	9/30/2025	Title: Chief Medical Officer Name: Robert Moore	Title: Executive Assistant Name: Sarah Browning	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2. Measurement, Analytics and Reporting											
2.a.	HEDIS® Reporting	Continued	**Goal #1:** By June 30, 2026, report HEDIS MY2025 final rate performance as required annually for NCQA Health Plan Accreditation (HPA) and the DHCS Managed Care Accountability Set (MCAS) and baseline Medicare data.	**Deliverable #1:** Annual Project Work Plans updated by 10/31/2025 to accommodate HPA, MCAS and Medicare unique activities/deliverables.	7/1/2025	10/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.a.				**Deliverable #2:** By June 30, 2026, report HEDIS MY2025 final rate performance as required annually for NCQA Health Plan Accreditation (HPA), the DHCS Managed Care Accountability Set (MCAS), and the baseline Medicare population.	1/1/2026	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.a.		Continued	**Goal #2**: By August 29, 2025, launch the HEDIS MY2025 Monthly Project in Inovalon to include data reporting for NCQA Health Plan Accreditation (HPA), the DHCS Managed Care Accountability Set (MCAS) and the Dual Eligible Special Needs Plan (D-SNP).	**Deliverable #1**: Create Monthly Project Work Plan updated by August 29, 2025 to include HPA, MCAS and D-SNP unique activities/deliverables.	7/1/2025	8/29/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.a.				**Deliverable #2**: By August 29, 2025, launch the HEDIS MY2025 Monthly Project which includes all populations for DHCS, HPA and D-SNP.	7/1/2025	8/29/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.a.				**Deliverable #3**: By August 29, 2025, send data exports for the HEDIS MY2025 Monthly Project which includes all populations for DHCS, HPA and D-SNP to the EDW & HA team's to create the PQD Monthly Dashboard.	7/1/2025	8/29/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.a.				Deliverable #4: Timely publication of the MY2025 HEDIS® Monthly Exploratory dashboard, based on efforts by HEDIS, EDW, and Health Analytics team member, to include enhancement requests. (Contingent on HRP® production implementation).	7/1/2025	10/15/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho Title: Director of Data Warehouse Name: Arun Saligame Title: Manager of Health Analytics Name: Tom Nguyen	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.a.		New	**Goal #3**: By June 30, 2026, submit supplemental data extracted from OCHIN Epic, eCW and NextGen for HEDIS Annual MY2025 from an NCQA certified data aggregator to support regulatory compliance required for NCQA Health Plan Accreditation (HPA) and the DHCS Managed Care Accountability Set (MCAS).	**Deliverable #1**: Submit ROADMAP Annual Audit Deliverable that includes an NCQA Certified Dav Aggrator for auditor(s) approval.	11/1/2025	3/31/2026	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.a.				**Deliverable #2**: Integrate data from certified Dav Aggregator upon auditor(s) approval into the HEDIS MY2025 Annual project.	2/1/2026	5/31/2026	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.b.		New	**Goal #1:** By June 30, 2026, in collaboration with the Finance Health Analytics team, design and implement an organization-wide patient experience performance visualization dashboard that will accomplish the 3 (three) deliverables.	**Deliverable #1:** Develop and approve a Business Requirements Document (BRD), to include the project scope and data that will be displayed as part of the NCQA-regulated CAHPS Survey Results, including; • NCQA Health Plan Star Ratings • Survey aggregate summary rates • Composite and rating measures • Quality Compass HEDIS benchmark comparisons • Star Rating performance by population segment	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #2:** Ensure stakeholder alignment and acceptance through: • Conducting regular stakeholder feedback sessions • Holding iterative design reviews with key department representatives • Documentation of stakeholder requirements and securing sign-off	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #3:** Validate functionality through: • User acceptance testing (UAT) with identified end-users • Data accuracy verification	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.b.	Member Experience Improvement	New	**Goal #2**: By June 30, 2026, the CAHPS® Team will collaborate with Press Ganey to develop both the Adult and Child CAHPS® non-regulated survey questions and standardized reporting templates. This effort will support clearer insights, establish a more consistent reporting framework, and reduce administrative burden, while informing improvement efforts.	**Deliverable #1:** By June 30, 2026, identify non-regulated survey questions that align with CAHPS H 5.1 core question framework; develop corresponding gateway questions to guide respondents appropriately, apply skip logic to improve streamline survey flow, and ensure the ability to drill down to actionable root causes.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #2:** By June 30, 2026, define the reporting logic, presentation guidelines, and analysis processes for final reporting, provided by Press Ganey's analytics team.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.b.				**Deliverable #3:** By June 30, 2026, develop and validate two distinct report templates: • A leadership-focused template designed to support strategic decision making by highlighting trends and key drivers for decision-makers • A consumer-friendly template designed for clear easy-to-understand comprehension.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.b.		New	**Goal #3**: By June 30, 2026, the CAHPS® Team will utilize the Association for Community Affiliated Plans (ACAP) CAHPS Best Practices Playbook to identify and prioritize actionable opportunities to improve member experience, focusing on alignment with proven strategies implemented by peer plans.	**Deliverable #1**: By June 30, 2026, complete a gap analysis comparing Partnership's CAHPS-related operations with the strategies outlined in the ACAP CAHPS® Best Practices Playbook to identify key areas for improvement.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #2**: By June 30, 2026, create an action plan to implement at least two high-priority improvement initiatives informed by the gap analysis findings that target favorable outcomes for both the Adult and Child populations.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.c.	Member Services Access	Continued	**Goal #1:** By June 30, 2026, ensure compliance of internal and delegated access standards as it relates to inbound call handling.	**Deliverable #1:** Monitor, Analyze and Recommend Corrective Action Plan(s) (CAP) when appropriate which includes: • Review internal call center performance stats monthly (performance benchmarks tracked quarterly) on several service level agreements (SLAs) • Plan to continue to track quarterly delegate call center performance (submitted quarterly by each respective delegate) against established performance thresholds (based on SLAs above) during Delegate Oversight quarterly meetings	7/1/2025	6/30/2026	Title: Senior Director of Member Services and Grievances Name: Edna Villasenor	Title: Associate Director of Member Services Name: Cyress Mendiola Title: Manager of Quality and Training Services Name: Kristen Clark	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.d.	Primary Care Provider Quality Incentive Program		**Goal #1:** By June 30, 2026, PCP QIP will continue to revise and ensure that the Data Validation Framework documents comprehensively support a robust and effective verification of payment accuracy. This involves confirming that data sources	**Deliverable #1:** Evaluate Data Validation Framework documents and examine the QIP specific validation procedures outlined in the documents to ensure they are robust and effective in verifying payment accuracy based on prior measurement years "lessons learned". Any enhancements to the process will be incorporated into the document as they are identified.	7/1/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.d.	Quality Incentive Program (PCP QIP) Payment Processing Report	New	payment accuracy. This involves confirming that data sources are clearly defined, with proper lineage and ownership established, and that validation procedures include thorough checks for data completeness, accuracy, consistency, and timeliness.	**Deliverable #2:** Upon review of prior year validation, incorporate stakeholder process improvement changes into QIP Data Validation framework and document any suggested enhancements made by the Executive team during the Executive walk-through.	7/1/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.e.	Web Based Member Information Assessment	Continued	**Goal #1:** By June 30, 2026, complete annual evaluation of the quality and accuracy of information provided to members via e-mail and telephone as stated in NCQA Standard ME 6 Element C: Quality and Accuracy of Information.	**Deliverable #1:** Complete annual evaluation of the quality and accuracy of information provided to members via e-mail and telephone as stated in ME 6 C: Quality and Accuracy of Information.	7/1/2025	6/30/2026	Title: Senior Director of Member Services and Grievances Name: Edna Villasenor Title: Associate Director of Member Services Name: Cyress Mendiola	Title: Manager of Quality and Training Services Name: Kristen Clark	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.f.	Primary Care Provider Quality Incentive Program (PCP QIP) eReports System	Continued *(Monitoring of previous issue)*	**Goal #1:** By June 30, 2026, PCP QIP will continue collaborating with the Partnership Web Team to align 2026 eReports with HRP® (Health Rules Payor) data elements in preparation for the launch of HRP®.	**Deliverable #1:** Review 2026 eReports scoping and development with Web Team to identify areas within eReports that need integration with HRP®. Finalize via annual Business Requirement Documents (BRD) approved by QI and IT management.	7/1/2025	11/1/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Teresa Lugo	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.f.				**Deliverable #2:** Complete User Acceptance testing (UAT), inclusive of HRP® integration testing, per approved 2026 eReports BRD, for on-time release to provider network.	11/1/2025	3/1/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Teresa Lugo	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.f.				**Deliverable #3:** Conduct weekly eReports check-in meetings with the Partnership Web Team to discuss project timeline, BRD revisions, application logic, UAT testing timelines, progress and bugs.	10/1/2025	3/15/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Teresa Lugo	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #1:** Complete an annual HEDIS® Monthly data user needs assessment for MY2026 Monthy Exploatory dashboard in PQD. In collaboration with the HEDIS® team and QMSI workgroup's leads and through use of the updated Master Measure List to confirm applicable measures.	7/1/2025	3/30/2026	Title: Director of Quality Management Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.g.	Partnership Quality Dashboard (PQD)	Continued *(Monitoring of previous issue)*	**Goal #1:** By June 30, 2026, apply annual development updates of the MY2026 HEDIS® Monthly Exploratory Dashboard in accordance with identified stakeholder needs (Contingent on HRP® implementation).	**Deliverable #2:** Complete updated HEDIS® Monthly Exploratory business requirements documentation for MY2026 Monthy Exploatory dashboard in PQD in collaboration with the HEDIS® team.	7/1/2025	3/30/2026	Title: Director of Quality Management Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #3:** Send data exports for the MY2026 HEDIS® Monthly Project to the EDW & Health Analytics teams to create the PQD Monthly Dashboard.	4/1/2026	6/30/2026	Title: Director of Quality Management Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #4:** Timely publication of the MY2026 HEDIS® Monthly Exploratory dashboard, based on efforts by HEDIS, EDW, and Health Analytics team members. (Contingent on HRP® production implementation).	4/1/2026	6/30/2026	Title: Director of Quality Management Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.g.		Continued	**Goal #2:** By June 30, 2026, apply annual development updates of the PCP QIP Provider and Internal View Dashboards in accordance with identified stakeholder needs.	**Deliverable #1:** Work with representatives of the provider network to review all enhancement requests to be included in the Business Requirements Document (BRD) to be reviewed and approved by the Enterprise Data Warehouse (EDW) team for the new measurement year (MY).	7/1/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune Title: Project Manager I Name: Anwar Hugais	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #2:** Work with stakeholders to submit updated annual dashboard business requirements document (BRD) to developers for review and approval.	7/1/2025	1/31/2026	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune Title: Project Manager I Name: Anwar Hugais	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #3:** Gain agreements between developers and business owners for identified new business requirements.	1/31/2026	3/31/2026	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune Title: Project Manager I Name: Anwar Hugais	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.g.				**Deliverable #4:** Completion of user acceptance testing (UAT) of dashboards.	5/31/2026	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune Title: Project Manager I Name: Anwar Hugais	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #5:** Timely publication of the dashboards in PQD for internal and external use.	5/1/2026	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune Title: Project Manager I Name: Anwar Hugais	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.h.	Enterprise Information Management	Continue	**Goal #1:** By June 30, 2026, integrate the HRP® version of the HEDIS® project data into the Enterprise Data Warehouse and use this data to create the HRP® version of the HEDIS® PQD modules.	**Deliverable #1:** Integrate HEDIS® Health Rules Payor data in to Enterprise Data Warehouse environment and make necessary programming changes to populate Provider Quality Dashboard-HEDIS® tables.	9/1/2025	10/15/2025	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.h.				**Deliverable #2:** Develop the HEDIS® PQD dashboards using the HRP® data and complete User Acceptance Testing (UAT).	10/16/2025	11/30/2025	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.h.		New	**Goal #2:** By June 30, 2026, Plan, Develop, Test, and have the files ready for Wakely to integrate the test data to their envornment to help build STAR measures dashboard for Medicare Line of Business (LOB).	**Deliverable #1:** Complete assessment of all the datasets (both HEDIS & non HEDIS measures data) that need to be delivered to Wakely. Create metadata document and other necessary documentation to finalize the requirements	8/1/2025	10/15/2025	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.h.				**Deliverable #2:** Develop, Build and test the files for Wakely to integrate all necessary datasets to help build STAR measures dashboard.	10/16/2025	3/31/2026	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.h.		New	**Goal #3:** By June 30, 2026, develop, test, and have the 2025 HEDIS® monthly project live in production with the data available to users via the HEDIS® PQD modules.	**Deliverable #1:** Complete development and testing to deliver 2025 HEDIS® monthly files to the QI Team. This might require building medi-cal, medi-medi and medicare population and catalogs on the Inovalon side.	7/1/2025	7/15/2025	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.h.				**Deliverable #2:** Integrate 2025 HEDIS® data from monthly project into the Enterprise Data Warehouse.	7/16/2025	8/1/2025	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.h.				**Deliverable #3:** Develop and test PQD HEDIS® dashboards using the 2025 HEDIS® monthly project data.	8/2/2025	8/15/2025	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.h.		New	**Goal #4**: By June 30, 2026, Plan, Develop, Test, and have the test files ready for PCP QIP project to support Medicare LOB. Integrate the necessary datasets to Cozeva platform to support QIP measures.	**Deliverable #1**: Complete assessment of all the datasets that need to be delivered to Cozeva platform to support Medicare LOB. Create metadata document and other necessary documentation to finalize the requirements.	10/1/2025	1/31/2026	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.h.				**Deliverable #2**: Develop and Build the test files for PCP QIP program and integrate all necessary datasets to Cozeva platform.	2/1/2026	6/30/2026	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.i.	Dual Eligible Special Needs Plan (D-SNP)	New	**Goal #1**: By June 30, 2026, develop the Quality Improvement framework to support the proposed Dual Eligible Special Needs Plan (D-SNP) program and monitoring of associated quality metrics.	**Deliverable #1:** By June 30, 2026, develop a training approach for D-SNP education specific to QI department staff for the ability to address anticipated low performing measures and initiate improvment activities ahead of D-SNP program launch in CY2027.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.i.				**Deliverable #2:** By February 15, 2026, complete the 2027 Model of Care document for submission to NCQA and DHCS.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.i.				**Deliverable #3:** By June 30, 2026, with collaboration from vendors Cirdan Wakely, Inovalon and Partnership internal stakeholders, develop the framework for data integration and analysis within the Stars analytics tool using baseline prospective Medicare member data.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.j.	HEDIS Reporting to Support D-SNP Data Collection and Analysis	Continue	**Goal #1:** By August 29, 2025 provide first set of data for D-SNP Monthly MY2025 data to the QI D-SNP Team and, send data monthly thereafter after each data refresh.	**Deliverable #1:** By August 29, 2025, send first set of Monthly MY2025 data exports to the EDW & HA team's to create the PQD Monthly Dashboard, send the Monthly data to the QI D-SNP team.	7/1/2025	8/29/2025	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.j.				**Deliverable #2:** By June 30, 2026, perform a comparative analysis of preliminary and final HEDIS MY 2025 data for the D-SNP baseline population against comparable Wakely HEDIS MY 2025 Medicare baseline data.	7/1/2025	6/30/2026	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.k.	Conduct Year Round Medical Record Review	New	**Goal #1**: By November 28, 2025 begin year-round medical record review to focus on priority measures identified.	**Deliverable #1**: Build Medical Record Project in the Prospective Monthly MY2025 Project. Utilize Inovalon's Electronic Record on Demand, and the supplemental data catalogs to support priority Admin measures.	7/1/2025	9/30/2025	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.k.				**Deliverable #2**: Develop outline and intent of the W30 Kaizen, Schedule Kaizen session to include all applicable attendees. Present outcome of Kaizen to QI Leadership and applicable stakeholder within the organization.	7/15/2025	11/29/2025	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3. Value Based Payment Programs - QIP											
3.a.	Primary Care Provider Quality Incentive Program (PCP QIP)	New	**Goal #1:** By June 30, 2026, the PCP QIP Program will be leveraged to support existing and newly added low performing providers in the Modified QIP measure set. This support will include provider education and encouragement to increase on-line data platform usage and monitoring which results in improved engagement and performance improvement activities.	**Deliverable #1:** For both new and exisiting Modified QIP providers, the QIP team will partner with the assigned Improvement Advisor to determine overall QIP skill-set level amongst modified QIP staff. This assessment will inform the QIP team how to move forward and what level of engagement/training is needed. This may include the QIP teams involvement in monthly or quarterly practice facilitation meetings.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.a.				**Deliverable #2:** Create a survey specifically for Modified QIP provider which includes questions to check-in, assess needs and important reminders. Survey will be distributed on quarterly basis. Results will be reviewed and, if necessary, followed up with a 1:1 email.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.a.				**Deliverable #3:** Assess survey results annually to determine effectivness and ongoing distribution.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.b.		New	**Goal #1:** By June 30, 2026, develop the 2026-2027 measurement year Hospital Quality Incentive Program (H-QIP) Measurement Set to support Hospital Performance Improvement.	**Deliverable #1:** Complete development of measures for 2026-27 H-QIP.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.b.		New	**Goal #2:** Develop Partnership's Hospital Quality Symposium	**Deliverable #1:** Select dates, venues, theme, topics, and tentative speakers for the event	7/1/2025	4/1/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.b.	Hospital Quality Incentive Program (H-QIP)	New	for the 2026-2027 H-QIP measurement year	**Deliverable #2:** Finalize agenda, complete speaker engagement, promote event with hospitals	1/1/2026	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.b.		New	**Goal #3:** By January 31, 2026, complete evaluation of the 2024-2025 HQIP and deliver summary to the Partnership Quality Committee meetings (IQI, QUAC, PAC).	**Deliverable #1:** Evaluate 2024-2025 hospital program performance by measure in comparison to prior measurement year.	7/1/2025	1/31/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.b.				**Deliverable #2:** Provide Evaluation summary to the Partnership Quality Committee meetings (IQI, QUAC, PAC).	7/1/2025	1/31/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.c.	Palliative Care Quality Incentive Program (PC QIP)	New	**Goal #1:** By December 31, 2025, develop a measurement set for the calendar year (CY) 2026 Palliative Care Quality Incentive Program (PC QIP), that supports quality improvement. On February 14, 2025, Palliative Care Quality Collaborative (PCQC), notified the Palliative Care QIP team that they were dissolving due to lack of funding to maintin operations and they were officially closing their doors on April 17, 2025. PCQC supplied the supplemental data required to calculate payment for measure III, Completion of Assessments and the Use of the PCQC tool. Due to PCQC no longer being able to provide the Palliative Care QIP team with this supplemental data, the creation of a new measure, Palliative Care Survey, is in development.	**Deliverable #1:** Complete measure development for CY 2026 PC QIP. This includes the creation of a new pallaitive measure, Palliative Care Survey, to replace measure III, Completion of PCQC Assessments and the Use of the PCQC tool.	7/1/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.c.		New	**Goal #2:** By June 30, 2026, complete CY 2025 PC QIP evaluation.	**Deliverable #1:** Complete evaluation of the program's CY 2025 measurement year to monitor performance.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.c.		New	**Goal #3**: By June 30, 2026, the PC QIP will work to revise the Data Validation Framework document to include the payment process for the new measure, Palliative Care Survey, that will be replacing measure III, Completion of Assessments and Use of the PCQC Tool, along with making any necessary revisions to the payment processes for measure I, Avoiding Hospital and Emergency Room admissions, and measure II, Completion of a POLST, to ensure these processes reflect the enhanced validation that is conducted for payment processing accuracy and timeliness.	**Deliverable #1**: Review the Data Validation Framework document to map out the paymenet process for the new palliative measure, Palliative Care Survey, and the current payment processes for measures I and II to identify any revisions needed to be made to ensure the payment processes are robust and accurate.	7/1/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.c.				**Deliverable #2**: Implement the enhanced Data Validation Framework document processes during payment processing for the Palliative Care QIP measure periods 1 (Jan-June 2025), which will begin in September 2025, and measure period II (Jul-Dec 2025), which will begin in April 2026. The Palliative Care QIP team will monitor this process to identify any additional areas for improvements.	