Quality Improvement Health Equity Transformation Annual Program Evaluation Fiscal Year 2023 – 2024

QIHEC Approval: February 5, 2025

Health Commission Approval: February 26, 2025

Contents

HPSJ's Vision, Mission, and Values

Mission, Vision and Values

QIHETP supports Health Plan's mission and vision through the development and maintenance of a quality driven network of care for all lines of business. Every three years, the plan evaluates the relevance of the mission, vision and core values to ensure alignment with the needs of the members it serves, the community, the provider network, the organization staff, that there is full alignment with regulatory requirements, and that adjustments are made accordingly

Vision

Healthy Communities with Equitable Access to Quality Care.

Mission

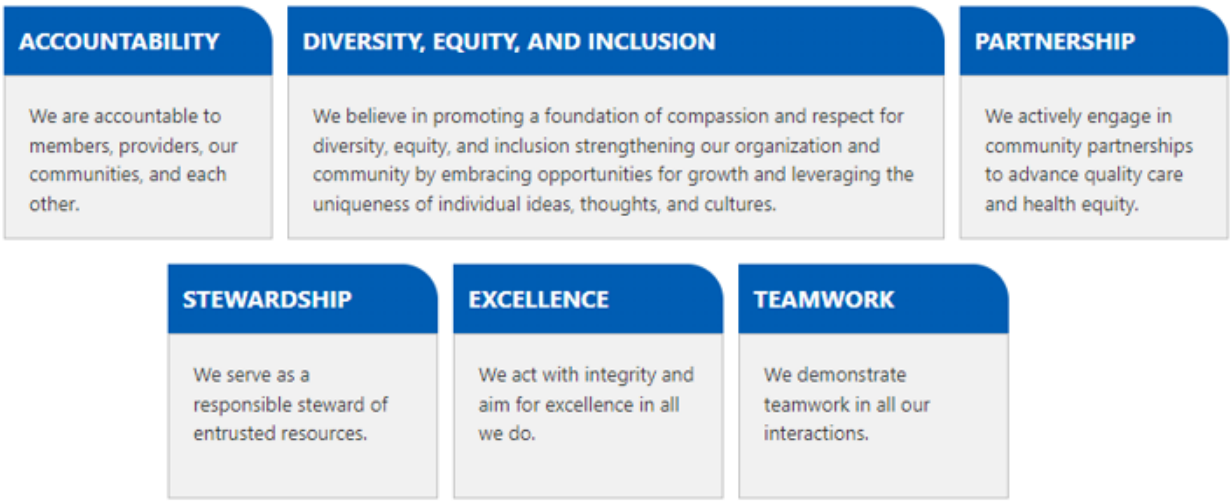
Provide high quality healthcare for our members through community partnerships.

Values

The Health Plan prides itself on its six core values. These values were developed on the principle that our values are behaviors that resonate, are genuine, and embody our activities daily.

Core Values

HPSJ's core values were developed on the principle that our values are behaviors that are true and embodied into our daily activities. Our QM program supports all our core values:



Anti-Discrimination Statement

HPSJ monitors, evaluates, and takes effective action to address needed improvement in any setting. The Health Plan is accountable for the quality of all covered services, regardless of additional hired contractors to render services on behalf of the Plan.

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

Executive Summary

Quality of Clinical Care

HEDIS Annual Report

2023-2024

Document Prepared By: Vanessa Lagemann, Manager of HEDIS & Quality Reporting

Introduction

The California Department of Healthcare Services (DHCS) and the California Department of Managed Care (DMHC) require Managed Care Plans (MCPs) to report quality and performance improvement measure data from nationally recognized entities. Health Plan is an NCQA Accredited health plan. NCQA uses predetermined quality measure rates to score plans for Health Plan Accreditation annually. The following stewards represent the full range of sources for the quality and reporting requirements set forth by DHCS, DMHC and NCQA. DHCS calls the required measure set "Managed Care accountability Set", DMHC calls the required measure set the Health Equity and Quality Measure Set (HEQMS).

- Healthcare Effectiveness Data and Information Set (HEDIS), a set of measures maintained, and promulgated by the National Committee for Quality Assurance (NCQA).
- Adult and Child Core Measures are developed and maintained by The Centers for Medicaid and Medicare (CMS).
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) member experience surveys.
- Dental Quality Association (DQA) dental related measures.
- The Joint Health Commission (TJC).

Health Plan implemented many initiatives during Measurement Year (MY) 2023 that impacted rates significantly. This annual evaluation will analyze the results of measures reported to DHCS and NCQA as well as identify opportunities.

The HEDIS MY 2023 Annual report has been prepared by the Health Plan HEDIS team and consists of the measures reported to NCQA and DHCS and selected HEDIS survey measures collected through CAHPS. Some measures have been

grouped to include sub-measures that are reported individually but are scored as one measure by NCQA and/or DHCS.

Table 1: Required Measures

The following table lists measures that are required for reporting by the DHCS and NCQA for accreditation and the measure type – Electronic Clinical Data System (ECDS), Administrative (Admin) or Hybrid and the measure steward.

MCAS measure rates are calculated and reported at the county level to DHCS. HEDIS rates reported to NCQA for Accreditation star ratings are calculated by combining both San Joaquin (SJ) and Stanislaus (ST) counties and reporting as one rate to NCQA. Table 1 lists all measures and metrics submitted by HPSJ for reporting annually. The measure steward is listed in the far-right column. An 'X' in the NCQA column indicates measures is reported to NCQA for the HPSJ Total population, and 'X' in the DHCS column indicates the measure is reported at the county level to DHCS.

Measure Acronym	Description	NCQA	DHCS	ECDS	Admin	Hybrid	Source
Behavioral Health							
FUM-30 Days	Follow-Up After ED Visit for Mental Illness – 30 Days		**X**		**X**		**NCQA**
FUA-30 Days	Follow-Up After ED Visit for Substance Use-30 Days		**X**		**X**		**NCQA**
FUM-7 Days	Follow-Up After ED Visit for Mental Illness – 7 days	**X**	**X**		**X**		**NCQA**
FUA-7 Days	Follow-Up After ED Visit for Substance Use-7 Days	**X**	**X**		**X**		**NCQA**
FUH-7 Days	Follow-Up After Hospitalization for Mental Illness – 7 days	**X**			**X**		**NCQA**
FUI-7 Days	Follow-Up After High Intensity Care for Substance Use Disorder-7 Days	**X**			**X**		**NCQA**
DSF-E	Depression Screening and Follow-Up for Adolescents and Adults		**X**	**X**			**NCQA**
DRR-E	Depression Remission or Response for		**X**	**X**			**NCQA**

Measure Acronym	Description	NCQA	DHCS	ECDS	Admin	Hybrid	Source
	Adolescents and Adults						
PND-E	Prenatal Depression Screening and Follow-Up		**X**	**X**			**NCQA**
PDS-E	Postpartum Depression Screening and Follow-Up		**X**	**X**			**NCQA**
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	**X**	**X**		**X**		**NCQA**
ADD-Init	Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase		**X**		**X**		**NCQA**
ADD-C&M	Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase	**X**	**X**		**X**		**NCQA**
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Blood Glucose & Cholesterol Testing – Total	**X**	**X**		**X**		**NCQA**
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	**X**			**X**		**NCQA**
AMM-Acute	Antidepressant Medication Management – Acute Phase Treatment		**X**		**X**		**NCQA**
AMM-Cont	Antidepressant Medication Management – Effective Continuation Phase Treatment	**X**	**X**		**X**		**NCQA**

Measure Acronym	Description	NCQA	DHCS	ECDS	Admin	Hybrid	Source
POD	Pharmacotherapy for Opioid Use Disorder – Total	**X**	**X**		**X**		**NCQA**
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – Total	**X**			**X**		**NCQA**
IET	Initiation and Engagement of Substance Use Disorder Treatment – Engagement of SUD Treatment – Total	**X**			**X**		**NCQA**
Children's Health Measures							
TFL-CH	Topical Fluoride for Children		**X**		**X**		**DQA**
CIS-Combo 10	Childhood Immunization Status-Combo 10	**X**	**X**			**X**	**NCQA**
IMA	Immunizations for Adolescents	**X**	**X**			**X**	**NCQA**
W30-0-15	Well-Child Visits in the First 30 Months of Life – 0-15 Months – 6 or More Well-Child Visits		**X**		**X**		**NCQA**
W30-15-30	Well-Child Visits in the First 30 Months of Life – 15-30 Months – 2 or More Well-Child Visits		**X**		**X**		**NCQA**
WCC	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – BMI Percentile-Total	**X**				**X**	**NCQA**
WCV	Child and Adolescent Well-Care Visits		**X**		**X**		**NCQA**
DEV	Developmental Screening in the First Three Years of Life		**X**		**X**		**CMS**
LSC	Lead Screening in Children		**X**			**X**	**NCQA**
Chronic Disease Management Measures							

Measure Acronym	Description	NCQA	DHCS	ECDS	Admin	Hybrid	Source
AMR	Asthma Medication Ratio	X	X		X		NCQA
CBP	Controlling High Blood Pressure	X	X			X	NCQA
HBD – Poor Control	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9%)		X			X	NCQA
HBD-Control	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Control (<8%)	X				X	NCQA
BPD	Blood Pressure Control (<140/90) for Patients with Diabetes	X				X	NCQA
EED	Eye Exam for Patients with Diabetes	X				X	NCQA
KED	Kidney Health Evaluation for Patients with Diabetes - Total	X			X		NCQA
Reproductive Health							
CHL	Chlamydia Screening in Women	X	X		X		NCQA
PPC	Prenatal & Postpartum Care	X	X			X	NCQA
PRS-E	Prenatal Immunizations Status – Combination Rate	X	X	X			NCQA
CCW-MMEC	Contraceptive Care-All Women: Most or Moderately Effective Contraception		X		X		CMS
CCP-MMEC60	Contraceptive Care-Postpartum Women: Most or Moderately Effective Contraception – 60 Days		X		X		CMS
NTSV CB	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate		X		X		TJC
Cancer Screening							

Measure Acronym	Description	NCQA	DHCS	ECDS	Admin	Hybrid	Source
BCS-E	Breast Cancer Screening	X	X	X			NCQA
CCS	Cervical Cancer Screening	X	X			X	NCQA
COL	Colorectal Cancer Screening		X		X		NCQA
Utilization/Access to Care							
PCR	Plan All-Cause Readmissions – Observed-to-Expected Ratio – 18-64 years	X	X		X		NCQA
AMB-ED	Ambulatory Care: ED Visits		X		X		NCQA
AAP	Adults' Access to Preventive/Ambulatory Health Services		X		X		NCQA
Long Term Care Measures							
HFS	Number of Out-patient ED Visits per 1,000 Long Stay Resident Days		X		X		CMS
SNF HAI	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalizations		X		X		CMS
PPR	Potentially Preventable 30-day Post-Discharge Readmission		X		X		CMS
Equity							
RDM	Race/Ethnicity Diversity of Membership	X			X		NCQA
Other							
AIS-E	Adult Immunization Status	X		X			NCQA
LBP	Use of Imaging Studies for Low Back Pain-Total	X			X		NCQA
Respiratory							
CWP	Appropriate Testing for Children with Pharyngitis	X			X		NCQA

Measure Acronym	Description	NCQA	DHCS	ECDS	Admin	Hybrid	Source
URI	Appropriate Treatment for Children W/ Upper Respiratory Infection	**X**			**X**		**NCQA**
AAB	Avoidance of Antibiotic Treatment in Adults W/ Acute Bronchitis	**X**			**X**		**NCQA**
PCE	Pharmacotherapy Management of COPD Exacerbation	**X**			**X**		**NCQA**
Heart Disease							
SPD-Therapy	Statin Therapy for Patients with Diabetes - Received Statin Therapy	**X**			**X**		**NCQA**
SPD-80%	Statin Therapy for Patients with Diabetes - Statin Adherence 80%	**X**			**X**		**NCQA**
SPC-Therapy	Statin Therapy for Patients with Cardiovascular Disease – Received Statin Therapy – Total	**X**			**X**		**NCQA**
SPC-80%	Statin Therapy for Patients with Cardiovascular Disease – Received Statin Therapy – 80%	**X**			**X**		**NCQA**

Table 2: San Joaquin County – Three Year Trend

The health plan evaluates performance at the county level. Tables 2 and 3 display a year over year 3-year trend report of health plan performance rates for San Joaquin and Stanislaus Counties.

The first 3 columns in tables 2 and 3 indicate whether the measure was held to the Minimum Performance Level (MPL) for the measure year indicated. The next column displays the NCQA National Medicaid 50th Percentile for the most recent measurement year. The last 3 columns show year over year final rates for measurement years 2021 – 2023. An 'NR' in a cell indicates the measure was Not Reported during the measurement year.

Cells colored green indicate the measure met the MPL. Cells colored yellow indicate that the rate was within 5% of the goal. Cells colored red indicate that

the measure did not meet the goal. Cells with no color indicate that there was no MPL for the measure the year indicated.

Measure Acronym	Description	MY2023 RY2024	MY2022 RY2023	MY2021 RY2022	MY2023 MPL	SJ MY2023/ RY2024	SJ MY2022/ RY2023	SJ MY2021/R Y2022
Behavioral Health								
FUM-30 Days	Follow-Up After ED Visit for Mental Illness – 30 Days	X	X		**54.87%**	23.71%	52.39%	59.69%
FUM-7 Days	Follow-Up After ED Visit for Mental Illness – 7 days				**40.59%**	15.89%	43.54%	52.25%
FUA-30 Days	Follow-Up After ED Visit for Substance Use-30 Days	X	X		**36.34%**	17.49%	17.08%	7.17%
FUA-7 Days	Follow-Up After ED Visit for Substance Use-7 Days				**24.51%**	11.69%	10.59%	3.79%
DSF-E-Screening	Depression Screening and Follow-Up for Adolescents and Adults - Screening				**NA**	20.84%	0.00%	NR
DSF-E-Follow-Up	Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up				**NA**	62.38%	0.00%	NR
DRR-E-Follow-Up	Depression Remission or Response for Adolescents and Adults-Follow-Up				**NA**	42.42%	0.00%	NR
DRR-E-Remission	Depression Remission or Response for Adolescents and Adults-Remission				**NA**	7.07%	0.00%	NR
DRR-E-Response	Depression Remission or Response for Adolescents and Adults-Response				**NA**	13.89%	0.00%	NR
PND-E-Screening	Prenatal Depression - Screening				**0.23%**	28.76%	0.00%	NR

[Name} Committee Approval: 00/00/00
Health Commission Approval: 00/00/00

Measure Acronym	Description	MY2023 RY2024	MY2022 RY2023	MY2021 RY2022	MY2023 MPL	SJ MY2023/ RY2024	SJ MY2022/ RY2023	SJ MY2021/R Y2022
PND-E - Follow-Up	Prenatal Depression - Follow-Up				**54.84%**	47.67%	0.00%	NR
PDS-E - Screening	Postpartum Depression - Screening				**0.10%**	21.27%	0.00%	NR
PDS-E - Follow-Up	Postpartum Depression - Follow-Up				**63.40%**	66.67%	0.00%	NR
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications				**79.05%**	88.07%	85.23%	84.30%
ADD-Init	Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase				**44.21%**	48.98%	61.90%	54.24%
ADD-C&M	Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase				**54.40%**	50.28%	46.12%	40.95%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Blood Glucose & Cholesterol Testing – Total				**34.38%**	39.58%	36.23%	55.56%
AMM-Acute	Antidepressant Medication Management – Acute Phase Treatment				**60.79%**	73.23%	59.38%	55.90%

Measure Acronym	Description	MY2023 RY2024	MY2022 RY2023	MY2021 RY2022	MY2023 MPL	SJ MY2023/ RY2024	SJ MY2022/ RY2023	SJ MY2021/R Y2022
AMM-Cont.	Antidepressant Medication Management – Effective Continuation Phase Treatment				**43.28%**	57.79%	48.47%	36.85%
POD	Pharmacotherapy for Opioid Use Disorder – Total				**28.49%**	17.03%	49.09%	NR
Children's Health Measures								
TFL-CH	Topical Fluoride for Children	X			19.30%	18.73%	2.15%	NR
CIS-Combo 10	Childhood Immunization Status-Combo 10	X	X	X	30.90%	27.98%	36.50%	36.98%
IMA-2	Immunizations for Adolescents-Combo 2	X	X	X	34.31%	40.88%	37.55%	39.17%
W30-0-15	Well-Child Visits in the First 30 Months of Life – 0-15 Months – 6 or More Well-Child Visits	X	X	X	58.38%	51.67%	50.36%	44.63%
W30-15-30	Well-Child Visits in the First 30 Months of Life – 15-30 Months – 2 or More Well-Child Visits	X	X	X	66.76%	62.46%	60.67%	58.30%
WCV	Child and Adolescent Well-Care Visits	X	X	X	48.07%	49.44%	47.26%	46.23%
DEV	Developmental Screening in the First Three Years of Life	X			34.70%	18.60%	27.34%	NR
LSC	Lead Screening in Children	X	X		62.79%	46.47%	46.11%	NR
Chronic Disease Management Measures								
AMR	Asthma Medication Ratio	X			64.61%	66.45%	58.86%	48.07%

Measure Acronym	Description	MY2023 RY2024	MY2022 RY2023	MY2021 RY2022	MY2023 MPL	SJ MY2023/ RY2024	SJ MY2022/ RY2023	SJ MY2021/R Y2022
CBP	Controlling High Blood Pressure	X	X	X	61.31%	68.68%	59.37%	57.18%
HBD – Poor Control	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9%)	X	X	X	37.96%	35.52%	35.52%	38.44%
Reproductive Health								
CHL	Chlamydia Screening in Women	X	X	X	56.04%	59.77%	58.78%	58.54%
PPC-Pre	Timeliness of Prenatal Care	X	X	X	84.23%	85.40%	87.59%	88.08%
PPC - Post	Postpartum Care	X	X	X	78.10%	84.43%	79.08%	78.83%
PRS-E	Prenatal Immunizations Status – Combination Rate				19.49%	23.71%	26.09%	NR
Cancer Screening								
BCS-E	Breast Cancer Screening	X	X	X	52.60%	50.54%	50.44%	47.29%
CCS	Cervical Cancer Screening	X	X	X	57.11%	63.99%	56.93%	56.26%
COL-E	Colorectal Cancer Screening				NA	37.92%	28.53%	NR
Utilization/Access to Care								
AAP	Adults' Access to Preventive/Ambulatory Health Services				72.91%	69.19%	70.27%	NR

Quantitative Analysis – San Joaquin County – Three Year Trend

Health Plan puts great emphasis on MCAS measures held to the DHCS established Minimum Performance Level (MPL). DHCS adopts the NCQA Quality Compass National Medicaid Managed Care 50th percentile as the performance goal. Of the 18 measures held to MPL during MY2023 the health plan reached or exceeded the goal for 9 measures. This is an increase of 3 additional measures meeting the goal compared to MY2022. Of the 18 measures, 9 did not meet the MPL for MY2023, 4 of the 9 measures not meeting were within 5% of meeting the MPL for MY2023. Of the 18 measures, 14 measures stayed the same or saw an increase in final rate from MY2022 to MY2023.

Table 3: Stanislaus County – Three Year Trend

Measure Acronym	Description	MY2023 RY2024	MY2022 RY2023	MY2021 RY2022	MY2023 MPL	ST MY2023/ RY2024	ST MY2022/ RY2023	ST MY2021/ RY2022
Behavioral Health								
FUM-30 Days	Follow-Up After ED Visit for Mental Illness – 30 Days	X	X		**54.87%**	26.56%	47.16%	49.18%
FUM-7 Days	Follow-Up After ED Visit for Mental Illness – 7 days				**40.59%**	13.50%	35.97%	40.27%
FUA-30 Days	Follow-Up After ED Visit for Substance Use-30 Days	X	X		**36.34%**	23.57%	18.06%	5.56%
FUA-7 Days	Follow-Up After ED Visit for Substance Use-7 Days				**24.51%**	14.91%	12.19%	2.22%
DSF-E-Screening	Depression Screening and Follow-Up for Adolescents and Adults - Screening				**NA**	0.16%	0.00%	NR
DSF-E-Follow-Up	Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up				**NA**	50.00%	0.00%	NR
DRR-E-Follow-Up	Depression Remission or Response for Adolescents and Adults-Follow-Up				**NA**	NA	0.00%	NR
DRR-E-Remission	Depression Remission or Response for Adolescents and Adults-Remission				**NA**	NA	0.00%	NR

[Name} Committee Approval: 00/00/00
Health Commission Approval: 00/00/00

Measure Acronym	Description	MY2023 RY2024	MY2022 RY2023	MY2021 RY2022	MY2023 MPL	ST MY2023/ RY2024	ST MY2022/ RY2023	ST MY2021/ RY2022
DRR-E-Response	Depression Remission or Response for Adolescents and Adults-Response				**NA**	NA	0.00%	NR
PND-E-Screening	Prenatal Depression - Screening				**0.23%**	0.16%	0.00%	NR
PND-E - Follow-Up	Prenatal Depression - Follow-Up				**54.84%**	NA	0.00%	NR
PDS-E - Screening	Postpartum Depression - Screening				**0.10%**	0.14%	0.00%	NR
PDS-E - Follow-Up	Postpartum Depression - Follow-Up				**63.40%**	NA	0.00%	NR
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications				**79.05%**	78.69%	78.13%	80.86%
ADD-Init	Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase				**44.21%**	50.00%	41.18%	50.00%
ADD-C&M	Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase				**54.40%**	50.00%	39.50%	43.52%

Measure Acronym	Description	MY2023 RY2024	MY2022 RY2023	MY2021 RY2022	MY2023 MPL	ST MY2023/ RY2024	ST MY2022/ RY2023	ST MY2021/ RY2022
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Blood Glucose & Cholesterol Testing – Total				**34.38%**	33.50%	37.31%	20.00%
AMM-Acute	Antidepressant Medication Management – Acute Phase Treatment				**60.79%**	74.37%	60.37%	54.94%
AMM-Cont	Antidepressant Medication Management – Effective Continuation Phase Treatment				**43.28%**	58.57%	48.37%	37.33%
POD	Pharmacotherapy for Opioid Use Disorder – Total				**28.49%**	23.03%	46.21%	NR
Children's Health Measures								
TFL-CH	Topical Fluoride for Children	X			**19.30%**	18.73%	0.61%	NR
CIS-Combo 10	Childhood Immunization Status-Combo 10	X	X	X	**30.90%**	20.68%	20.92%	29.20%
IMA-2	Immunizations for Adolescents-Combo 2	X	X	X	**34.31%**	30.66%	30.20%	33.33%
W30-0-15	Well-Child Visits in the First 30 Months of Life – 0-15 Months – 6 or More Well-Child Visits	X	X	X	**58.38%**	46.21%	35.32%	37.98%

Measure Acronym	Description	MY2023 RY2024	MY2022 RY2023	MY2021 RY2022	MY2023 MPL	ST MY2023/ RY2024	ST MY2022/ RY2023	ST MY2021/ RY2022
W30-15-30	Well-Child Visits in the First 30 Months of Life – 15-30 Months – 2 or More Well-Child Visits	X	X	X	**66.76%**	62.67%	56.49%	54.30%
WCV	Child and Adolescent Well-Care Visits	X	X	X	**48.07%**	46.04%	41.89%	37.71%
DEV	Developmental Screening in the First Three Years of Life	X			**34.70%**	18.60%	16.25%	NR
LSC	Lead Screening in Children	X	X		**62.79%**	43.55%	39.37%	NR
Chronic Disease Management Measures								
AMR	Asthma Medication Ratio	X			**64.61%**	61.90%	60.07%	58.38%
CBP	Controlling High Blood Pressure	X	X	X	**61.31%**	61.56%	59.85%	55.96%
HBD – Poor Control	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9%)	X	X	X	**37.96%**	28.95%	40.63%	41.61%
Reproductive Health								
CHL	Chlamydia Screening in Women	X	X	X	**56.04%**	51.72%	52.60%	50.77%
PPC-Pre	Timeliness of Prenatal Care	X	X	X	**84.23%**	86.86%	86.37%	87.10%
PPC - Post	Postpartum Care	X	X	X	**78.10%**	86.37%	80.05%	79.81%
PRS-E	Prenatal Immunizations Status – Combination Rate				**19.49%**	24.24%	28.09%	NR
Cancer Screening								

Measure Acronym	Description	MY2023 RY2024	MY2022 RY2023	MY2021 RY2022	MY2023 MPL	ST MY2023/ RY2024	ST MY2022/ RY2023	ST MY2021/ RY2022
BCS-E	Breast Cancer Screening	X	X	X	**52.60%**	52.64%	50.42%	49.96%
CCS	Cervical Cancer Screening	X	X	X	**57.11%**	56.45%	58.15%	59.12%
COL-E	Colorectal Cancer Screening				**NA**	33.56%	25.85%	NR
Utilization/Access to Care								
AAP	Adults' Access to Preventive/Ambulatory Health Services				**72.91%**	68.15%	68.54%	NR

Quantitative Analysis – Stanislaus County – Three Year Trend

Of the 18 measures held to MPL during MY2023 the health plan reached or exceeded the goal for 5 measures, this is an increase of 1 additional measure meeting the goal compared to MY2022. Of the 18 measures, 13 did not meet the MPL for MY2023, 7 of the 13 measures not meeting were within 5% of meeting the MPL for MY2023. Of the 18 measures, 14 measures stayed the same or saw an increase in final rate from MY2022 to MY2023.

Health Plan of San Joaquin Total HEDIS Trends 3 Year Comparison

The health plan reports HEDIS measures at the health plan total level for NCQA Health Plan Rankings. Table 4 displays a year over year 3-year trend report of health plan performance rates for the health plan total population.

The first column displays the NCQA National Medicaid 50th Percentile for the most recent measurement year. The last 3 columns show year over year final rates for measurement years 2021 – 2023. An 'NR' in a cell indicates the measure was Not Reported during the measurement year.

Cells colored green indicate the measure met the MPL. Cells colored yellow indicate that the rate was within 5% of the goal. Cells colored red indicate that the measure did not meet the goal. Cells with no color indicate that there was no MPL for the measure the year indicated.

Table 4: HPSJ Total HEDIS Trends 3 Year Comparison

Measure Acronym	Description	MY2023 50TH Percentile	HPSJ MY2023/ RY2024	HPSJ MY2022/ RY2023	HPSJ MY2021/ RY2022
Behavioral Health					
FUM-7 Days	Follow-Up After ED Visit for Mental Illness – 7 days	**40.59%**	14.75%	39.81%	46.43%
FUA-7 Days	Follow-Up After ED Visit for Substance Use-7 Days	**24.51%**	13.04%	11.28%	3.17%
FUH-7 Days	Follow-Up After Hospitalization for Mental Illness – 7 days	**29.48%**	5.63%	0.00%	NR
FUI-7 Days	Follow-Up After High Intensity Care for Substance Use Disorder-7 Days	**30.02%**	10.93%	8.42%	8.05%
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	**79.05%**	83.22%	81.51%	82.62%
ADD-C&M	Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase	**54.40%**	50.18%	55.93%	52.58%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Blood Glucose & Cholesterol Testing – Total	**34.38%**	36.84%	36.66%	51.22%
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	**61.39%**	76.36%	76.93%	5.55%
AMM-Cont	Antidepressant Medication Management – Effective Continuation Phase Treatment	**43.28%**	58.17%	48.42%	37.07%
POD	Pharmacotherapy for Opioid Use Disorder – Total	**28.49%**	20.00%	47.74%	57.14%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – Total	**60.22%**	27.74%	18.98%	36.36%
IET	Initiation and Engagement of Substance Use Disorder Treatment – Engagement of SUD Treatment – Total	**13.87%**	3.27%	2.17%	NR
Children's Health Measures					
CIS-Combo 10	Childhood Immunization Status-Combo 10	**30.90%**	23.36%	30.90%	37.71%
IMA-2	Immunizations for Adolescents-Combo 2	**34.31%**	36.83%	34.96%	38.69%
WCC	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents – BMI Percentile-Total	**67.76%**	81.82%	80.05%	78.59%

[Name} Committee Approval: 00/00/00
Health Commission Approval: 00/00/00

Measure Acronym	Description	MY2023 50TH Percentile	HPSJ MY2023/ RY2024	HPSJ MY2022/ RY2023	HPSJ MY2021/ RY2022
Chronic Disease Management Measures					
AMR	Asthma Medication Ratio	**64.61%**	64.48%	59.38%	52.47%
CBP	Controlling High Blood Pressure	**61.31%**	64.48%	63.75%	57.18%
HBD-Control	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Control (<8%)	**37.96%**	32.60%	51.58%	49.64%
BPD	Blood Pressure Control (<140/90) for Patients with Diabetes	**61.31%**	70.07%	64.72%	62.29%
EED	Eye Exam for Patients with Diabetes	**52.31%**	38.93%	45.74%	48.42%
KED	Kidney Health Evaluation for Patients with Diabetes - Total	**33.52%**	46.04%	45.65%	NR
Reproductive Health					
CHL	Chlamydia Screening in Women	**56.04%**	56.70%	56.44%	55.59%
PPC-Pre	Timeliness of Prenatal Care	**84.23%**	83.94%	88.56%	86.37%
PPC - Post	Postpartum Care	**78.10%**	83.21%	82.24%	76.89%
PRS-E	Prenatal Immunizations Status – Combination Rate	**19.49%**	23.92%	26.86%	31.26%
Cancer Screening					
BCS-E	Breast Cancer Screening	**52.60%**	51.35%	50.43%	48.33%
CCS	Cervical Cancer Screening	**57.11%**	55.96%	58.15%	57.42%
Other					
AIS-E-Flu	Adult Immunization Status-Flu	**13.57%**	17.14%	NR	NR
AIS-E-Tdap	Adult Immunization Status-Tdap	**34.39%**	52.70%	NR	NR
AIS-E-Zoster	Adult Immunization Status-Zoster	**7.10%**	12.15%	NR	NR
AIS-E-Pnuemo	Adult Immunization Status-Pneumo	**NA**	60.21%	NR	NR
LBP	Use of Imaging Studies for Low Back Pain-Total	**73.15%**	74.40%	76.20%	78.36%
Respiratory					
CWP	Appropriate Testing for Children with Pharyngitis	**73.55%**	51.13%	32.51%	29.05%
URI	Appropriate Treatment for Children W/ Upper Respiratory Infection	**93.31%**	89.06%	89.64%	88.83%
AAB	Avoidance of Antibiotic Treatment in Adults W/ Acute Bronchitis	**61.42%**	55.02%	59.73%	51.02%
PCE – Syst Cort	Pharmacotherapy Management of COPD Exacerbation - Systematic Corticosteroid	**72.46%**	65.03%	71.28%	61.84%

Measure Acronym	Description	MY2023 50TH Percentile	HPSJ MY2023/ RY2024	HPSJ MY2022/ RY2023	HPSJ MY2021/ RY2022
PCE-Bronc	Pharmacotherapy Management of COPD Exacerbation-Bronchodilator	**85.15%**	87.43%	88.69%	85.85%
Heart Disease					
SPD-Therapy	Statin Therapy for Patients with Diabetes - Received Statin Therapy	**65.11%**	70.63%	72.32%	72.62%
SPD-80%	Statin Therapy for Patients with Diabetes - Statin Adherence 80%	**66.33%**	77.73%	89.36%	57.51%
SPC-Therapy	Statin Therapy for Patients with Cardiovascular Disease – Received Statin Therapy – Total	**80.36%**	82.57%	83.13%	84.45%
SPC-80%	Statin Therapy for Patients with Cardiovascular Disease – Received Statin Therapy – 80%	**71.05%**	81.79%	90.91%	64.65%

Health Plan's overall rates show 21 measures reached or exceeded the 50th percentile and 7 were within 5% of the 50th percentile. 16 measures showed increases in rates from MY2022 to MY2023. HPSJ received a 3-star rating for MY2023 from NCQA, a decrease of .5 stars from the prior year MY2022.

Report Only Measures

DHCS also requires health plans to report rates for non-HEDIS MCAS measures. These non-HEDIS MCAS measures are derived from the CMS Core Measures for Adults and Children. Tables 5-7 below show trended results as presented to the DHCS for San Joaquin and Stanislaus Counties. There are no benchmarks published as of the time of this report. Therefore, in depth analysis is not performed.