9/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.d.	Perinatal Quality Incentive Program (PQIP)	New	**Goal #1:** By June 30, 2026, continue to develop Perinatal QIP Measurement set to support HEDIS® Score Improvement through May 30, 2026, and leverage support from Partnership's Population Health team and the Growing Together Program to improve scores for the Timely Prenatal Care measures.	**Deliverable #1:** Develop Perinatal QIP Measurement set to support HEDIS® Score Improvement through May 30, 2026 and leverage support from Partnership's Population Health team and the Growing Together Program to improve scores for the Timely Prenatal Care measure.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.d.		New	**Goal #2:** By June 30, 2026, continue to support provider on-boarding and ECDS implementation to satisfy programmatic gateway measure (ECDS).	**Deliverable #1:** For existing PQIP providers: Continue ECDS education and on-boarding for gateway measure compliance.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.d.				**Deliverable #2:** Support contracting with DataLink by providing education and one-on-one meetings with provider staff.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.d.		New	**Goal #3:** By June 30, 2026, complete PQIP program evaluation for FY 24-25.	**Deliverable #1:** Complete FY 24-25 PQIP program evaluation and deliver to internal commities; IQI, PAC, & QU/AC.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.e.	Enhanced Care Management Quality Incentive Program (ECM QIP)	Continued	**Goal #1:** By December 31, 2025, develop a measurement set for the calendar year (CY) 2026 Enhanced Care Management Quality Incentive Program (ECM QIP) that supports quality improvement and aligns with DHCS's requirements.	**Deliverable #1:** Complete measure development for CY 2026 ECM QIP measurement year.	7/1/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.e.		Continued	**Goal #2:** By December 31, 2025, complete CY 2024 ECM QIP evaluation.	**Deliverable #1:** Complete evaluation of the program's CY 2024 measurement year to monitor performance	7/1/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.e.		Continued	**Goal #3:** By June 30, 2026, improve provider engagement by offering one-on-one assistance through meetings and trainings, and annual Advisory Group.	**Deliverable #1:** Outreach to new ECM providers and offer one-on-one meetings to include an overview of the ECM QIP, review the detailed specifications and answer questions	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.e.				**Deliverable #2:** Outreach to low-performing ECM providers immediately after payment processing and offer one-on-one meetings to review the areas needing improvement, re-review relevant areas in the specifications, and share best practices for success.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.e.				**Deliverable #3:** Facilitate Advisory Group meeting for providers to review proposed CY 2026 measurement set and offer their feedback and suggestions for improvement.	7/1/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.f.		New	**Goal #1:** By October 31, 2025, complete the Advance Care Planning and Annual Wellness Visit (AWV) measure development for inlcusion in the 2027 D-SNP QIP measurement year.	**Deliverable #1:** Evaluate the current framework for Advance Care Planning (ACP) and Annual Wellness Visit (AWV) for inclusion in the D-SNP QIP.	7/1/2025	9/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.f.				**Deliverable #2:** Present proposed ACP and AWV measures to Executive Leadership for approval.	7/1/2025	10/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.f.		New	**Goal #2:** By October 31, 2025, obtain a signed contract agreement with Partnership Healthplan and our selected D	**Deliverable #1:** I.T purchasing will submit vendor information, SOW/MSA, estimated purchasing price, contract term to Non-Contracting Provider team.	7/1/2025	7/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.f.				**Deliverable #2:** Review SOW/MSA with QI Leadership and I.T. stakeholders.	7/1/2025	8/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.f.	Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development	New	agreement with Partnership Healthplan and our selected D-SNP system vendor, Cozeva.	**Deliverable #3**: Pricing and negotiation will be conducted by Finance, I.T, and Executive Leadership team. Cozeva will provide a detailed price breakdown for additional system enhancement which may include Advance Care Planning (ACP) and Annual Wellness Visit (AWV).	7/2/2025	09/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.f.				**Deliverable #4**: Finalize contract agreement will be signed by Partnership Healthplan (PHC) and Cozeva on or before October 31, 2025.	7/3/2025	10/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.f.		New	**Goal #3**: By June 30, 2026, develop a detailed implementation plan and timeline (Project kick-off, Pre-Implementation phase, Implementation phase) with internal PHC teams and Cozeva.	**Deliverable #1:** Project scoping will begin after a executed contract has been signed. Scoping meetings with D-SNP IT stakeholders, QIP and Cozeva to begin November 1, 2025 through December 31, 2025.	11/1/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.f.				**Deliverable #2:** Pre-implementation phase: includes, but not limited to, setup SFTP/ECG gile transfer, Data kick-off & requirement, finalization of key business decisions and hierarchy design, provide finalized measure set, QIP incentive data logic, and submission & validation of all transactional files.	1/1/2026	3/31/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.f.				**Deliverable #3**: Implementation phase: includes, but not limited to, incremental file delivery, weekly inboud & outbound feed days, QA testing, user access, scheduled training, deployment of incentive, regression testing, and UAT in CERT/PROD.	4/1/2026	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.f.		New	**Goal #4**: By June 30, 2026, the D-SNP Quality Incentive Program (QIP) will prepare Cozeva systems for the anticipated 2027 go-live.	**Deliverable #1**: Cozeva will complete each requirement for go-live: 1) Generate outbound extract post historic load 2) Registries enable Cozeva UI 3) Analytics enable in Cozeva UI 4) Enterprise and Practice level Resource Page configured	1/1/2026	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.f.				**Deliverable #2**: Deployment of Quality Incentive Program to production, along with payment extract generation. Cozeva will perform measure set validation and score comparison against legacy system data, user training, utilizer interface walk-through, features & measures visibility and go-live sign-off.	1/1/2026	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.f.				**Deliverable #3**: Post Go-Live phase. To include: incremental file self-validation by PHC Data warehouse team, configure time capsule, validate and load 2nd and 3rd incremental files, and automate load of subsequent weekly feeds.	1/1/2026	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.f.				**Deliverable #4**: Begin Provider Rollout/Onboarding in conjunction with EHR integration. EHR framework will consist of confirmation of configuration capabilities, embedded App, chart retrieval, diagnosis Writeback, and browser extension overlay.	5/1/2026	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4. Improvement Projects and Programs, Clinical Quality											
4.a.	Quality Measure Score Improvement (QMSI)	Continued	**Goal #1:** By June 30, 2026, the Quality Measure Score Improvement (QMSI) group will complete all defined deliverables for each measure-specific workgroup. The goal the Quality Measure Score Improvement group is to improve Partnership's Quality performance over measurement years 2024 and 2025 under all required accountable and reportable quality measure sets under the DHCS Managed Care Accountability Measure Set as well as additional HEDIS measures required of accredited NCQA Medicaid health plans. There are 4 measure-specific workgroups: 1. Pediatrics 2. Behavioral Health 3. Chronic Diseases 4. Women's Health	**Deliverable #1:** Define 5 (five) specific deliverables for each measure-specific workgroup by December 1, 2025.	7/1/2025	12/1/2025	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Name: Nancy Steffen	Title: Manager of Performance Improvement (NR) Name: James Devan Title: Improvement Advisor Name: Amanda Kim	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.a.				**Deliverable #2:** Successfully complete all required deliverables for each measure-specific workgroup by June 30, 2025.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Name: Nancy Steffen	Title: Manager of Performance Improvement (NR) Name: James Devan Title: Improvement Advisor Name: Amanda Kim	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.b.	Healthy Kids Growing Together Program	New	**Goal #1:** By June 30, 2026, 50% of the members who agreed to participate in the Healthy Kids Growing Together Program must attend their annual well-child visit prior to their 4th, 5th and 6th birthdays. This program includes any 3 - 6 year old who has never had a well-child visit in the last eleven (11) months and offers an incentive to members who have birthdays within the upcoming 120 days and complete a well-child visit within 90 days of the outreach. This will be completed by sending reminder mailers to the entire eligible population and conducting two outbound phone calls to members with birthdays within the upcoming 120 days.	**Deliverable #1:** Review claims data to verify attendance for a well-child visit. If the claim does not reflect a well-child visit, follow up with the Primary Care Provider (PCP) to confirm whether the visit occurred and obtain any necessary documentation.	7/1/2025	6/30/2026	Title: Associate Director of Population Health Name: Monika Brunkal	Title: Manager of Population Health Name: Nicole Curreri	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.b.				**Deliverable #2:** Include results of this intervention in the 2026 Impact Analysis report.	5/1/2026	6/30/2026	Title: Associate Director of Population Health Name: Monika Brunkal	Title: Manager of Population Health Name: Nicole Curreri	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #1:** Complete at least 3 event days in the Auburn Region.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #2**: Complete at least 9 event days in the Chico Region.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
4.c.	Mobile Mammography Program	New	**Goal #1**: By June 30, 2026 the Mobile Mammography/Your Partner in Prevention team will schedule at least 60 mobile event days, including Women's Wellness Days, across the provider network, resulting in a minimum of 1,500 completed breast cancer screenings in support of reaching the 75th percentile benchmark	**Deliverable #3**: Complete at least 20 event days in the Eureka Region.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #4**: Complete at least 5 event days in the Fairfield Region.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #5**: Complete at least 15 event days in the Redding Region.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #6**: Complete at least 8 event days in the Santa Rosa Region.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.c.		New	**Goal #2**: By June 30, 2026, complete at least 3 wellness days as part of the new Your Partner in Prevention Program (YPIP).	**Deliverable #1:** Complete at least 2 Women's Wellness Days.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #2**: Complete at least 1 Kids or Teen and Young Adult Wellness Days.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #3**: Develop workflows for successful event day planning.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #4**: Conduct an evaluation to include lessons learned and areas for improvement.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.d.				**Deliverable #1**: HEDIS team will provide Health Plan ratings scoresheet, which identifying measures performing at a score of 1 or 0.	7/1/2025	7/11/2025	Title: Director of Quality Management Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Manager of Performance Improvement (NR) Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
4.d.	QI3 - Performance Improving Planning for low Scoring HPA measures	New	**Goal #1**: By June 30, 2026, the PI and HEDIS teams will meet the factor QI- 3 Factors B and C requirements for Health Plan Accreditation Renewal, including identifying low scoring measures, selecting measures of focus for improvement, and developing an improvement plan for remediation.	**Deliverable #2:** The PI team will select a measure or measures of focus for improvement : " at least one required measure for which the organization received a rating of "1" or "0."	7/1/2025	8/1/2025	Title: Director of Quality Management Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Manager of Performance Improvement (NR) Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.d.				**Deliverable #3:** The PI team will develop an improvement plan related to the measure or mesaures of focus selected in deliverable two and documents "all actions the organization plans to take, or has already taken, to improve each measure's rating."	8/1/2025	8/30/2025	Title: Director of Quality Management Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Manager of Performance Improvement (NR) Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.d.				**Deliverable #4:** The PI team will Monitor progress through monthly check-ins and utilize PDSA cycles as needed	8/30/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Manager of Performance Improvement (NR) Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5. Service and Patient Experience											
5.a.	Member Experience Data	Continued	**Goal #1:** By June 30, 2026, launch the annual CAHPS® survey for Measure Year (MY) 2025 Reporting Year (RY) 2026 and collect data results.	**Deliverable #1:** By December 30, 2025, present Measure Year (MY) 2024 / Report Year (RY) 2025 CAHPS® and Member Experience results to internal and external committees.	7/1/2025	12/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5.a.				**Deliverable #2**: By June 30, 2026, confirm HEDIS® team Measure Year (MY) 2025 sample frame submission to Press Ganey, launch survey, and collect results as part of the NCQA member experience process.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5.b.				**Deliverable #1:** Submit evidence for the Mock Renewal Survey scheduled in October 2025.	8/1/2025	8/22/2025	Title: Director of Care Management Name: Kelly Stone	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
5.b.	Complex Case Management	Continued	**Goal #1:** By June 30, 2026, We will ensure that Partnership remains compliant with the National Committee for Quality Assurance (NCQA) Population Health Management Standard PHM5, Standards A-E, in preparation for our NCQA Renewal Survey in November 2026 and beyond. This will be demonstrated through the results of our upcoming NCQA renewal audit, as well as through ongoing quarterly internal compliance audits of Complex Case Management to maintain overall file compliance.	**Deliverable #2:** Update the annual HPA Workbook. • Work Plan and Evidence Submission Library	10/1/2025	10/24/2025	Title: Director of Care Management Name: Kelly Stone	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5.b.				**Deliverable #3:** Obtain a "yes" score on all assigned elements during the HPA Mock Renewal Survey. • Business Owners to submit an Action Plan to address recommendations. Note: Evidence to be corrected by the applicable look-back period, timelines, and/or expectations by NCQA. Any revised evidence will be reviewed by MHR for approval.	11/17/2025	12/5/2025	Title: Director of Care Management Name: Kelly Stone	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5.b.				**Deliverable #4:** Submit annotated evidence for the HPA Renewal Survey. • The NCQA Program Management Team to host evidence collection training and provide submission instructions in March 2026.	5/1/2026	5/29/2026	Title: Director of Care Management Name: Kelly Stone	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5.b.				**Deliverable #5:** Obtain a "yes" score on all assigned elements during the HPA Mock Renewal Survey. • Any modifications to approved evidence that affect NCQA requirements must be shared with the NCQA Program Management Team.	6/1/2026	6/30/2026	Title: Director of Care Management Name: Kelly Stone	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5.b.				**Deliverable #6:** Departments that oversee file review requirements will maintain strict oversight of Partnership and non-NCQA Accredited delegates' files to ensure compliance.	6/1/2026	6/30/2026	Title: Director of Care Management Name: Kelly Stone	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
	6. Quality Assurance and Patient Safety										
6.a.		New	**Goal #1:** By June 30, 2026, QI Member Safety Quality Investigation team will provide in-services to at least two other Partnership Departments/teams to educate on Potential Quality Issues (PQI) and how to refer. In addition, the team will monitor referral track and trending reports to determine if inservice training results in an increase in PQI referrals from respective departments/teams.	**Deliverable #1:** Review and update the PQI power point presentation to ensure the information is relevant for the staff/department receiving the information.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #2:** Offer and provide the PQI presentation to at least the Utilization Management department teams, Enhanced Health Services nurses, and Grievance & Appeals nurses.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #3:** Send a feedback questionnaire/survey to attendees for feedback on areas to consider for improvement.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #4:** Monitor referral track and trending reports to determine if inservice training results in an increase in PQI referrals from respective departments.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
6.a.	Potential Quality Issues (PQI) (safety)			**Deliverable #5**: Edit and revise the PQI Referral Form Reference table to assist staff with determining if a concern or issue may be a PQI.	7/1/2025	12/31/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.		New	**Goal #2**: By June 30, 2026, the enhancement of Potential Quality Issue documentation system- SUGARCRM PQI app will be completed. Rationale: To enhance security by patching vulnerabilities, improve performance, maintain stability and efficiency, ultimately benefiting users and organizations. In addition, updates can optimize how systems utilize resources, like memory and processing power, leading to more efficient operations. By these enhancements, our DHCS and NCQA report should be improved.	**Deliverable #1:** With significant on-going requests and direction from the Member Safety Investigation team, IT will upgrade and enhance the SugarCRM PQI application from version 8 to version 14.	7/1/2025	8/31/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #2:** Member Safety Investigation team will continue to test, monitor, and provide feedback to IT for any problems and areas for additional improvement or enhancements.	7/1/2025	12/31/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.		New	**Goal #3**: By June 30, 2026, the Member Safety Investigations Team will have an effective Corrective Action Plan (CAP) monitoring tool.	**Deliverable #1:** Review and edit the current CAP desktop policy including the CAP template for providers/facilities and the CAP Monitoring Tool to align with current and more directive CAP procedures.	7/1/2025	10/1/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #2:** Review the updated CAP Monitoring Tool monthly, and as needed, to ensure all actions determined in Peer Review Committee are implemented, followed up, or completed.	7/1/2025	12/31/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #3**: To monitor if a CAP was effective in preventing a reoccurrence, the PQI Track and Trending reports will be monitored to determine if a subsequent PQI referral is received against any providers/facilities receiveing a CAP.	7/1/2025	3/31/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #4**: On-going periodic re-evaluation of the CAP desktop policy, including the CAP template for providers/facilities and the CAP Monitoring Tool, to determine effectiveness. Edit and revise as needed.	3/31/2026	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.b.	Fluoride Varnish	New	**Goal #1:** By June 30, 2026, the Site Review Inspections team will create a detailed directory of dental providers in our service area, categorizing them by type of organization (e.g., FQHC, RHC, Tribal health, dental group, private practice). We will begin with a small scope, and work on developing relationships.	**Deliverable #1:** Create a detailed directory of dental providers in our service area, categorizing them by type of organization (e.g., FQHC, RHC, Tribal health, dental group, private practice).	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.b.				**Deliverable #2:** Develop a desktop for maintaining and updating providers.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
6.c.	Initial Health Appointment	New	**Goal #1:** By June 30, 2026 the Site Review Inspections team will initiate a new process to monitor sites on two contact attempts to get members into the clinic within 120 days.	**Deliverable #1:** Create a method to document compliance for Initial Health Appointement attempts to get members into the clinic within 120 days.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.c.				**Deliverable #2:** Create a desktop on the new process for IHA monitoring attempts of providers.	7/2/2025	12/31/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.d.	Latent TB Infection Treatment (safety)	Continued	**Goal #1:** By June 30, 2026, a clinical pharmacist will conduct concurrent review of Latent Tuberculosis Infection (LTBI) medication treatments and provide timely notification of all identified potential LTBI treatment regimen gaps, which result from late refill, non-adherence, inappropriate prescribing, and/or inappropriate dispensing. The regimens to be monitored will include 30-doses of isoniazid/rifapentine (1HP), 12-doses of isoniazid/rifapentine (3HP), 90-doses of isoniazid/rifampin (3HR), and 120-doses of rifampin (4R).	**Deliverable #1:** Pharmacist will identify potential treatment gaps and provide notification to prescribers within two timeframes: day 16 and day 20. • Pharmacist will identify and notify providers (via fax) whose members are ≥14 days late in refilling their prescribed LTBI medication. • ≥ 80% of identified potential non-adherence cases will receive provider notification (via fax) no later than day 16 of their member not having their LTBI medication based on the last refill date. • ≤ 20% of the identified potential non-adherence cases will receive provider notification (via fax) no later than day 20 of their member not having their LTBI medication based on the last refill date. Pharmacist will verify gap and confirm member's prescribed LTBI regimen was not completed in the accepted timeframe. • Pharmacist will provide notification to prescribers (via fax) of their member's potential non-adherence to their prescribed LTBI regimen.	7/1/2025	6/30/2026	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.d.				**Deliverable #2:** Pharmacist will monitor for inappropriate prescribing / dispensing of 84-dose isoniazid/rifampin (3HR), 100-dose rifampin (4R regimen) and 112-dose (4R regimen) • Pharmacist will identify and provide information for correct prescribing of 3HR and 4R regimen. • Pharmacist will notify prescriber (via fax) that 84-dose isoniazid/rifampin, 100-dose rifampin, or 112-dose rifampin is insufficient and is not considered completion of 3HR or 4R regimen.	7/1/2025	6/30/2026	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.d.		New	**Goal #2:** By June 30, 2026, a clinical pharmacist will provide Latent Tuberculosis Infection (LTBI) summary updates to Partnership's Medical Directors and to the County Public Health Officers.	**Deliverable #1:** Pharmacist will provide semi-annual LTBI summary updates to Partnership's Medical Directors for tracked LTBI regimens (identified late fills, identified possible non-adherence to regimen, actions taken, and results of provider outreach).	7/1/2025	6/30/2026	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.d.				**Deliverable #2:** Pharmacist will provide quarterly update of Parftnership members who are prescribed a LTBI regimen and the current status of that LTBI regimen to the County Public Health Officers.	7/1/2025	6/30/2026	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
	7. Quality Improvement Training and Coaching										

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.a.	QI Technical Assistance with Health Center Consortia	Continued	**Goal #1:** By June 30, 2026, collaborate with local consortia to bring Quality Improvement (QI) awareness and education to providers.	**Deliverable #1:** Northern: • Develop and post storyboards and infographics to demonstrate successful QI improvement projects over time • Host recurring forums for QI engagement • Develop measure best practices to share with Northern Region consortia members • Complete comprehensive organizational profiles (i.e. inclusive of QI, PCMH, Workforce, and Finance updates) for each Federally Qualified Health Center (FQHC) member to support Partnership's assessment of current performance and identification of key areas for partnering in improvement. • Develop at least two project storyboards outlining regional Quality Improvement (QI) projects and post on consortia websites. • Present Partnership updates and timely provider education at least 4 times via monthly QI and Chief Medical Officer (CMO) Peer Network Calls and in-person Rural Round Table events. • Develop materials that highlight best practices for focus HEDIS®/Quality Incentive Program measures and proactively share with Northern Region consortia members via consortia hosted webinars, its eNews, or its Peer Network.	7/1/2025	5/30/2026	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Manager of Performance Improvement (NR) Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #2:** Southern: • Identify, document, and publish at least 2 promising practices by consortia members that can be shared throughout the region and beyond to improve underperforming regional and/or plan-wide HEDIS measures. • Participate in consortia-led QI Peer Network meetings (attend at least 4 meetings per year) • Co-facilitate with consortia the Solano QIP Improvement (SQIP-I) meetings •Engage the consortia in supporting underperforming member health centers	7/1/2025	5/30/2026	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Manager of Performance Improvement (NR) Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #3:** Eastern: • Identify consortia coverage in Auburn and Chico region. • Identify opportunities for collaboration between consortia and Partnership Healthplan's regional leadership and quality improvement.	8/30/2025	12/30/2025	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Manager of Performance Improvement (NR) Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.b.				**Deliverable #1:** By June 30, 2026, offer at least four (4) virtual training sessions on priority MCAS measures between January 2026 and June 2026 across the provider network.	7/1/2025	6/30/2026	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.b.	Performance Improvement Training Offerings	Continued	**Goal #1:** By June 30, 2026, the Improvement Academy will offer multiple forms of Quality Improvement education to the Partnership provider network.	**Deliverable #2:** By June 30, 2026, offer at least two (2) in-person ABCs of Quality Improvement training series across the provider network. Targeted Regions: Fairfield - January 2026; Redding - March 2026; Auburn - May 2026	7/1/2025	6/30/2026	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.b.				**Deliverable #3:** By June 30, 2026, offer at least two (2) Microlearnings focused on improving outcomes around priority measures for the provider network.	7/1/2025	6/30/2026	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.b.		Continued	**Goal #2:** By December 30, 2025, the Improvement Academy will develop strategies to evaluate Microlearnings.	**Deliverable #1:** By December 30, 2025, develop evaluation for ePrompts and Preventive Care Reports utilizing surveys and coaching engagement feedback.	7/1/2025	12/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.b.				**Deliverable #2:** By December 30, 2025, explore website capabilities for tracking attendance.	7/1/2025	12/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.b.		New	**Goal #3**: By June 30, 2026, Improvement Academy will improve training attendance by 20% for in-person trainings and 15% for Improving Measure Outcomes virtual trainings.	**Deliverable #1**: By June 30, 2026, develop marketing strategies to include evaluation and outreach to sites to include criteria: •Sites with zero (0) attendance at ABCs of QI and/or IMOs with QIP scores <50% in MY 2023 and MY 2024. •Determine attendance barriers.	7/1/2025	6/30/2026	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.b.		New	**Goal #4**: By October 30, 2025, the Improvement Academy will conduct an evaluation to meet the training needs of the network.	**Deliverable #1**: By October 30, 2025, survey the provider network to gather insights on future training needs and preferred delivery modalities.	7/1/2025	10/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.c.	Provider Coaching and Engagement	New	**Goal #1:** By June 30, 2026, the Performance Improvement teams will launch interventions with 80 percent of provider organizations identified as low performing providers on the 2024 Primary Care Provider Quality Incentive Program (PCP QIP) assigned to Enhanced Provider Engagement or a Corrective Action Plan, aimed at improving performance on the Modified QIP.	**Deliverable #1:** By September 30, 2025, the Performance Improvement team will complete a Needs Assessment with 80 percent of provider organizations newly assigned to Enhanced Provider Engagement OR Corrective Action Plan in 2025.	7/1/2025	9/30/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.c.				**Deliverable #2:** By December 31, 2025, 80 percent of provider organizations with a completed Needs Assessment will select and begin implementation of at least 1 intervention aligned with a Needs Assessment recommendation provided by Partnership.	9/30/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.c.				**Deliverable #3:** By June 30, 2026, the Performance Improvement team will evaluate the 2025 Enhanced Provider Engagement program, including the use of Corrective Action engagement and advance of QIP dollars for Phase 2 Modified QIP practices.	3/1/2026	6/30/2026	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.c.				**Deliverable #4:** By June 30, 2026, the Performance Improvement team will partner with regional leadership to develop a strategy for including low performing providers, new to Partnership in 2024, for inclusion in the 2026 Enhanced Provider Engagement and Modified QIP programs.	3/1/2026	6/30/2026	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.c.			**Goal #2:** By June 30, 2026, the Performance Improvement teams will engage with at least two lower performing, mid	**Deliverable #1:** By July 31, 2025, the Performance Improvement teams will identify the PCP practices of focus in each quality region and measures of focus for intervention.	7/1/2025	7/31/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.c.		New	teams will engage with at least two lower performing, mid-volume providers in each of the three regions on a high-priority HEDIS and PCP-QIP measure.	**Deliverable #2:** By December 31, 2025, the Performance Improvement team will plan and begin implementation of at least one intervention to impact at least one measure of focus with the six identified providers.	8/1/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.c.		New	**Goal #3:** By December 31, 2025, the Performance Improvement teams will engage with all high-volume (greater than 15,000 members) Primary Care Provider (PCP) practices in each quality region on high-priority measures.	**Deliverable #1:** By July 31, 2025, the Performance Improvement team will identify the high-volume PCP practices of focus in each of the six Partnership regions and measures of focus for engagement.	7/1/2025	7/31/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.c.				**Deliverable #2:** By December 31, 2025, the Performance Improvement teams will establish a coaching relationship with two high-volume PCP practices in each sub-region and plan and implement at least one intervention to address high-priority measures. The intervention can be measure-specific or focused on foundational elements in the organization.	8/1/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.d.	Implementation of Regional Quality Meetings	Continued	**Goal #1:** By June 30, 2026, Performance Improvement (PI) will implement quarterly regional quality meetings in all six (6) operational regions to offer forums for regional dialogue to address quality improvement opportunities and barriers.	**Deliverable #1:** By June 30, 2026, PI will conduct at least four (4) meetings in each of the six regions.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.d.				**Deliverable #2:** By June 30, 2026, PI will survey attendees at least once for feedback on quality forums and make adjustments as necessary.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.d.				**Deliverable #3:** By June 30, 2026, PI will inventory projects and activities identified through the regional forums to identify potential for scale and spread across the region(s).	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.e.	QI Project Toolkit & Training Program	New	**Goal #1**: By December 31, 2025, successfully launch and complete a pilot of the QI Project Toolkit and Training Program, designed to test the curriculum, tools, and delivery model with invited participants.	**Deliverable #1**: Invite at least six (6) external participants, representing at least four (4) distinct organizations, to engage in the pilot.	7/1/2025	8/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Areli Carrillo Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Tasha Krongard	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.e.				**Deliverable #2**: Collect structured feedback on content relevance, delivery format, and practical applicability from at least 80% of pilot participants.	7/1/2025	11/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Areli Carrillo Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Tasha Krongard	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.e.				**Deliverable #3**: Produce a pilot summary report outlining lessons learned, participant feedback, and recommendations for refinement.	7/1/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Areli Carrillo Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Tasha Krongard	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.e.			**Goal #2**: By March 31, 2026, kick off the full-scale QI Project	**Deliverable #1**: Develop and launch a formal registration process and public-facing webpage housing program materials and sign-up details.	7/1/2025	12/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Areli Carrillo Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Tasha Krongard	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.e.				**Deliverable #2**: Ensure 100% of program materials (Toolkit, curriculum outline, promotional content) are accessible via the public webpage.	7/1/2025	1/31/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Areli Carrillo Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Tasha Krongard	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.e.		New	Toolkit and Training Program, making it available to eligible Partnership entities (e.g., counties, providers, CBOs, etc.).	**Deliverable #3**: Develop a formal process for collecting session-specific participant feedback and recommendations, with a defined method for analyzing and apply results to support continuous improvement, including standardized feedback tools (e.g. surveys, in-person feedback sessions, etc.) for data collection.	7/1/2025	1/31/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Areli Carrillo Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Tasha Krongard	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.e.				**Deliverable #4**: Enroll at least 10 participants (representing at least 5 distinct organizations) in the first full training cohort.	7/1/2025	3/31/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Areli Carrillo Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Tasha Krongard	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
	8. Delegation Oversight										
8.a	QI Delegation Oversight	Continued	**Goal #1:** By June 30, 2026, demonstrate strong delegation oversight process in support of delegation standards and Partnership policies and procedures.	**Deliverable #1:** Quarterly and yearly review of delegation committee reports and delegated activities based on submitted documents. Present findings at the Delegation Oversight Committee (DORS) meetings with recommendations.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Sfety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
8.a				**Deliverable #2:** Participation with the annual delegation audits by Partnership Compliance department. Submit audit findings within required timeframe.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Sfety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
	9. NCQA Program Management										
9.a.				**Deliverable #1:** By January 16, 2026, Business Owners will update the annual HEA Workbook (Work Plan and Evidence Submission Library): • Review and/or update the HEA Work Plan information based on the 2026 HEA Standards and Guidelines; collect attestations from newly identify key stakeholders and contributors if applicable. • Review and/or update the Evidence Submission Library based on the 2026 HEA Standards and Guidelines changes and learnings from the HEA Initial Survey. All evidence must be produced and dated based on the date(s) listed under the Evidence Submission Library. Any date changes or document revisions must be reviewed and agreed upon by the NCQA Program Management Team in collaboration with the NCQA Consultant. • Contributors identified from FY 24-25 should share their questions with Business Owners for further evaluation and discussion. Submissions of HEA Workbooks that do not follow the instructions are considered incomplete. The NCQA Program Management Team will request the Business Owner make corrections and resubmit, which may cause a delay in meeting the submission deadline. The NCQA Program Management Team will share the annual HEA Workbook by December 12, 2025.	12/15/2025	1/16/2026	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Network Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
9.a.	Compliance with NCQA HEA and Sustain Performance	New	**Goal #1:** By June 30, 2026, departments will maintain compliance of all assigned NCQA Health Equity Accreditation (HEA) Standards and Guidelines, following the 2026 HEA Standards and Guidelines once available, as measured by the three (3) deliverables listed.	**Deliverable #2:** By January 16, 2026, complete the 2026-2028 HEA Report Schedule by indicating the contributors involved, the reporting period of the data sources, when data sources will become available, and the targeted approval date of the analysis reports. • Submit the analysis reports based on the draft report date provided under the 2026-2028 HEA Report Schedule. All reports must be submitted to the NCQA Consultant for review. All edits must be incorporated in a timely manner prior to any committee review and/or approval, or by the production date as agreed upon under the 2026-2028 HEA Report Schedule. Submissions of 2026-2028 HEA Report Schedules that do not follow the instructions are considered incomplete. The NCQA Program Management Team will request the Business Owner make corrections and resubmit, which may cause a delay in meeting the submission deadline. The NCQA Program Management Team will share the 2026-2028 HEA Report Schedule by December 12, 2025.	12/15/2025	6/30/2026	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Network Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
9.a.				**Deliverable #3:** All Business Owners must confirm and/or submit the following to meet the look-back period for each assigned standard: • Documented Processes: By March 3, 2026 (tentative; date may vary, pending assignment of HEA Renewal Survey date in 2028), provide acknowledgement that documented processes meet the scope of review throughout the look-back period. Any revisions that impact NCQA requirements must be finalized in May 2026, including timely review by the NCQA Consultant and approval at committee meetings. No edits should be made without review and/or assessment by the NCQA Consultant. • Materials: By May 15, 2026 (tentative; date may vary, pending assignment of HEA Renewal Survey date in 2028), submit all applicable screenshots as indicated under the Evidence Submission Library to demonstrate that compliance is met.	2/4/2026	5/15/2026	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Network Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
9.b.				**Deliverable #1:** By August 22, 2025, Business Owners will submit all annotated evidence for the Mock Renewal Survey based on the dates listed in the Evidence Submission Library for Year 1 of the look-back period, and the submission guidelines provided by the NCQA Program Management Team.	7/7/2025	8/22/2025	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Care Coordination, Compliance, Grievance & Appeals, Health Equity, Human Resources, Member Services, Network Services, Pharmacy, Population Health, Quality Improvement, Utilization Management Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
9.b.	Compliance with NCQA HPA and Sustain Performance	New	**Goal #1:** By June 30, 2026, departments will maintain compliance of all assigned NCQA Health Plan Accreditation (HPA) Standards and Guidelines, and prepare for the HPA Renewal Survey in September 2026, as measured by the six (6) deliverables listed.	**Deliverable #2:** By October 24, 2025, Business Owners will update the annual HPA Workbook (Work Plan and Evidence Submission Library): • Review and/or update the HPA Work Plan information based on the 2026 HPA Standards and Guidelines; collect attestations from newly identify key stakeholders and contributors if applicable. • Review and/or update the Evidence Submission Library based on the 2026 HPA Standards and Guidelines changes and recommendations from the HPA Mock Renewal Survey. All evidence must be produced and dated based on the date(s) listed under the Evidence Submission Library. Any date changes or document revisions must be reviewed and agreed upon by the NCQA Program Management Team in collaboration with the NCQA Consultant. • Contributors identified from FY 24-25 should share their questions with Business Owners for further evaluation and discussion. Submissions of HPA Workbooks that do not follow the instructions are considered incomplete. The NCQA Program Management Team will request the Business Owner make corrections and resubmit, which may cause a delay in meeting the submission deadline. The NCQA Program Management Team will share the annual HPA Workbook by September 30, 2025.	10/1/2025	10/24/2025	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Care Coordination, Compliance, Grievance & Appeals, Health Equity, Human Resources, Member Services, Network Services, Pharmacy, Population Health, Quality Improvement, Utilization Management Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
9.b.				**Deliverable #3**: Complete subset of analysis reports based on the approval dates outlined under the 2024-2026 HPA Report Schedule: • By October 24, 2025, submit edits to the 2024-2026 HPA Report Schedule, if applicable. This would include any changes related to the reporting period of the data sources, when data sources will become available, and the targeted approval date of the analysis reports. • Submit the analysis reports based on the draft report date provided under the 2024-2026 HPA Report Schedule. All reports must be submitted to the NCQA Consultant for review. All edits must be incorporated in a timely manner prior to any committee review and/or approval, or by the production date as agreed upon under the 2024-2026 HPA Report Schedule.	10/1/2025	10/24/2025	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Care Coordination, Compliance, Grievance & Appeals, Health Equity, Human Resources, Member Services, Network Services, Pharmacy, Population Health, Quality Improvement, Utilization Management Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
9.b.				**Deliverable #4**: Obtain a "yes" score on all assigned elements during the HPA Mock Renewal Survey. If gaps are identified on Year 1 evidence, Business Owners will: • By December 5, 2025, submit an Action Plan (AP) to address any applicable recommendations. • Correct evidence by the applicable look-back period, timelines, and/or expectations by NCQA. Any revised or new evidence must be submitted to MHR for review and approval and must align with the timeline of committee meetings for review. No edits should be made without review and/or assessment by the NCQA Consultant. • After the Mock Survey, any modifications to approved evidence that affect NCQA requirements, including documented processes, must be shared with the NCQA Program Management Team for review and further assessment prior to the effective/production date. The NCQA Program Management Team will share the AP document by November 13, 2025.	11/14/2025	6/30/2026	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
9.b.				**Deliverable #5**: Departments that oversee file review requirements will maintain strict oversight of Partnership and non-NCQA Accredited delegates' files to ensure compliance. The departments are Network Services, Utilization Management, Pharmacy, Grievance and Appeals, and Care Coordination: • Participate in a Mock File Review with the NCQA Consultant. Additional follow-up activities and subsequent monitoring may be required. At the discretion of the NCQA Steering Committee, ad hoc file review audits with the NCQA Consultant may follow. • Continue the quarterly file review audit of Partnership files and share results with the NCQA Program Management Team, who will provide regular updates to the NCQA Steering Committee. Business Owners will implement an AP for files that do not score "yes" on each factor. • Continue ongoing monitoring of files from non-NCQA Accredited delegates. Business Owners will provide regular updates, including the annual audit results and risks identified, with the NCQA Program Management Team. More frequent monitoring may be required, if applicable. These updates will be shared with the NCQA Steering Committee.	7/1/2025	6/30/2026	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
9.b.				**Deliverable #6:** By May 29, 2026 Business Owners will submit all annotated evidence for HPA Renewal Survey based on the dates listed in the Evidence Submission Library for Year 1 (if applicable) and Year 2 of the look-back period, and the submission guidelines provided by the NCQA Program Management Team.	4/3/2026	5/29/2026	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
	10. Grand Analysis										
10.a.	Grand Analysis - Member Experience (ME7) Report	Continued	**Goal #1:** By August 31, 2026, complete the annual Member Experience Grand Analysis (ME7) report. (Note, the ME 7 report is dependent on CAHPS data results, which are managed by an external vendor (Press Ganey) and not available until after the goal period ends).	**Deliverable #1:** By June 30, 2026, continue the fiscal/quarterly year process to collect and analyze Grievance & Appeals data. Ensure stakeholders at a minimum meet quarterly or as needed to review data compared to prior and current year CAHPS® survey results.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
10.a.				**Deliverable #2**: By June 30, 2026, collect and analyze CAHPS® regulated Measure Year (MY) 2025 survey results, 2025 Grievance & Appeals annual filings, and other data sources.	7/1/2025	6/30/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
10.a.				**Deliverable #3**: By August 31, 2026, complete the Member Experience Grand Analysis Report (ME7).	7/1/2025	8/31/2026	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
10.a.	Grand Analysis - Pharmacy and Utilization Management (UM1B) Report	Continued	**Goal #1:** By June 30, 2026, complete annual Pharmacy & Utilization Management Grand Analysis (UM1B) report per NCQA Health Plan Accreditation standards.	**Deliverable #1:** Complete 2024 UM1B report.	7/1/2025	6/30/2026	Title: Chief Health Services Officer Name: Katherine Barresi	Title: Clinical Pharmacist Name: Andrea Ocampo Title: Associate Director of UM Regulations Name: Tony Hightower	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
10.a.	Grand Analysis - Access and Availability (NET3) Report	Continued	**Goal #1:** By June 30, 2026, the 2025 NET 3 Report will be complete.	**Deliverable #1:** Complete the NET 3 Report	7/1/2025	6/1/2026	Title: Director of Provider Relations Name: Priscila Ayala	Title: Manager of Network Services Compliance Name: Renee Trosky	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan - Monitoring of Previous Issues