Contraceptive Care - All Women

Among women ages 15 to 20 years and ages 21-44 years, at risk of unintended pregnancy (defined as those that have ever had sex, are not pregnant or seeking pregnancy, and are fecund), the percentage that was provided a most effective or moderately effective method of contraception.

Table 5: Contraceptive Care- All Women- San Joaquin County

Measure	MY2023/RY2024	MY2022/RY2023	MY2021/RY2022
CCW – MMEC – 15-20	10.91%	12.29%	14.14%
CCW – MMEC – 21-44	24.29%	26.32%	28.57%

Table 6: Contraceptive Care- All Women- Stanislaus County

Measure	MY2023/RY2024	MY2022/RY2023	MY2021/RY2022
CCW – MMEC – 15-20	12.41%	14.46%	15.47%
CCW – MMEC – 21-44	23.91%	24.44%	25.79%

Contraceptive Care- Postpartum Women

Among women ages 15 to 20 years and 21-44 years who had a live birth, the percentage that was provided within 3 and 60 days of delivery a most effective or moderately effective method of contraception.

Table 7: Contraceptive Care- Postpartum Women- San Joaquin County

Measure	MY2023/RY2024	MY2022/RY2023	MY2021/RY2022
CCP – MMEC – 60 days – 15-20	39.23%	32.00%	34.73%
CCP – MMEC – 60 days – 21-44	39.88%	32.82%	37.18%

Table 8: Contraceptive Care- Postpartum Women- Stanislaus County

Measure	MY2023/RY2024	MY2022/RY2023	MY2021/RY2022
CCP – MMEC – 60 days – 15-20	46.46%	39.87%	36.96%
CCP – MMEC – 60 days – 21-44	44.85%	36.84%	37.32%

Rates in both San Joaquin and Stanislaus County show patients of all ages are receiving most or moderately effective contraception.

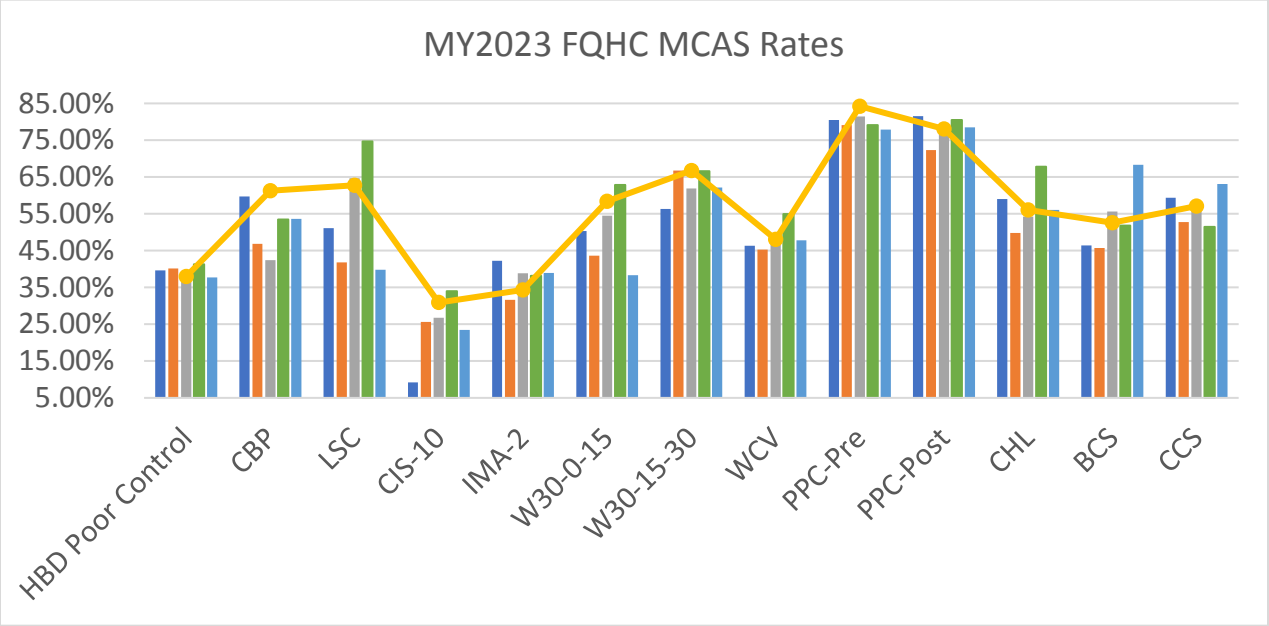
Patients receiving contraceptive care overall in both San Joaquin and Stanislaus counties saw a decrease in rates for all age ranges. Patients 15-20 in San Joaquin County rate decreased by 1.38%, patients 21-44 decreased 2.03% from MY2022 to MY2023. Patients 15-20 in Stanislaus County saw a decrease of 2.05% while patients 21-44 saw a decrease of .53%.

Postpartum patients saw strong increases in rates across the board from MY2022 to MY2023 of patients receiving contraceptive care post-delivery in both counties. San Joaquin county patients ages 15-20 saw an increase of 7.23%, patients ages 21-44 saw an increase of 7.06%. In Stanislaus County patients ages 15-20 saw an increase of 6.59% and patients ages 21-44 years saw the largest increase overall of 8.01%

Federally Qualified Health Center (FQHC) Performance

HPSJ trends all MCAS measures monthly using Inovalon' s Provider Enablement platform for reporting and compares FQHCs measure rates to each other. Graph 1 shows high priority MY2023 MCAS rates for FQHC's and is reported from MY2023 final HEDIS data including administrative, ECDS (where applicable) and hybrid (where applicable) data.

Graph 1: HPSJ FQHC Comparison



	HBD Poor Control	CBP	LSC	CIS-10	IMA-2	W30-0-15	W30-15-30	WCV	PPC-Pre	PPC-Post	CHL	BCS	CCS
CMC	39.62%	59.74%	51.09%	9.22%	42.23%	50.36%	56.34%	46.31%	80.48%	81.57%	58.99%	46.45%	59.40%
GVHC	40.12%	46.85%	41.80%	25.61%	31.67%	43.66%	66.72%	45.29%	79.07%	72.30%	49.83%	45.74%	52.79%
HSA	37.65%	42.39%	64.66%	26.81%	38.83%	54.50%	61.93%	47.51%	81.48%	76.85%	54.25%	55.65%	57.61%
SJCC	41.27%	53.43%	74.69%	33.95%	38.16%	62.85%	66.59%	54.92%	79.10%	80.47%	67.79%	51.77%	51.50%
LHC	37.70%	53.62%	39.80%	23.47%	38.93%	38.36%	62.11%	47.81%	77.91%	78.53%	56.04%	68.36%	63.11%
2023 MPL	37.96%	61.31%	62.79%	30.90%	34.31%	58.38%	66.76%	48.07%	84.23%	78.10%	56.04%	52.60%	57.11%

Community Medical Center (CMC) had 4 measures reach or exceed MPL including: IMA-2 (42.23%) exceeding the MPL by 7.92%, PPC-Post (81.57%) exceeding the MPL by 3.47%, CHL (58.99%) exceeding the MPL by 2.95%, and CCS (59.40%) exceeding the MPL by 2.29%.

Golden Valley Health Centers (GVHC) did not reach the MPL for any measures in 2023 but had several measures within range of the MPL including – HBD Poor Control (40.12%) within 2.16% of the MPL, IMA-2 (31.67%) within 2.64%, W30-15-30 (66.72%) with .04% of the MPL and WCV (45.29%) within 2.78%.

Stanislaus Health Service Agency (has) had 5 measures that reach or exceed the MPL including – HBD Poor Control (37.65%) exceeding the MPL by -0.31%, LSC (64.66%) exceeding the MPL by 1.87%, IMA-2 (38.83%) exceeding the MPL by 4.52%, BCS (55.65%) exceeding the MPL by 3.05% and CCS (57.61%) exceeding the MPL by 0.50%.

San Joaquin County Clinics (SJCC) had 7 measures that reached of exceeded the MPL including- LSC(74.69%) exceeding the MPL by 11.9%, CIS-10 (33.95%) exceeding the MPL by 3.05%, IMA-2 (38.16%) exceeding the MPL by 3.85%, W30 - 0-15 (62.85%) exceeding the MPL by 4.47%, WCV (54.92%) exceeding the MPL by 6.85%, PPC-Post (80.47%) exceeding the MPL by 2.37%, and CHL (67.79%) exceeding the MPL by 11.75%.

Livingston Health Center (LHC) had 6 measures reach or exceed the MPL including- HBD Poor Control (37.70%) exceeding the MPL by 0.26%, IMA-2 (38.93%) exceeding the MPL by 4.62%, PPC-Post (78.53%) exceeding the MPL by 0.43%, CHL (56.04%) meeting the MPL of 56.04%, BCS (68.36%) exceeding the MPL by 15.76%, and CCS (63.11%) exceeding the MPL by 6.00%.

SJCC was the highest performing FQHC with 7 measures reaching the MPL and 4 additional measures (HBD Poor Control, W30-15-30, PPC-Pre and BCS) within 5% of their respective MPL's. GVHC was the lowest performing with no measures meeting or exceeding the MPL during MY2023.

Seniors and Persons with Disabilities (SPD) Report only measures

HPSJ stratified utilization measures in Tables 9-11 by SPD/Non-SPD members. Stratified measures include Emergency Department Visits and All Cause Readmissions.

Tables 9-11 Emergency Visits – San Joaquin County – MY2021 – MY2023

Table 9: San Joaquin MY2021 Rates:

Age	ED Visits (SPD)		ED Visits (Non-SPD)		Total ED Visits *(Must match IDSS & PLD file)*	
	Visits	Visits/1,000 MM	Visits	Visits/1,000 MM	Total Visits	Total Visits/1,000 MM
<1	22	NA	2,874	58.35	2,896	58.57
1-9	460	39.03	15,616	26.66	16,076	26.90
10-19	552	29.48	12,932	20.33	13,484	20.60
20-44	3,125	77.86	37,951	52.28	41,076	53.62
45-64	5,228	88.94	14,034	44.11	19,262	51.10
65-74	498	23.74	64	27.98	562	24.15
75-84	234	23.81	0	NA	234	23.75
85+	84	39.11	0	NA	84	39.05
Unknown	0		0		0	
Total	10,203	62.76	83,471	36.02	93,674	37.77

Table 10: San Joaquin MY2022 Rates:

Age	ED Visits (SPD)		ED Visits (Non-SPD)		Total ED Visits *(Must match IDSS & PLD file)*	
	Visits	Rate (Member Years)	Visits	Rate (Member Years)	Total Visits	Total Rate (Member Years)
<1	16	NA	4,559	1,112.90	4,575	1,113.21
1-9	550	642.21	24,245	516.15	24,795	518.40
10-19	694	481.53	16,511	311.38	17,205	315.88
20-44	3,073	941.12	41,687	649.03	44,760	663.16
45-64	5,386	1,158.07	15,593	545.60	20,979	631.32
65-74	459	254.80	175	411.28	634	284.70
75-84	311	325.31	0	NA	311	321.00
85+	93	453.29	0	NA	93	433.40
Unknown	0		0		0	
Total	10,582	802.30	102,770	520.75	113,352	538.38

Table 11: San Joaquin MY2023 Rates:

	Ambulatory Care - Total (AMB)																															
Data Element	Population	SPD										Non SPD										Total										
	General Measure Data	ED Visits										ED Visits										ED Visits										
		<1	1-9	10-19	20-44	45-64	65-74	75-84	85+	Unknown	Total	<1	1-9	10-19	20-44	45-64	65-74	75-84	85+	Unknown	Total	<1	1-9	10-19	20-44	45-64	65-74	75-84	85+	Unknown	Total
Measurement Year	2023																															
Data Collection Methodology	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Member Months		189	11367	18017	37267	54931	25672	12277	3114	0	162834	46257	554210	640819	806059	369892	7038	1124	302	0	2E+06	46446	565577	658836	843326	424823	32710	13401	3416	0	3E+06
Visits		28	728	667	3118	5845	842	357	127	0	11712	3685	23126	17499	46068	18627	259	33	9	0	109306	3713	23854	18166	49186	24472	1101	390	136	0	121018
Rate (Member Years)		NA	768.54	444.25	1004.00	1276.87	393.59	348.95	469.40	NA	863.11	955.96	500.73	327.69	685.83	604.30	441.60	352.31	NA	NA	540.74	959.31	506.12	330.97	699.89	691.26	403.91	349.23	477.75	NA	561.02

Table 12-14: Emergency Visits - Stanislaus County—MY2021 – MY2023

Table 12: Stanislaus MY2021 Rates:

Age	ED Visits (SPD)		ED Visits (Non-SPD)		Total ED Visits *(Must match IDSS & PLD file)*	
	Visits	Visits/1,000 MM	Visits	Visits/1,000 MM	Total Visits	Total Visits/1,000 MM
<1	14	NA	2,112	69.75	2,126	70.04
1-9	257	37.24	11,383	32.03	11,640	32.13
10-19	327	36.98	8,667	23.75	8,994	24.06
20-44	1,652	88.26	27,651	55.65	29,303	56.83
45-64	3,417	108.68	9,453	45.39	12,870	53.70
65-74	201	25.61	69	28.19	270	26.23
75-84	95	23.83	0		95	23.83
85+	34	25.39	0	NA	34	25.32
Unknown	0		0		0	
Total	5,997	75.77	59,335	40.69	65,332	42.50

Table 13: Stanislaus MY2022 Rates:

Age	ED Visits (SPD)		ED Visits (Non-SPD)		Total ED Visits *(Must match IDSS & PLD file)*	
	Visits	Rate (Member Years)	Visits	Rate (Member Years)	Total Visits	Total Rate (Member Years)
<1	18	NA	3,028	1,214.80	3,046	1,217.34
1-9	333	718.71	17,860	610.55	18,193	612.24
10-19	384	538.70	11,294	367.29	11,678	371.18
20-44	1,619	1,030.99	29,673	688.67	31,292	700.70
45-64	3,327	1,291.08	10,932	582.36	14,259	667.91
65-74	239	340.62	145	444.79	384	373.66
75-84	130	329.67	2	NA	132	328.02
85+	41	298.18	0	NA	41	287.89
Unknown	0		0		0	
Total	6,091	927.59	72,934	584.91	79,025	602.05

Table 14: Stanislaus MY2023 Rates:

Ambulatory Care - Total (AMB)																																
Data Element	Population	SPD										Non SPD										Total										
	General Measure Data	ED Visits										ED Visits										ED Visits										
		<1	1-9	10-19	20-44	45-64	65-74	75-84	85+	Unknown	Total	<1	1-9	10-19	20-44	45-64	65-74	75-84	85+	Unknown	Total	<1	1-9	10-19	20-44	45-64	65-74	75-84	85+	Unknown	Total
Measurement Year	2023																															
Data Collection Methodology	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Member Months		189	11367	18017	37267	54931	25672	12277	3114	0	162834	46257	554210	640819	806059	369832	7038	1124	302	0	2E+06	46446	565577	658836	843326	424823	32710	13401	3416	0	3E+06
Visits		28	728	667	3119	5845	842	357	127	0	11712	3685	23126	17499	46068	16627	259	33	9	0	109306	3713	23854	18166	49186	24472	1101	390	136	0	121018
Rate (Member Years)		NA	768.54	444.25	1004.00	1276.87	393.58	348.95	489.40	NA	863.11	955.96	500.73	327.69	685.83	604.30	441.60	352.31	NA	NA	540.74	959.31	506.12	330.87	699.89	691.26	403.91	349.23	477.75	NA	561.02

Both SPD and Non-SPD members in Stanislaus County continue to utilize emergency care at a higher rate than members in San Joaquin County.

Table 15-17: Plan All Cause Readmissions - San Joaquin County – MY2021-MY2023

Table 15: San Joaquin MY2021 Rates:

Plan All-Cause Readmissions (PCR) *for* SPD/Non-SPD									
HEDIS® Reporting Year 2022/Measurement Year 2021									
Data Collection Methodology: Admin									
Age	SPD			Non-SPD			Total *(Must match IDSS & PLD file)*		
	Count of Index Stays *(Denominator)*	Count of Observed 30-Day Readmissions *(Numerator)*	Observed Readmission Rate *(Num/Den)*	Count of Index Stays *(Denominator)*	Count of Observed 30-Day Readmissions *(Numerator)*	Observed Readmission Rate *(Num/Den)*	Count of Index Stays *(Denominator)*	Count of Observed 30-Day Readmissions *(Numerator)*	Observed Readmission Rate *(Num/Den)*
18-44	262	29	11.07%	1,598	100	6.26%	1,860	129	6.94%
45-54	260	25	9.62%	878	74	8.43%	1,138	99	8.70%
55-64	563	71	12.61%	914	94	10.28%	1,477	165	11.17%
Total (18-64)	1,085	125	11.52%	3,390	268	7.91%	4,475	393	8.78%

Table 16: San Joaquin MY2022 Rates:

Plan All-Cause Readmissions (PCR) *for* SPD/Non-SPD									
HEDIS® Reporting Year 2023/Measurement Year 2022									
Data Collection Methodology: Admin									
Age	SPD			Non-SPD			Total *(Must match IDSS & PLD file)*		
	Count of Index Stays *(Denominator)*	Count of Observed 30-Day Readmissions *(Numerator)*	Observed Readmission Rate *(Num/Den)*	Count of Index Stays *(Denominator)*	Count of Observed 30-Day Readmissions *(Numerator)*	Observed Readmission Rate *(Num/Den)*	Count of Index Stays *(Denominator)*	Count of Observed 30-Day Readmissions *(Numerator)*	Observed Readmission Rate *(Num/Den)*
18-44	247	21	8.50%	1,625	116	7.14%	1,872	137	7.32%
45-54	200	22	11.00%	904	80	8.85%	1,104	102	9.24%
55-64	593	68	11.47%	914	95	10.39%	1,507	163	10.82%
Total (18-64)	1,040	111	10.67%	3,443	291	8.45%	4,483	402	8.97%

Table 17: San Joaquin MY2022 Rates:

	Plan All-Cause Readmissions (PCR-AD)												
Data Element	Population	SPD				Non SPD				Total			
	General Measure Data	Observed Rate				Observed Rate				Observed Rate			
		18-44	45-54	55-64	Total	18-44	45-54	55-64	Total	18-44	45-54	55-64	Total
Measurement Year	2023												
Data Collection Methodology	A	A	A	A	A	A	A	A	A	A	A	A	A
Count of Members		210	218	505	933	1599	836	867	3302	1809	1054	1372	4236
Count of Index Stays *(Denominator)*		254	270	612	1136	1846	977	1059	3882	2100	1247	1671	5018
Count of Observed 30-day Readmissions *(Numerator)*		23	34	74	131	146	101	122	369	169	135	196	500
Observed Readmissions Rate		9.06%	12.59%	12.09%	11.53%	7.91%	10.34%	11.52%	9.51%	8.05%	10.83%	11.73%	9.96%

SPD readmission rates increased by 0.86% while non-SPD readmission rates increased by 1.06% from MY2022 to MY2023 in San Joaquin County.

Table 18-20: Plan All Cause Readmissions - Stanislaus County- MY2021-MY2023
Table 18: Stanislaus MY2021 Rates:

Plan All-Cause Readmissions (PCR) *for* SPD/Non-SPD									
HEDIS® Reporting Year 2022/Measurement Year 2021									
Data Collection Methodology: Admin									
Age	SPD			Non-SPD			Total *(Must match IDSS & PLD file)*		
	Count of Index Stays *(Denominator)*	Count of Observed 30-Day Readmissions *(Numerator)*	Observed Readmission Rate *(Num/Den)*	Count of Index Stays *(Denominator)*	Count of Observed 30-Day Readmissions *(Numerator)*	Observed Readmission Rate *(Num/Den)*	Count of Index Stays *(Denominator)*	Count of Observed 30-Day Readmissions *(Numerator)*	Observed Readmission Rate *(Num/Den)*
18-44	138	9	NA	1,087	79	7.27%	1,225	88	7.18%
45-54	140	14	NA	627	49	7.81%	767	63	8.21%
55-64	365	47	12.88%	575	52	9.04%	940	99	10.53%
Total (18-64)	643	70	10.89%	2,289	180	7.86%	2,932	250	8.53%

Table 19: Stanislaus MY2022 Rates:

Plan All-Cause Readmissions (PCR) *for* SPD/Non-SPD									
HEDIS® Reporting Year 2023/Measurement Year 2022									
Data Collection Methodology: Admin									
Age	SPD			Non-SPD			Total *(Must match IDSS & PLD file)*		
	Count of Index Stays *(Denominator)*	Count of Observed 30-Day Readmissions *(Numerator)*	Observed Readmission Rate *(Num/Den)*	Count of Index Stays *(Denominator)*	Count of Observed 30-Day Readmissions *(Numerator)*	Observed Readmission Rate *(Num/Den)*	Count of Index Stays *(Denominator)*	Count of Observed 30-Day Readmissions *(Numerator)*	Observed Readmission Rate *(Num/Den)*
18-44	105	17	NA	1,173	73	6.22%	1,278	90	7.04%
45-54	153	16	10.46%	592	42	7.09%	745	58	7.79%
55-64	376	48	12.77%	639	67	10.49%	1,015	115	11.33%
Total (18-64)	634	81	12.78%	2,404	182	7.57%	3,038	263	8.66%

Table 20: Stanislaus MY2023 Rates:

	Plan All-Cause Readmissions (PCR-AD)												
Data Element	Population	SPD				Non SPD				Total			
	General Measure Data	Observed Rate				Observed Rate				Observed Rate			
		18-44	45-54	55-64	Total	18-44	45-54	55-64	Total	18-44	45-54	55-64	Total
Measurement Year	2023												
Data Collection Methodology	A	A	A	A	A	A	A	A	A	A	A	A	A
Count of Members		134	136	312	582	1078	577	606	2261	1212	713	918	2843
Count of Index Stays *(Denominator)*		154	170	336	660	1278	688	714	2680	1432	858	1050	3340
Count of Observed 30-day Readmissions *(Numerator)*		16	18	30	64	123	59	95	277	139	77	125	341
Observed Readmissions Rate		10.39%	10.59%	8.93%	9.70%	9.62%	8.58%	13.31%	10.34%	9.71%	8.97%	11.90%	10.21%

Readmissions for SPD members in MY2023 decreased by 3.08% while readmission rates for non-SPD members increased by 2.77% from MY2022 to MY2023 in Stanislaus County.

CAHPS Member Survey Measures

HPSJ reports the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measure for Smoking Cessation as part of the health plan rankings required measure reporting. Health Plan rankings are calculated using percentile ranking. Given that Health Plan scores are all below the 25th percentile, a score if zero is attributed. Table 21 shows the results of the 2023 HEDIS CAHPS Survey Measures for Smoking Cessation.

Table 21: 2023 HEDIS CAHPS Survey Measures

MEASURE SUMMARY

MEDICAID ADULT

MEASURE	SUMMARY RATE		CHANGE	2024 PG BOOK OF BUSINESS BENCHMARK		
	2023	2024		PERCENTILE DISTRIBUTION (0 20 40 60 80 100)	PERCENTILE RANK	BoB SRS
Effectiveness of Care						
Advised to Quit Smoking: 2YR % Sometimes, Usually, or Always	60.7%	55.4%	-5.3		<5th	73.7% ▼
Discussing Cessation Meds: 2YR + % Sometimes, Usually, or Always	39.1%	37.8%	-1.3		9th	53.4% ▼
Discussing Cessation Strategies: 2YR + % Sometimes, Usually, or Always	39.3%	35.1%	-4.2		13th	47.1% ▼

HPSJ saw decreases in 3 out of 3 CAHPS smoking related survey measures from the prior year survey. Rates are continuing to trend low when ranked against the Book of Business Benchmarks for the measurement year. All metrices related to smoking are significantly lower than the survey vendor benchmark.

MCAS Measures by Domain

DHCS evaluates MCP quality performance on MCAS measures based on the number of measures meeting MPL by domain as well as the number of metrics meeting MPL by measure. The results are compared to health plan prior year performance to determine whether the performance is improved or decreased, and by metric to health plan competitors serving enrollees in the same county. Performance determines enrollment default auto assignment as well as the degree to which monetary sanctions are imposed when metric performance does not reach MPL.

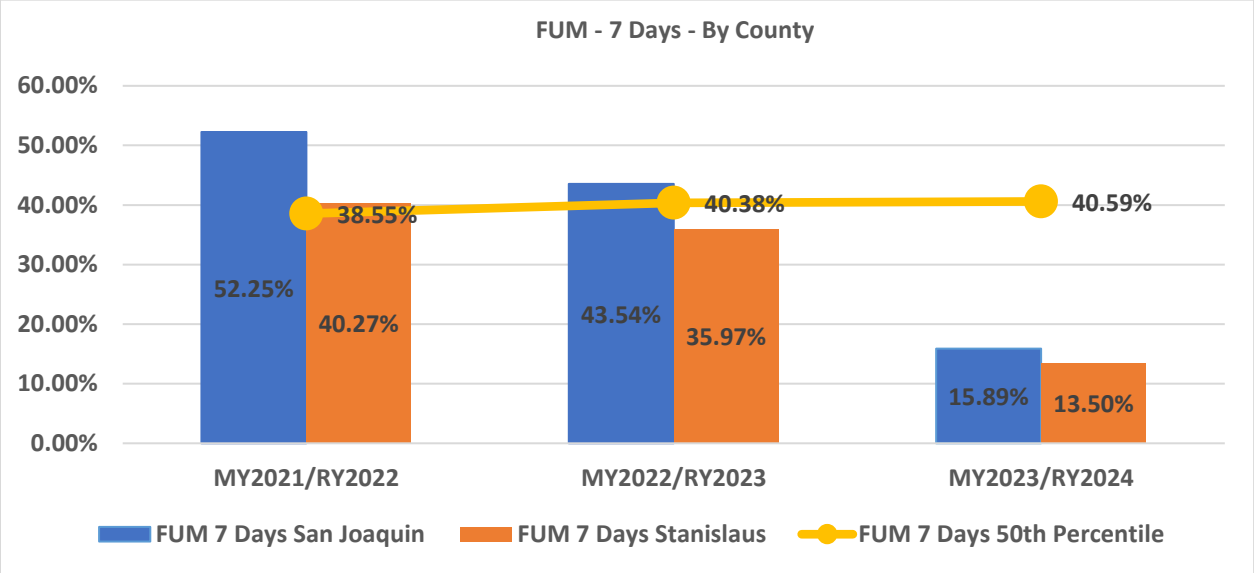
Three years of trended metric rate performance are grouped by domain and displayed by county by metric.

Behavioral Health –

The following graphs show three-year trends for each county for the following measures:

- **Follow-Up after ED visit for Mental** Illness (FUM) Follow-Up for patients recently discharged from the ED with a Mental Illness diagnosis who received follow-up care within 7 days and 30 days.

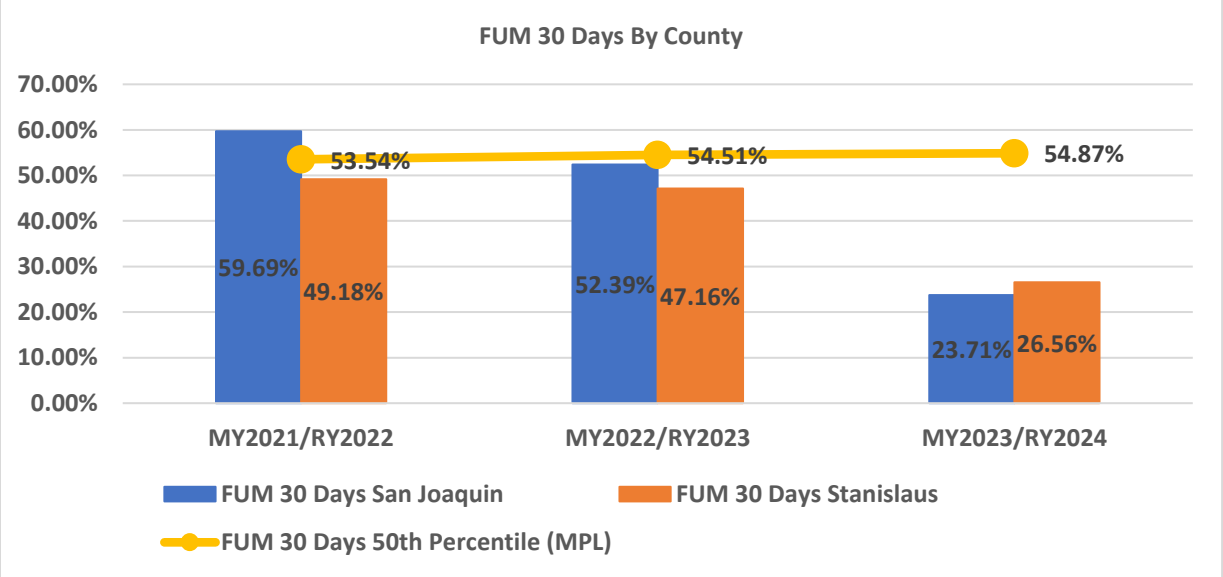
Graph 2: Follow – Up for ED visit for Mental Illness (FUM) by County – 7 Days



Quantitative Analysis:

The health plan has seen a continuous decrease in FUM 7-day compliance in both counties for MY2023 and is currently performing below the 50th percentile for the measure in both counties. San Joaquins compliance rate decreased by 27.65% while Stanislaus' compliance rate decreased by 22.47% from MY2022 to MY2023. Patient follow up within 7 days is not a metric held to MPL but provides insight into the barriers that may be impacting follow up within 30 days.

Graph 3: Follow – Up for ED visit for Mental Illness (FUM) by County – 30 Days



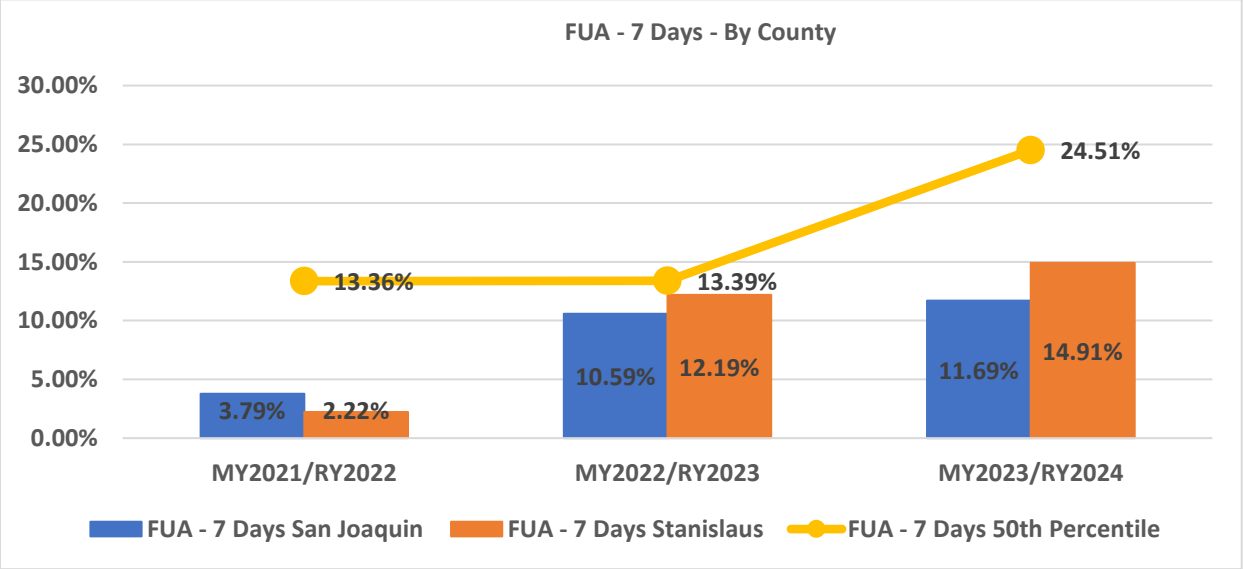
Quantitative analysis:

Rates for the FUM 30-day measure have also shown a continuous decrease over time from MY2021 to MY2023. Compliance for both counties is falling far below the Minimum Performance Level (MPL) for MY2023. San Joaquin's rate decreased by 28.68% while Stanislaus decreased by 20.60%.

The following graphs show three-year trends for both counties for the following measure:

- **Follow-Up after ED visit for Alcohol & Other substances (FUA)** Follow-Up for patients recently discharged from the ED with a diagnosis for alcohol & other Substance abuse who received follow-up care within 7 days and 30 days.