1. QI Program Infrastructure						
Item #	**Project/Program**	**25/26 Goal**	**Status**	**Monitoring of Previous Issues (FY 2024-25)**	**N/A**	**42**
1.a.	QI Program Documents	.....	N/A	.....	Total:	42
1.b.	Improve Partner Satisfaction	.....	N/A	.....		
1.c.	Streamline QI Trilogy Document Processes	.....	N/A	.....		
1.d.	Enhance QI Trilogy Training Tools	.....	N/A	.....		
1.e.	Physician Advisory Committee (PAC) Oversight of QI Program	.....	N/A	.....		
2. Measurement, Analytics and Reporting						
2.a.	HEDIS Reporting	.....	N/A	.....		
2.b.	Member Experience Data	.....	N/A	.....		
2.c.	Member Services Access	.....	N/A	.....		
2.d	Primary Care Provider Quality Incentive Program (PCP QIP) Payment Process Reporting	.....	N/A	.....		
2.e.	Web Based Member Information Assessment	.....	N/A	.....		
2.f.	Primary Care Provider Quality Incentive Program (PCP QIP) eReports System	**Goal #1:** By June 30, 2026, PCP QIP will continue collaborating with the Partnership Web Team to align 2026 eReports with HRP® (Health Rules Payor) data elements in preparation for the launch of HRP®.	Continued	eReports team has been unsuccessful with launching eReports with HRP® (Health Rules Payor) data due to continued delays of HRP® implementation. Tentative date of HRP® go live is TBD.		
2.g.	Partnership Quality Dashboard (PQD)	**Goal #1**: By June 30, 2026, apply annual development updates of the MY2026 HEDIS® Monthly Exploratory Dashboard in accordance with identified stakeholder needs (Contingent on HRP® implementation).	Continued	HRP® Delay - Development and implementation of the HEDIS® Monthly Exploratory Dashboards are largely dependent on the implementation timeline for Health Rules Payor (HRP®). Once the HRP® timeline has been re-established, an adjusted timeline for the HEDIS® Monthly exploratory will be identified, but at this time, timeline appears to be achievable.		
2.g.	Partnership Quality Dashboard (PQD)	.....	N/A	.....		
2.h.	Enterprise Information Management	.....	N/A	.....		
2.i.	Dual Eligible Special Needs Plan (D-SNP)	.....	N/A	.....		
2.j.	HEDIS Reporting to Support DSNP Data Collection and Analysis	.....	N/A	.....		
2.k.	Conduct Year Round Medical Record Review	.....	N/A	.....		
3. Value Based Payment Programs (QIP)						
3.a.	Primary Care Provider Quality Incentive Program (PCP QIP)	.....	N/A	.....		
3.b.	Hospital Quality Improvement Program (H-QIP)	.....	N/A	.....		
3.c.	Palliative Care Quality Incentive Program (PC QIP)	.....	N/A	.....		
3.d.	Perinatal Quality Incentive Program (PQIP)	.....	N/A	.....		
3.e.	Enhanced Care Management Quality Incentive Program (ECM QIP)	.....	N/A	.....		
3.f.	Dual Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development	.....	N/A	.....		
4. Improvement Projects and Programs, Clinical Quality						
4.a.	Quality Measure Score Improvement (QMSI)	.....	N/A	.....		
4.b.	Healthy Kids Growing Together Program	.....	N/A	.....		
4.c.	Mobile Mammography Program	.....	N/A	.....		
4.d.	QI3 - TBD Title	.....	N/A	.....		
5. Service and Patient Experience						
5.a.	Member Experience Data	.....	N/A	.....		
5.b.	Complex Case Management	.....	N/A	.....		
6. Quality Assurance and Patient Safety						
6.a.	Potential Quality Issues (PQI)	.....	N/A	.....		
6.b.	Fluoride Varnish	.....	N/A	.....		
6.c.	Initial Health Appointment	.....	N/A	.....		
6.d.	Latent TB Infection Treatment	.....	N/A	.....		
7. Quality Improvement Training and Coaching						
7.a.	QI Technical Assistance with Health Center Consortias	.....	N/A	.....		

7.b.	Performance Improvement Training Offerings		N/A			
7.c.	Provider Coaching and Engagement		N/A			
7.d.	Implementation of Regional Quality Meetings		N/A			
7.e.	QI Project Toolkit & Training Program		N/A			
8. Delegation Oversight						
8.a.	QI Delegation Oversight		N/A			
9. NCQA Project Management						
9.a.	Compliance with NCQA HEA and Sustain Performance		N/A			
9.b.	Compliance with NCQA HPA and Sustain Performance		N/A			
10. Grand Analysis						
10.a.	Grand Analysis - Member Experience (ME7) Report		N/A			
10.a.	Grand Analysis - Pharmacy & Utilization Management (UM1B) Report		N/A			
10.a.	Grand Analysis - Access and Availability (NET3) Report		N/A			

Approval Signatures

Robert Moore, MD, MPH, MBA	8/20/2025
Quality/Utilization Advisory Committee Chairperson	*Date Approved*

Angela Brennan, DO	9/10/2025
Physician Advisory Committee Chairperson	*Date Approved*

Kim Tangerman	10/22/2025
Board of Commissioners Chairperson	*Date Approved*

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
1. QI Program Infrastructure											
1.a.	QI Program Documents	Continued	**Goal #1:** By July 2025, complete draft QI Program Description, QI Work Plan and QI Evaluation revisions in preparation for August Quality Committee meetings.	**Deliverable #1:** Finalize 2025 - 2026 QI Program Description.	10/1/2024	7/30/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
1.a.				**Deliverable #2:** Finalize 2024 - 2025 QI Work Plan.	10/1/2024	7/30/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.a.				**Deliverable #3:** Finalize 2024 - 2025 QI Evaluation.	10/1/2024	7/30/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.a.				**Deliverable #4:** 2025 - 2026 QI Work Plan – Complete Draft.	5/1/2025	7/30/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.b.	Physician Advisory Committee (PAC) Oversight of QI Program	Continued	**Goal #1:** By June 30, 2025, Ensure PAC oversight of Partnership's QI Program through semi-annual monitoring of the QI Work Plan.	**Deliverable #1:** By September 30, 2024, QI Trilogy Documents to be reviewed for approval by PAC in September 2024, post-review of other Quality committees to include but not limited to: * FY 2024-25 - Work Plan * FY 2024-25 - Program Descriptions * FY 2023-24 - QI Program Evaluation	9/11/2024	9/30/2024	Title: Chief Medical Officer Name: Robert Moore	Title: Executive Assistant Name: Sarah Browning	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2. Measurement, Analytics and Reporting											
2.a.	HEDIS® Reporting	Continued	**Goal #1:** By June 30, 2025, report HEDIS® MY2024 final rate performance as required annually for NCQA Health Plan Accreditation (HPA) and the DHCS Managed Care Accountability Set (MCAS).	**Deliverable #1:** • Monthly Project Work Plan updated by 09/30/2024 to accommodate HPA and MCAS unique activities/deliverables. • Annual Project Work Plans updated by 10/31/2024 to accommodate HPA and MCAS unique activities/deliverables.	9/1/2024	10/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.a.				**Deliverable #2:** By October 31, 2024, build HEDIS® MY2024 Monthly Project which includes all populations for DHCS, HPA and Dual Eligible Special Needs Plan (D-SNP). (Contingent on HRP production implementation in 2024)	9/1/2024	10/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.a.				**Deliverable #3:** • By February 1, 2025 build production environments for the Annual project and collect, prepare and integrate administrative data, inclusive of new Electronic Clinical Data Systems (ECDS) data sources. • By May 31, 2025, conclude the HEDIS® Annual Medical Record projects for MCAS and HPA required reporting in support of the HEDIS® MY2023 Annual Project. • By June 30, 2025, report HEDIS® MY2024 final rate performance as required annually for NCQA Health Plan Accreditation (HPA) and the DHCS Managed Care Accountability Set (MCAS).	1/1/2025	6/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.		Continued	**Goal #1:** By June 30, 2025, gather, analyze and highlight areas of opportunity for the plan using the CAHPS® survey and Grievances & Appeals (G&A) data as it relates to NCQA requirements.	**Deliverable #1:** By December 30, 2024, present measure year (MY) 2023 CAHPS® and Member Experience results to internal and external committees.	7/1/2024	12/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.b.				**Deliverable #2:** By June 30, 2025, continue the fiscal/quarterly year process to collect and analyze G&A data. Ensure stakeholders at a minimum meet quarterly or as needed to review data compared to prior and current year CAHPS® survey results.	7/1/2024	6/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #3:** By June 30, 2025, collect and analyze CAHPS®-regulated measure year (MY) 2024 survey results, 2024 G&A annual filings, and other data sources (inclusive of Adult Drill Down survey dependent upon execution date).	7/1/2024	6/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.b.	Member Experience Data	New	**Goal #2**: By June 30, 2025, Org. Goal # 4 Access & Member Experience (Milestone 3), Member Experience (ME) Workgroup will drive CAHPS® Score Improvement (CSI) fiscal year 2023-2024 pilot from analysis phase to Strike-Team "action" phase. The enhanced ME improvement strategy is continuous, with the intent to leverage quarterly data (G&A, PHM) sources to drive proactive interventions throughout fiscal year 2024-2025. Outcome(s)/Deliverable(s): • Workgroup will adhere to Quality Improvement Model: Plan, Do, Study, and Act (PDSA) • Collaborate with subject matter experts to review prior fiscal year quarter interventions against new quarter datasets • Analyze new quarterly data sets (G&A, PHM) against pilot ME abrasion thresholds* o Access o Attitude and Service o Billing and Financial o Quality of Care o Quality of Practitioner Office Site	**Deliverable #1:** By August 31, 2024 - Analyze 2024 Q2 Quarterly G & A Pulse Report data against established member experience abrasion thresholds that target at least three areas intended to improve service delivery and member experience. The action includes and is not limited to root-cause analysis, and operational research/investigation to determine Plan or provider gaps. Action to influence experience or service improvement requires cross-department resources dedicated to this pilot. Department Leadership in the FY 23-24 pilot continuation is essential to drive improvement.	7/1/2024	8/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.b.				**Deliverable #2:** By November 30, 2024 - Analyze 2024 Q3 Quarterly G & A Report data against established member experience abrasion thresholds that target at least three areas intended to improve service delivery and member experience. The action includes and is not limited to root-cause analysis, and operational research/investigation to determine Plan or provider gaps. Action to influence experience or service improvement requires cross-department resources dedicated to this pilot. Department Leadership in the FY 23-24 pilot continuation is essential to drive improvement.	8/1/2024	11/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #3:** By January 31, 2025 - Analyze 2024 Q4 Quarterly G & A Pulse Report data against established member experience abrasion thresholds that target at least three areas intended to improve service delivery and member experience. The action includes and is not limited to root-cause analysis, and operational research/investigation to determine Plan or provider gaps. Action to influence experience or service improvement requires cross-department resources dedicated to this pilot. Department Leadership in the FY 23-24 pilot continuation is essential to drive improvement.	11/1/2024	1/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
2.b.				**Deliverable #4:** By May 30, 2025 - Analyze 2025 Q1 Quarterly G & A Pulse Report data against established member experience abrasion thresholds that target at least three areas intended to improve service delivery and member experience. The action includes and is not limited to root-cause analysis, and operational research/investigation to determine Plan or provider gaps. Action to influence experience or service improvement requires cross-department resources dedicated to this pilot. Department Leadership in the FY 23-24 pilot continuation is essential to drive improvement.	2/3/2025	5/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
2.b.				**Deliverable #5:** By June 30, 2025 - Evaluate pilot strike-team quarterly outcomes and effectiveness. Use evaluation to inform and propose recommendations.	4/1/2025	6/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.c.	Member Services Access	Continued	**Goal #1:** By June 30, 2025, ensure compliance of internal and delegated access standards as it relates to inbound call handling.	**Deliverable #1:** Monitor, Analyze and Recommend Corrective Action Plan(s) (CAP) when appropriate which includes: • Review internal call center performance stats monthly (performance benchmarks tracked quarterly) on several service level agreements (SLAs) • Plan to continue to track quarterly delegate call center performance (submitted quarterly by each respective delegate) against established performance thresholds (based on SLAs above) during Delegate Oversight quarterly meetings	7/1/2024	6/30/2025	Title: Senior Director of Member Services and Grievances Name: Edna Villasenor	Title: Associate Director of Member Services Name: Cyress Mendiola	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.d.			**Goal #1:** By June 30, 2025, PCP QIP will	**Deliverable #1:** Evaluate Data Validation Framework documents and examine the validation procedures outlined in the documents to ensure they are robust and effective in verifying payment accuracy.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.d.	Primary Care Provider Quality Inceptive Program (PCP QIP) Payment Processing Report	New	continue to refine the Data Validation Framework documents which includes identifying areas for improvement in efficiency and accuracy, ensuring that the updated documents provide clear guidance on each step of the payment process, strengthening the validation processes to enhance the accuracy of payment calculations, establishing clear timelines for each stage of the payment process and continuing to monitor the effectiveness of the refined process and make adjustments as needed going forward.	**Deliverable #2:** Engage in collaboration with a sister plan to Partnership (Alameda Alliance) to understand their payment processing methods and to possibly integrate best practices into our own payment process.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.d.				**Deliverable #3:** Maintain ongoing collaboration with contributing teams and executive leadership to enhance payment processes to ensure future payment accuracy.	7/1/2024	5/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.e.	Web Based Member Information Assessment	Continued	**Goal #1:** By June 30, 2025, complete annual evaluation of the quality and accuracy of information provided to members via e-mail and telephone as stated in NCQA Standard ME 6 Element C: Quality and Accuracy of Information.	**Deliverable #1:** Complete annual evaluation of the quality and accuracy of information provided to members via e-mail and telephone as stated in ME 6 C: Quality and Accuracy of Information.	7/1/2024	6/30/2025	Title: Senior Director of Member Services and Grievances Name: Edna Villasenor Title: Associate Director of Member Services Name: Cyress Mendiola	Title: Supervisor of Quality and Training, Member Services Name: Kristen Clark	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.f.	Primary Care Provider Quality Incentive Program (PCP QIP) eReports System	Continued *(Monitoring of previous issue)*	**Goal #1:** By June 30, 2025, PCP QIP will continue collaborating with the Partnership Web Team to align 2025 eReports with HRP® (Health Rules Payor) data elements in preparation for the launch of HRP®.	**Deliverable #1:** Review 2025 eReports scoping and development with Web Team to identify any remaining areas within eReports needing integration with HRP®. Finalize via annual Business Requirement Documents (BRD) approved by QI and IT management.	7/1/2024	11/1/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.f.				**Deliverable #2:** Complete User Acceptance Testing (UAT), inclusive of HRP® integration testing, per approved 2025 eReports BRD, for on-time release to provider network.	11/1/2024	3/1/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.f.				**Deliverable #3:** Conduct weekly eReports check-in meetings with the Partnership Web Team to discuss project timeline, BRD revisions, application logic, UAT testing timelines, progress and bugs.	10/1/2024	3/15/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #1:** Complete development of PQD of HEDIS® MY2024 Monthly Exploratory dashboard (Contingent on HRP® production implementation) **Complete project status denotes completion of previous year's PQD Work Plan Goal	10/1/2024	11/29/2024	Title: Director of Quality Management Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.g.		Continued	**Goal #1:** Goal #1: By June 30, 2025, apply annual development updates of the MY2025 HEDIS® Monthly Exploratory Dashboard in accordance	**Deliverable #2:** Complete an annual HEDIS® Monthly data user needs assessment for MY2025 Monthly Exploratory dashboard in PQD. In collaboration with the HEDIS® team and QMSI workgroup's leads and through use of the updated Master Measure List to confirm applicable measures..	7/1/2024	3/30/2025	Title: Director of Quality Management Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.g.		Continued	Monthly Exploratory dashboard in accordance with identified stakeholder needs (Contingent on HRP® implementation).	**Deliverable #3:** Complete updated HEDIS® Monthly Exploratory business requirements documentation for MY2025 Monthly Exploratory dashboard in PQD in collaboration with the HEDIS® team.	7/1/2024	3/30/2025	Title: Director of Quality Management Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #4:** Timely publication of the MY2025 HEDIS® Monthly Exploratory dashboard (Contingent on HRP® production implementation).	4/1/2025	6/30/2025	Title: Director of Quality Management Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	
2.g.	Partnership Quality Dashboard (PQD)	Continued *(Monitoring of previous issue)*	**Goal #2:** By June 30, 2025, apply annual development updates of the PCP QIP Provider and Internal View Dashboards in accordance with identified stakeholder needs.	**Deliverable #1:** Work with representatives of the provider network to review all enhancement requests to be included in the Business Requirements Document (BRD) to be reviewed and approved by the Enterprise Data Warehouse (EDW) team for the new measurement year (MY).	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #2:** Work with stakeholders to submit updated annual dashboard business requirements document (BRD) to developers for review and approval.	7/1/2024	2/29/2024	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #3:** Work with developers and business owners to finalize which proposed new business requirements/enhancements will be deemed in scope for dashboard updates in 2025. Escalate to QI and IT senior leadership if consensus cannot be reached to finalize prioritization	2/1/2025	3/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**
2.g.				**Deliverable #4:** Completion of user acceptance testing (UAT) of dashboards	4/1/2025	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	
2.g.				**Deliverable #5:** Timely publication of the dashboards in PQD for internal and external use.	1/1/2025	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	
2.h.		Continue	**Goal #1:** By December 31, 2024, integrate the HRP® version of the HEDIS® monthly project data into the Enterprise Data Warehouse and use	**Deliverable #1:** Integrate HEDIS® Health Rules Payor data in to Enterprise Data Warehouse environment and make necessary programming changes to populate Provider Quality Dashboard-HEDIS® tables.	9/1/2024	10/15/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.h.	Enterprise Information Management	*(Monitoring of previous issue)*	data into the Enterprise Data Warehouse and use this data to create the HRP® version of the HEDIS® PQD modules.	**Deliverable #2:** Develop the HEDIS® PQD dashboards using the HRP® data and complete UAT.	10/15/2024	11/30/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	**No**
2.h.		New	**Goal #2:** By December 31, 2024, develop, test, and have the 2024 HEDIS® monthly project live in production with the data available to users via the HEDIS® PQD modules.	**Deliverable #1:** Complete development and testing to deliver 2024 HEDIS® monthly files to the Quality Improvement (QI) Team. This might require building new medi-medi population and catalogs on the Inovalon side.	7/1/2024	9/15/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.h.				**Deliverable #2:** Integrate 2024 HEDIS® data from monthly project into the Enterprise Data Warehouse.	9/15/2024	10/1/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.h.				**Deliverable #3:** Develop and test PQD HEDIS® dashboards using the 2024 HEDIS® monthly project data and support D-SNP processes.	10/1/2024	10/31/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.h.		Continue *(Monitoring of previous issue)*	**Goal #3:** By December 31, 2024, integrate Electronic Clinical Data Systems data (behavioral health, depression screening, various clinical measures) from Data Link and Sutter into the Enterprise Data Warehouse environments, and use as a source for various QI programs and processes.	**Deliverable #1:** Establish a connection to receive clinical data from Data Link.	7/1/2024	7/30/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.h.				**Deliverable #2:** Integrate clinical data from Data Link into the Enterprise Data Warehouse environments and integrate the data to HEDIS® Monthly project and various QI processes.	8/30/2024	11/15/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.h.				**Deliverable #3:** Incorporate clinical data from Sutter into the HEDIS® program and various QI processes.	8/15/2024	9/30/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.i.	Dual Eligible Special Needs Plan (D-SNP)	New	**Goal #1**: By June 30, 2025, develop systems to manage data sourcing, analysis and stakeholder communication for the proposed D-SNP population and associated CMS Part C&D and DHCS measure sets.	**Deliverable #1:** By December 31, 2024, develop an interdepartmental D-SNP Stars Strategy Work Group to manage and assess data needs pertaining to the Medicare D-SNP product line and reportable measures.	7/1/2024	12/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.i.				**Deliverable #2:** By February 1, 2025, complete Chapter 4 of the Model of Care document for submission to DHCS	7/1/2024	2/1/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.i.				**Deliverable #3:** By June 30, 2025, develop the process for integration of MOC-related goals and re-evaluation into the QI Trilogy.	7/1/2024	6/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.i.				**Deliverable #4:**By June 30, 2025, develop communication strategies through appropriate committee structure to inform stakeholders of D-SNP goals and progress with defined ongoing communication frequency.	7/1/2024	6/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.j.				**Deliverable #1:** By 10/31/2024, Create Monthly Project Work Plan to accommodate D-SNP unique activities/deliverables.	8/1/2024	10/31/2024	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.j.	D-SNP HEDIS Reporting	New	**Goal #1:** By June 30, 2025, Develop systems and processes for analysis of Stars and DHCS HEDIS® data for proposed D-SNP population of focus.	**Deliverable #2:** By 10/31/2024, build HEDIS® MY2024 Monthly Project which includes all populations for DHCS, HPA and D-SNP. (Contingent on HRP production implementation in 2024)	9/1/2024	10/31/2024	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.j.				**Deliverable #3:** By 03/31/2025, collect, analyze, validate, and disseminate HEDIS® MY2024 D-SNP preliminary results for the required D-SNP Measure Sets.	11/1/2024	3/31/2025	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3. Value Based Payment Programs - QIP											
3.a.	Primary Care Provider Quality Incentive Program (PCP QIP)	New	**Goal #1:** By June 30, 2025, the PCP QIP Program will be leveraged to support existing and newly added low performing providers in the Modified QIP measure set. This support will include provider education and encouragement to increase on-line data platform usage and monitoring and result in improved reporting and performance improvement activities.	**Deliverable #1:** For new Modified QIP provider, a warm hand-off is made to the QIP team as the result of the work completed by initial PI Needs Assessment, the QIP team will meet with individual modified QIP providers and perform a PCP QIP specific needs assessment to determine QIP tools skill-set level amongst modified QIP staff. Assessment will inform the QIP team how to move forward and what level of engagement/training is needed. May include monthly or quarterly check-ins meetings.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.a.				**Deliverable #2:** For existing Modified QIP provider, the QIP team will continue to conduct and offer monthly or quarterly check-ins meetings.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.a.				**Deliverable #3:** Create a survey specifically for Modified QIP provider which includes questions to check-in, assess needs and important reminders. Survey will be distributed on quarterly basis. Answers will be reviewed and followed-up with a 1:1 email.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.a.		Continued	**Goal #2:** By June 30, 2025, the PCP QIP Program will be leveraged to support new Eastern Region PCPs in their efforts to use data to improve reporting and performance improvement activities.	**Deliverable #1:** Partner with the Performance Improvement (PI) Team to conduct welcome and/or on going check-in meetings. Check-ins will create an opportunity for both the PI and QIP team to assess how to move forward and what level of engagement/training is needed. Monthly or quarterly check-ins meetings may be required.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.a.				**Deliverable #2:** Create a survey specifically for expansion provider which includes questions to check-in, assess needs and important reminders. Survey will be distributed on quarterly basis. Answers will be reviewed and followed-up with a 1:1 email.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.b.	Hospital Quality Incentive Program (H-QIP)	New	**Goal #1:** By June 30, 2025, develop the 2025-2026 measurement year Hospital Quality Incentive Program (H-QIP) Measurement Set to support Hospital Performance Improvement.	**Deliverable #1:** Complete development of measures for 2025-26 H-QIP.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.b.		New	**Goal #2:** Develop Partnership's Hospital Quality Symposium for the 2025-2026 H-QIP measurement year.	**Deliverable #1:** Select dates, venues, theme, topics, and tentative speakers for the event.	7/1/2024	4/1/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.b.				**Deliverable #2:** Finalize agenda, complete speaker engagement, promote event with hospitals.	1/1/2025	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.b.		New	**Goal #3:** By January 31, 2025, complete evaluation of the 2023-2024 HQIP and deliver summary to the Partnership's Quality Committee meetings (IQI, QUAC, PAC).	**Deliverable #1:** Evaluate 2023-2024 hospital program performance by measure in comparison to prior measurement year.	7/1/2024	1/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.b.				**Deliverable #2:** Provide Evaluation summary to the Partnership Quality Committee meetings (IQI, QUAC, PAC).	7/1/2024	1/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.c.	Palliative Care Quality Incentive Program (PC QIP)	New	**Goal #1:** By December 31, 2024, develop a measurement set for the calendar year (CY) 2025 Palliative Care Quality Incentive Program (PC QIP), that supports quality improvement.	**Deliverable #1:** Complete measure development for CY 2025 PC QIP.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.c.		Continued *(Monitoring of previous issue)*	**Goal #2:** By June 30, 2025, complete CY 2024 PC QIP evaluation.	**Deliverable #1:** Complete evaluation of the program's CY 2024 measurement year to monitor performance	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	**No**
3.d.	Perinatal Quality Incentive Program (PQIP)	Continued	**Goal #1:** By June 30, 2025, continue to develop Perinatal QIP Measurement set to support HEDIS® Score Improvement through May 30, 2025, and leverage support from Partnership's Population Health team and the Growing Together Program to improve scores for the Timely Prenatal Care measures.	**Deliverable #1:** Develop Perinatal QIP Measurement set to support HEDIS® Score Improvement through May 30, 2025 and leverage support from Partnership's Population Health team and the Growing Together Program to improve scores for the Timely Prenatal Care measure.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.d.		Continued	**Goal #2:** By June 30, 2025, continue to support provider on-boarding and ECDS implementation to satisfy programmatic gateway measure (ECDS).	**Deliverable #1:** For existing PQIP providers: Continue ECDS education and on-boarding for gateway measure compliance.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.d.				**Deliverable #2:** For new PQIP providers: Support implementation of ECDS by providing education and one-on-one meetings with provider staff.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.d.		Continued	**Goal #3:** By June 30, 2025, complete PQIP program evaluation for FY 23-24	**Deliverable #1:** Complete FY 23-24 PQIP program evaluation	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.e.	Enhanced Care Management Quality Incentive Program (ECM QIP)	Continued	**Goal #1:** By December 31, 2024, develop a measurement set for the calendar year (CY) 2025 Enhanced Care Management Quality Incentive Program (ECM QIP) that supports quality improvement and aligns with DHCS' CalAIM initiatives.	**Deliverable #1:** Complete measure development for CY 2025 ECM QIP	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.e.		Continued	**Goal #2:** By December 31, 2024, complete CY 2023 ECM QIP evaluation.	**Deliverable #1:** Complete evaluation of the program's CY 2023 measurement year to monitor performance.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	**No**
3.e.		Continued	**Goal #3:** By June 30, 2025, improve provider engagement through Advisory Group and offering one-on-one assistance through meetings and trainings.	**Deliverable #1:** Facilitate Advisory Group meeting for providers to review proposed CY 2025 measurement set and offer their feedback and suggestions for improvement.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.e.				**Deliverable #2:** Outreach to low-performing ECM providers immediately after payment processing and offer one-on-one meetings to review the areas needing improvement, re-review relevant areas in the specifications, and share best practices for success.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.e.				**Deliverable #3:** Outreach to new ECM providers and offer one-on-one meetings to include an overview of the ECM QIP, review the detailed specifications and answer questions.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.f.	Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development	New	**Goal #1:** Explore vendor options and Partnership options for the development of system solution for performance tracking of D-SNP QIP launch in January 2026.	**Deliverable #1:** Evaluate external vendor system solution products. Gather feedback from sister Healthplans on systems used for D-SNP QIPs.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.f.				**Deliverable #2:** Evaluate in-house system solution. Gather feedback from Web Team on feasibility of development for 2026 launch of D-SNP QIP.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.f.				**Deliverable #3:** Provide an update to the executive team on available options for decision on which vendor or in-house solution will be used to manage D-SNP QIP starting January 2026.	1/1/2025	3/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.f.				**Deliverable #4:** Develop and gain approval of a project plan, with a scope including execution of provider contracting for an external solution or executive approval for in-house solution through go-live.	1/1/2025	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.f.				**Deliverable #5:** Demonstrate timely progress against approved project plan by June 30, 2025.	1/1/2025	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.f.		New	**Goal #2:** Develop a Primary Care Provider (PCP) Incentive Program for the provider network contracting with Partnership to serve the D-SNP member population as of its D-SNP implementation in January 2026.	**Deliverable #1:** By December 31, 2024, develop D-SNP PCP Incentive Program (D-SNP QIP) measure set with methodology for setting thresholds and scoring to assure organizational goals are achieved relative to Partnership's STARs strategy and demonstrating feasibility of its D-SNP product line. Any measure set variation will be considered, if applicable, across PCP Incentive Program Groups defined within the D-SNP QIP Portfolio.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.f.				**Deliverable #2:** By June 30, 2025, define D-SNP PCP Incentive Program's (D-SNP QIP's) framework including (but not limited to): program goals and principles, member eligibility criteria, provider participant eligibility criteria, performance reporting solution, scoring methodology, and payment mechanisms, and governance structure for each PCP Incentive Program Group selected by Execs for go-live in January 2026	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.g.	Patient Experience Unit of Service (UOS) Measure Development	New	**Goal #1:** By December 31, 2024, Org. Goal # 4 Access & Member Experience (Milestone 8), Member Experience (ME) Workgroup will collaborate with the Quality Improvement Pay-for-Performance team to explore Unit-of-Service measure development opportunities.	**Deliverable #1:** Complete and propose Unit-of-Service - Patient Experience Measure Development aligned with CAHPS® Scores / NCQA Health Plan Rating. (Access, Communication, Customer Service).	7/1/2024	12/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett Title: Manager of Quality Incentive Programs name: Amy McCune	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
4. Improvement Projects, Clinical Quality											
4.a.	Quality Measure Score	Continued	**Goal #1:** By June 30, 2025, the Quality Measure Score Improvement group will complete all defined deliverables for each measure-specific workgroup. The goal the Quality Measure Score Improvement group is to improve Partnership's Quality performance over measurement years 2024 and 2025 under all required accountable and	**Deliverable #1:** Define five (5) specific deliverables for each measure-specific workgroup by December 1, 2024.	7/1/2024	12/1/2024	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Name: Nancy Steffen Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Manager of Performance Improvement (NR) Name: James Devan Title: Improvement Advisor Name: Amanda Kim	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	Yes