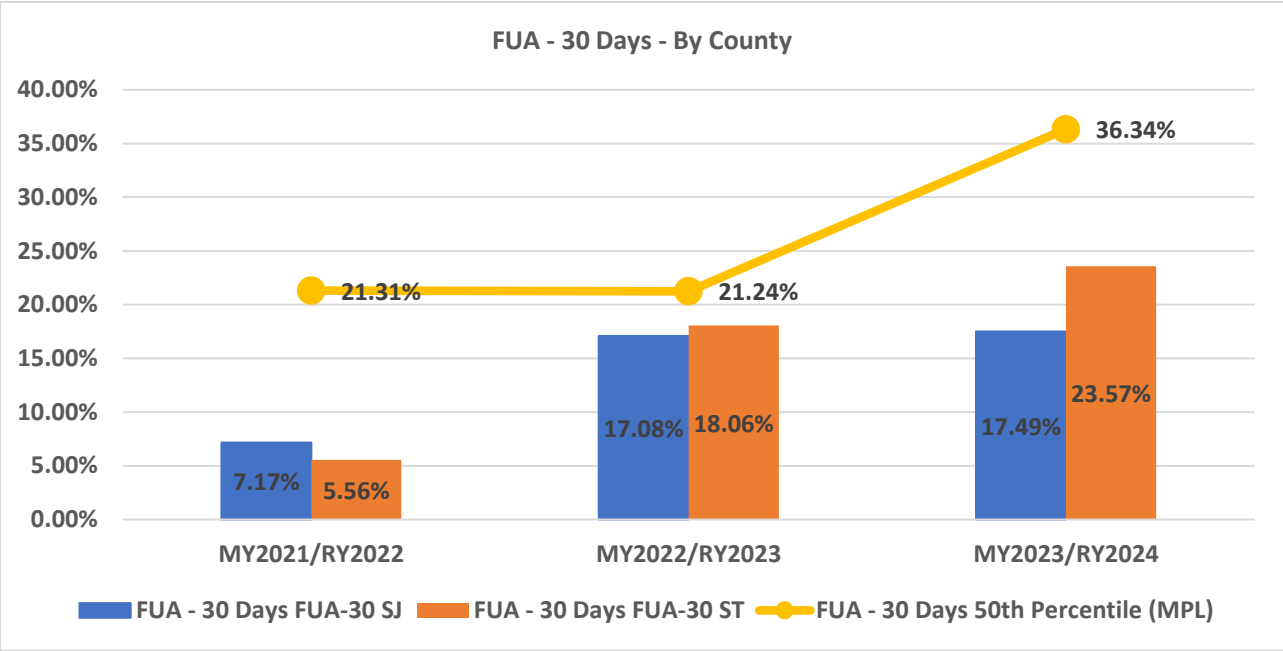
Graph 4: Follow–Up for ED visit for Alcohol & Other Substances (FUA) by County – 7 Days



Quantitative analysis:

Rates for FUA-7 day are performing below the overall MPL but both counties saw increases in compliance for the rates from MY2022 to MY2023. San Joaquins rate increased by 1.10% and Stanislaus' rate increased by 2.72% from MY20222 to MY2023.

Graph 5: Follow–Up for ED visit for Alcohol & Other Substances (FUA) by County – 30 Days



Quantitative analysis:

Both counties are performing below the MPL for the FUA 30-day sub measure, however both counties saw increases in compliance from MY2022 to MY2023. San Joaquin saw a small increase of 0.41% and Stanislaus had a notable increase of 5.51% compliance from MY2022 to MY2023.

Qualitative analysis for emergency room visits for substance use and mental illness:

The health plan and PCPs continue to struggle to receive timely and accurate data about emergency room visits when patients are discharged from the ED. The plan and PCPs are reliant on claims data and sparsely populated ADT reporting to identify patients who were recently discharged. Claims data rarely reaches the plan within 7 days and frequently not within 30 days. ADT data file layouts are not standardized which means that there are critical fields often missing such as discharge disposition and discharge diagnosis. The delays and gaps in reporting inhibits the health plan and PCPs ability to effectively outreach for appropriate and timely follow up. Additionally, many patients in the measures' denominators face multiple social factors that further exacerbate their underlying substance use and mental illness conditions and have factors that complicate the approach to outreach. Many members are unhoused and often have temporary trac phones or change phone numbers frequently,

making follow-up more difficult to complete within the 7 and 30 days turn around thresholds. Additionally, members who visit the ER often visit ERs more than once in 30 days further complicating the ability of the ER, health plan and PCP to determine the follow up windows required to meet compliance.

In addition, DHCS changed the process for transmitting fee for service data to the health plans reflective of care and services provided by specialty mental health offered by the county. County behavioral health handles behavioral health conditions that are severe and persistent as well as conditions that acutely impact members ability to function. Without reliable transmission of data, Medi-Cal health plan rates throughout the state dropped dramatically in MY2023.

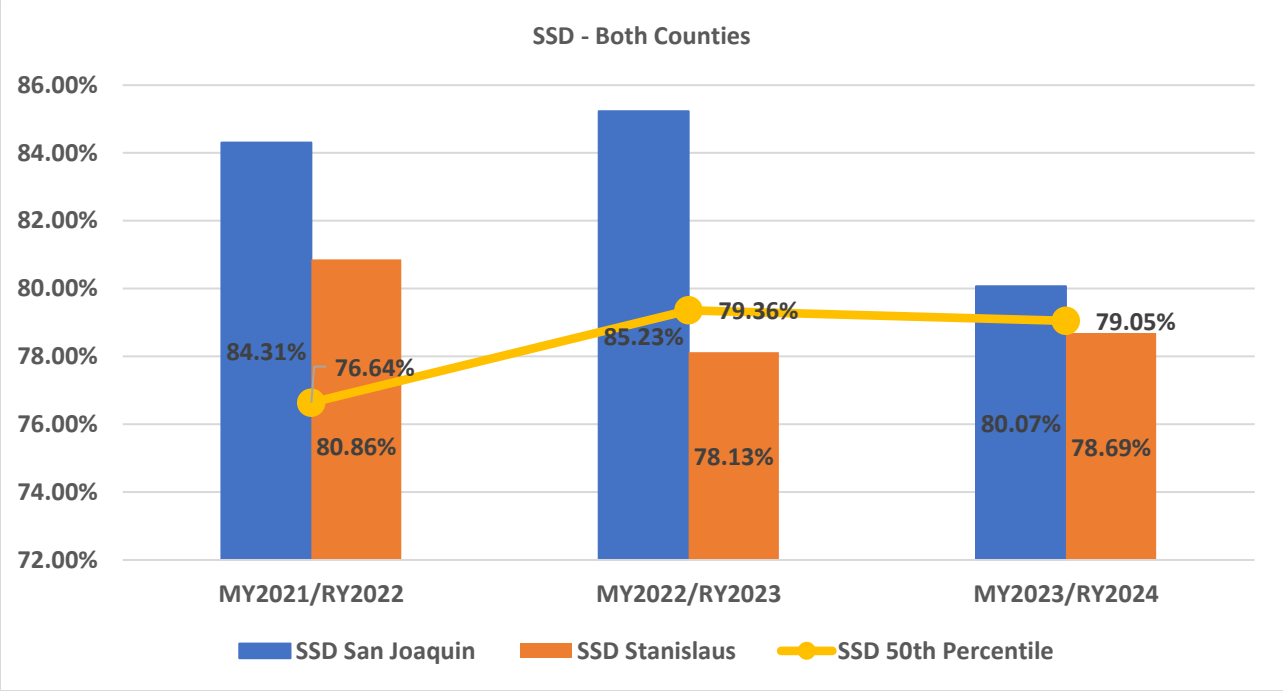
Improvement initiatives:

The health plan has multiple initiatives to drive improvement for the FUM and FUA measures including developing internal processes for the Health Plan Behavioral Health team to perform member outreach and conduct follow-up visits. Improved data collection for daily reporting to provider partners recently discharged. Provider alerts outlining measure requirements and best practices and ongoing discussions with provider partners to develop and partner on improvement initiatives at the health plan provider level.

The following graphs show three-year trends for both counties for the following measure:

- **Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD)** **-** Patients 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test.

Graph 6: Diabetes Screening for People with Schizophrenia or Bipolar Disorder by County

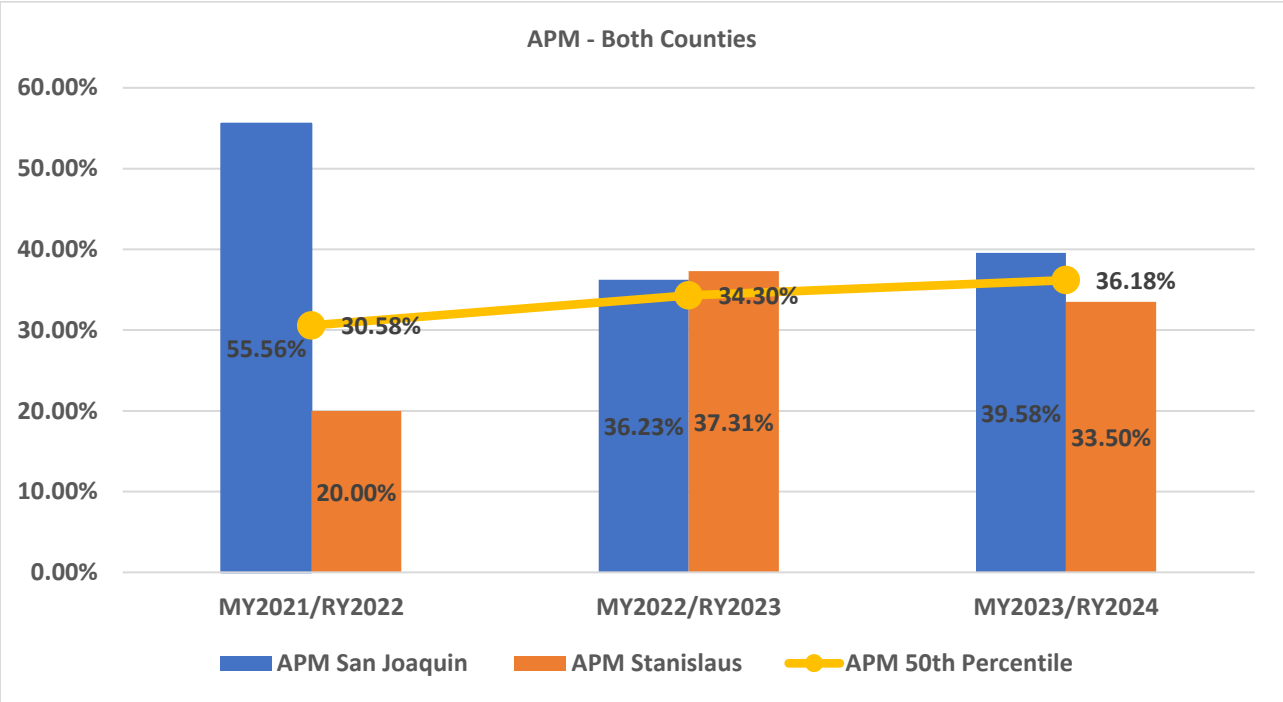


San Joaquin is performing above the MPL but decreased by 5.16% from MY2022 to MY2023. Stanislaus is performing just below the MPL but saw a small increase of 0.56% from MY2022 to MY2023.

The following graphs show three-year trends for both counties for the following measure:

- **Metabolic Monitoring for Children & Adolescents on Antipsychotics (APM)** - Children and Adolescents with ongoing antipsychotic medication use who had metabolic testing for blood glucose and cholesterol.

Graph 7: Metabolic Monitoring for Children & Adolescents on Antipsychotics



Quantitative analysis:
San Joaquin saw an increase in compliance of 3.35% and continues to perform above the MPL while Stanislaus is performing below the MPL and decreased by 3.81% from MY202 to MY2023.

Qualitative analysis: Although Health Plan is not accountable to perform to the MPL for the APM measure by state regulatory entities, Health Plan is attuned to the impact of multiple data sources on logical groupings of measures. Health Plan experienced a disruption in lab data feeds in early 2024. The well publicized healthcare clearinghouse cyberattack incident in March of 2024 affected historical and concurrent lab claims data feeds, and all data may not have been fully reconciled during the 2024 reporting period.

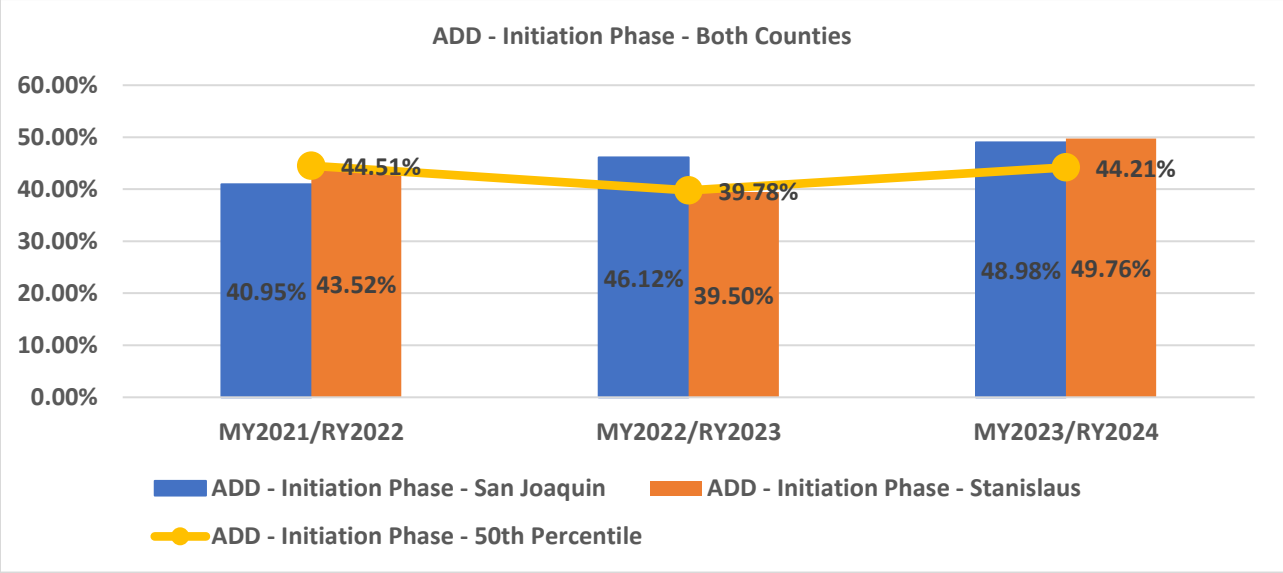
Improvement activities:

Health Plan has implemented multiple initiatives to maintain, monitor and improve lab data collection from all vendors and provider partners. Historical data feed resubmissions were requested from all lab vendors. Additionally, the HEDIS team has partnered with IT team to work with provider partners to establish and maintain monthly supplemental data feeds including all available lab data and results.

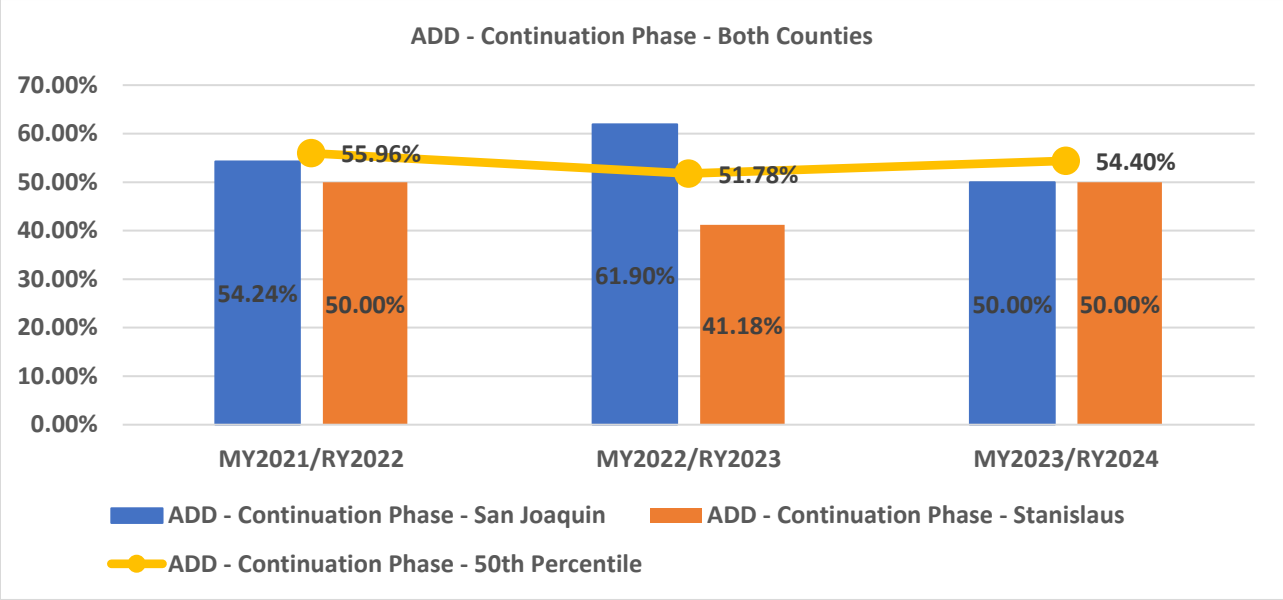
The following graphs show three-year trends for both counties for the following measure:

- **Follow-Up Care for Children Prescribed ADHD Medications Initiation & Continuation (ADD)** Patients 6 – 12 years of age who were diagnosed with ADHD and had at least one follow-up visit with a prescribing provider within 30 days of their first prescription and patients who remained on medication for at least 210 days and had at least 2 follow-up visits within 9 months of the initiation phase.

Graph 8: Follow-Up Care for Children Prescribed ADHD Medications Initiation Phase (ADD)



Graph 9: Follow-Up Care for Children Prescribed ADHD Medications Continuation Phase (ADD)



Quantitative analysis:

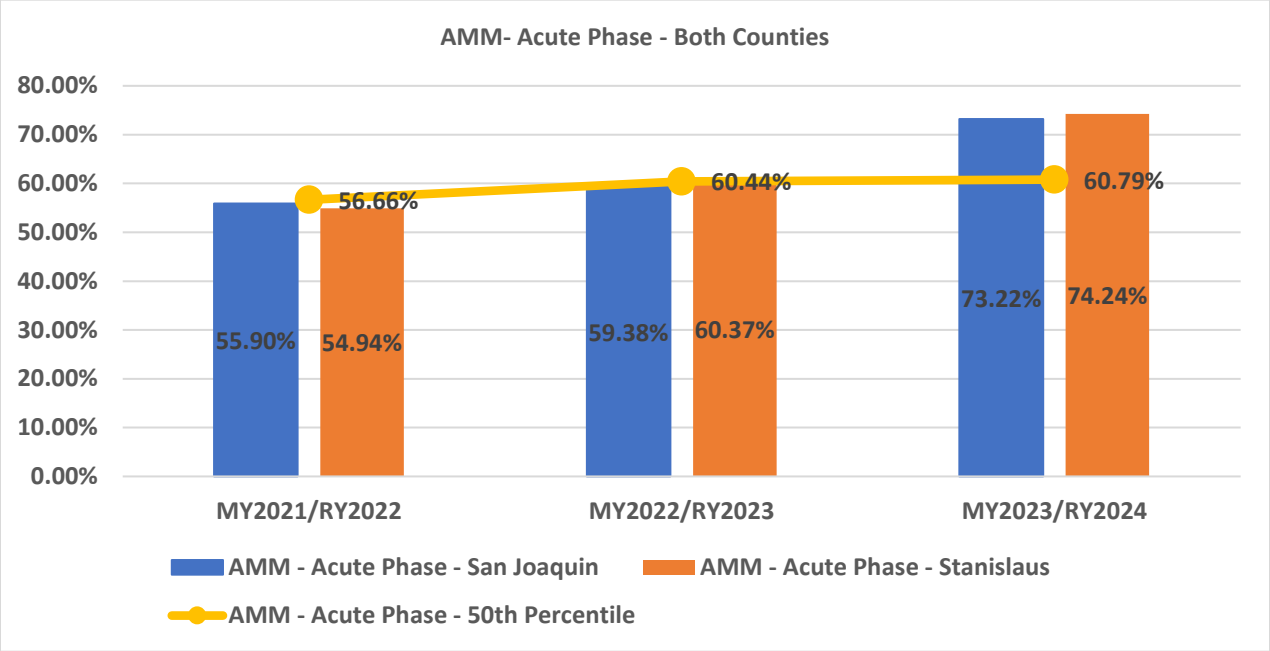
Both San Joaquin and Stanislaus counties increased in compliance with ADD Medication Initiation Phase. San Joaquin increased 2.86% from MY2022's rate. Stanislaus increased 10.26% from MY2022 to MY2023. Although not held to MPL, both counties have reached the MPL for the ADD Initiation Phase sub measure.

San Joaquin county decreased from MY2022 (61.90%) to MY2023 (50.00%) of 11.90% for the ADD Continuation Phase sub measure and is now reporting below the MPL by 4.40%. Stanislaus County saw an increase from MY2022 (41.18%) to MY2023 (50.00%) of 8.82%. Stanislaus county is also reporting below the

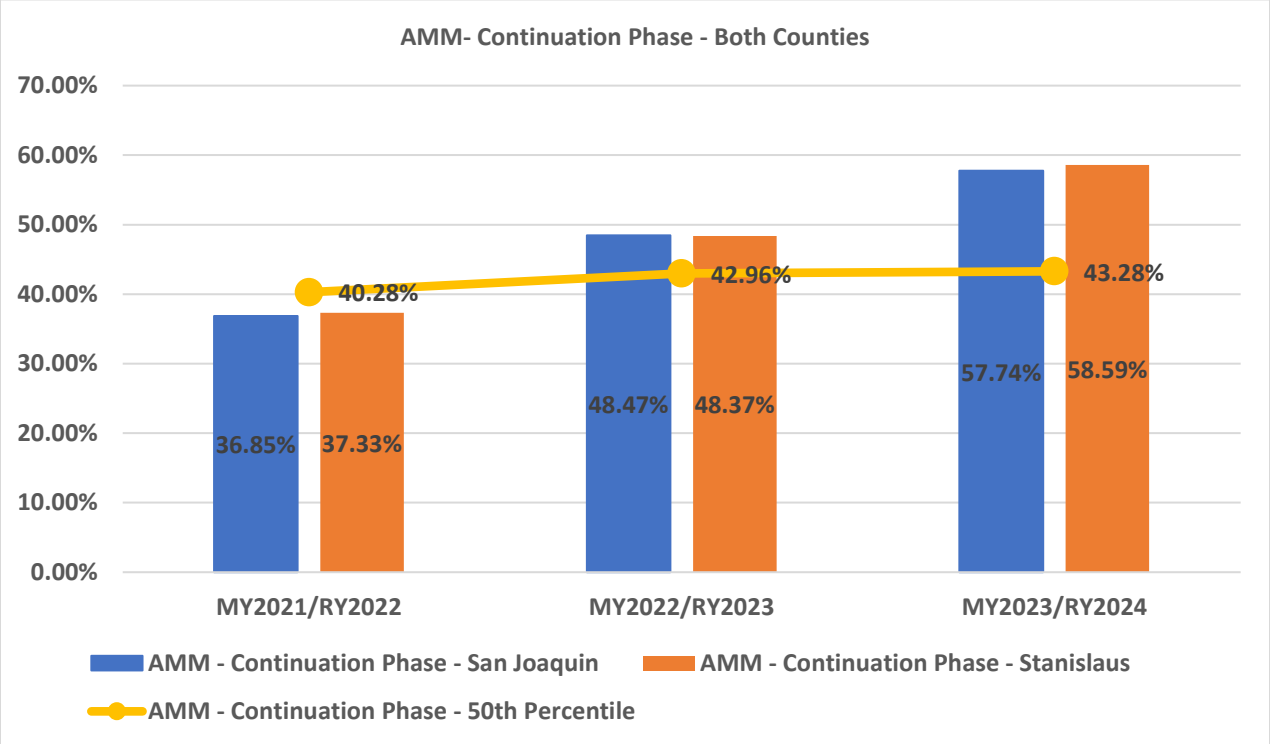
The following graph shows three-year trends for both counties for the following measure:

- **Antidepressant Medication Acute and Continuation Phases (AMM)** Patients 18 and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on their antidepressant medications.

Graph 10: Antidepressant Medication Acute Phase – Both Counties



Graph 11: Antidepressant Medication Continuation Phase – Both Counties



San Joaquin county increased from MY2022 (59.38%) to MY2023 (73.22%) by 13.84% and Stanislaus County also increase from MY2022 (60.37%) to MY2023

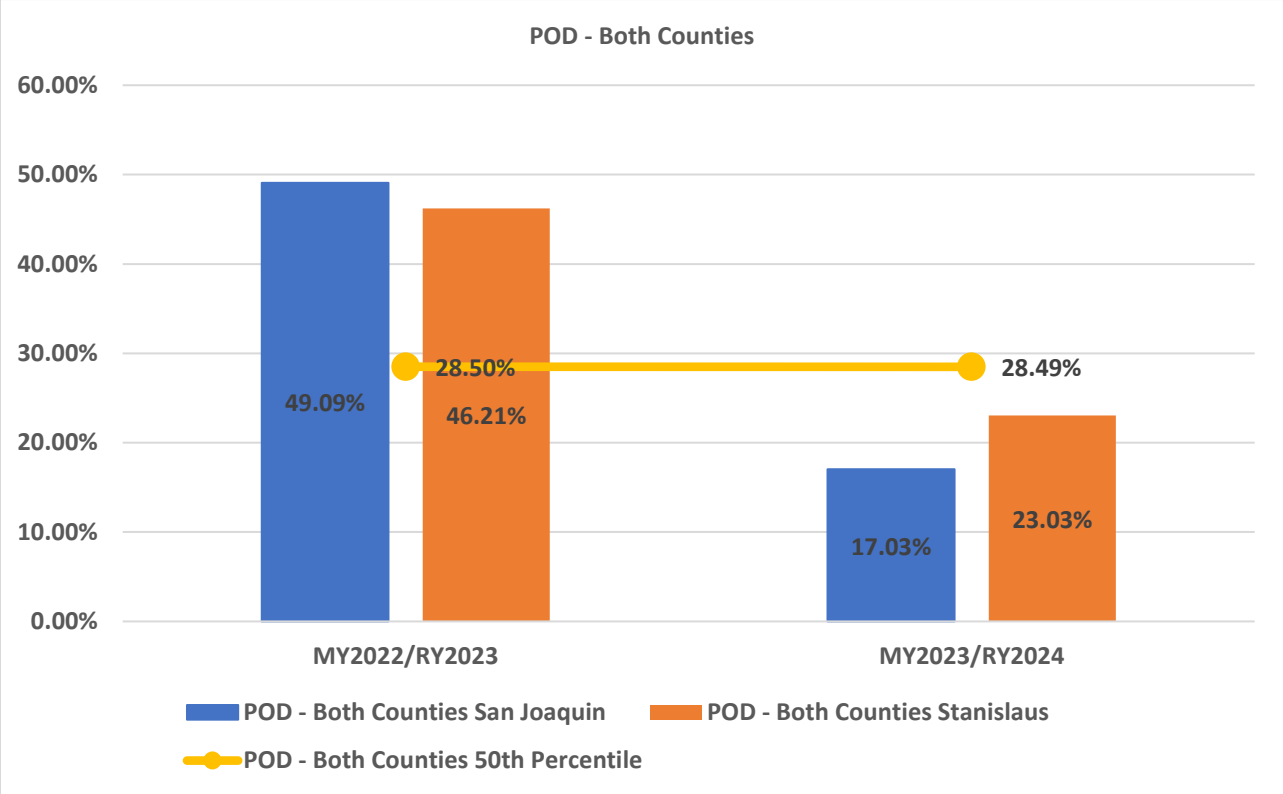
(74.24%) by 13.87% for the AMM- Acute Phase sub measure. Both counties are performing above the MPL for MY2023.

San Joaquin also saw an increase from MY2022 (48.47%) to MY2023 (57.74%) of 9.27% and Stanislaus County increased from MY2022 (48.37%) to MY2023 (58.59%) by 10.22%.

The following graph shows two-year trends for both counties for the following measure:

- **Pharmacotherapy for Opioid Use Disorder (POD)** Patients 16 and older who received pharmacotherapy treatment for opioid use disorder that continued for at least 180 days (6 months)

Graph 12: Pharmacotherapy for Opioid Use Disorder – Both Counties



This is the second year for reporting on the POD measure for both counties. Both counties saw a significant drop from MY2022 to MY2023. San Joaquin decreased from MY2022 (49.09%) to MY2023 (17.03%) by 32.06%. Stanislaus also decreased significantly in performance from MY2022 (46.21%) to MY2023 (23.03%) by 23.18%. Both counties are performing below the measure MPL.

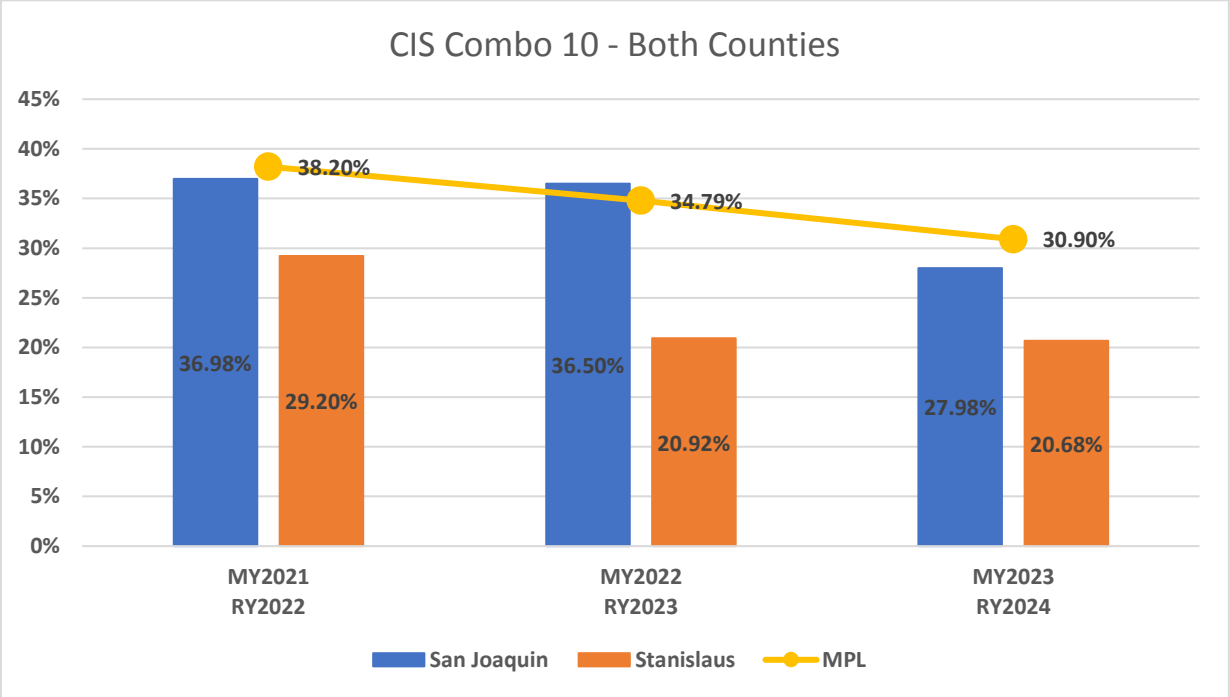
Children Health Measures

The following graph shows three-year trends for both counties for the following measure:

- **Childhood Immunization Status- Combination 10 (CIS)** All vaccines completed by the child's second birthday.

Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Graph 13: Childhood Immunization Status – Combo 10 – Both Counties



Quantitative analysis:

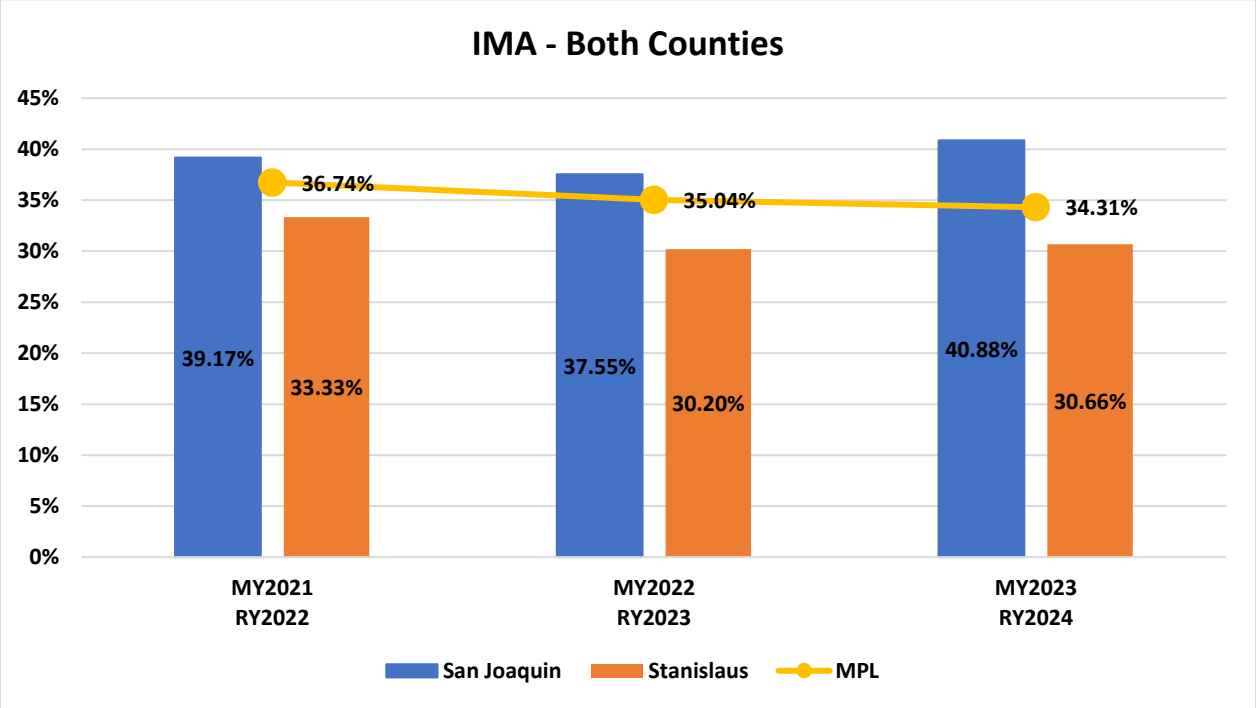
In both counties, CIS-10 rates continue to decline and are currently performing below the MPL. San Joaquin decreased from MY2022 (36.50%) to MY2023 (27.98%) which is 8.52% lower than prior year and over 16% lower than two years ago. Stanislaus saw a small decrease from MY2022 (20.92%) to MY2023 (20.68%) of 0.24%. Both counties are performing below the MPL for MY2023.

The following graph shows three-year trends for both counties for the following measure:

- **Immunizations for Adolescents-Combo 2 (IMA)** Vaccines completed between the child's ninth and thirteenth birthdays.

Combination	Meningococcal	Tdap	HPV
Combo 2	✓	✓	✓

Graph 14: Immunizations for Adolescents – Combo 2 (IMA) – Both Counties



Quantitative analysis:

San Joaquin county increased from MY2022 (37.55%) to MY2023 (40.88%) by 3.33% for the IMA – Combo 2 measure. While Stanislaus saw a small increase from MY2022 (30.20%) to MY2023 (30.66%) of 0.46%. San Joaquin County continues to perform above the MPL while Stanislaus continues to perform below the MPL.

Qualitative analysis for vaccination status measures:

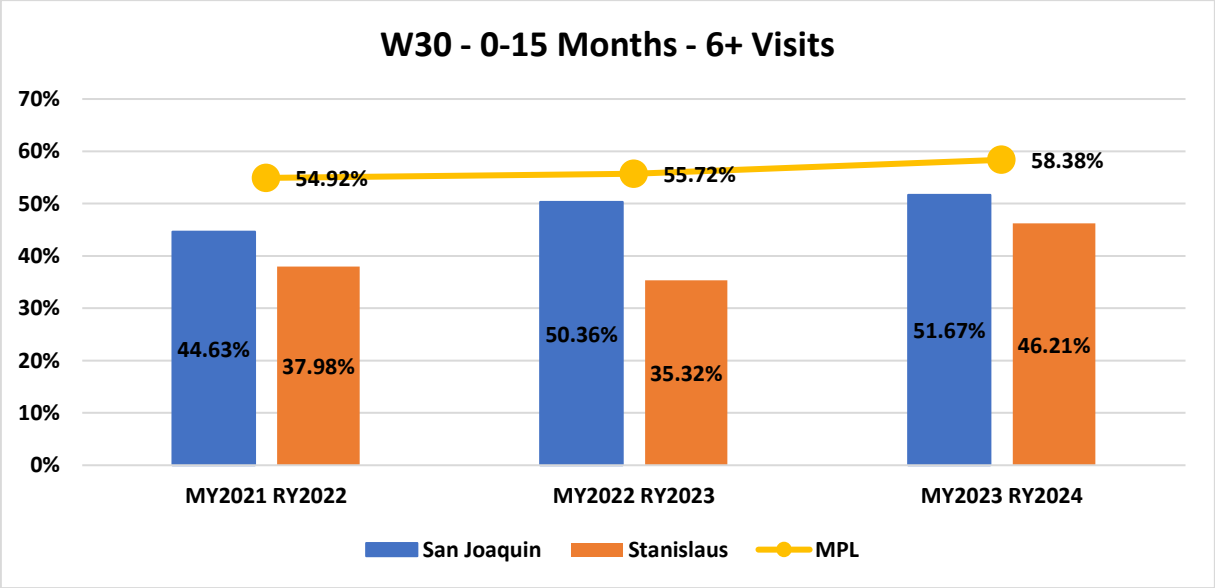
Decreasing vaccination rates are experienced nationwide. Decreasing quality benchmarks calculated by NCQA are showing a decrease in CIS-10 of ~7.5% and IMA-2 of ~2.5% over the past 3 years. There are many contributors to declining rates in the central valley of California. With the advent of MRNA Covid-19 vaccinations entering the market along with strong misinformation campaigns on social media, vaccine hesitancy is on the rise. Vaccine hesitancy and vaccine negotiation which is evidenced by caregivers prolonging or refusing to administer full series vaccinations. Additionally, the standards applied

by the California Department of Public Health (CDPH) and Center for Disease Prevention (CDC) and DHCS vary. Each apply a different standard for minimum acceptable vaccinations. Applying varying standards may encourage providers to focus on the vaccinations required for school entrance by CDPH over those required by DHCS. Additionally, longstanding data gaps still exist for infants which is caused by delays in enrollment after the infant is born. The first vaccines administered at the hospital are often not distinguishable through data because the vaccine is tied to the birthing parent's ID. Finally, the HIE that the health plan participates in does not transmit infant vaccine records making the opportunity to identify data gaps more difficult.

The following graph shows three-year trends for both counties for the following measure:

- **Well-Child Visits in the first 30 Months of Life (0-15 Months) –** 6 or more well child visits by the child's 15-month birthday.

Graph 15 – Well Visits, 6 visits by age 15 Months



Quantitative analysis:

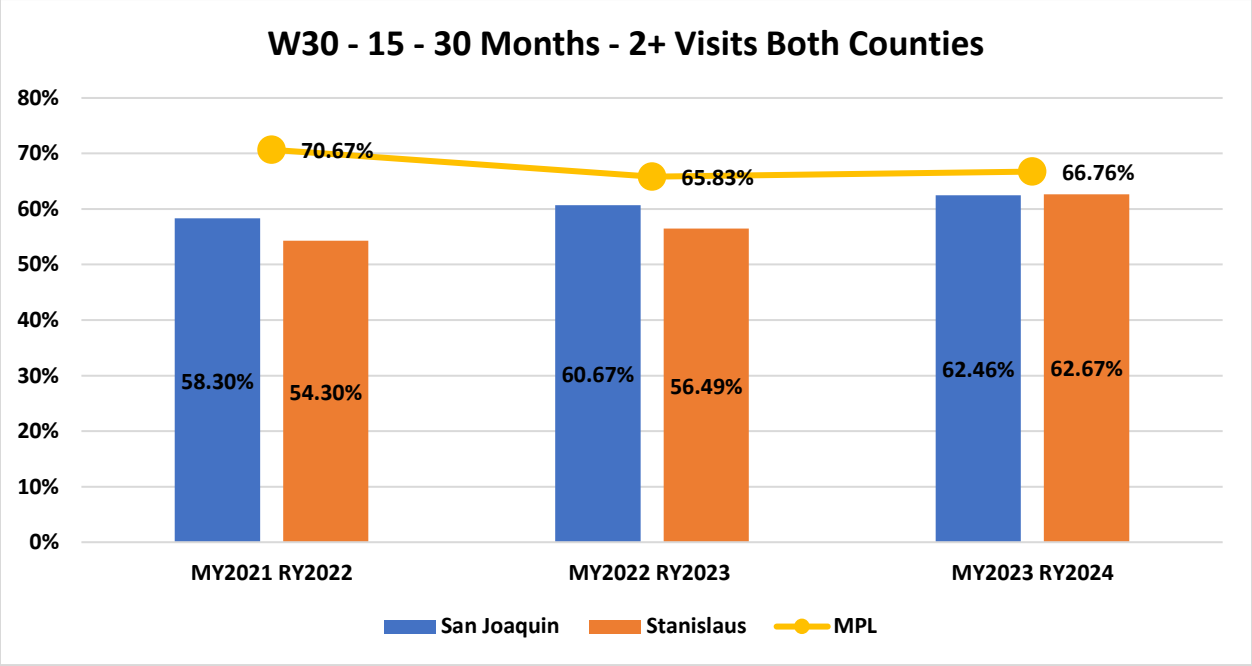
San Joaquin continues to improve performance year over year for the W30 – 0-15 Months sub measure with an increase in rate from MY2022 (50.36%) to MY2023 (51.67%) of 1.31%. Stanislaus saw a strong increase in performance from MY2022 (35.32%) to MY2023 (46.21%) of 10.89%. Despite the improvement in both

counties, they continue to perform under the MPL. This measure is held to minimum performance by DHCS.

The following graph shows three-year trends for both counties for the following measure:

- **Well-Child Visits in the first 30 Months of Life (15-30 Months) –** 2 or more well child visits by the child's 30-month birthday.

Graph 16 – Well Visits, 2 visits by age 30 Months



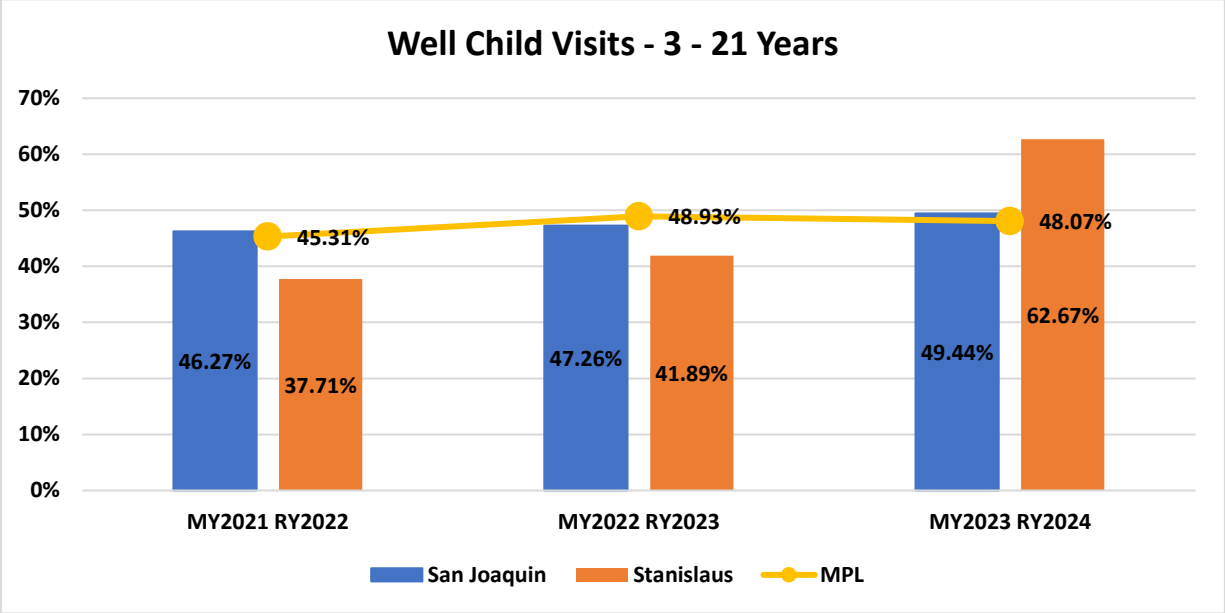
Quantitative analysis:

Both counties continue to show improvement year over year for the W30 – 15-30 months sub measures. San Joaquin increased from MY2022 (60.67%) to MY2023 (62.46%) by 1.79%. Stanislaus saw a notable increase in compliance from MY2022 (56.49%) to MY2023 (62.67%) of 6.18%. Both counties have shown strong improvement but continue to perform under the MPL.

The following graph shows three-year trends for both counties for the following measure:

- **Well-Child Visits 3-21 years –** Annual wellness visit for adolescents ages 3-21 years.

Graph 17– Well-Child Visits 3-21 years –



Quantitative analysis:

Both counties have continued to show improvement year over year for the WCV measure. San Joaquin increased from MY2022 (47.26%) to MY2023 (49.44%) by 2.18%. Stanislaus saw a significant increase in performance from MY2022 (41.89%) to MY2023 (62.67%) by 20.78%. Due to these increases both counties performed above the MPL for MY2023.

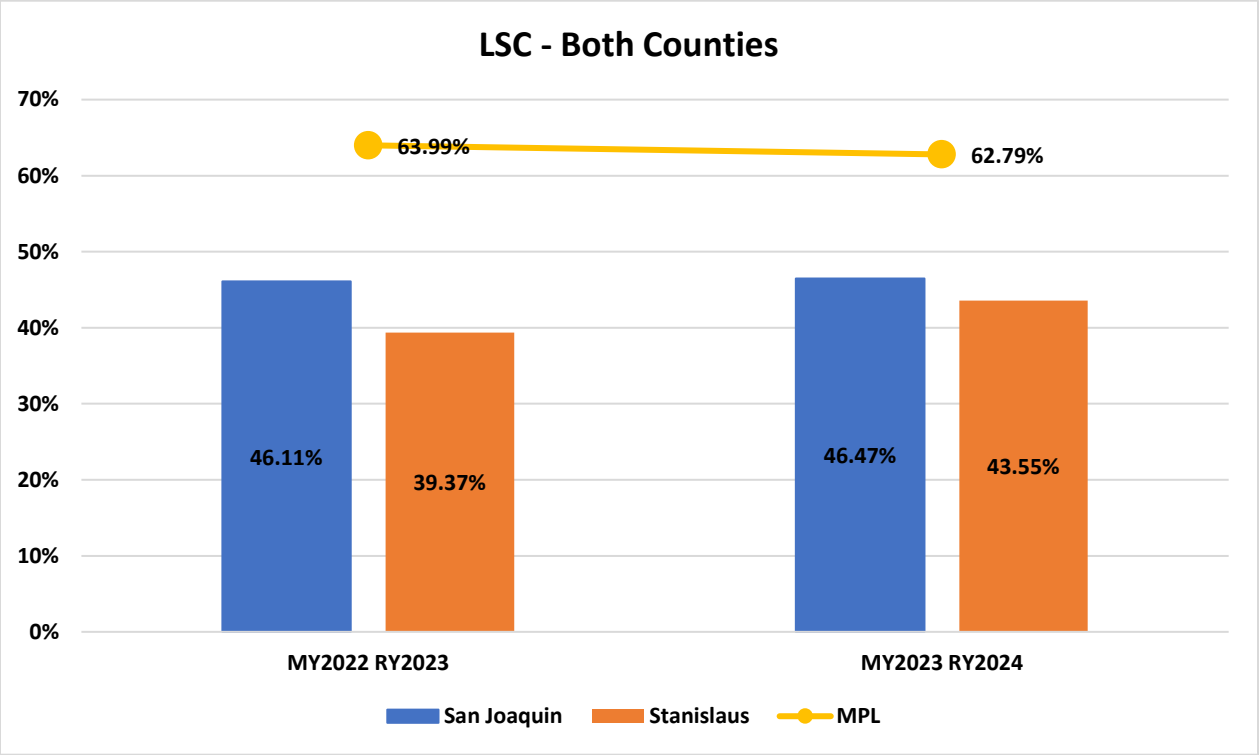
Qualitative analysis for well-child visits in the first 30 months as well as child and adolescents:

There are many barriers to reaching MPL for W30- 6+ visits by 15 months. They are transportation issues, appointment availability, missed appointments, social determinants like conflicting priorities and lack of familial support which makes it difficult to care for one child if another is also in need of care (e.g., one child needs a well visit, the other needs to work on homework), and sick visits and illness, which impact the caregivers ability to keep appointments timely. Well child and adolescent visits have these barriers and additionally have the increased barriers of trying to appeal to teens and young adults to make and keep well visit appointment. The rate of compliance for child and adolescent well visits decreases as the age of the child increases.

The following graph shows three-year trends for both counties for the following measure:

- **Lead Screening in Children** – Children who completed a lead screening before their 2nd birthday.

Graph 18 – Lead Screening in Children



Quantitative analysis:

MY2023 was the second year for lead screening reporting for MCAS reporting in both counties. San Joaquin saw a small increase in rate from MY2022 (46.11%) to MY2023 (46.47%) by 0.36%. Stanislaus increased from MY2022 (39.37%) to MY2023 (43.55%) by 4.18%. Despite these increases both counties continue to perform below the measure MPL.

Qualitative analysis:

Lead screening for children two years of age is complicated by many factors. The most impactful is access to convenient lead screening. Many offices do not provide point of care lead screening. Caregivers of infants often have just completed a visit with the PCP at the time the PCP is recommending a capillary

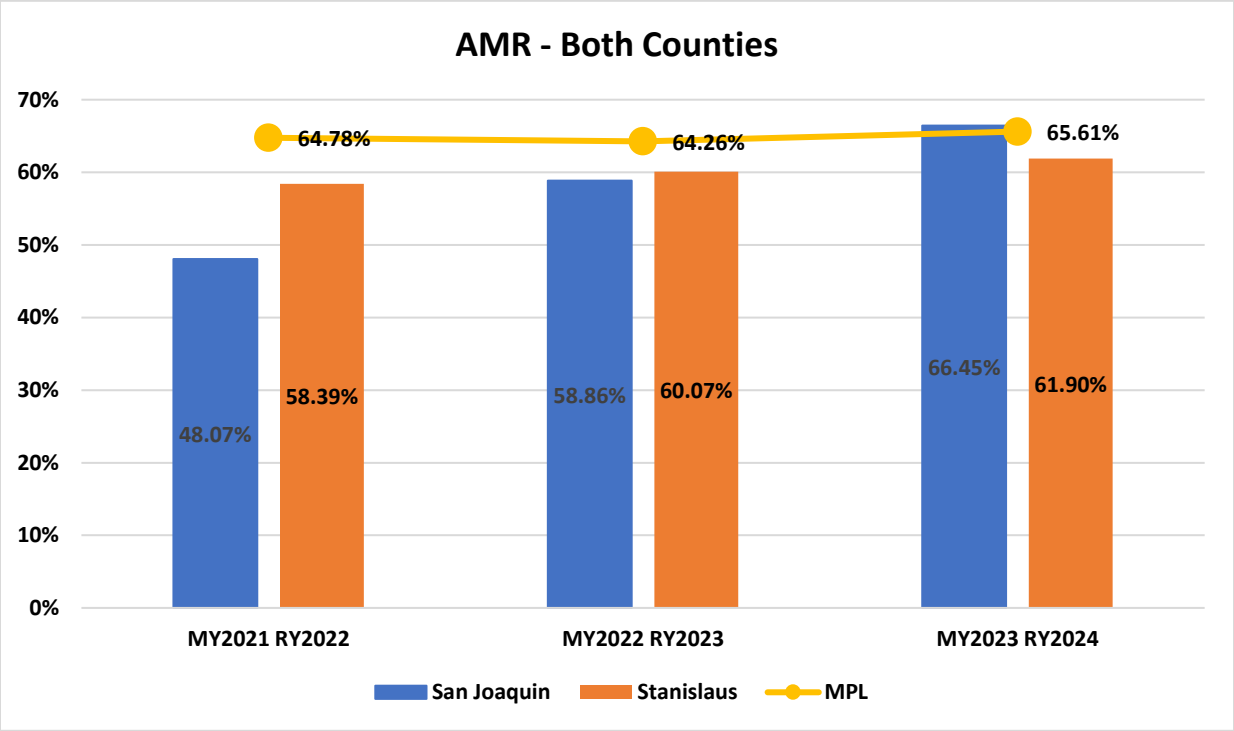
or venous blood draw for lead testing. The infant is often already stressed by the visit, especially if vaccinations were administered. The likelihood of caregiver traveling to a new location to complete lead screening is lessened because they may already have introduced stress to the infant and the caregiver is less likely to prolong the stress. Additionally, there is broad-based ignorance about the many sources of lead in the environment and in consumer goods and the invisible and detrimental impact that lead poisoning can have on a developing brain until the lead levels are so high that outward symptoms of physical disease manifest.

Chronic Disease Management Measures

The following graph shows three-year trends for both counties for the following measure:

- **Asthma Medication Ratio -** 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.

Graph 19 – Asthma Medication Ratio



Quantitative analysis:

Both counties have continued to show improvement in AMR measure performance year over year. San Joaquin saw a notable increase from MY2022 (58.86%) to MY2023 (66.45%) of 7.59%. Stanislaus county saw a smaller increase from MY2022 (60.07%) to MY2023 (61.90%) of 1.83%.

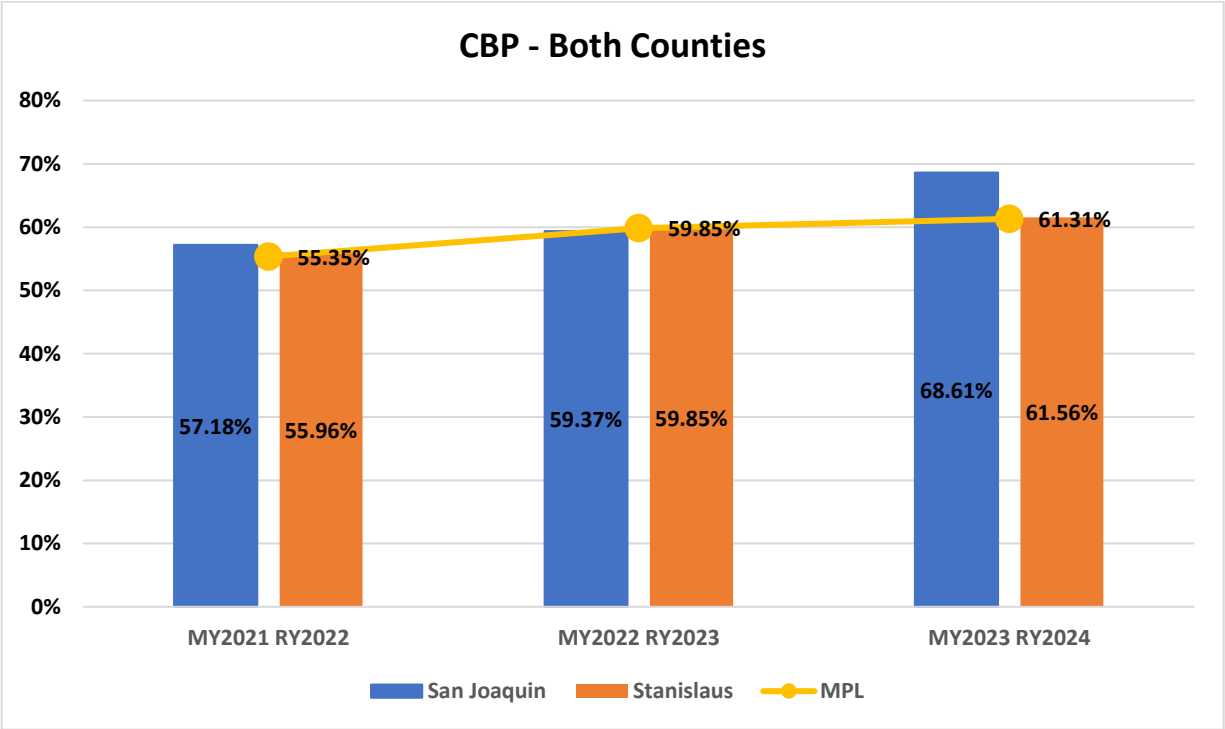
Qualitative analysis:

Asthma medication management continues to be challenging due to the reliance on rescue inhalers and the incidence of emergency room or acute care visits for asthma exacerbation. One of the positive impacts to the measure rates is that an opportunity to maximize data was identified. Not all asthma combination medication NDCs were present in the HEDIS value set. By mapping not present medications to medication NDCs in the value set, the plan was able to capture more compliant members and meet the MPL in SJ County. Finally, health plan teams focus on outreach and education for providers who care for and members who have asthma.

The following graph shows three-year trends for both counties for the following measure:

- **Controlling High Blood Pressure** - 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.

Graph 20: Controlling High Blood Pressure

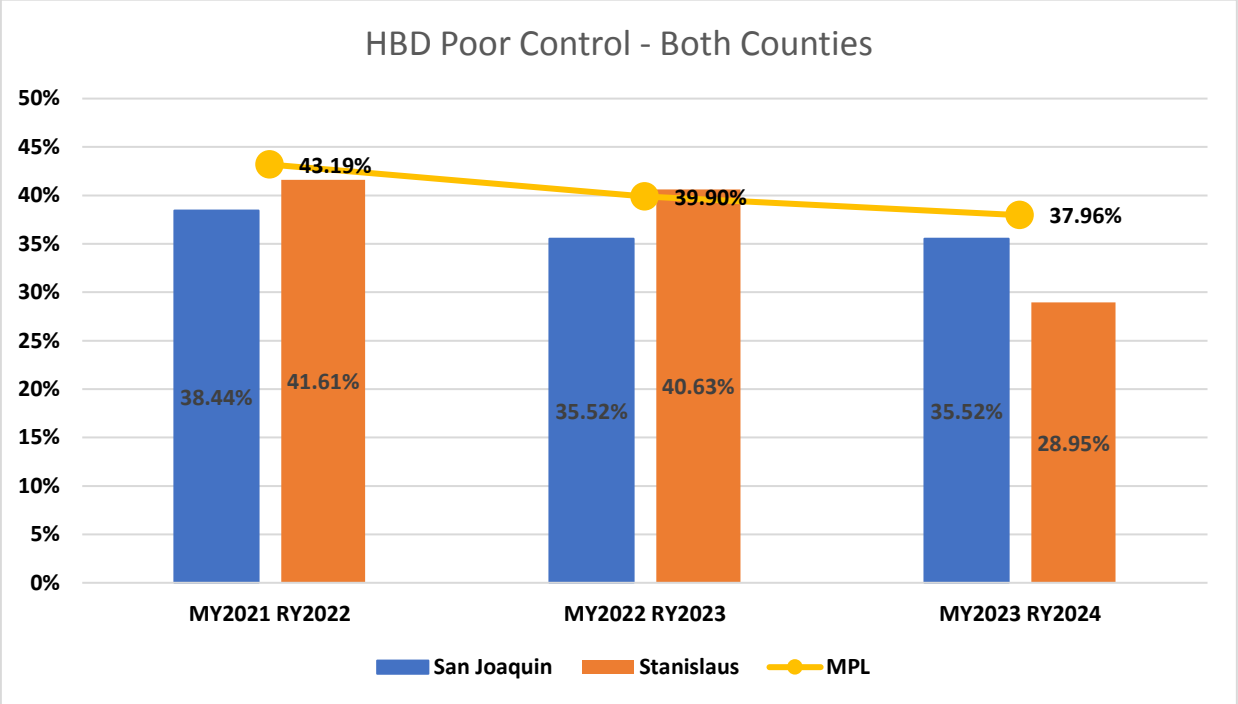


Both counties have continued to show improvement year over year for the CBP measure. San Joaquin increased from MY2022 (59.37%) to MY2023 (68.61%) by 9.24%. Stanislaus increased from MY2022 (59.85%) to MY2023 (61.56%) by 1.71%. Both counties performed above the MPL for MY2023.

The following graph shows three-year trends for both counties for the following measure:

- **Diabetic A1c >9 (HBD >9)** The percentage of members 18-75 years of age with type 1 and type 2 diabetes who had a Hemoglobin A1c test result of 9.0 or greater (a lower rate is better).

Graphs 21: HbA1c Testing – Poor Control (>9%)



Quantitative analysis:

HBD Poor Control is an inverse reporting measure. San Joaquin saw no change in rate from MY2022 (35.52%) to MY2023 (35.52%). Stanislaus saw a fantastic improvement from MY2022 (40.63%) to MY2023 (28.95%) of 11.68%. Both counties are performing above the MPL for MY2023. Stanislaus county is performing at the high-performance benchmark of 90th percentile.

Qualitative analysis:

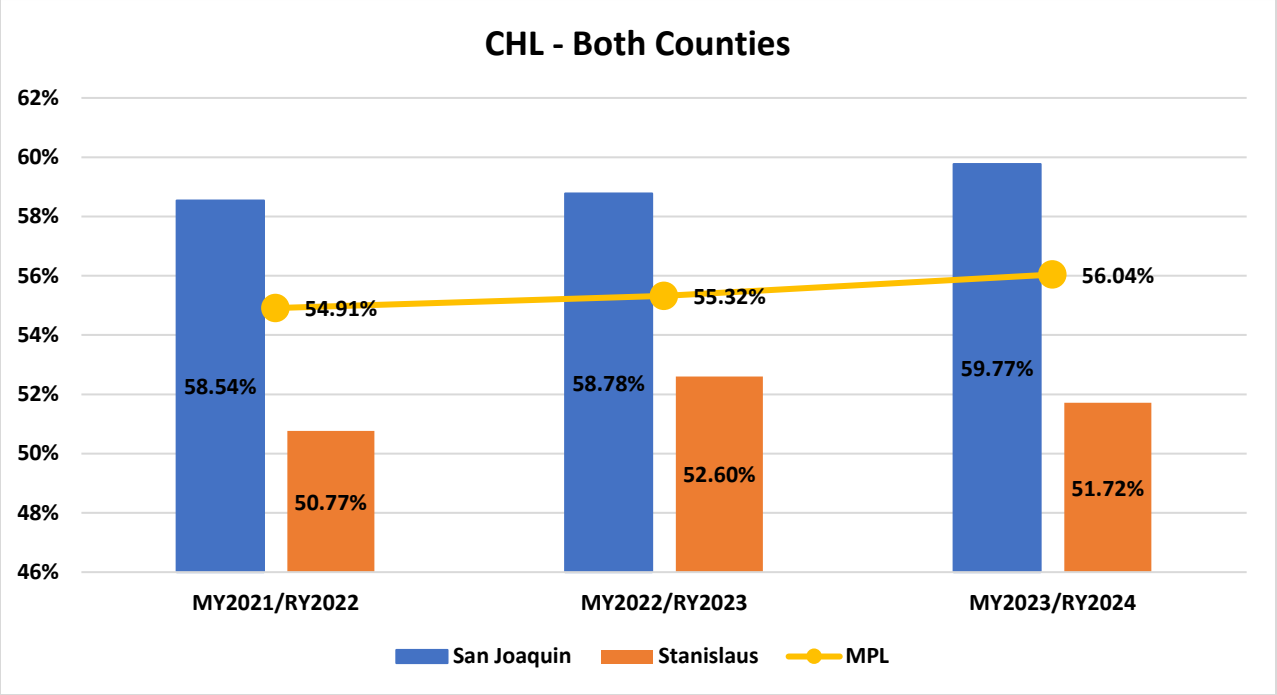
Both counties have exceeded the MPL through active management by PCPs of diabetes. Health Plan offers diabetes disease management and PCPs are engaging members more with care and treatment.

Reproductive Health Measures

The following graph shows three-year trends for both counties for the following measure:

- **Chlamydia Screening in Women –** Sexually active patients ages 15 to 24 who were screened for chlamydia.