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
4.a.	Improvement (QMSI)	Continued	2023 under all required accountable and reportable quality measure sets (DHCS MCAS, DHCS D-SNP, CMS Part C and Part D, HEDIS®) There are 4 measure-specific workgroups: 1. Pediatrics 2. Behavioral Health 3. Chronic Diseases 4. Women's Health	**Deliverable #2:** • Successfully complete all required deliverables for each measure-specific workgroup by June 30, 2025. • By June 30, 2025, identify all D-SNP measures which fall within the QMSI workgroups by work group domain.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Name: Nancy Steffen Title: Senior Medicare QI Program Manager Name: Kimberly Rabadilla	Title: Manager of Performance Improvement (NR) Name: James Devan Title: Improvement Advisor Name: Amanda Kim	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	Yes
4.b.	Missed Opportunities and Member Engagement	Continued	**Goal 1:** By June 30, 2025 Incorporate missed opportunity data and feedback from the 23/24 goal and include in the member engagement dashboard currently in development and publish externally for providers to use.	**Deliverable #1:** By November 30, 2024, meet with provider stakeholders to solicit input on updated dashboard use and determine scope of requirements for making the dashboard provider-facing.	7/1/2024	11/30/2024	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Manager of Performance Improvement (NR) Name: James Devan	Title: Director of Quality Management Name: Isaac Brown	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**
4.b.				**Deliverable #2:** By January 1, 2025, submit provider-facing dashboard business requirements for development team review.	7/1/2024	1/1/2025	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Manager of Performance Improvement (NR) Name: James Devan	Title: Director of Quality Management Name: Isaac Brown	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	
4.b.				**Deliverable #3:** By June 30, 2025, publish dashboard for provider on-demand use.	1/1/2025	6/30/2025	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Manager of Performance Improvement (NR) Name: James Devan	Title: Director of Quality Management Name: Isaac Brown	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	
4.c.	Healthy Kids Growing Together Program	New	**Goal #1:** By June 30, 2025, modify the Healthy Kids Growing Together Program to include any 3 - 6 year old who has never had a well-child visit in the last nine (9) months and offer an incentive to complete a well-child visit within 90 days prior to 4th, 5th and 6th birthday.	**Deliverable #1:** Campaign lists showing members identified for the Healthy Kids Growing Together Program	7/1/2024	9/30/2024	Title: Associate Director of Population Health Name: Monika Brunkal	Title: Manager of Population Health Name: Nicole Curreri Title: Supervisor of Population Health Name: Cynthia Galicia-Huizar	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
4.c.				**Deliverable #2:** Program Impact Analysis report showing results of this intervention.	5/1/2025	6/30/2025	Title: Associate Director of Population Health Name: Monika Brunkal	Title: Manager of Population Health Name: Nicole Curreri Title: Supervisor of Population Health Name: Cynthia Galicia-Huizar	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
4.d.	Mobile Mammography Program	New	**Goal #1**: By June 30, 2025, the Mobile Mammography Program Team will have scheduled 60 Mobile Mammography event days throughout the provider network, resulting in at least 1,500 completed breast cancer screenings towards meeting the 50th percentile benchmark.	**Deliverable #1:** • Complete at least 10 event days in the legacy Eastern Region. • Complete at least 40 event days in the legacy Northern Region. • Complete at least 10 event days in legacy Southern Region.	7/1/2024	6/30/2025	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Areli Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
4.d.				**Deliverable #2**: By December 31 2024, reach the Primary Care Provider Quality Incentive Program (PCP QIP) Breast Cancer Screening 50th percentile benchmark (52.20%) in the Northwest, Northeast, Southwest and Southeast legacy regions.	7/1/2024	12/31/2024	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Areli Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
4.d.		New	**Goal #2**: By June 30, 2025, focus efforts on engaging Enhanced Provider Engagement (EPE) provider organizations and Tribal Health Centers.	**Deliverable #1:** By June 30, 2025, schedule at least five (5) event days with at least five (5) eligible Tribal Health Centers.	7/1/2024	6/30/2025	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Areli Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
4.d.				**Deliverable #2**: By June 30, 2025, schedule at least five (5) event days with at least five (5) eligible EPE provider organizations.	7/1/2024	6/30/2025	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Areli Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
4.d.		New	**Goal #3:** By June 30, 2025 pilot a new innovation to engage Tribal Health Center patients at mobile event days.	**Deliverable #1:** By June 30, 2025 pilot one (1) new innovation at three (3) Tribal Health Center mobile event days.	7/1/2024	6/30/2025	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Areli Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
5. Service and Patient Experience											