Graph 22: Chlamydia Screening



Quantitative analysis:

San Joaquin County continues to show small increases year over year with an increase from MY2022 (58.78%) to MY2023 (59.77%) of 0.99%. Stanislaus County saw a decrease from MY2022 (52.60%) to MY2023 (51.72%) of 0.88%. San Joaquin County is performing above the MPL while Stanislaus County continues to perform under the MPL.

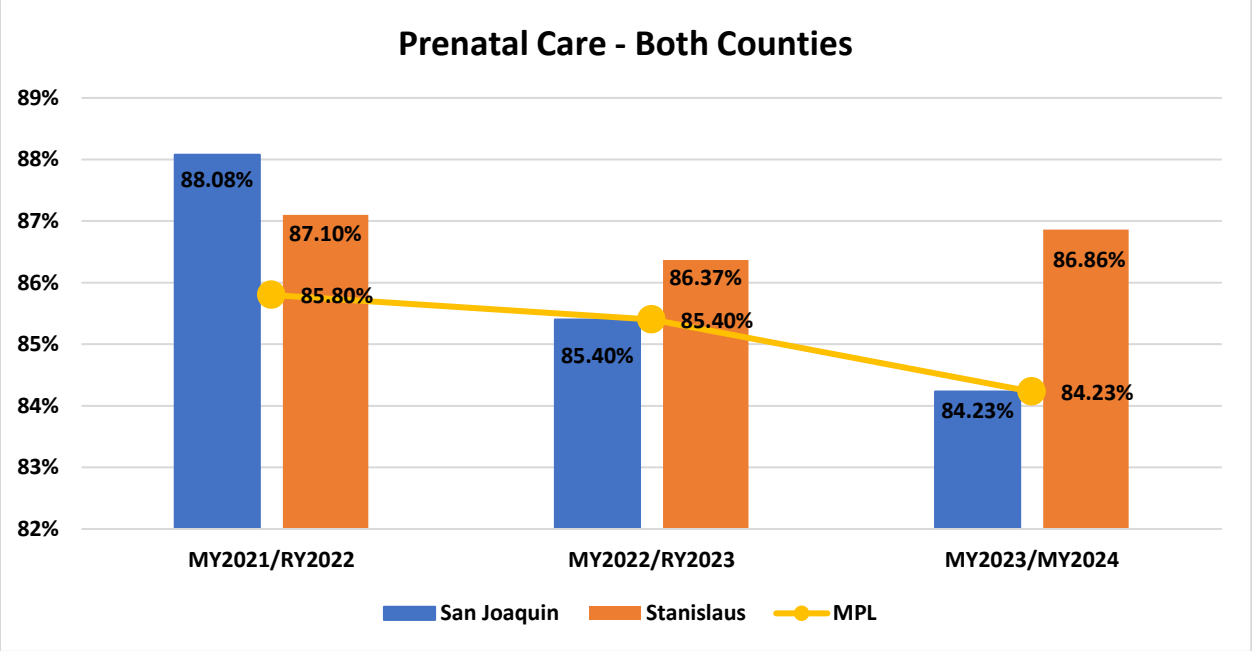
Qualitative analysis:

There are many ways in which young women can enter the chlamydia screening denominator. The most common is through prescriptions for contraceptives. Many of these prescriptions are long standing and as such, the member is not likely to return to the doctor's office to perform urinalysis or a blood test. Another way members can enter the denominator is through pregnancy tests with or without evidence or admission of sexual activity. As a result, many opportunities to test women are missed. Once the woman is out of the care setting, the best opportunity to test has often passed. Additionally, there is evidence in health plan data that lab tests were impacted by the change in healthcare cyber-attacks. As such data may be incomplete.

The following graph shows three-year trends for both counties for the following measure:

- **Prenatal Care (PPC-PRE)** Patients who had a live birth and completed prenatal care in the first trimester.

Graph 23: Prenatal Care



Quantitative analysis:

San Joaquin county has continued to decrease year over year with a decrease from MY2022 (85.40%) to MY2023 (84.23%) of 1.17%. Stanislaus County saw a slight increase from MY2022 (86.37%) to MY2023 (86.86%) of 0.49%. Both counties met or exceeded the MPL for MY2023.

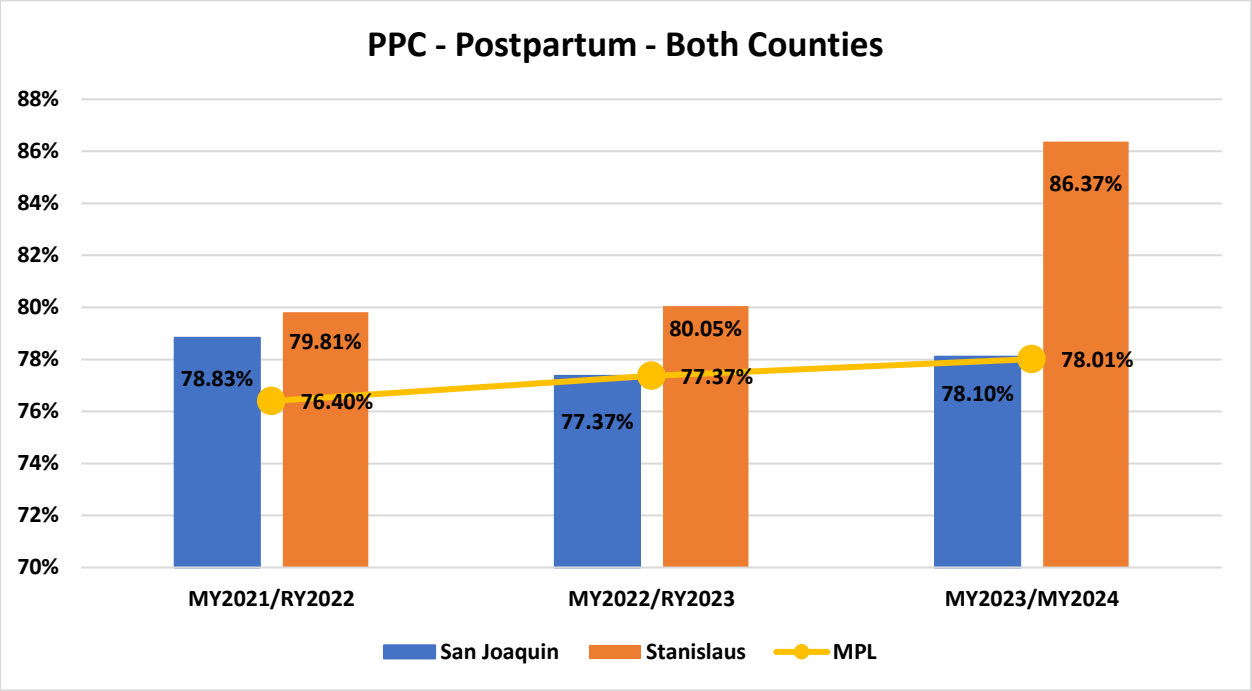
Qualitative analysis:

Over the past years, less priority has been given and fewer resources given to prenatal care. The plan used to outreach at the time of identified pregnancy for all members. Calls for all members were dropped mid-year 2022. The Me and My Baby program continues, which is probably contributing to sustained performance in Stanislaus. In San Joaquin County, there may be higher incidence of pregnant members enrolling later in pregnancy as well.

The following graph shows three-year trends for both counties for the following measure:

- **Postpartum Care (PPC-POST)** Patients who had a live birth and completed postpartum follow up care between 7- 84 days after delivery

Graph 24: Postpartum Care



Quantitative analysis:

San Joaquin saw a small increase from MY2022 (77.37%) to MY2023 (78.10%) of 0.73%. Stanislaus County increased from MY2022 (80.05%) to MY2023 (86.37%) by 6.32%. Both counties met or exceeded the MPL for MY2023.

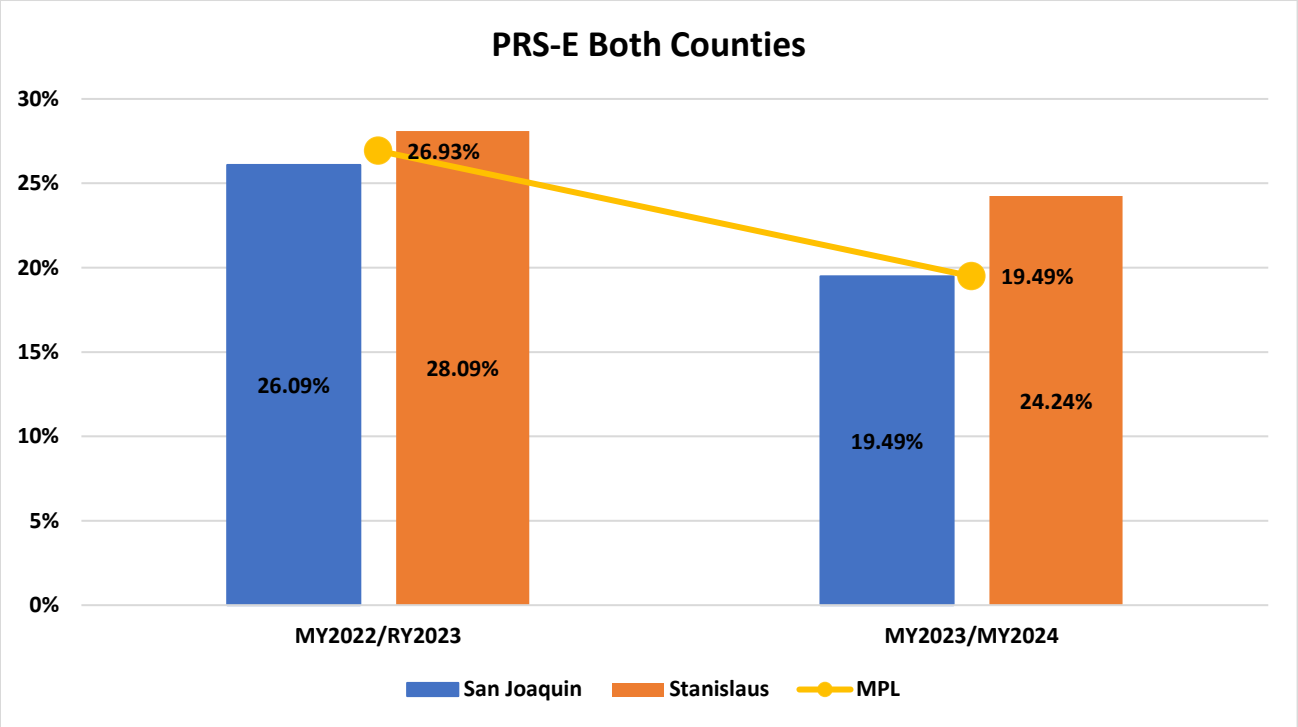
Qualitative analysis:

Postpartum rates are greatly impacted by social factors experienced by members. There is less likelihood of members who have had prior deliveries to seek postpartum care timely. Additionally, when members have visits post-delivery that happen within the first week after delivery, they are less likely to return unless they are experiencing complications.

The following graph shows three-year trends for both counties for the following measure:

- **Prenatal Immunizations – Combo (PRS-E)** Patients who had a live birth who received both an influenza vaccine and a Tdap vaccine in the recommended timeframe.

Graph 25: Prenatal Immunizations



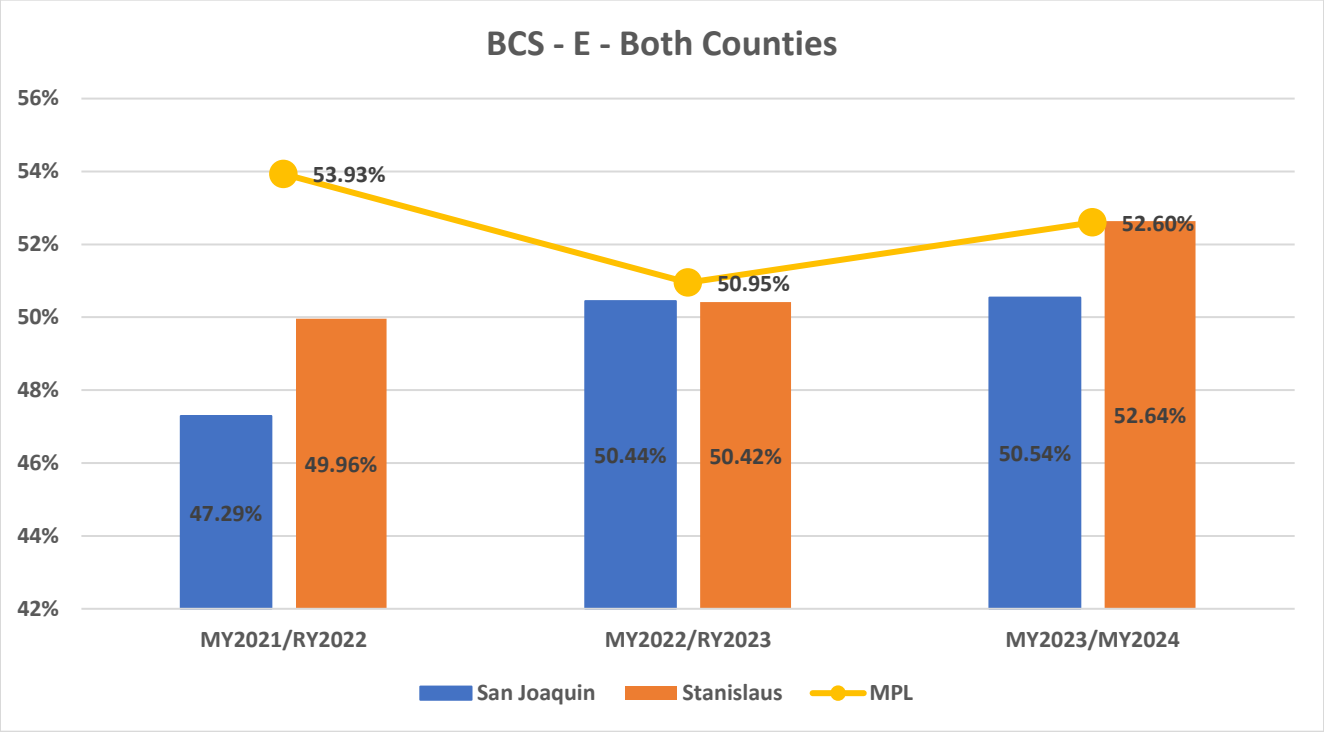
MY2023 was the second year reporting the PRS-E measure. San Joaquin County saw a decrease from MY2022 (26.09%) to MY2023 (19.49%) of 6.6%. Stanislaus county decreased from MY2022 (28.09%) to MY2023 (24.24%) by 3.85%. Both counties met or exceeded the MPL during MY2023. This measure is not held to MPL.

Cancer Screening Measures

The following graph shows three-year trends for both counties for the following measure:

- **Breast Cancer Screening – BCS-E -** Patients 50-74 years of age who had at least one mammogram to screen for breast cancer in the past 2 years.

Graph 26: Breast Cancer Screening



Quantitative analysis:

Both counties continue to show improvement over the past 3 years. San Joaquin county saw a slight increase from MY2022 (50.44%) to MY2023 (50.54%) of 0.10%. Stanislaus county increased from MY2022 (50.42%) to MY2023 (52.64%) of 2.22%. San Joaquin county performed below the MPL for MY2023 while Stanislaus met the MPL for MY2023.

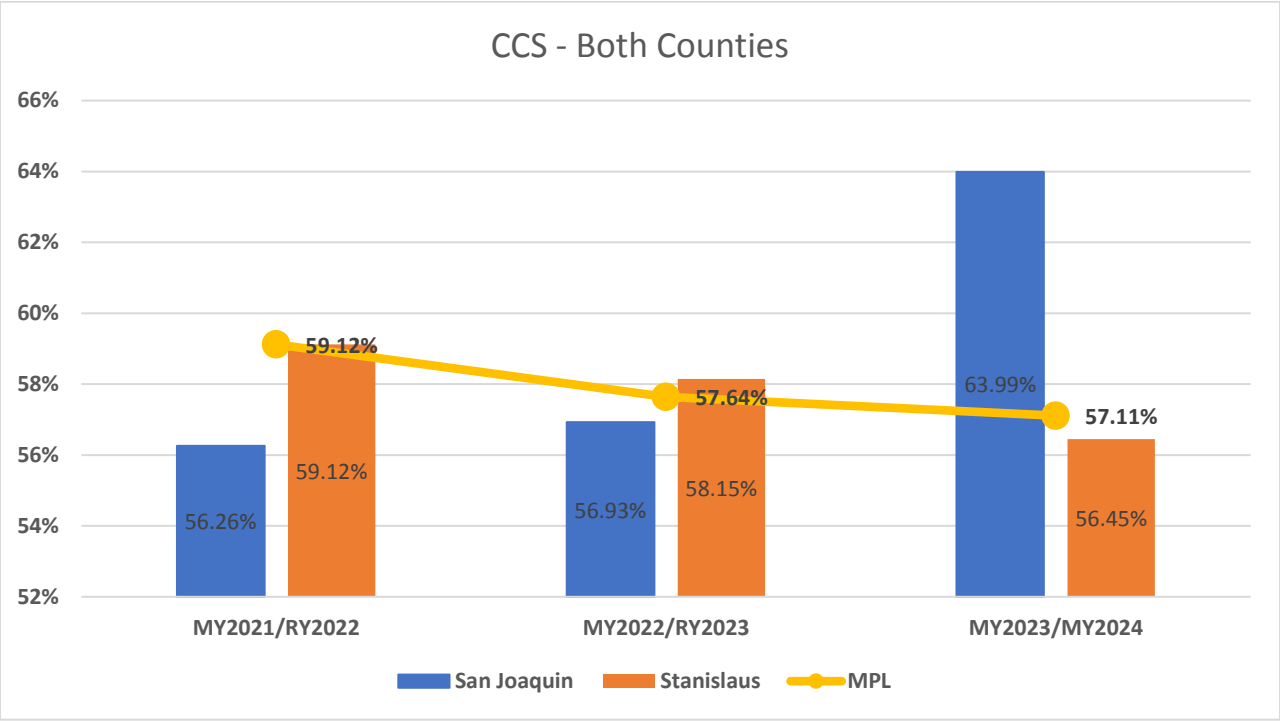
Qualitative analysis:

One of the key drivers of breast cancer screening rates not meeting MPL is the accessibility of mammography. There is an insufficient network of radiology centers offering mammography in both counties. To remediate that, the health plan has contracted with mobile mammography. Mobile mammography is available by appointment at predetermined locations. Although mobile mammography is limited, it has helped Stanislaus County reach the MPL.

The following graph shows three-year trends for both counties for the following measure:

- **Cervical Cancer Screening -CCS -** Patients with a cervix ages 21-64 years old who had cervical cytology in the past 3 years and/or high-risk human papillomavirus (hrHPV) co-testing performed during the past 5 years.

Graph 27: Cervical Cancer Screening



Quantitative analysis:

San Joaquin county increased from MY2022 (56.93%) to MY2023 (63.99%) by 7.06%. Stanislaus county decreased from MY2022 (58.15%) to MY2023 (56.45%) by 1.7%. San Joaquin met the MPL while Stanislaus was just below the MPL for MY2023.

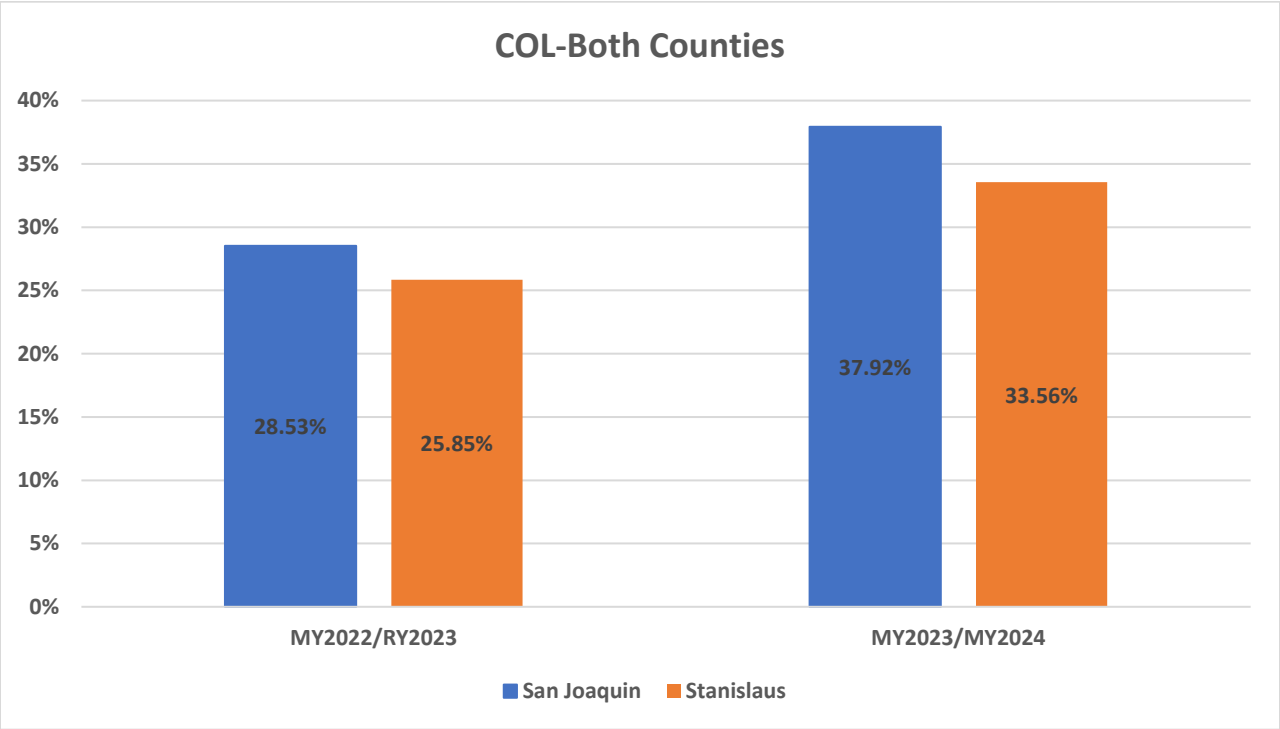
Qualitative analysis:

San Joaquin county FQHCs have offered many additional clinic days, including weekends to help with access to cervical cancer screening. This has proven very effective in reaching and exceeding the MPL. Stanislaus county has prioritized meeting MPL for other measures and has struggled with access to primary care.

The following graph shows three-year trends for both counties for the following measure:

- **Colorectal Cancer Screening-COL**- Patients ages 50- 75 years old who had appropriate screening for colorectal cancer during the past 10 years.

Graph 28: Colorectal Cancer Screening



Quantitative analysis:

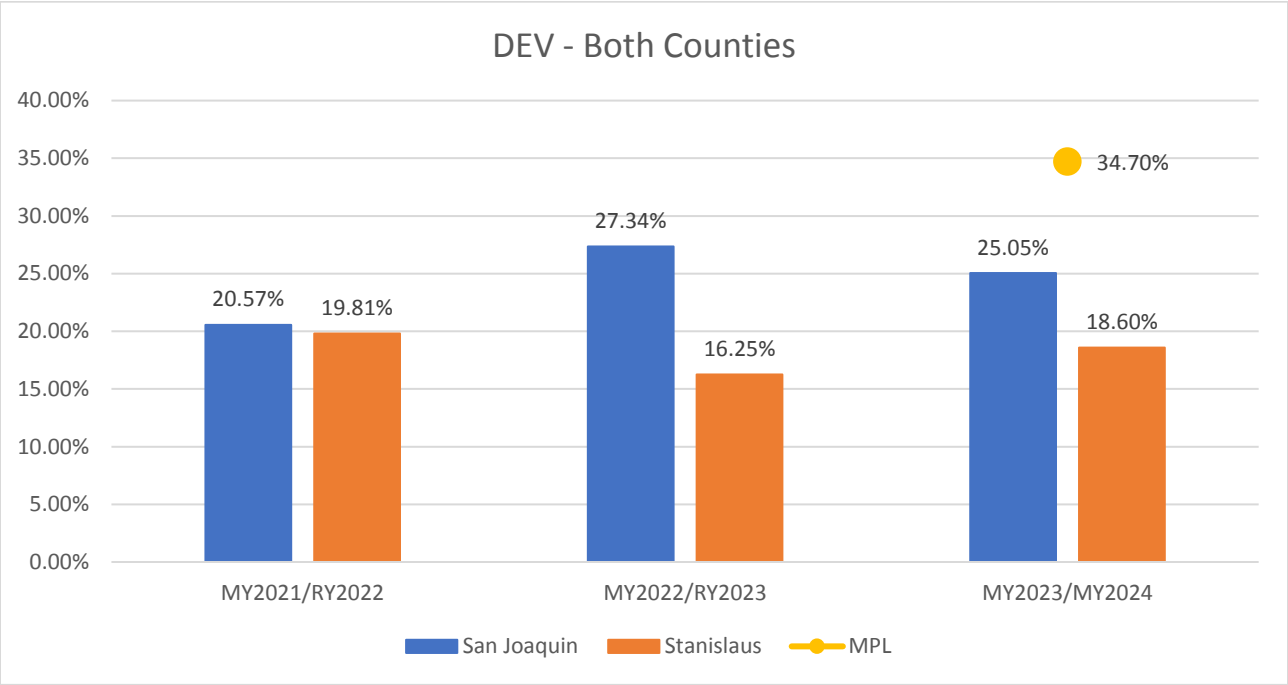
MY2023 was the second-year reporting for COL measure as a Medicaid measure and MCAS measure. San Joaquin increased from MY2022 (28.53%) to MY2024 (37.92%) of 9.39%. Stanislaus increased from MY2022 (25.85%) to MY2023 (33.56%) by 7.71%. An MPL has not been established for the COL measure as of MY2023.

Non-NCQA Measures

The following graph shows three-year trends for both counties for the following measure:

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

Graph 29: Developmental Screening in the First Three Years of Life



Quantitative analysis:

San Joaquin decreased in performance from MY2022 (27.34%) to MY2023 (25.05%) by 2.29%. Stanislaus county increased from MY2022 (16.25%) to MY2023 (18.60%) by 2.35%. MY2023 was the first year an MPL was established for the DEV measure. Both counties were under the MPL for MY2023.

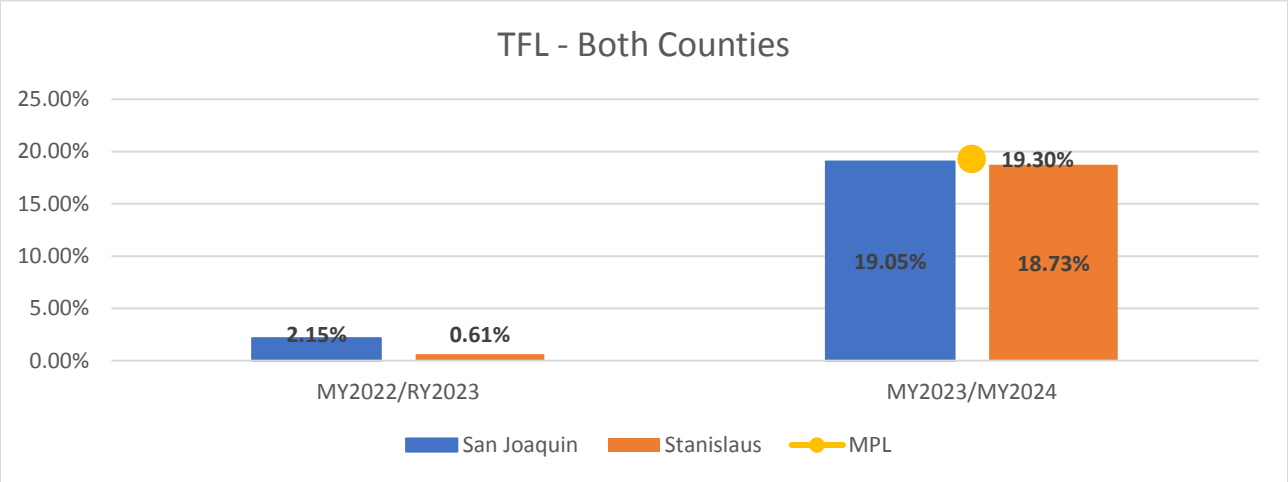
Qualitative analysis:

DEV screening measure rate performance ties to the rates of well visits. Additionally, when a comprehensive well visit is performed, the PCP is often noting whether developmental milestones are met. However, in the absence of documenting the use of a standardized assessment tool and the results of that tool, the metric is not met.

The following graph shows three-year trends for both counties for the following measure:

- **Topical Fluoride for Children-TFL-** The percentage of children ages 1-20 years who had at least two topical fluoride treatments during the measurement year.

Graph 30: Topical Fluoride for Children 1-20 Years



Quantitative analysis:

MY2023 was the second reporting year for the TFL measure in MCAS and for both counties. Both counties showed significant increases in performance San Joaquin increased from MY2022 (2.15%) to MY2023 (19.05%) by 16.90% while Stanislaus increased from MY2022 (0.61%) to MY2023 (18.73%) by 18.12%.

Qualitative analysis:

Fluoride varnish is a common procedure in young people. However, there is an ongoing dispute over whether the PCP or dental provider is the appropriate practitioner to apply fluoride varnish, and some practitioners feel that fluoride varnish is not beneficial to the health of young people. This creates confusion between practitioners as well as among members. Additionally, there is a strong disconnect between the criteria for achievement of fluoride varnish and the measure specifications. Fluoride varnish is not a covered benefit for members over the age of 6 years.

Race and Ethnicity (RE) Data reporting

MY2023 was the second year HPSJ was required to report race and ethnicity data for 17 key measures to NCQA and DHCS.