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
5.a.	Collect Member Experience Data	Continued	**Goal #1:** By June 30, 2025, launch the annual CAHPS® survey for Measure Year (MY) 2024 Reporting Year (RY) 2025 and collect data results	**Deliverable #1:** By June 30, 2025, confirm HEDIS® team Measure Year (MY) 2024 sample frame submission to Press Ganey, launch survey, and collect results as part of the NCQA member experience process	11/1/2024	6/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
5.b.	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Dual Eligible Special Needs Plan (D-SNP)	New	**Goal #1:** By June 30, 2025, select and contract with a Medicare Dual Eligible Special Needs Plan (D-SNP) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) CMS-approved vendor.	**Deliverable #1:** By December 31, 2025 execute RFP process with Medicare D-SNP CAHPS® CMS approved vendors.	7/1/2024	12/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Project Manager I Name: Tasha Krongard	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	**No**
5.b.		New	**Goal #2**: By June 30, 2025 develop D-SNP CAHPS® programmatic work plan and timeline.	**Deliverable #1**: By December 31, 2024 conduct interviews with at least three (3) sister plans regarding their D-SNP programs in an effort to help inform the D-SNP CAHPS® programmatic work plan and timeline.	7/1/2024	12/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Project Manager I Name: Tasha Krongard	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
6. Care for Members with Complex Needs											
6.a.	Complex Case Management	Continued	**Goal #1:** By June 30, 2025, we will ensure Partnership remains compliant with meeting the National Committee for Quality Assurance (NCQA) Population Health Management Standard PHM5, A-E, standards for our NCQA Renewal Survey in November 2026 and thereafter as evidenced in the results of our upcoming NCQA renewal audit and continuous quarterly internal compliance audits of Complex Case Management to meet overall compliance of files.	**Deliverable #1:** Documented Processes: Provide acknowledgement that documented processes meet the scope of review throughout the look-back period. Any revisions that impact NCQA requirements must be finalized in August 2024, including timely review by the NCQA Consultant and approval at committee meetings.	7/1/2024	7/25/2024	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
6.a.				**Deliverable #2:** Materials: Submit all applicable screenshots as indicated under the Evidence Submission Library to demonstrate the compliance is met.	8/1/2024	8/8/2024	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #3:** August 2024 Quarterly Internal Audit (Audit Period 05/01/2024-07/31/2024)	8/1/2024	8/15/2024	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #4:** Review and update the annual HPA Workbook (Work Plan and Evidence Submission Library)	10/1/2024	10/18/2024	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #5:** November 2024 Quarterly Internal Audit (Audit Period 08/01/2024-10/31/2024)	11/1/2024	11/15/2024	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #6:** Continue to maintain strict oversight of Partnership and non-NCQA Accredited delegates' files to ensure compliance and participate in a Mock File Review with the NCQA Consultant. This review will include files from Partnership and non-NCQA Accredited delegates.	4/1/2025	4/30/2025	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #7:** February 2025 Quarterly Internal Audit (Audit Period 11/01/2024-01/31/2025)	2/1/2025	2/14/2025	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
6.a.				**Deliverable #8:** May 2025 Quarterly Internal Audit (Audit Period 02/01/2025-04/30/2025)	5/1/2025	5/15/2025	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #9:** Business Owners will submit all annotated evidence for the Mock Renewal Survey based on the dates listed in the Evidence Submission Library for Year 1 of the look-back period, and the submission guidelines provided by the NCQA Program Management Team	6/1/2025	6/20/2025	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
	7. Quality Assurance and Patient Safety										
7.a.	Potential Quality Issues (PQI) (safety)	New	**Goal #1:** By June 30, 2025, QI Member Safety Quality Investigation Team will provide in-services to other Partnership Departments educating on Potential Quality Issues (PQI) and how to refer. In addition, the team will monitor referral track and trending reports to determine if inservice training results in an increase in PQI referrals from respective departments.	**Deliverable #1:** Review and update power point presentation on PQI for internal staff.	7/1/2024	12/31/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.a.				**Deliverable #2:** Reach out to departments Managers/Directors for potential inservice dates. Schedule and provide in-services.	7/1/2024	12/31/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #3:** Develop a survey monkey feedback questionnaire. Send survey monkey to attendees for feedback on areas to consider for improvement.	7/1/2024	5/31/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #4:** Monitor referral track and trending reports to determine if inservice training results in an increase in PQI referrals from respective departments.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.a.		New	**Goal #2**: By June 30, 2025, QI Member Safety Quality Investigation Team will assess SugarCRM Potential Quality Issues (PQI) application and determine potential enhancements or replacement options.	**Deliverable #1:** Review and list issues/areas in SugarCRM PQI app that require an enhancement or upgrade. Consult with IT to determine best action.	7/1/2024	8/31/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.a.				**Deliverable #2:** Reach out to other Managed Care Plans for feedback on using JIVA/ZeOmega system to monitor and manage PQI cases.	7/1/2024	9/30/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.a.		Continued	**Goal #3**: By June 30, 2025, QI Member Safety Quality Investigation Team will continue to provide Provider Preventable Conditions (PPC) trainings to Partnership network acute inpatient hospitals.	**Deliverable #1:** Reach out to at least five (5) acute care inpatient hospitals and provide an inservice to at least three (3) regarding PPC and reporting requirements.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.a.				**Deliverable #2:** Continue to monitor track and trend reports to determine if inservice training results in an increase in PPC reporting to Partnership.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.a.		New	**Goal #4:** By June 30, 2025, QI Member Safety Quality Investigation Team will investigate/research requirements for the Dual	**Deliverable #1:** Develop a project plan that includes identifying P&P and system changes required to be ready for D-SNP implementation.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #2:** Continue discussions with Senior Medicare QI Program Manager and obtain any D-SNP documents and resources related to Potential Quality Issues (PQI). Review documents to determine potential impact to PQI process and reporting.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.a.		New	Special Needs Plan (D-SNP) program related to Partnership's Potential Quality Issues process and modify/update related policies.	**Deliverable #3:** Review and update related policies.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #4:** Contact other Managed Care Plans for information on D-SNP impact on their PQI process.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.b.	QI Collaboration	New	**Goal #1:** By June 30, 2025, the Site Review Inspections Team currently conducts Medical Record Reviews (MRR) that can take between 5-16 hours side by side with staff/ providers at Primary Care Provider (PCP) sites. In an effort to better utilize that 1:1 time with the site, the Inspections Team will incorporate additional Quality Improvement (QI) department knowledge with the PCP site thereby improving patient care.	**Deliverable #1:** Develop and implement a process to open up communication and share areas of focus between Partnership Quality Department teams (e.g., Performance Improvement (PI), Quality Incentive Programs (QIP), etc.) prior to scheduled site reviews.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.b.				**Deliverable #2:** In an effort to be collaborative, the Site Review Nurse will research recent QI communications with 15 PCP sites prior to the Site Review. Using the knowledge gleaned from the other QI teams' contacts with a PCP site, topics discussed will be reviewed with the site during the 1:1 time spent conducting the MRR to further drive quality improvements.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.b.				**Deliverable #3:** Develop a post MRR survey to be completed by the Site Review Nurses to obtain a subjective evaluation to determine if the additional information assisted in making the site review more informative on a broader scope of quality topics (i.e. QIP/PI Plan-Do-Study-Act (PDSAs), Mammo or Immunization clinics, etc.)	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.c.	CHDP	New	**Goal #1:** Due to Child Health and Disability Program (CHDP) sun setting effective July 1, 2024, the Site Review Inspections Team will be taking over CHDP mandated trainings for the following topics: vision, hearing, fluoride varnish application, anthropometric screenings and information on Vaccines for Children (VFC), per the CHDP Transition Plan (March 2024).	**Deliverable #1:** By December 31, 2024, create Child Health and Disability Program (CHDP) training materials covering the following topics: vision, hearing, fluoride varnish application, anthropometric screenings and information on Vaccines for Children (VFC).	7/1/2024	12/31/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.c.				**Deliverable #2:** By December 31, 2024, implement a process to roll out CHDP training to the Partnership network.	7/1/2024	12/31/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.c.				**Deliverable #3:** Develop a monitoring process for sites regarding their CHDP training status.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.d.	Latent TB Infection Treatment (safety)	Continued	**Goal #1:** By June 30, 2025, a clinical pharmacist will conduct concurrent review of Latent Tuberculosis Infection (LTBI) medication treatments and provide timely notification of all identified potential LTBI treatment regimen gaps, which result from late refill, non-adherence, inappropriate prescribing, and/or inappropriate dispensing. The regimens to be monitored will include 30-doses of isoniazid/rifapentine (1HP), 12-doses of isoniazid/rifapentine (3HP), 90-doses of isoniazid/rifampin (3HR), and 120-doses of rifampin (4R).	**Deliverable #1:** Pharmacist will identify potential treatment gaps and provide notification to prescribers within two timeframes: day 16 and day 20. • Pharmacist will identify and notify providers (via fax) whose members are ≥14 days late in refilling their prescribed LTBI medication. • ≥ 80% of identified potential non-adherence cases will receive provider notification (via fax) no later than day 16 of their member not having their LTBI medication based on the last refill date. • ≤ 20% of the identified potential non-adherence cases will receive provider notification (via fax) no later than day 20 of their member not having their LTBI medication based on the last refill date. Pharmacist will verify gap and confirm member's prescribed LTBI regimen was not completed in the accepted timeframe. • Pharmacist will provide notification to prescribers (via fax) of their member's potential non-adherence to their prescribed LTBI regimen.	7/1/2024	6/30/2025	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.d.				**Deliverable #2:** Pharmacist will monitor for inappropriate prescribing / dispensing of 100-dose rifampin (4R regimen). • Pharmacist will identify and provide information for correct prescribing of 4R regimen. • Pharmacist will notify prescriber (via fax) that 100-dose rifampin is insufficient and is not considered completion of 4R regimen.	7/1/2024	6/30/2025	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.d.		New	**Goal #2:** By June 30, 2025, a clinical pharmacist will provide Latent Tuberculosis Infection (LTBI) summary updates to Partnership's Medical Directors and to the County Public Health Officers.	**Deliverable #1:** Pharmacist will provide semi-annual LTBI summary updates to Partnership's Medical Directors for tracked LTBI regimens (identified late fills, identified possible non-adherence to regimen, actions taken, and results of provider outreach).	7/1/2024	6/30/2025	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.d.				**Deliverable #2:** Pharmacist will provide quarterly update of Partnership members who are prescribed a LTBI regimen and the current status of that LTBI regimen to the County Public Health Officers.	7/1/2024	6/30/2025	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
	8. Quality Improvement Training and Coaching										
8.a.	QI Technical Assistance in Partnership with Northern Region Consortia	Continued	**Goal #1:** By June 30 2025, collaborate with Northern Region consortia to bring QI awareness and education to Northern Region providers: • Develop and post storyboards and infographics to demonstrate successful QI improvement projects over time • Host recurring forums for QI engagement • Develop measure best practices to share with Northern Region consortia members • Complete annual comprehensive organizational profiles for each member to inform and support Partnership and provider partnering in improvement activities	**Deliverable #1:** Develop at least two project storyboards outlining regional Quality Improvement (QI) projects and post on consortia websites.	7/1/2024	6/30/2025	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
8.a.				**Deliverable #2:** Present Partnership updates and timely provider education at least 4 times via monthly QI and Chief Medical Officer (CMO) Peer Network Calls and in-person Rural Round Table events.	7/1/2024	6/30/2025	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.a.				**Deliverable #3:** Develop materials that highlight best practices for focus HEDIS®/Quality Incentive Program measures and proactively share with Northern Region consortia members via consortia hosted webinars, its eNews, or its Peer Network.	7/1/2024	6/30/2025	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.a.				**Deliverable #4:** Complete comprehensive organizational profiles (i.e. inclusive of QI, PCMH, Workforce, and Finance updates) for each Federally Qualified Health Center (FQHC) member to support Partnership's assessment of current performance and identification of key areas for partnering in improvement.	7/1/2024	6/30/2025	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.b.	Performance Improvement Training Offerings	Continued	**Goal #1:** By June 30, 2025, the Improvement Academy will offer multiple forms of Quality Improvement education to the Partnership provider network.	**Deliverable #1:** By June 30, 2025, offer at least four (4) virtual training sessions on priority MCAS measures between January 2025 and June 2025 across the provider network.	1/1/2025	6/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**
8.b.				**Deliverable #2:** By June 30, 2025, offer at least two (2) virtual or in-person ABCs of Quality Improvement training series across the provider network	7/1/2024	6/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.b.				**Deliverable #3:** By June 30, 2025, offer at least two (2) Microlearnings focused on improving outcomes around priority measures for the provider network.	7/1/2024	6/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	
8.b.				**Deliverable #4:** By June 30, 2025, develop a strategy to align ABCs of Quality Improvement curriculum for all regions.	7/1/2024	6/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.b.		Continued	**Goal #2:** By June 30, 2025, the Improvement Academy will develop a strategy to measure the impact of trainings on both MCAS rates and provider network foundational knowledge.	**Deliverable #1:** By June 30, 2025, offer at least four (4) virtual training sessions on priority MCAS measures between January 2025 and June 2025 across the provider network.	7/1/2024	6/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**
8.b.				**Deliverable #2:** By June 30, 2025, continue to measure effectiveness of the ABCs of Quality Improvement trainings by evaluating knowledge pre and post training and develop a mechanism to track implementation of concepts.	7/1/2024	6/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
8.b.				**Deliverable #3:** By June 30, 2025, develop a strategy to evaluate Microlearnings and guide further build out of Microlearning development.	7/1/2024	6/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	
8.c.	Joint Leadership Initiative	Continued	**Goal #1:** Continue Joint Leadership Initiative (JLI) meetings structure plan-wide as Partnership's strategic program for engaging executive teams of high-volume provider organizations around quality improvement. Revisit Partnership attendees to ensure proper alignment given organizational title and role changes, and adapting to updated regional structure.	**Deliverable #1:** By September 30, 2024, review prior year JLI evaluation to assess program effectiveness, and identify update Partnership attendees to reflect new regional structure.	7/1/2024	9/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality & Performance Name: Nancy Steffen	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
8.c.				**Deliverable #2:** By June 30, 2025, conduct all JLI meetings in accordance with new tier structure. The number of JLI meetings by parent organization can range from zero to four meetings during the calendar year, based on MY2023 and MY2024 Quality Incentive Program (QIP) performance.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality & Performance Name: Nancy Steffen	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.c.				**Deliverable #3:** By June 30, 2025, conduct a qualitative and quantitative evaluation of JLI providers for MY 2024 to determine effectiveness of JLI series.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality & Performance Name: Nancy Steffen	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.d.	Provider Coaching and Engagement	Continued	**Goal #1:** By June 30, 2025, the Performance Improvement teams will launch interventions with 80 percent of provider organizations identified as low performing providers on the 2023 Primary Care Provider Quality Incentive Program (PCP QIP) (<25% of clinical points earned) assigned to Enhanced Provider Engagement or a Corrective Action Plan, aimed at improving performance on the Modified QIP.	**Deliverable #1:** By December 31, 2024, the Performance Improvement team will complete a Needs Assessment with 80 percent of provider organizations newly assigned to Enhanced Provider Engagement OR Correction Action Plan in 2024.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	**Yes**
8.d.				**Deliverable #2:** By December 31, 2024, 80 percent of provider organizations with a completed Needs Assessment will select and implement at least one (1) intervention aligned with a Needs Assessment recommendation provided by Partnership.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.d.				**Deliverable #3:** By June 30, 2025, the Performance Improvement team will evaluate the Enhanced Provider Engagement program in 2024, including the use of Corrective Action engagement and advance of QIP dollars for Phase 2 Modified QIP practices.	1/1/2025	6/30/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.d.				**Deliverable #4:** By March 31, 2025, the Performance Improvement team will partner with senior leadership to develop a strategy for evaluating practices new to Partnership in 2024 for inclusion in the Enhanced Provider Engagement and Modified QIP programs.	1/1/2025	3/31/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.d.		New	**Goal #2:** By June 30, 2025, the Performance Improvement teams will engage with practices in the 10 incoming counties joining Partnership in 2024. We will engage with practices holding 70% of assigned membership for incoming counties around PCP QIP performance.	**Deliverable #1:** By December 31, 2024, the Performance Improvement teams will engage primary care practices holding 70% of assigned membership for the 10 incoming counties in regular coaching meetings with assigned Improvement Advisor.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**
8.d.				**Deliverable #2:** By June 30, 2025, the Performance Improvement teams will engage primary care practices holding 60% of assigned membership for incoming counties in regional meetings in partnership with regional leadership.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
8.d.				**Deliverable #3:** By June 30, 2025, the Performance Improvement team, in partnership with regional leadership, will evaluate incoming practices' performance on the 2024 PCP QIP.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.d.		New	**Goal #3:** By December 31, 2024, the Performance Improvement teams will engage with two high-volume Primary Care Provider (PCP) practices in each DHCS reporting sub-region around improvement on high-priority HEDIS® and PCP QIP measures.	**Deliverable #1:** By July 31, 2024, the Performance Improvement team will identify the high-volume PCP practices of focus in each sub-region and measures of focus for engagement.	7/1/2024	7/31/2024	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
8.d.				**Deliverable #2:** By December 31, 2024, the Performance Improvement team will establish a coaching relationship with two (2) high-volume PCP practices in each sub-region and plan and implement at least one intervention to impact at least one measure of focus.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.e.	Expansion of Regional Quality Meetings	Continued	**Goal #1:** By June 30, 2025, Partnership will implement regional quality meetings in all six (6) operational regions to offer forums for regional dialogue to address quality improvement opportunities or barriers.	**Deliverable #1:** By September 30, 2024, Quality Improvement (QI) will evaluate existing regional quality meeting structure and the new expansion counties to determine roles and attendees to ensure alignment with Partnership operations.	7/1/2024	9/30/2024	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**
8.e.				**Deliverable #2:** By June 30, 2025 Quality Improvement (QI) will conduct at least four (4) quarterly meetings in each of the respective regions. The meetings may be comprised of different modalities such as regional quality meetings, the Solano Quality Improvement Program - Improvement workgroup (SQIP-I), How to Succeed sessions, etc.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	
8.e.				**Deliverable #3:** By June 30, 2025 QI will survey attendees for feedback on quality forums as well as inventory projects and activities identified through the regional forums to possibly leverage for scale and spread of successful activities.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
8.f.	Implementation of Plan Wide HEDIS Week in 2023	Continued	**Goal #1:** By June 30, 2025, the HEDIS® team will develop content and conduct a HEDIS® Week to include plan wide activities focused on HEDI®S education. HEDIS® Week is planned to occur in mid-October 2024.	**Deliverable #1:** By August 31, 2024, develop a work plan and materials to conduct a virtual HEDIS® week. Material will be solicited from the HEDIS®, Performance Improvement, Quality Incentive, and NCQA accreditation teams.	7/1/2024	8/31/2024	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
8.f.				**Deliverable #2:** By December 30, 2024: • Conduct the virtual HEDIS® week utilizing LMS created modules, online presentations and email communications. • Develop a survey and distribute to staff to solicit feedback on HEDIS® week. • Review survey feedback to determine any changes or adjustments required for future events. • Develop a sustainability plan to ensure HEDIS® week remains an annual event.	7/1/2024	12/30/2024	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
	9. Cultural and Linguistics Services (See Partnership's 2020 Population Health and Health Education Work Plan)										
	10. Delegation Oversight										
10.a	QI Delegation Oversight	Continued	**Goal #1:** By June 30, 2025, demonstrate strong delegation oversight process in support of delegation standards and Partnership policies and procedures.	**Deliverable #1:** Quarterly and yearly review of delegation committee reports and delegated activities based on submitted documents. Present findings at the Delegation Oversight Committee (DORS) meetings with recommendations.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
10.a				**Deliverable #2:** Participation with the annual delegation audits by Partnership Compliance department. Submit audit findings within required timeframe.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
	11. NCQA Program Management										

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
11.a.	Compliance with NCQA HEA and Preparation for Initial Survey	New	**Goal #1:** By June 30, 2025, departments will maintain compliance of all assigned NCQA Health Equity Accreditation (HEA) Standards and Guidelines and prepare for the HEA Initial Survey in June 2025, as measured by the four (4) deliverables listed.	**Deliverable #1:** Obtain a "yes" score on all assigned requirements during the HEA Mock Initial Survey. If gaps are identified, Business Owners will: • Submit a Corrective Action Plan (CAP) to address all applicable recommendations by September 20, 2024. • All revised evidence must be submitted to the NCQA Consultant for review and approval. • All evidence must be corrected by the date indicated on the CAP in accordance to NCQA's look-back period, timelines, and/or expectations. • Documented processes (policies and/or program descriptions) that require committee's approval must be edited and approved by the NCQA Consultant on or before September 23, 2024.	7/1/2024	9/27/2024	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
11.a.				**Deliverable #2:** By October 25, 2024, Business Owners will update the annual HEA Workbook (Work Plan and Evidence Submission Library). • Review and/or update the HEA Work Plan information based on the 2024 HEA Standards and Guidelines (finalized by July 2024); collect attestations from newly identify key stakeholders and contributors if applicable. • Review and/or update the Evidence Submission Library based on the 2024 HEA Standards and Guidelines (finalized by July 2024) and recommendations from the HEA Mock Initial Survey. All evidence must be produced and dated based on the date(s) listed under the Evidence Submission Library. Any date changes or document revisions must be reviewed and agreed upon by the NCQA Program Management Team in collaboration with the NCQA Consultant. • Contributors identified from FY 23-24 should share their questions with Business Owners for further evaluation and discussion. Submissions of the HEA Workbook that do not follow the instructions are considered incomplete. The NCQA Program Management Team will request the Business Owner make corrections and resubmit, which may cause a delay in meeting the submission deadline. The NCQA Program Management Team will share the annual HEA Workbook by September 27, 2024.	9/27/2024	10/25/2024	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
11.a.				**Deliverable #3:** All Business Owners must confirm and/or submit the following to meet the look-back period for each assigned standard: • Documented Processes: By October 25, 2024, provide acknowledgement that documented processes meet the scope of review throughout the look-back period. Any revisions that impact NCQA requirements must be finalized in November 2024, including timely review by the NCQA Consultant and approval at committee meetings. No edits should be made without review and/or assessment by the NCQA Consultant. • Materials: By November 15, 2024, submit all applicable screenshots as indicated under the Evidence Submission Library to	7/1/2024	6/30/2025	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
11.a.				**Deliverable #4:** By March 28, 2025, Business Owners will submit all annotated evidence for HEA Initial Survey based on the dates listed in the Evidence Submission Library and the submission guidelines provided by the NCQA Program Management Team.	2/3/2025	3/28/2025	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
11.b.				**Deliverable #1:** All Business Owners must confirm and/or submit the following to meet the look-back period for each assigned standard: • Documented Processes: By July 25, 2024, provide acknowledgement that documented processes meet the scope of review throughout the look-back period. Any revisions that impact NCQA requirements must be finalized in August 2024, including timely review by the NCQA Consultant and approval at committee meetings. No edits should be made without review and/or assessment by the NCQA Consultant. • Materials: By August 8, 2024, submit all applicable screenshots as indicated under the Evidence Submission Library to demonstrate the compliance is met.	7/1/2024	8/8/2024	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
11.b.	Compliance with NCQA HPA and Sustain Performance	New	**Goal #1:** By June 30, 2025, departments will maintain compliance of all assigned NCQA Health Plan Accreditation (HPA) Standards and Guidelines, following the most up-to-date Standards and Guidelines once available, as measured by the five (5) deliverables listed.	**Deliverable #2:** By October 18, 2024, Business Owners will update the annual HPA Workbook (Work Plan and Evidence Submission Library) • Review and/or update the HPA Work Plan information based on the 2025 HPA Standards and Guidelines; collect attestations from newly identify key stakeholders and contributors if applicable. • Review and/or update the Evidence Submission Library based on the 2025 HPA Standards and Guidelines changes. All evidence must be produced and dated based on the date(s) listed under the Evidence Submission Library. Any date changes or document revisions must be reviewed and agreed upon by the NCQA Program Management Team in collaboration with the NCQA Consultant. • Contributors identified from FY 23-24 should share their questions with Business Owners for further evaluation and discussion. Submissions of the HPA Workbook that do not follow the instructions are considered incomplete. The NCQA Program Management Team will request the Business Owner make corrections and resubmit, which may cause a delay in meeting the submission deadline. The NCQA Program Management Team will share the annual HPA Workbook by September 20, 2024.	9/20/2024	10/18/2024	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
11.b.				**Deliverable #3**:Complete subset of analysis reports based on the approval dates outlined under the 2024-2026 HPA Report Schedule: • By October 18, 2024, submit edits to the 2024-2026 HPA Report Schedule, if applicable. This would include any changes relative to the reporting period of the data sources, when data sources will become available, and the targeted approval date of the analysis reports. • Submit the analysis reports based on the draft report date provided under the 2024-2026 HPA Report Schedule. All reports must be submitted to the NCQA Consultant for review. All edits must be incorporated in a timely manner prior to any committee review and/or approval, or by the production date as agreed upon under the 2024-2026 HPA Report Schedule	7/1/2024	6/30/2025	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
11.b.				**Deliverable #4**: Departments that oversee file review requirements will maintain strict oversight of Partnership and non-NCQA Accredited delegates' files to ensure compliance. The departments are Provider Relations, Utilization Management, Pharmacy, Grievance and Appeals, and Care Coordination. • By April 2025, participate in a Mock File Review with the NCQA Consultant. This review will include files from Partnership and non-NCQA Accredited delegates. Submit a detailed Corrective Action Plan (CAP) for files that do not score "yes" on each factor within 10 business days from the date of Mock File Review. • The CAP will indicate detailed steps on how to improve file review performance. Business Owners must assess risks and propose a timeline in collaboration with the NCQA Program Management Team. Additional follow-up activities and subsequent monitoring may be required. • At the discretion of the NCQA Steering Committee, ad hoc file review audits with the NCQA Consultant may follow before June 30	7/1/2024	6/30/2025	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
11.b.				**Deliverable #5:** By June 20, 2025, Business Owners will submit all annotated evidence for the Mock Renewal Survey based on the dates listed in the Evidence Submission Library for Year 1 of the look-back period, and the submission guidelines provided by the NCQA Program Management Team.	5/5/2025	6/20/2025	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
	12. Contracting										
	13. Population Health Management: See Partnership's 2020 Population Health Work Plan										
	14. Grand Analysis										

2024-25 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
14.a.	Grand Analysis - Member Experience (ME7) Report	Continued	**Goal #1:** By August 31, 2025, complete the annual Member Experience Grand Analysis (ME7) report. (Note, the ME 7 report is dependent on CAHPS® data results, which are managed by an external vendor (Press Ganey) and not available until after the goal period ends).	**Deliverable #1:** By August 31, 2025, complete the Member Experience Grand Analysis Report (ME7).	6/1/2025	8/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Project Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
14.a.	Grand Analysis - Pharmacy and Utilization Management (UM1B) Report	Continued	**Goal #1:** By June 30, 2025, complete annual Pharmacy & Utilization Management Grand Analysis (UM1B) report per NCQA Health Plan Accreditation standards.	**Deliverable #1:** Complete 2024 UM1B report.	7/1/2024	6/30/2025	Title: Chief Health Services Officer Name: Katherine Barresi	Title: Clinical Pharmacist Name: Andrea Ocampo Title: Associate Director of UM Regulations Name: Tony Hightower	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
14.a.	Grand Analysis - Continuity and Coordination of Medical Care (QI3) Report	Continued	**Goal #1:** By June 30, 2025, Quality Improvement will complete as much as possible of the annual Continuity and Coordination of Medical Care Grand Analysis (QI3) report, given the complete data sets that are available. (The delay for full document completion past June 30, 2025 is required to allow appropriate analysis of all of the	**Deliverable #1:** Complete those sections of the Continuity and Coordination of Medical Care Annual Grand Analysis Report (QI3) for which all needed data is available, including a quantitative and qualitative analysis by June 30, 2025.	7/1/2024	6/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Improvement Advisor Name: Emily Wellander Title: Medical Director for Quality Name: Mark Netherda	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☒ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	**No**
14.a.	Grand Analysis - Continuity and Coordination of Behavioral Health (QI4) Report	Continued	**Goal #1:** By June 30, 2025, Behavioral Health will complete the annual Continuity and Coordination of Behavioral Health Grand Analysis (QI4).	**Deliverable #1:** Complete- QI4 Grand Analysis as measured by completion of report, review and approval by NCQA consultant, and presentation at IQI and QUAC.	9/1/2024	6/30/2025	Title: Chief Health Services Officer Name: Katherine Barresi	Title: Behavioral Health Administrator Name: Mark Bontrager	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☒ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	**No**
14.a.	Grand Analysis - Access and Availability (NET3) Report	Continued	**Goal #1:** By June 30, 2025, the 2024 NET 3 Report will be complete.	**Deliverable #1:** Complete the NET 3 Report	7/1/2024	6/1/2025	Title: Associate Director of Provider Relations Name: Priscila Ayala	Title: Manager of Provider Relations Compliance Name: Renee Trosky	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**

2024-25 Quality Improvement Work Plan - Monitoring of Previous Issues

Item #	Project/Program	24/25 Goal	Status	Monitoring of Previous Issues (FY 2023-24)	Type of Goal
1. QI Program Infrastructure					
1.a.	QI Program Documents	.....	N/A	.....	
1.b.	Physician Advisory Committee (PAC) oversight of QI Program	.....	N/A	.....	
2. Measurement, Analytics and Reporting					
2.a.	HEDIS Reporting	.....	N/A	.....	
2.b.	Member Experience Data	.....	N/A	.....	
2.c.	Member Services Access	.....	N/A	.....	
2.d	Primary Care Provider QIP Payment Process Reporting	.....	N/A	.....	
2.e.	Web Based Member Information Assessment	.....	N/A	.....	
2.f.	PCP QIP eReports System	**Goal #1:** By June 30, 2025, PCP QIP will continue collaborating with the Partnership Web Team to align 2025 eReports with HRP® (Health Rules Payor) data elements in preparation for the launch of HRP®.	N/A	eReports team has been unsuccessful with launching eReports with HRP (Health Rules Payor) data due to continued delays of HRP® implementation. Tentative date of HRP® go live is TBD.	Continued
2.g.	Partnership Quality Dashboard (PQD)	**Goal #1**: By June 30, 2025, apply annual development updates of the MY2025 HEDIS® Monthly Exploratory Dashboard in accordance with identified stakeholder needs (Contingent on HRP® implementation).	N/A	HRP® Delay - Development and implementation of the HEDIS® Monthly Exploratory Dashboards are largely dependent on the implementation timeline for Health Rules Payor (HRP®). Once the HRP® timeline has been re-established, an adjusted timeline for the HEDIS® Monthly exploratory will be identified, but at this time, timeline appears to be achievable.	Continued
2.h.	Enterprise Information Management	**Goal #1**: By June 30, 2025, integrate the HRP® version of the HEDIS® monthly project data into the Enterprise Data Warehouse and use this data to create the HRP® version of the HEDIS® PQD modules	N/A	Integrating the HRP HEDIS® data to the data warehouse and using this data for the HRP® version of the HEDIS® PQD dashboards was a goal in the previous year and this goal had to be delayed due to the HRP® go live date being pushed back. Therefore, this goal will be continued into this next	Continued
2.h.	Enterprise Information Management	**Goal #3:** By June 30, 2025, integrate Electronic Clinical Data Systems data (behavioral health, depression screening, various clinical measures) from Data Link and Sutter into the Enterprise Data Warehouse		Deliverables #1 and #2 are new to FY 24-25 and Deliverable #3 is continuation of previous year FY 23-24 goal as there were delays in meeting the HEDIS® & QIP timelines	Continued
2.i.	D-SNP	.....	N/A	.....	
2.j.	D-SNP HEDIS Reporting	.....	N/A	.....	
3. Value Based Payment Programs (QIP)					
3.a.	Primary Care Provider Quality Improvement Program (PCP QIP)	.....	N/A	.....	
3.b.	Hospital Quality Improvement Program (H-QIP)	.....	N/A	.....	
3.c.	Palliative Care Quality Improvement Program (PC QIP)	Goal #2: By June 30, 2025, complete CY 2024 PC QIP evaluation.	N/A	Payment for measure period II (July-December 2023) has been delayed due to the following reasons: • PCQC delayed the submission of the Bi-Annual report for measure period II (July-December 2023)	Continued
3.d.	Perinatal QIP	.....	N/A	.....	
3.e.	Enhanced Care Management Quality Improvement Program (ECM QIP)	.....	N/A	.....	
3.f.	D-SNP QIP Development	.....	N/A	.....	
3.g.	Patient Experience Unit of Service Measure Development	.....	N/A	.....	
4. Improvement Projects, Clinical Quality					
4.a.	Quality Measure Score Improvement (QMSI)	.....	N/A	.....	
4.b.	Reduced Missed Opportunities	.....	N/A	.....	
4.c.	Healthy Kids Growing Together Program	.....	N/A	.....	
4.d.	Mobile Mammography Program	.....	N/A	.....	
5. Service and Patient Experience					
5.a.	Collect Member Experience Data	.....	N/A	.....	
5.b.	CAHPS D-SNP	.....	N/A	.....	
6. Population Health Management and Care for Members with Complex Needs					
6.a.	Care for Members with Complex Needs	.....	N/A	.....	
7. Quality Assurance and Patient Safety					
7.a.	Potential Quality Issues (PQI)	.....	N/A	.....	
7.b.	QI Collaboration	.....	N/A	.....	
7.c.	CHDP	.....	N/A	.....	

7.d.	Latent TN Infection -12 Dose Treatment	.....	N/A	.....	
8. Quality Improvement Training and Coaching					
8.a.	QI Technical Assistance in Partnership with Northern Region Consortia	.....	N/A	.....	
8.b.	Performance Improvement Training Offering	.....	N/A	.....	
8.c.	Joint Leadership Initiative	.....	N/A	.....	
8.d.	Provider Coaching and Engagement		N/A		
8.e.	Expansion of Regional Quality Meetings	.....	N/A	.....	
8.f.	Implementation of Plan Wide HEDIS Week	.....	N/A	.....	
9. Cultural and Linguistics Services (See PHC Cultural and Linguistics Health Education/Cultural and Linguistics Work Plan)					
10. Delegation Oversight					
10.a.	QI Delegation Oversight	.....	N/A	.....	
11. NCQA Project Management					
11.a.	Compliance with NCQA HEA and Preparation for Initial Survey	.....	N/A	.....	
11.b.	Compliance with NCQA HPA and Sustain Performance	.....	N/A	.....	
12. Contracting					
13. Population Health Management					
14. Grand Analysis					
14.a.	Grand Analysis - Member Experience (ME7) Report	.....	N/A	.....	
14.a.	Grand Analysis - Pharmacy & Utilization Management (UM1B) Report	.....	N/A	.....	
14.a.	Grand Analysis - Continuity and Coordination of Medical Care (QI3) Report	.....	N/A	.....	
14.a.	Grand Analysis - Continuity and Coordination of Behavioral Health (QI4) Report	.....	N/A	.....	
14.a.	Grand Analysis - Access and Availability (NET3) Report	.....	N/A	.....	

Approval Signatures

Robert Moore, MD, MPH, MBA	8/12/2025
Quality/Utilization Advisory Committee Chairperson	*Date Approved*
Angela Brennan, DO	9/10/2025
Physician Advisory Committee Chairperson	*Date Approved*
Kim Tangerman	10/22/2025
Board of Commissioners Chairperson	*Date Approved*