Measures included are:

- Controlling High Blood Pressure (CBP)
- HbA1c Poor Control >9% (HBD>9%)
- Colorectal Cancer Screening (COL)
- Prenatal & Postpartum (PPC)

- Child & Adolescent Well-Care Visits (WCV)
- Well-Child Visits in the First 15 & 30 Months of Life (W30)
- Childhood Immunization Status (CIS-10)
- Immunizations for Adolescents (IMA-2)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- Follow-Up After ED Visit for Mental Illness (FUM)
- Follow-Up After ED Visit for Substance Abuse (FUA)
- Asthma Medication Ratio (AMR)
- Breast Cancer Screening (BCS)
- Pharmacotherapy for Opioid Use Disorder (POD)

Race by County

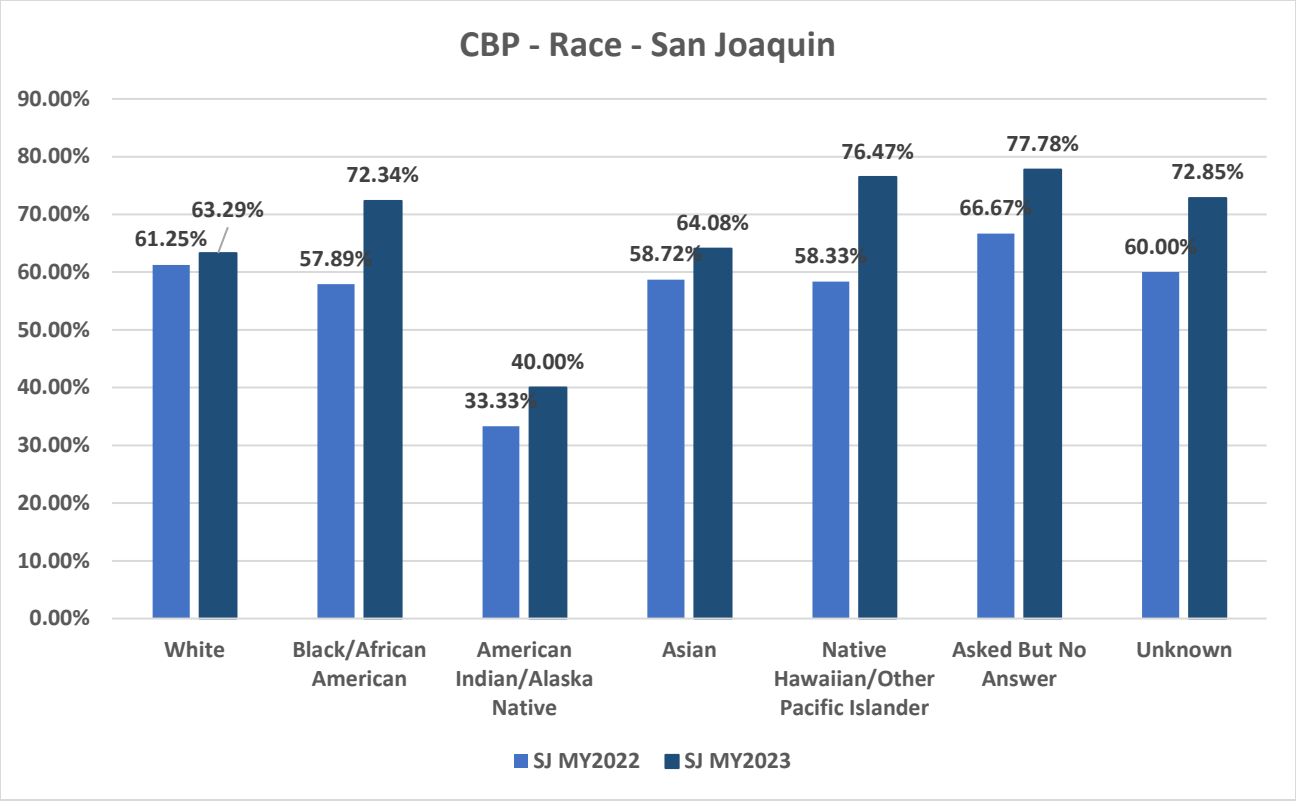
Graphs 31 & 32: CBP – Race – by county

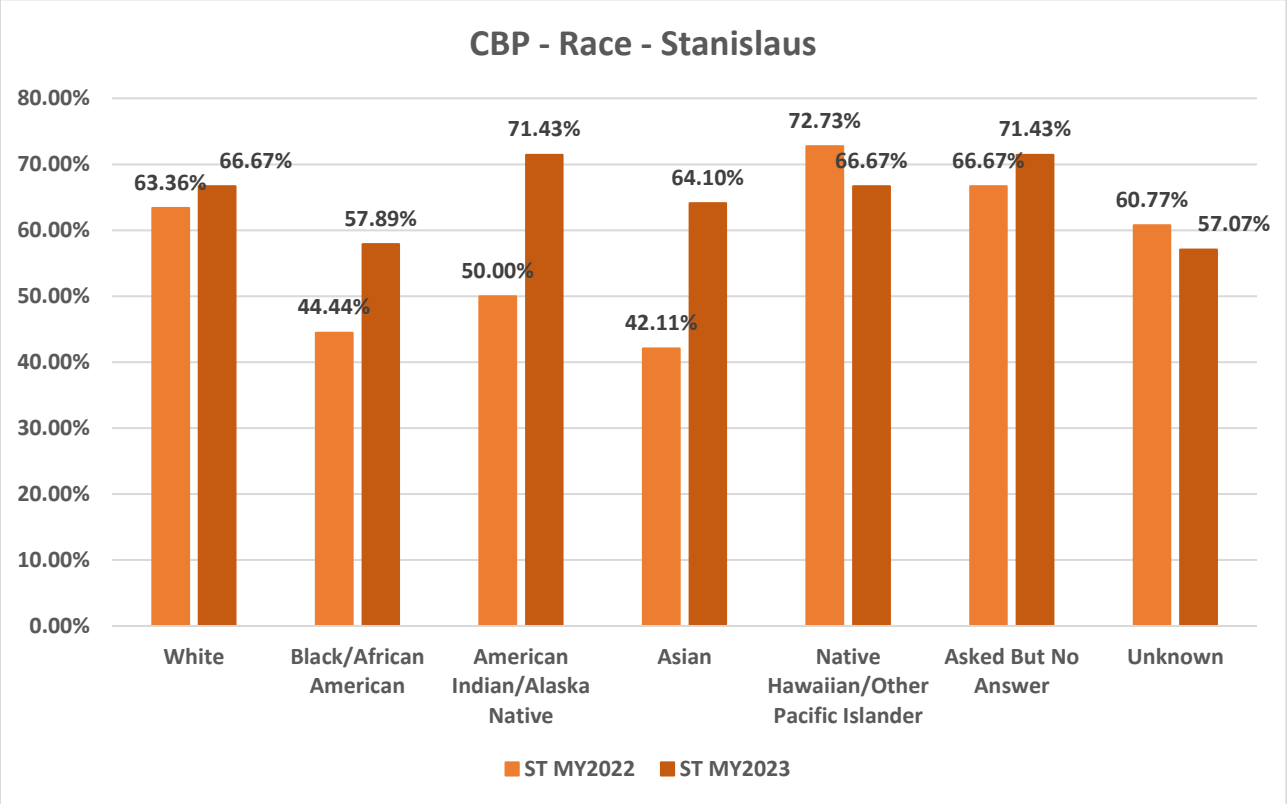
San Joaquin County quantitative analysis.

In San Joaquin County, rates of compliance are higher for all races when compared to prior year. The highest performing races are asked but not answered and Native Hawaiian. Of those that are known, Black and Native Hawaiian Pacific Island are highest performing. Lowest performing subpopulations are Asian (specifically Asian Indian and Native American).

San Joaquin qualitative analysis:

Upon further review, in San Joaquin County, Asian Indian members are genetically more susceptible to heart disease and more likely to live sedentary lifestyles. Native Americans are historically marginalized and suffer from more mistrust of the western healthcare system.





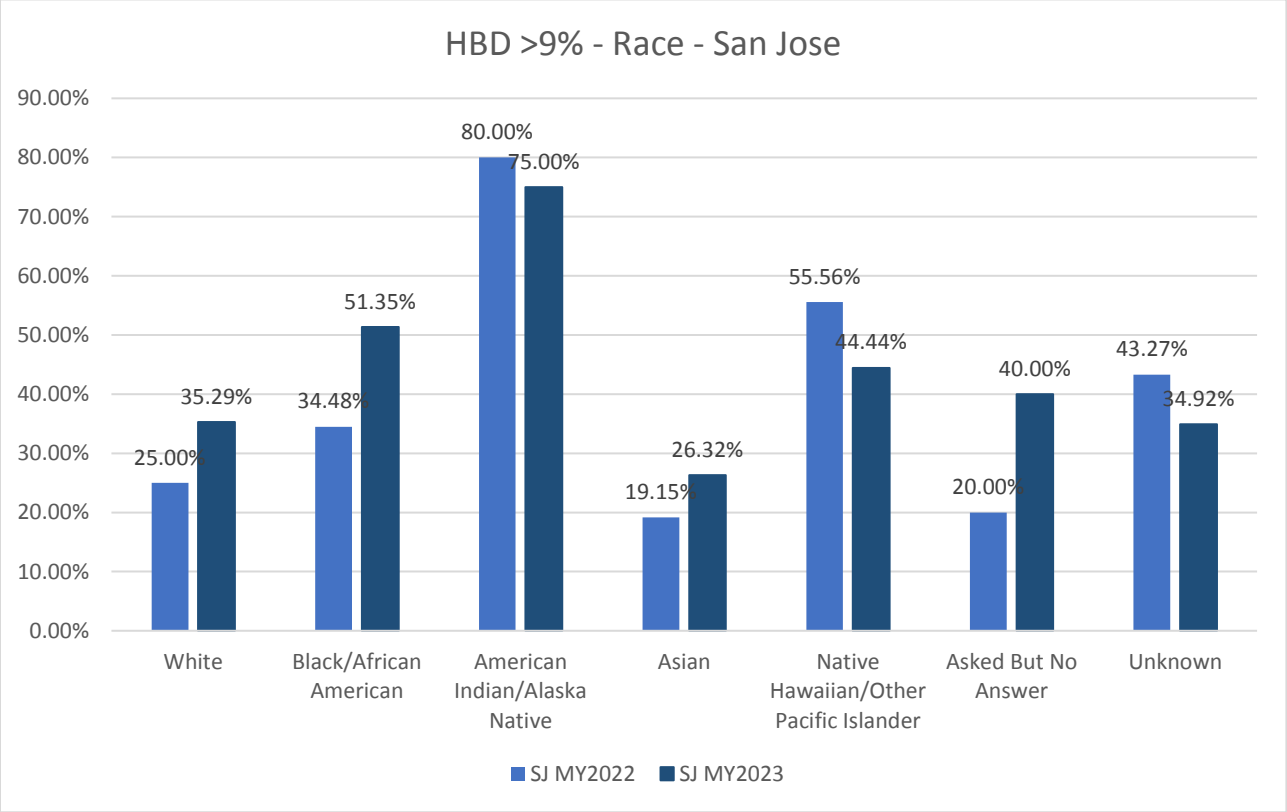
Stanislaus County quantitative analysis:

In Stanislaus County, rates of compliance are higher in all race categories when compared to prior year except for asked but not answered. It is difficult to analyze the unknown category for health disparities, as they are not disclosing their race. The higher performing races are Native Hawaiian and American Indian. The lowest performing are Unknown and Black/African American. As the rate of compliance is increasing for Blacks in Stanislaus County. Therefore, trending is postponed due to low denominators. The Asian Indian rate of compliance is also underperforming other subpopulations in Stanislaus County.

Qualitative analysis:

It will be beneficial to understand the populations that are asked but not answering and those who are unknown. The Asian Indian population is also underperforming other races in Stanislaus County.

Graphs 33 & 34: HBD >9% (lower rate is better) – Race – by county

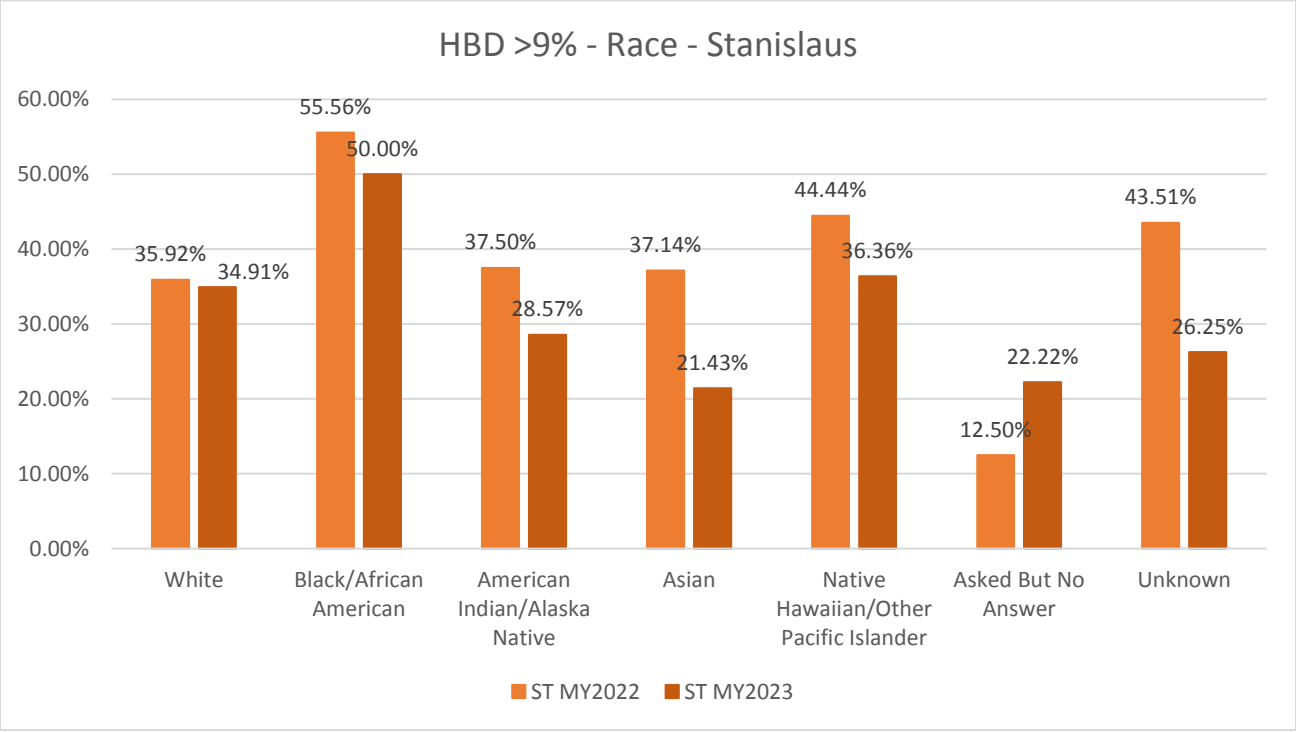


San Joaquin quantitative analysis:

All subpopulations have decreased compliance except for those who are Native American or Native Hawaiian/Pacific Island and unknown races. Higher rates indicate that fewer members have acceptable rates of A1c control. Among those with the poorest control are American Indian and Black, among those with the best A1c control are Asian and Unknown. Both White and Black members have notable decreases in A1c control.

San Joaquin qualitative analysis:

White members tend to avoid healthcare until it is vitally necessary. As a result, it is likely that White members are not seeking care until they feel unwell. Black and Native American members tend to mistrust medicine and rely on spiritual activities to assist with healing.



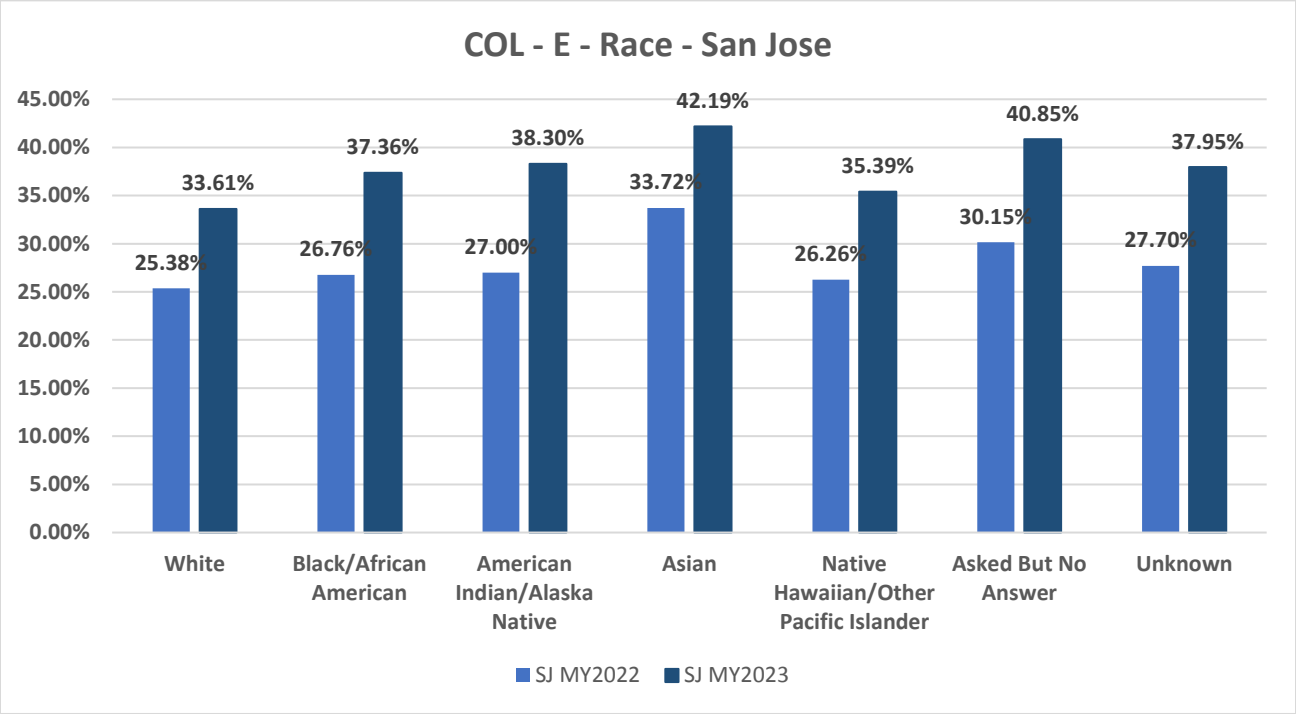
Stanislaus County HBD quantitative analysis:

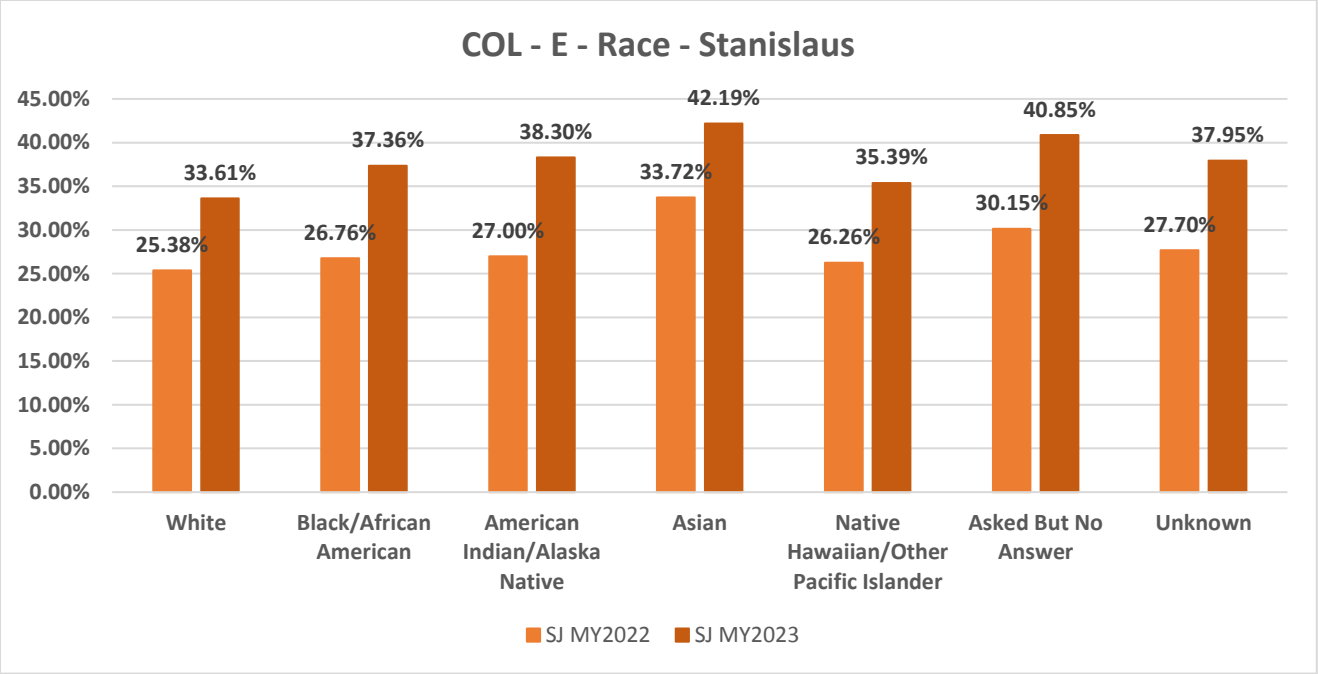
All races except those who were asked but not answered improved. Highest performing are unknown and asked but not answered. Lowest performing subpopulations are Black and Native Hawaiian/Pacific Island and White.

Qualitative analysis:

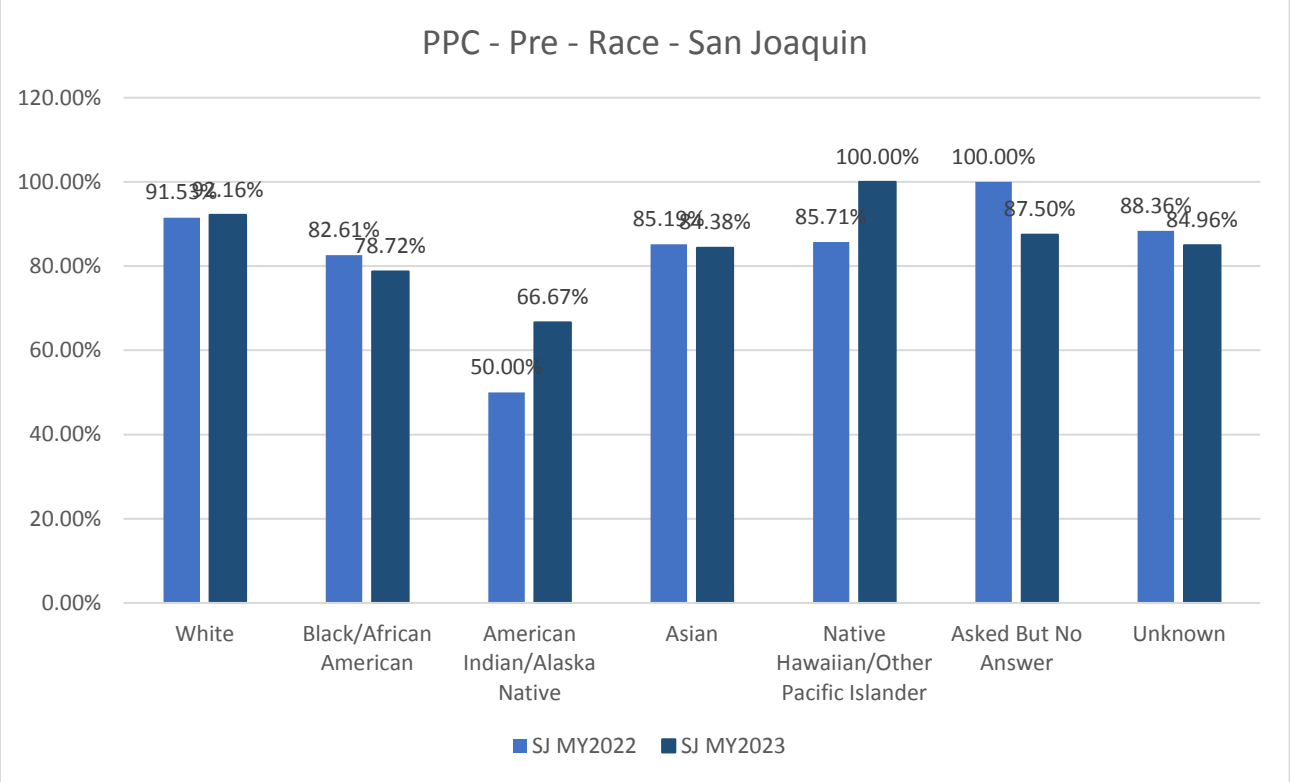
As noted in the analysis above, White members tend to avoid health care until it is vitally necessary. As a result, it is likely that White members are not seeking care until they feel unwell. Black and Native American members tend to mistrust medicine and rely on spiritual activities to assist with healing.

Graphs 35 & 36: COL-E – Race – by county





Graphs 37 & 38: PPC - Prenatal – Race – by county



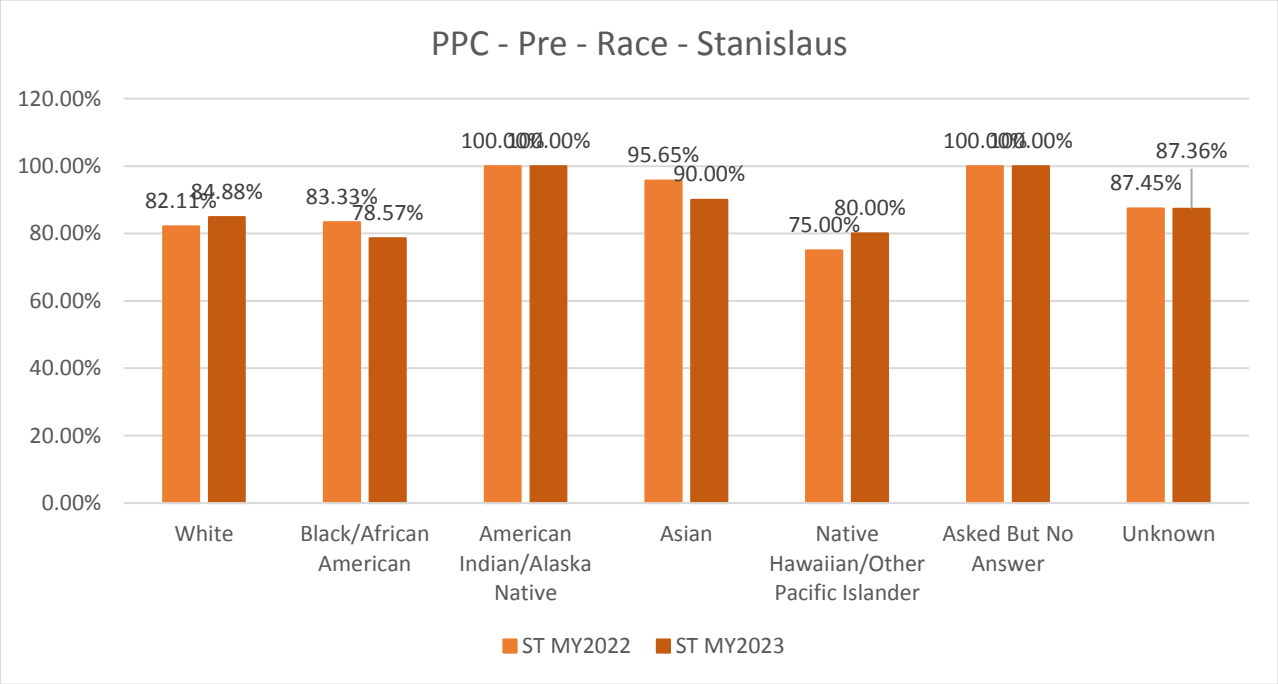
Quantitative analysis:

In San Joaquin County, the rates compared to prior year are variable. The highest performing races are Asked but answered, Native Hawaiian, and White.

The lowest performing subpopulations are American Indian, Black and Asian.

Qualitative analysis:

Native American, Black and Asian women suffer disproportionally from poverty, limited access to health care, dissimilar communication styles and ambiguity around pregnancy. These factors make it very important although less likely for these subpopulations to seek prenatal care.



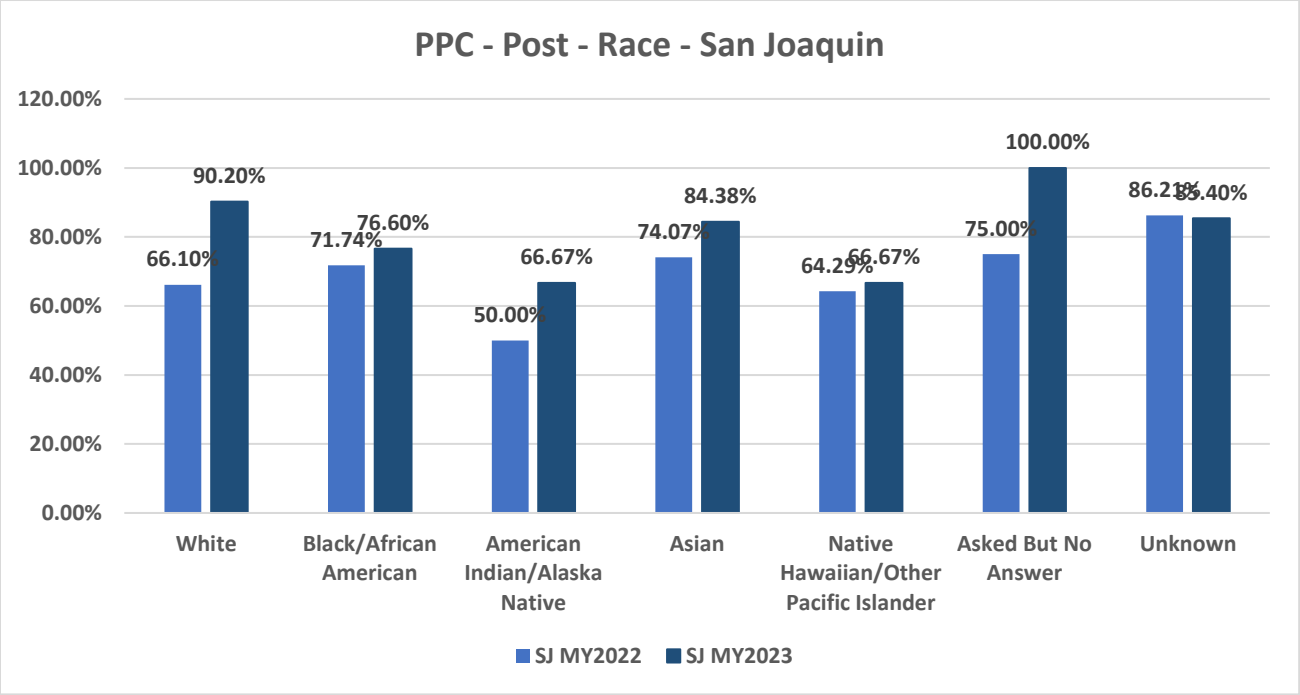
Quantitative analysis Stanislaus County:

Prenatal rates are higher in all subpopulations are mixed compared to prior year. Lowest performing are Black and Native Hawaiian. Caution is used when comparing subpopulation with low denominators as is the case with Black and Native American in Stanislaus County.

Qualitative analysis:

Black women suffer disproportionally from poverty, limited access to health care, dissimilar communication styles and ambiguity around pregnancy. These factors make it very important although less likely for these subpopulations to seek prenatal care.

Graphs 39 & 40: PPC - Postpartum – Race – by county

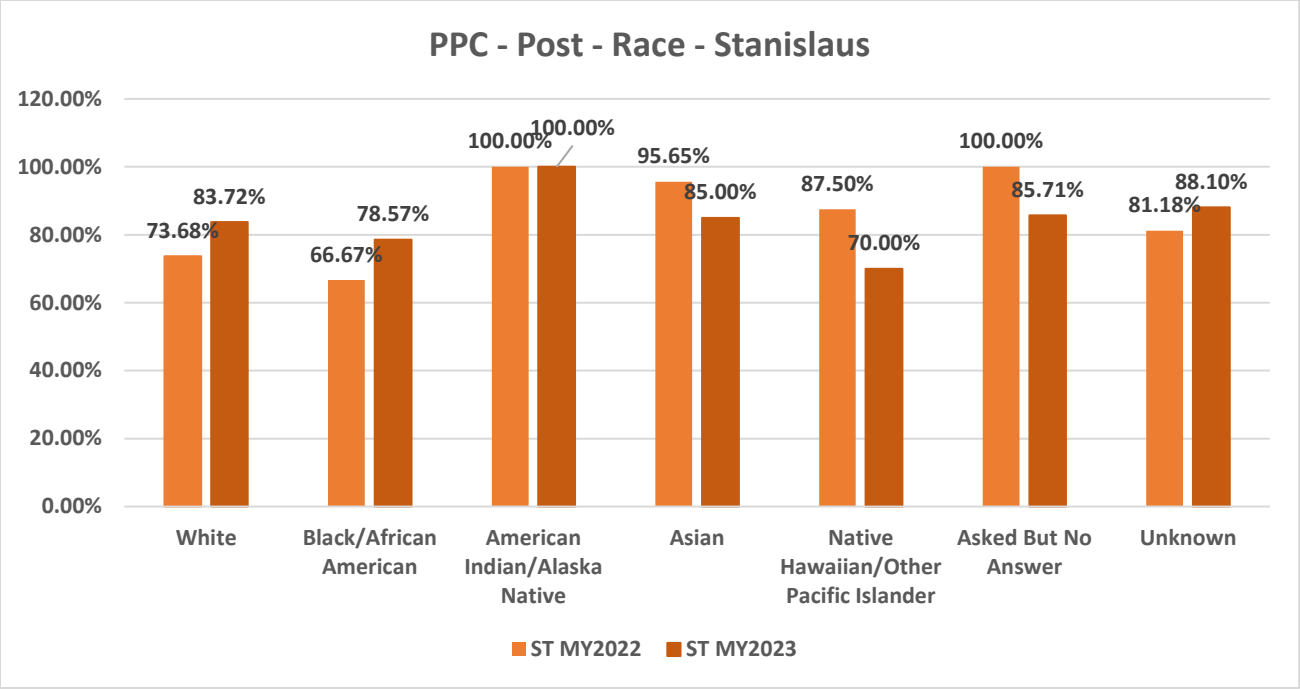


Quantitative analysis:

All racial subpopulations improved when compared to prior year. The highest performing subpopulations are asked but not answered and White. Lowest performing subpopulations are American Indian and Native Hawaiian.

Qualitative analysis:

American Indian and Native Hawaiian women suffer disproportionally from poverty, limited access to health care, generational trauma and culturally different approaches to pregnancy. These factors make it very important although less likely for these subpopulations to seek postpartum care.



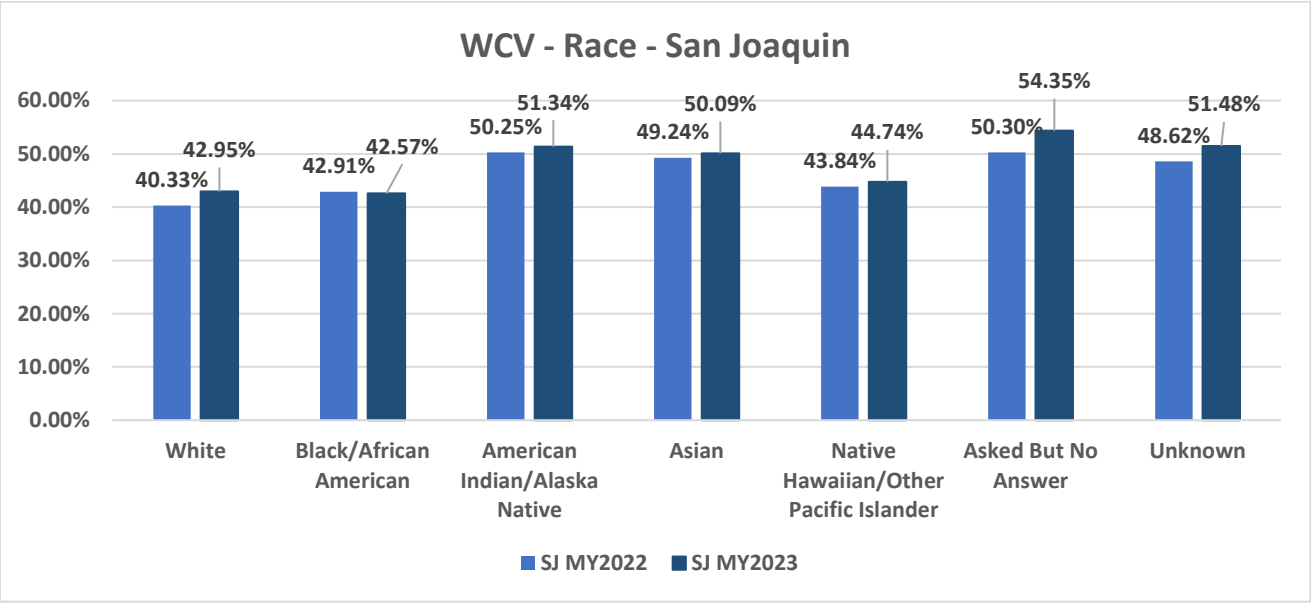
Stanislaus quantitative analysis:

WCV rates show mixed results when comparing subpopulation performance to the previous year. Highest performing races are American Indian and unknown. Lowest performing are Black and Native Hawaiian.

Stanislaus qualitative analysis:

Caution is used when evaluating subpopulations with small denominators. However, Native Hawaiian and Black women suffer disproportionally from poverty, limited access to health care, generational trauma and culturally different approaches to pregnancy. These factors make it very important although less likely for these subpopulations to seek postpartum care.

Graphs 41 & 42: WCV – Race – by county

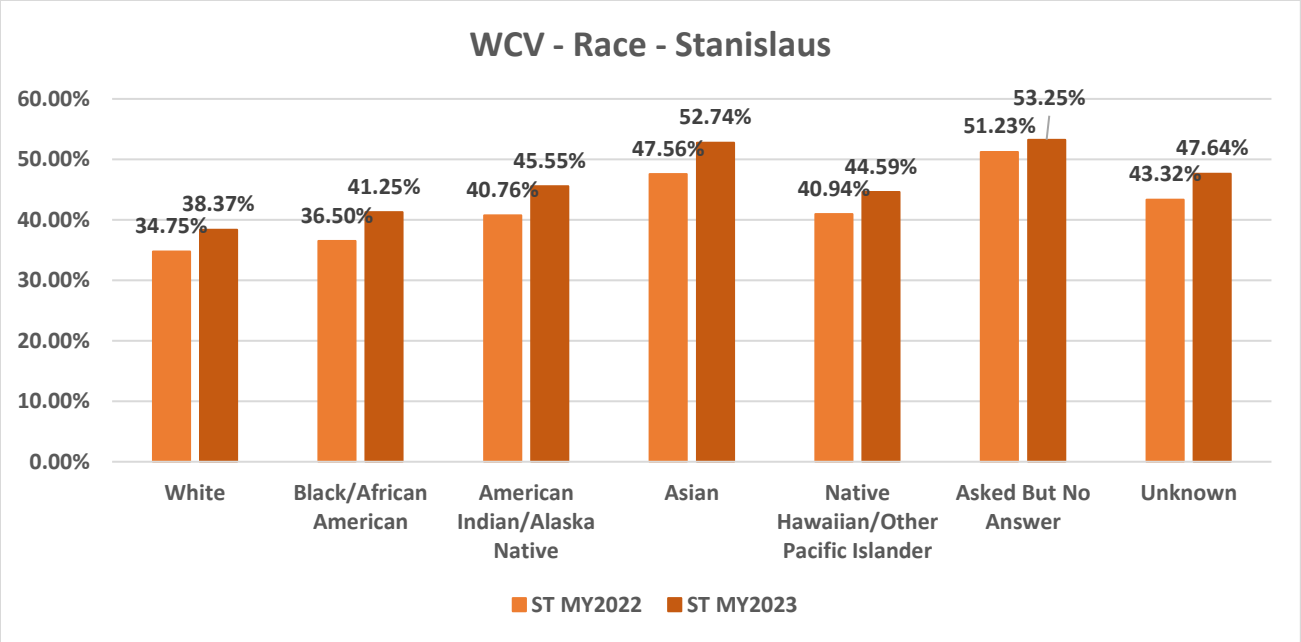


San Joaquin county quantitative analysis:

All subpopulations have increased performance when compared to prior year. The highest performing subpopulations are asked but now answered, and American Indian. The lowest are White and Black.

San Joaquin county qualitative analysis:

Adolescent boys are the age categories that are driving the lower performance for both White and Black subpopulations. Adolescents and young adults are faced with many social factors that contribute to lower well-visit rates. They are faced with a high degree of social pressure to appear healthy and resilient and spend time with their peers. Going to the doctor's office for an appointment seems like it is contradictory to resilient behavior.



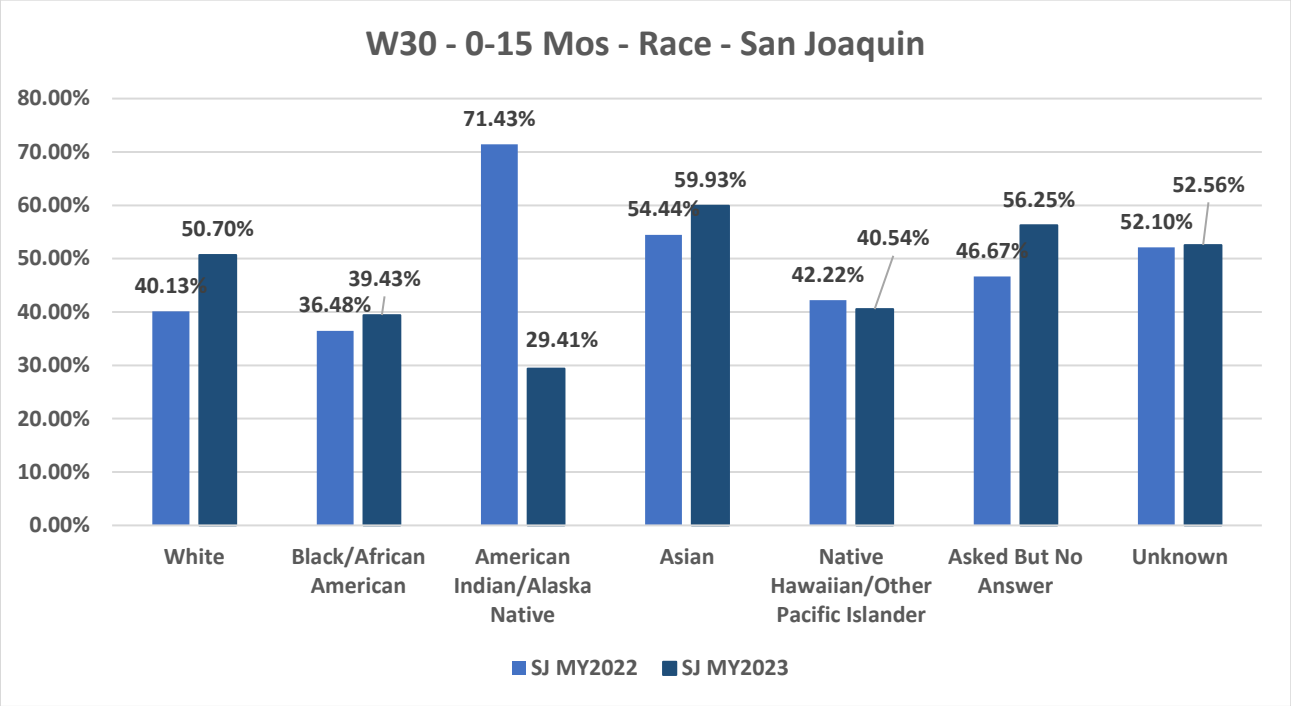
Stanislaus County quantitative analysis:

All subpopulations are performing higher than prior year. Highest performing is Asian and Asked but not answered. The lowest performing subpopulations are White and Black.

Stanislaus County qualitative analysis:

Adolescent boys are the age categories that are driving the lower performance for both White and Black subpopulations. Adolescents and young adults are faced with many social factors that contribute to lower well-visit rates. They are faced with a high degree of social pressure to appear healthy and resilient and spend time with their peers. Going to the doctor's office for an appointment seems like it is contradictory to resilient behavior.

Graphs 43 & 44: W30 -0-15 Mos– Race – by county

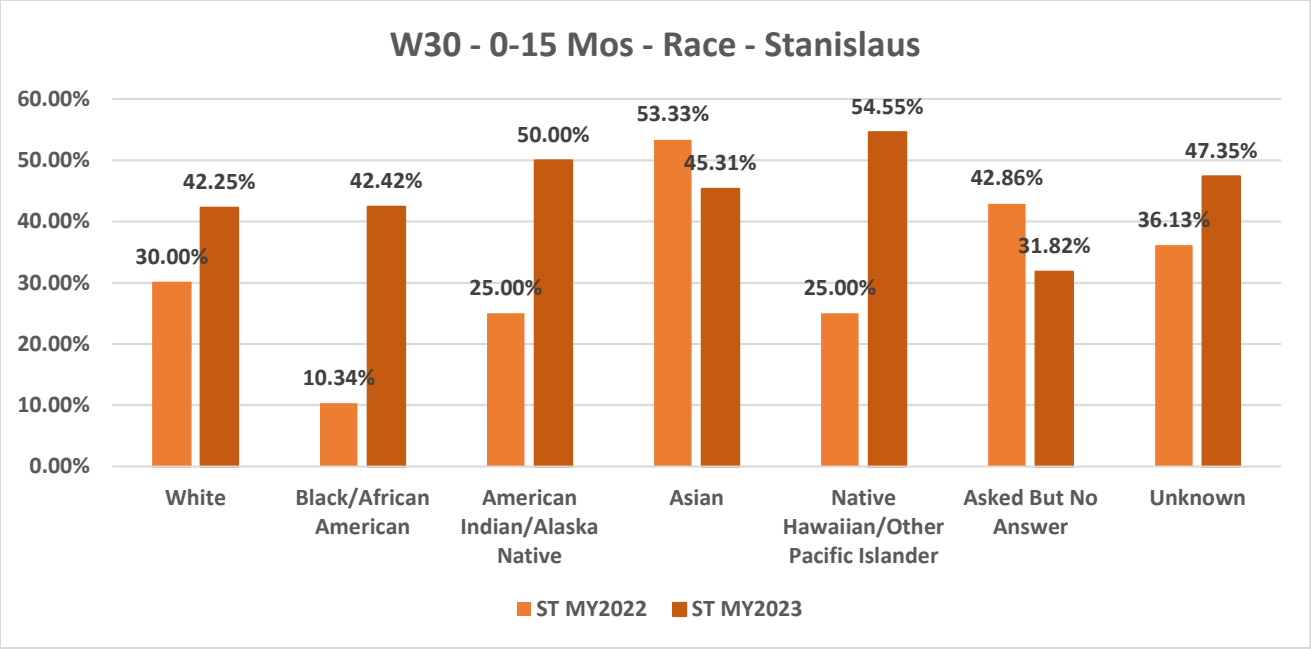


San Joaquin County quantitative analysis:

Subpopulation performance is mixed when compared to prior year. Overall rates are trending higher for all subpopulations except for American Indian. However, trending is approached with caution for measures with low denominators.

San Joaquin Qualitative analysis:

Black and Native Hawaiian subpopulations face many social barriers to health. They are disproportionally impacted by poverty, housing insecurity and access to care. These factors make it more difficult to complete the required number of well visits for their infants.



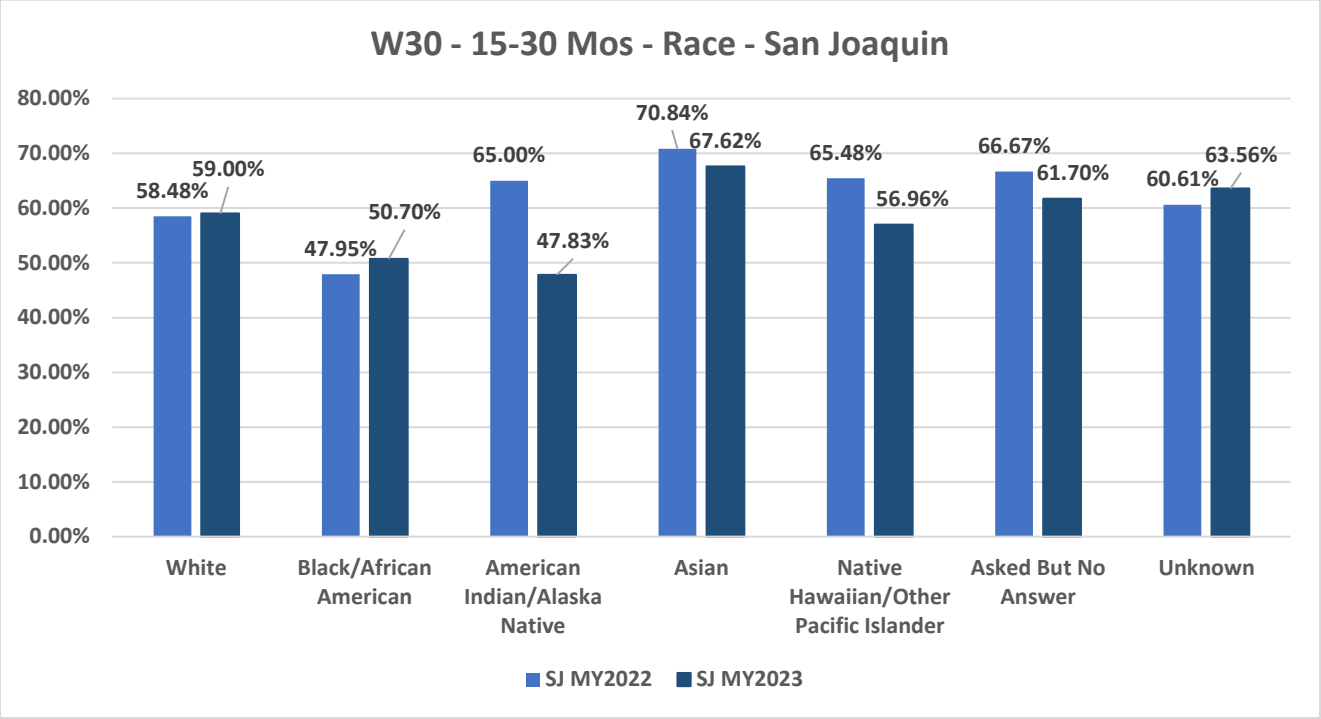
Stanislaus County quantitative analysis:

Subpopulation performance is improved for all but Asian and asked but not answered members when compared to the previous year.

Stanislaus County qualitative analysis:

Declining performance for Asian members is unexpected. However, it is important to note that rates are still among the highest subpopulation.

Graphs 45 & 46: W30 -15-30 Mos– Race – by county

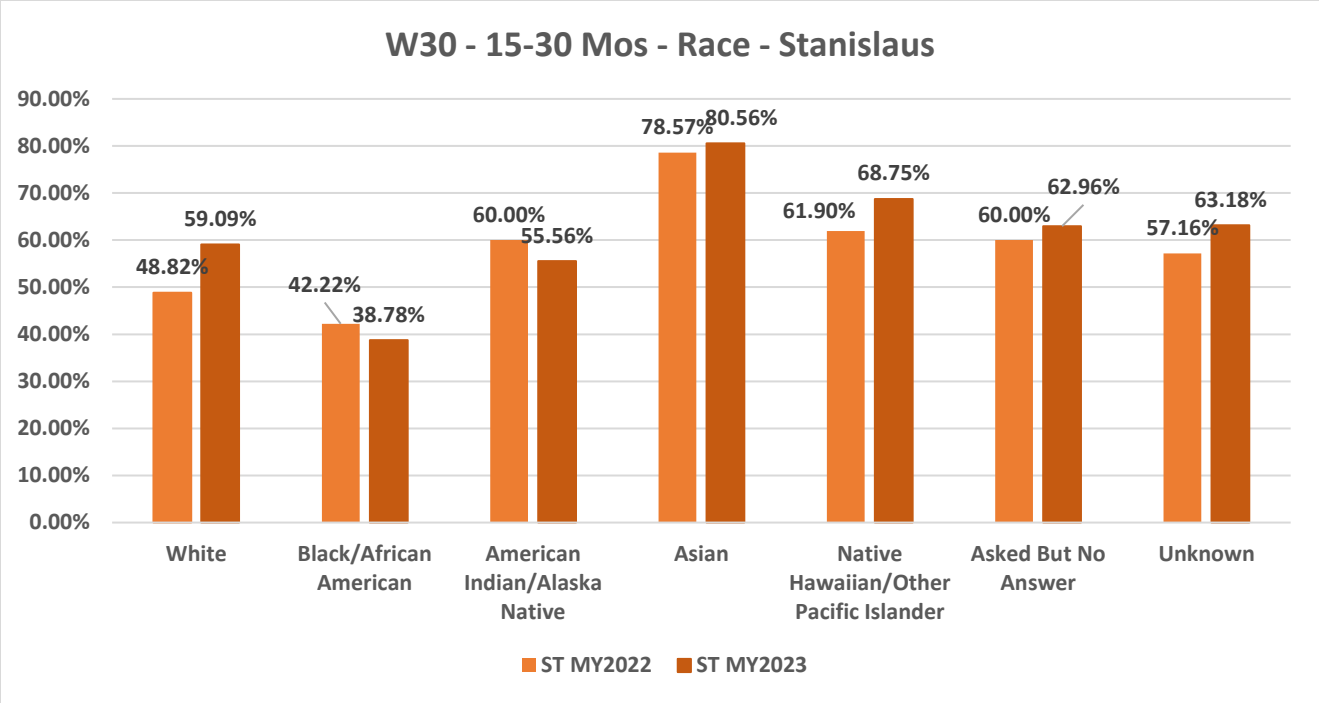


San Joaquin County quantitative analysis:

San Joaquin county rates are mixed when compared to previous years rates. Highest performing subpopulations are Asian and Unknown. Lowest performing subpopulations are American Indian and Black.

San Joaquin Qualitative analysis:

Black caregivers are disproportionally impacted by social factors such as poverty and housing insecurity. These social factors make it difficult to ensure healthy children receive timely well visits.



Stanislaus County quantitative analysis:

Stanislaus county rates are mixed when compared to previous years' rates. Highest performing subpopulations are Asian and Native Hawaiian. Lowest performing subpopulations are American Indian and Black.

Stanislaus Qualitative analysis:

Black caregivers are disproportionally impacted by social factors such as poverty and housing insecurity. These social factors make it difficult to ensure healthy children receive timely well visits.

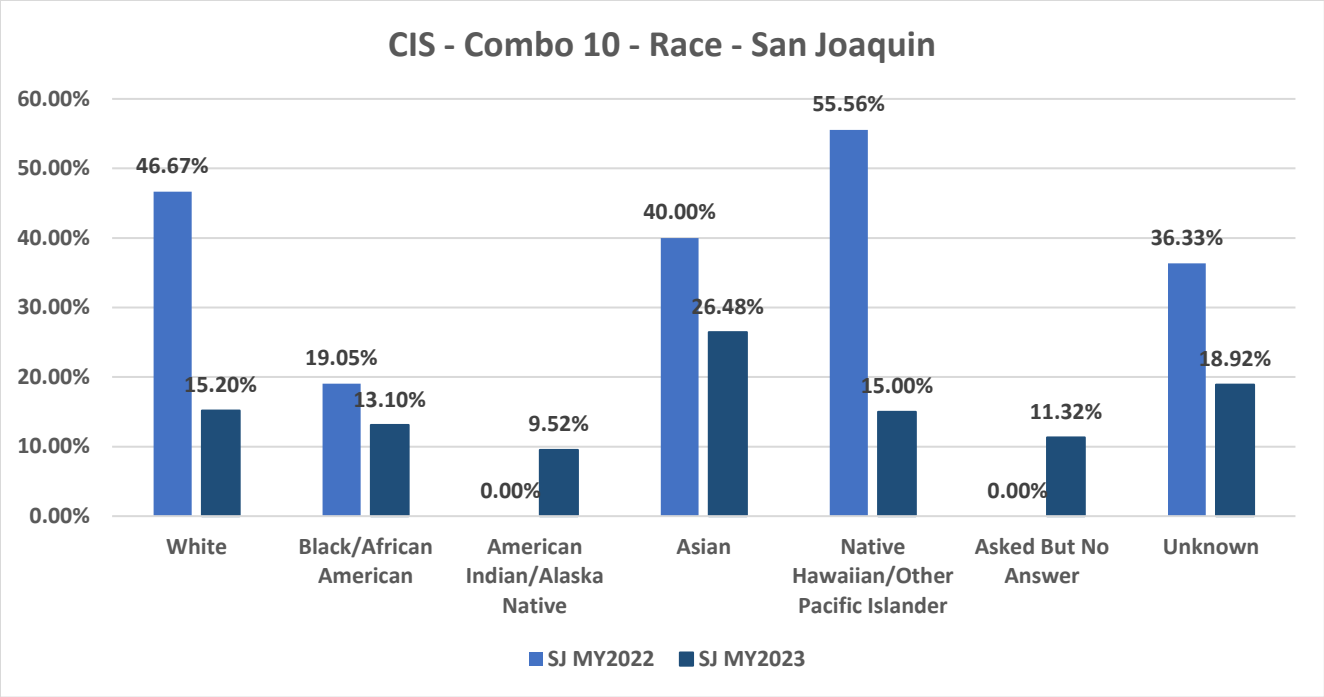
Graphs 47 & 48: CIS – Combo 10– Race – by county

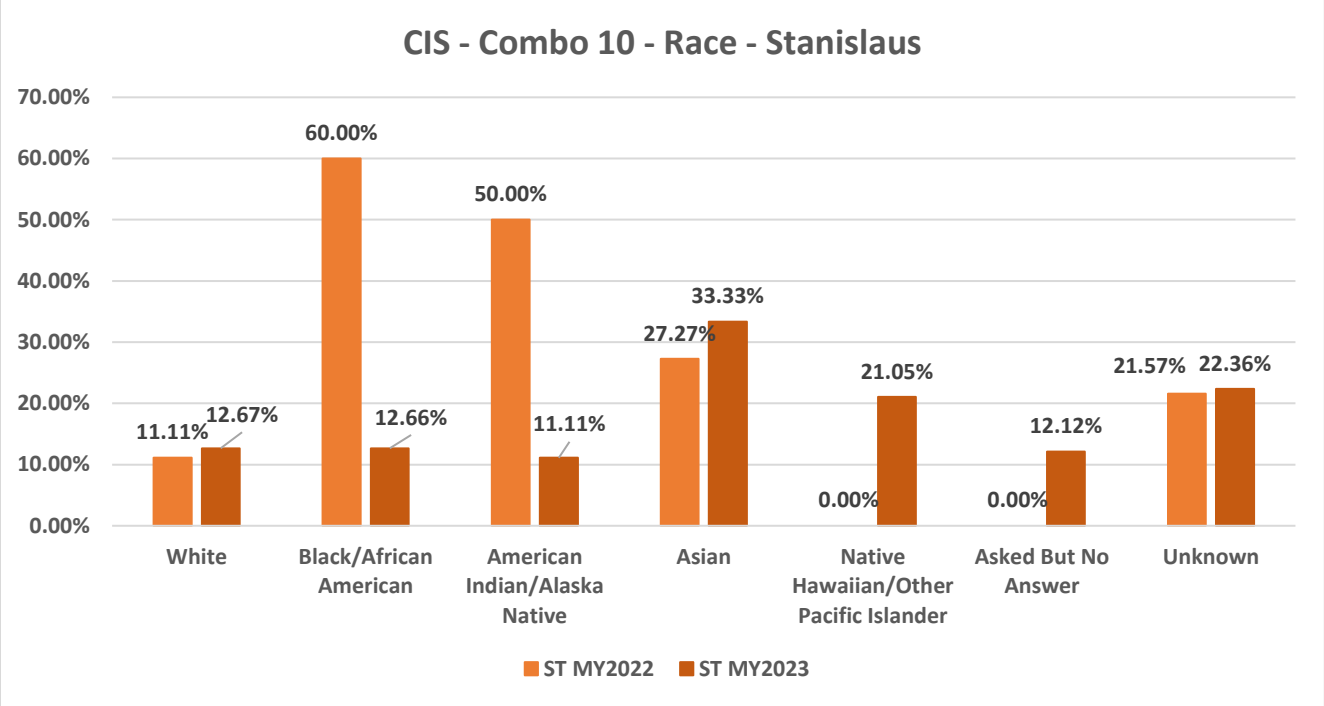
San Joaquin and Stanislaus Quantitative analysis:

There is a tremendous amount of variability in the rates of vaccinations for each given subpopulation. It is difficult to analyze rates due to this variability. What is important to note is that every subpopulation is declining. The least impacted is Asian who have the highest rate of vaccinations in both counties.

Qualitative analysis:

As the health plan learns more about the factors impacting vaccination status and the impact of barriers to transmitting vaccine data, further analysis will be performed.





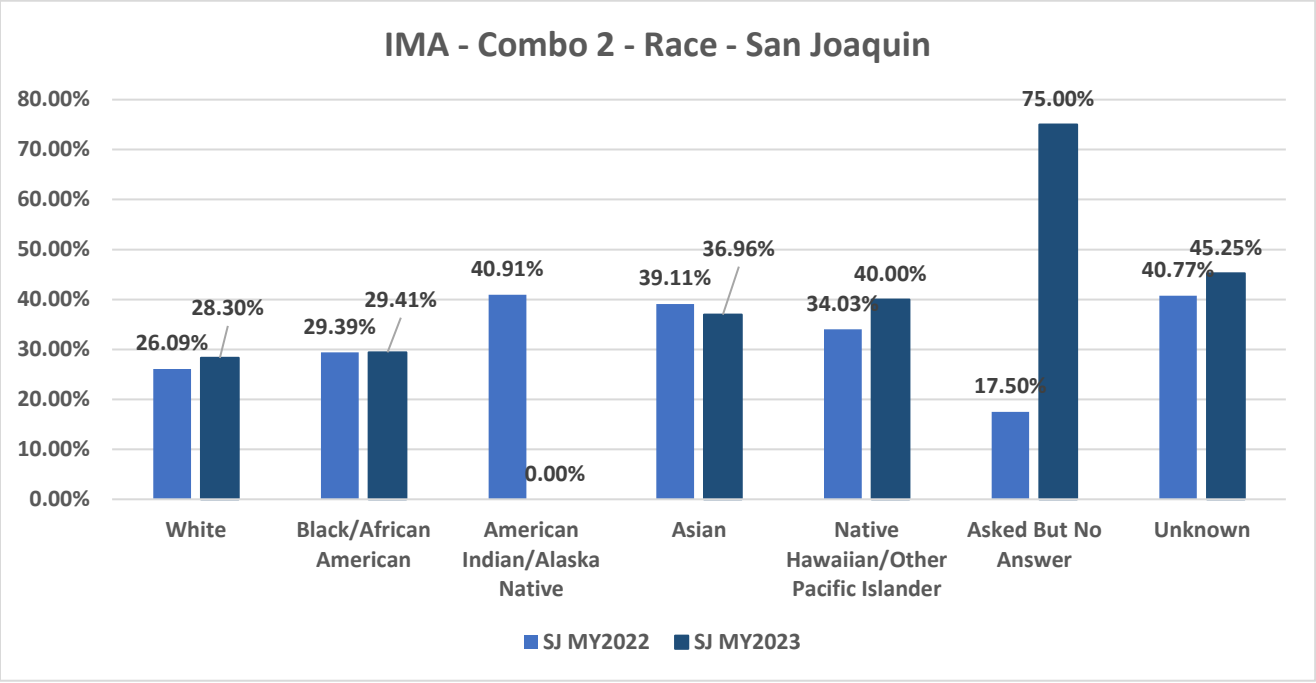
Graphs 49 & 50: IMA – Combo 2– Race – by county

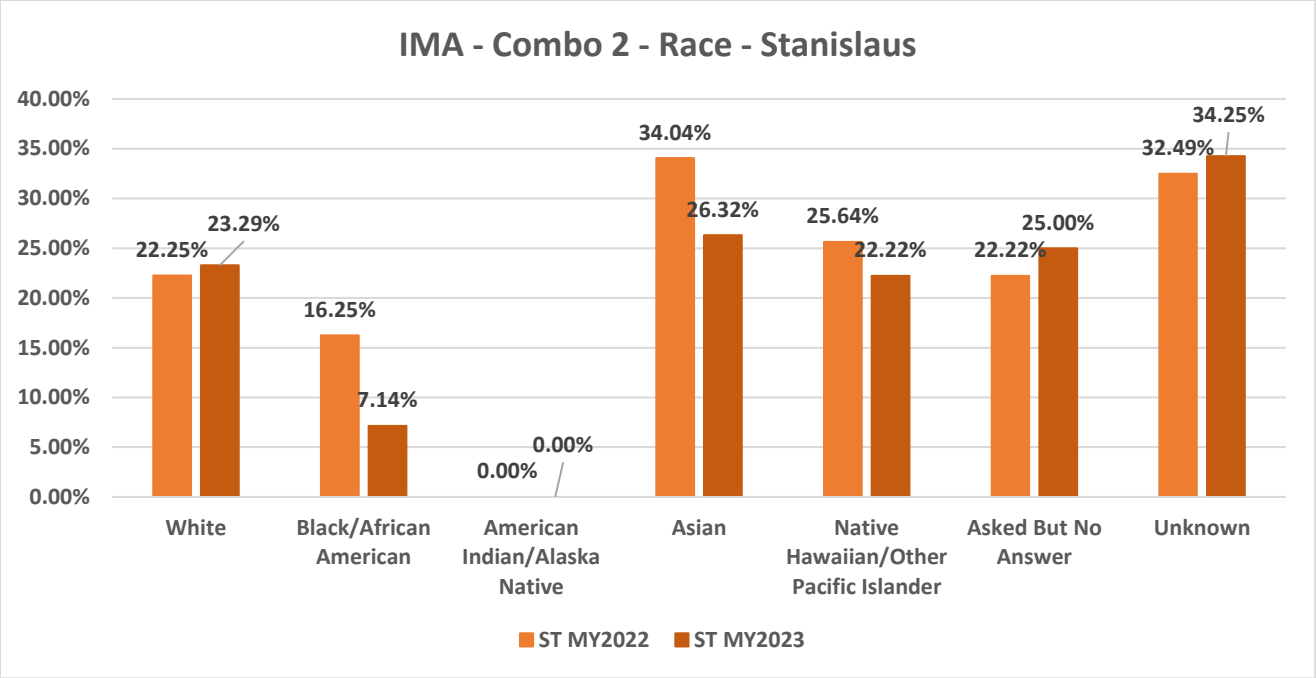
San Joaquin and Stanislaus quantitative analysis:

The lowest performing subpopulation in San Joaquin County is White, the highest is asked but not answered. In Stanislaus County, the lowest performing is Black, the highest is Asian.

Qualitative analysis:

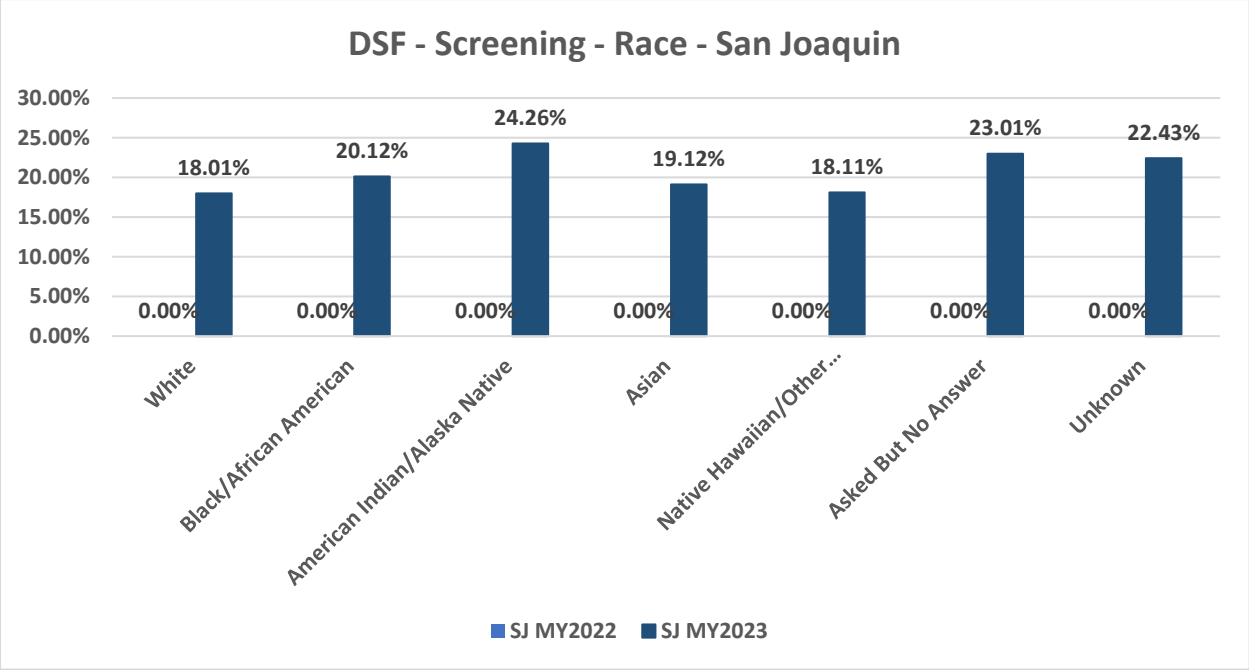
Both Black and White subpopulations have increased vaccine hesitancy and vaccine negotiation. Performance for these subpopulations is lowest in both counties.

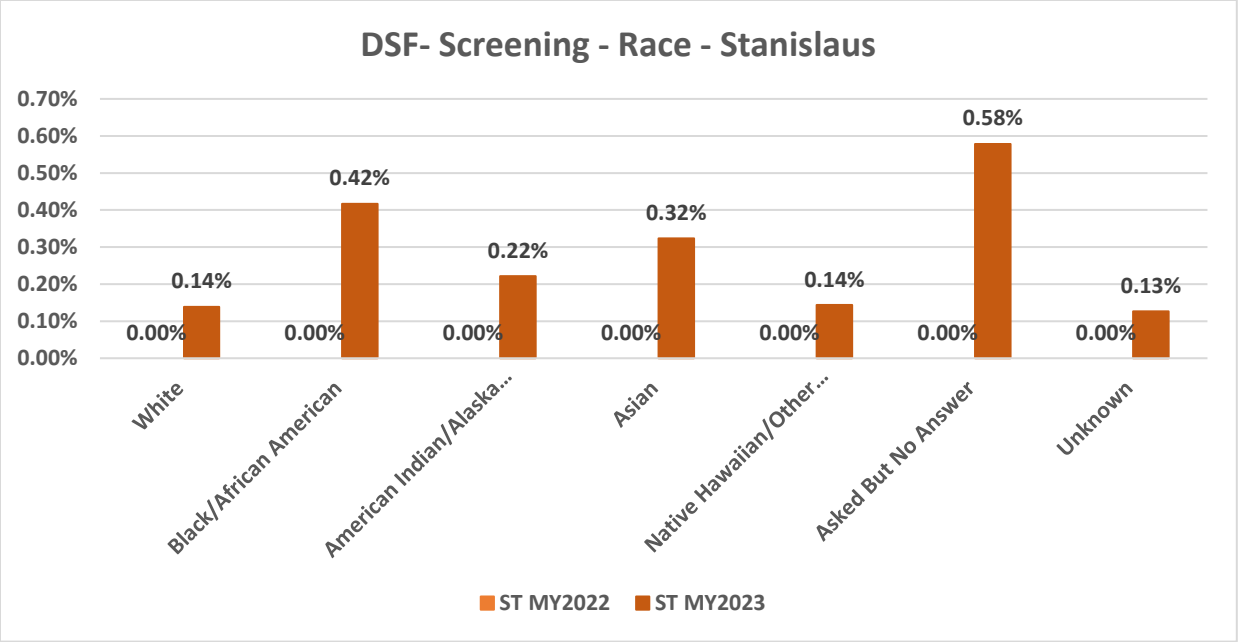




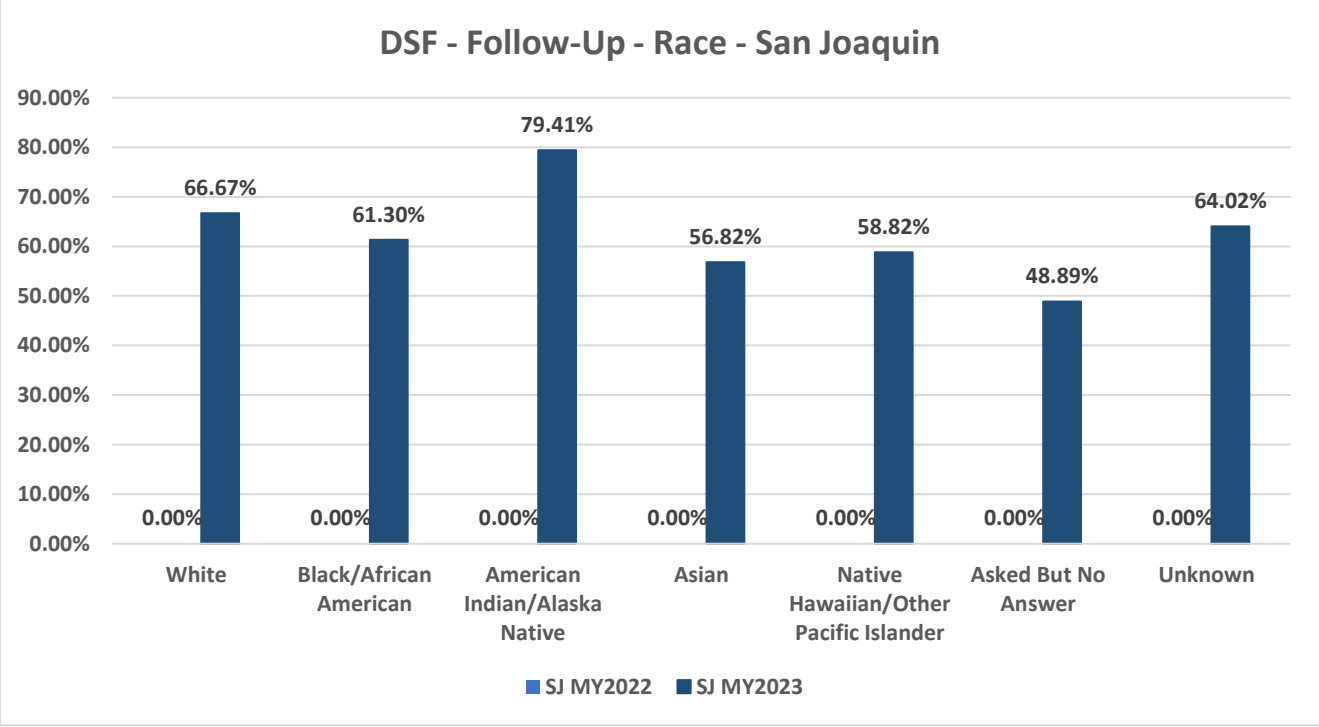
Graphs 51 & 52: DSF-Screening – Race – by county

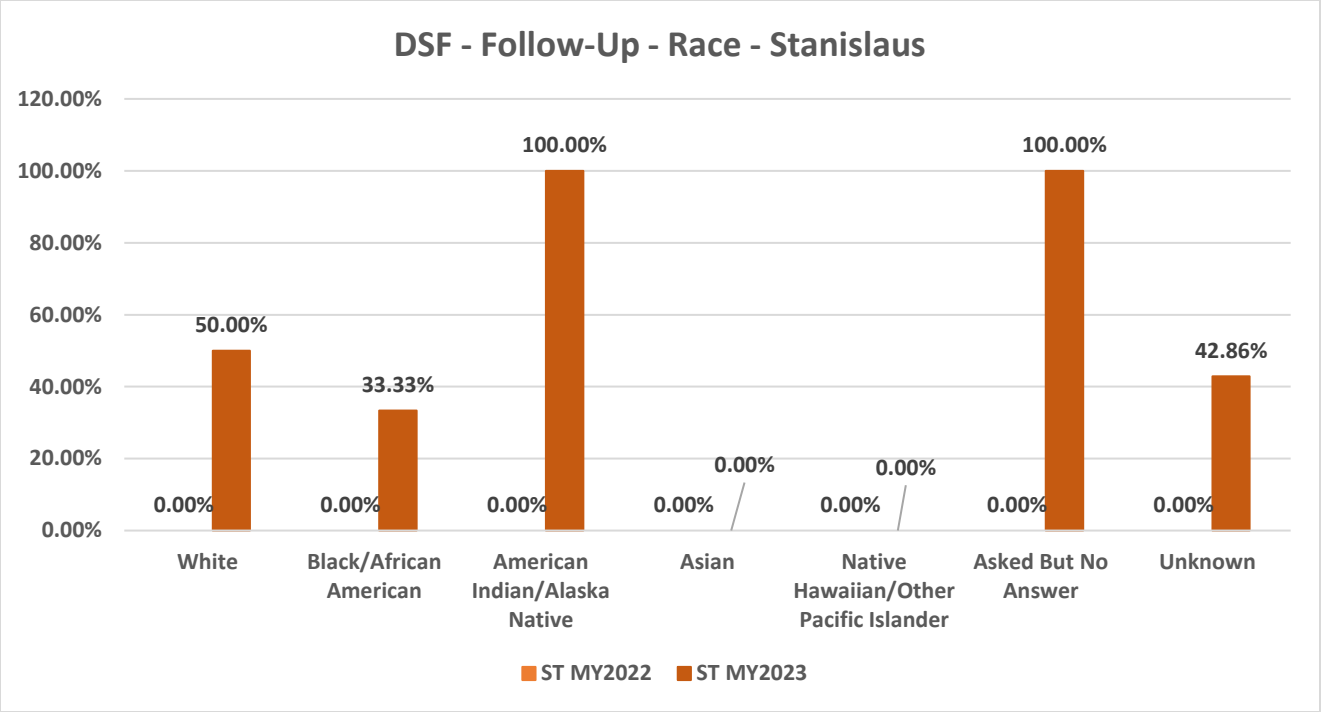
This is the first year that depression screening is reported. There are many challenges with collecting and transmitting depression screening and follow up data. No analysis will be performed on this data.



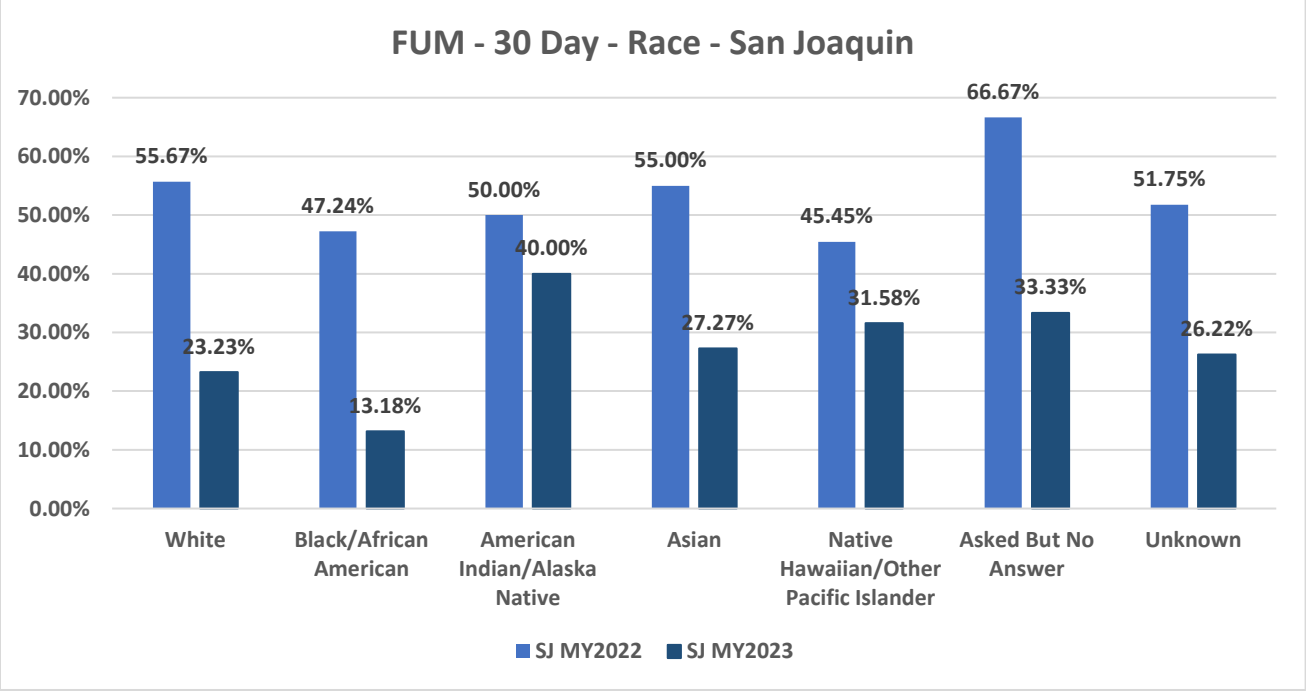


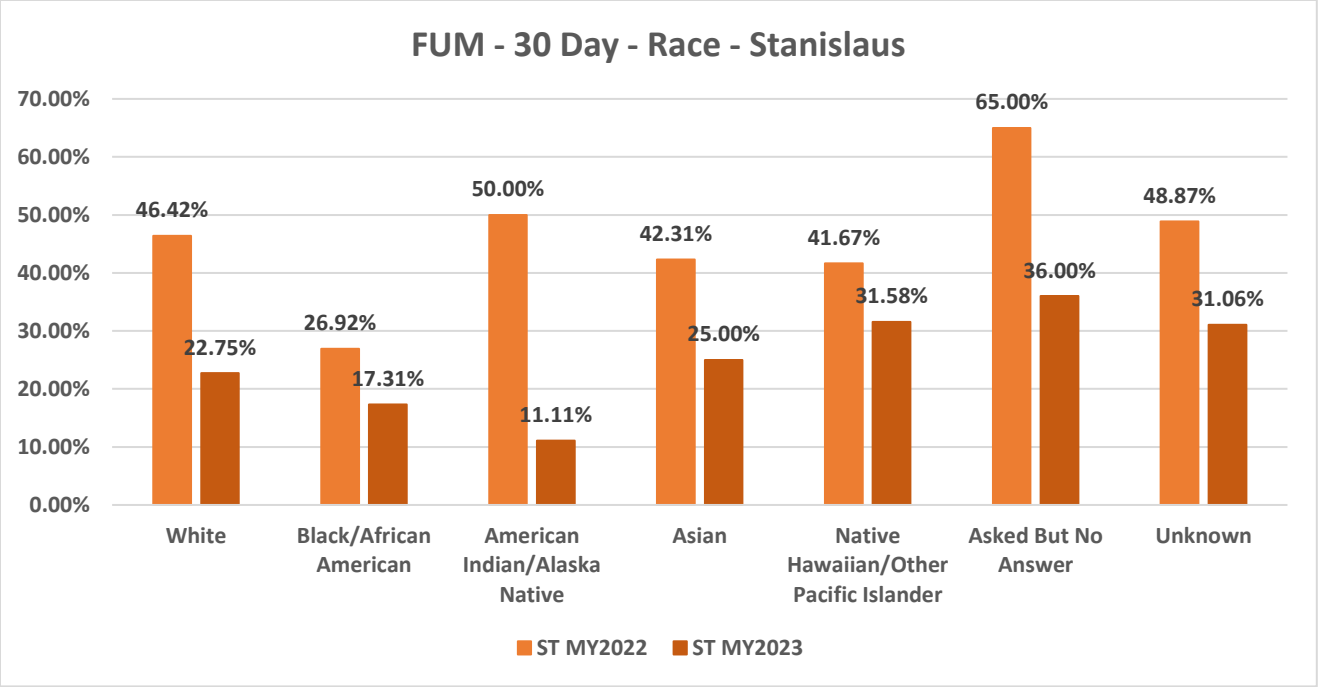
Graphs 53 & 54: DSF-Follow-Up – Race – by county



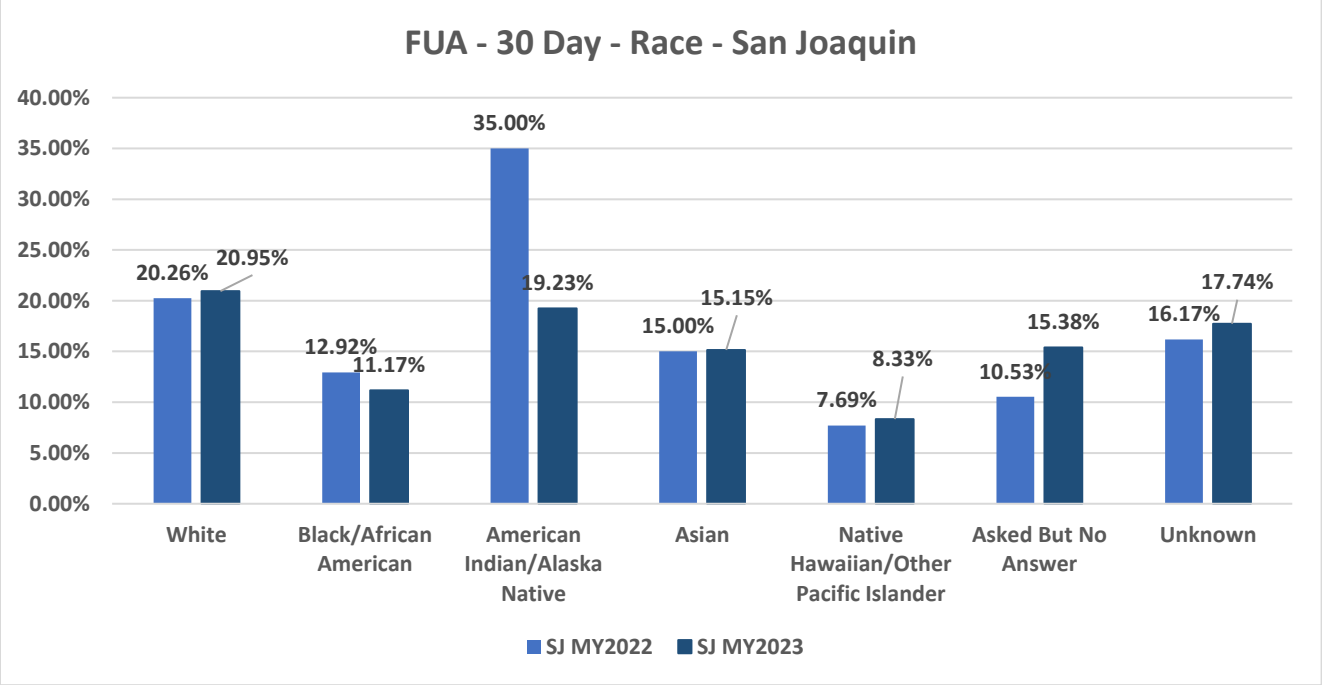


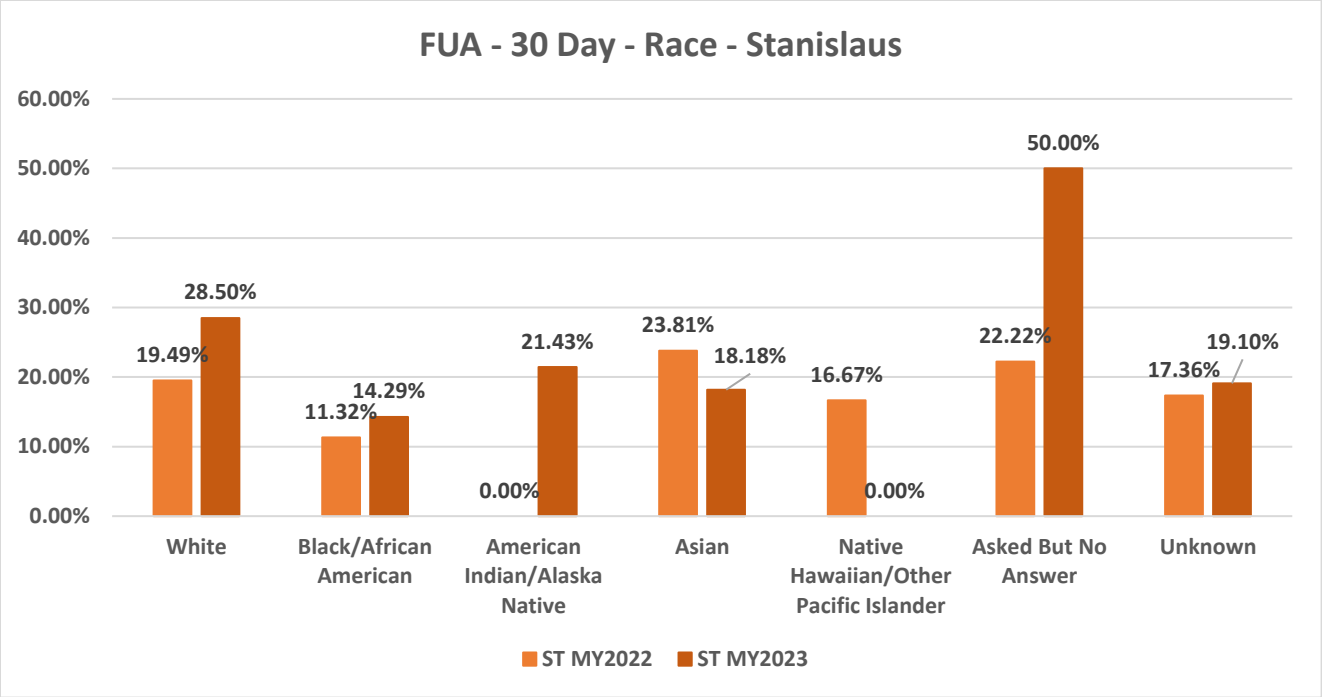
Graphs 55 & 56: FUM – 30 Day– Race – by county





Graphs 57 & 58: FUA – 30 Day– Race – by county

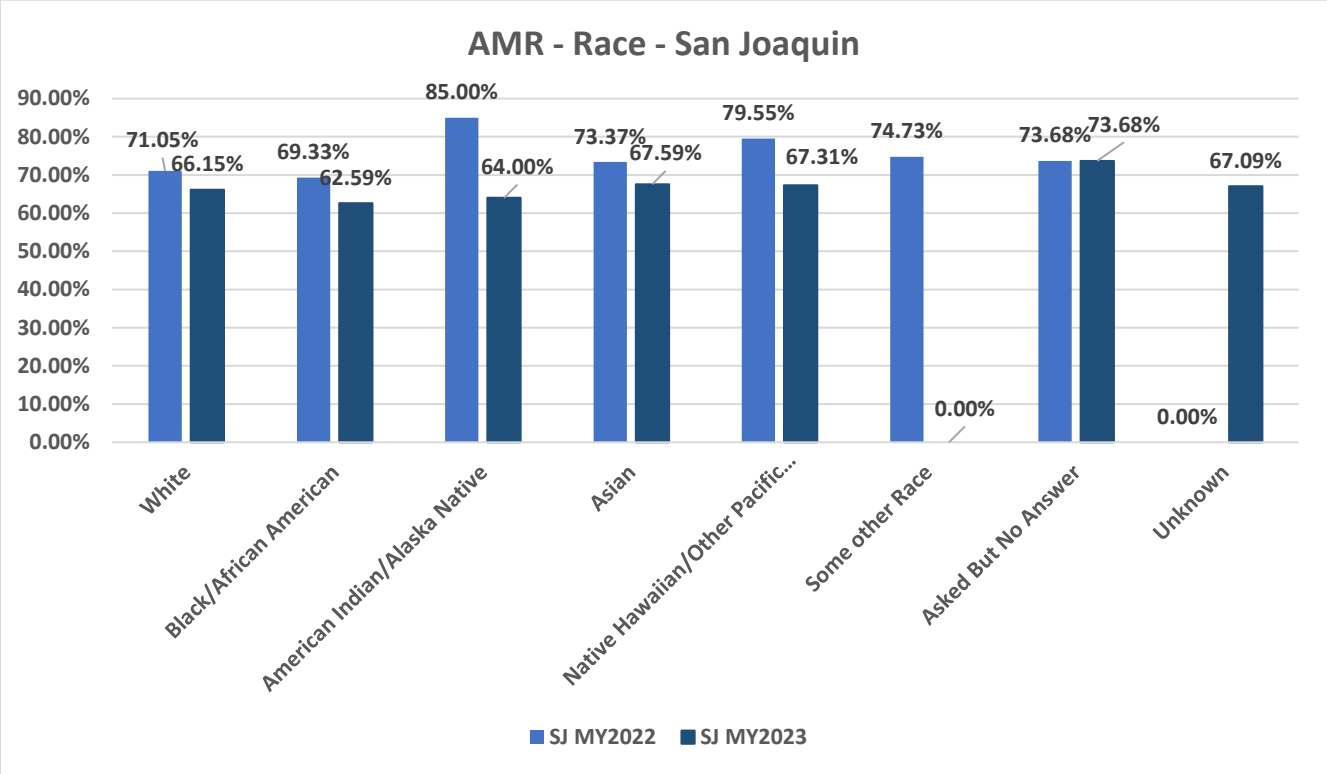


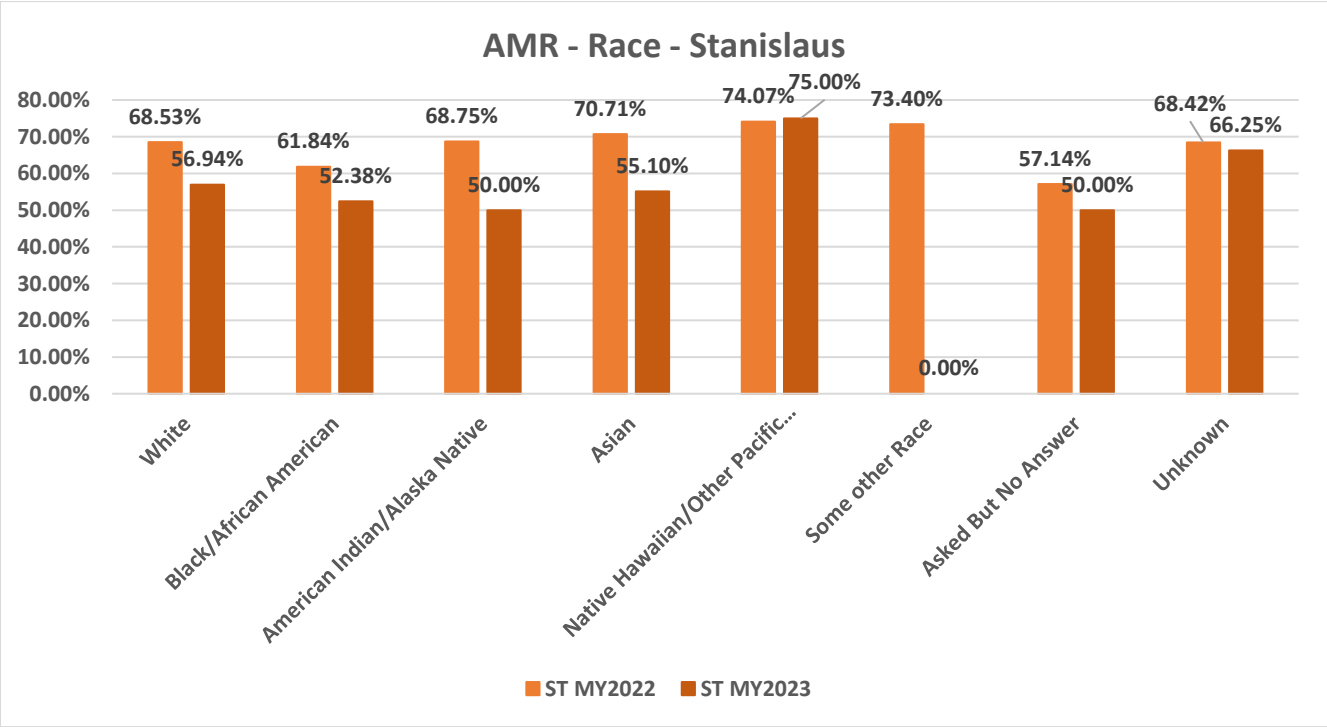


Data for measures that related to follow up after ER visits for substance use and mental illness are not reliable. There were issues with collecting and reporting specialty mental health data from DHCS. As such reductions in rates are artifact as are the racial disparities that come from that data.

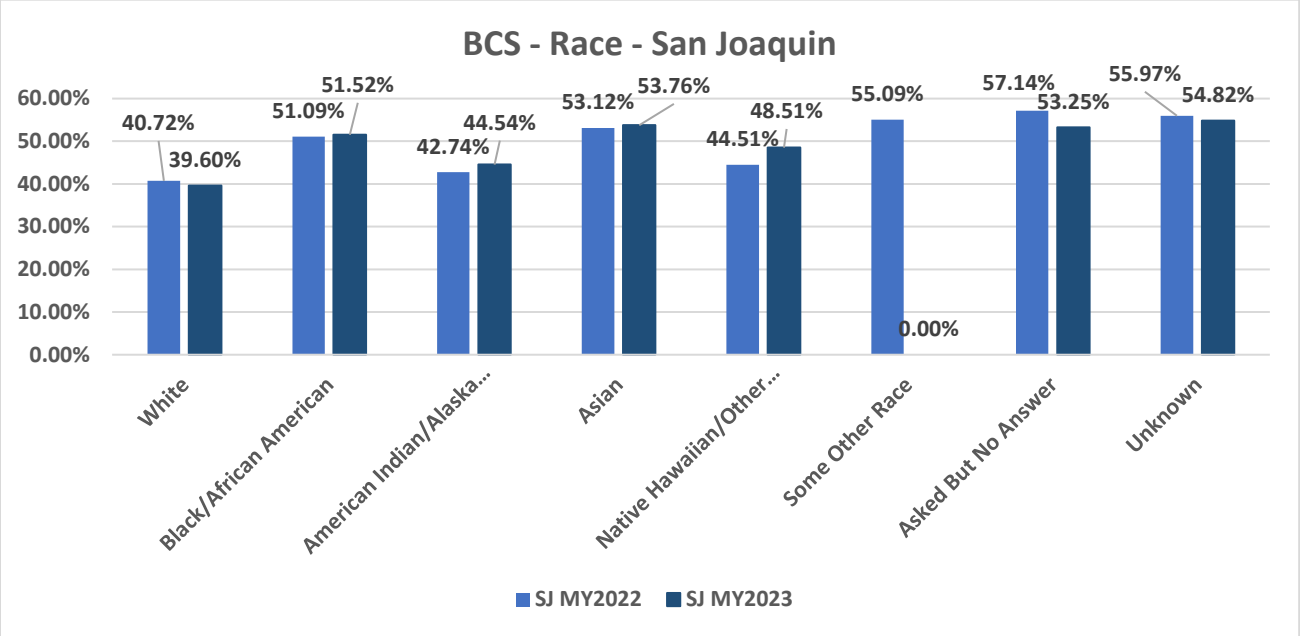
Further disparity analysis will be performed next reporting period when data are more reliable.

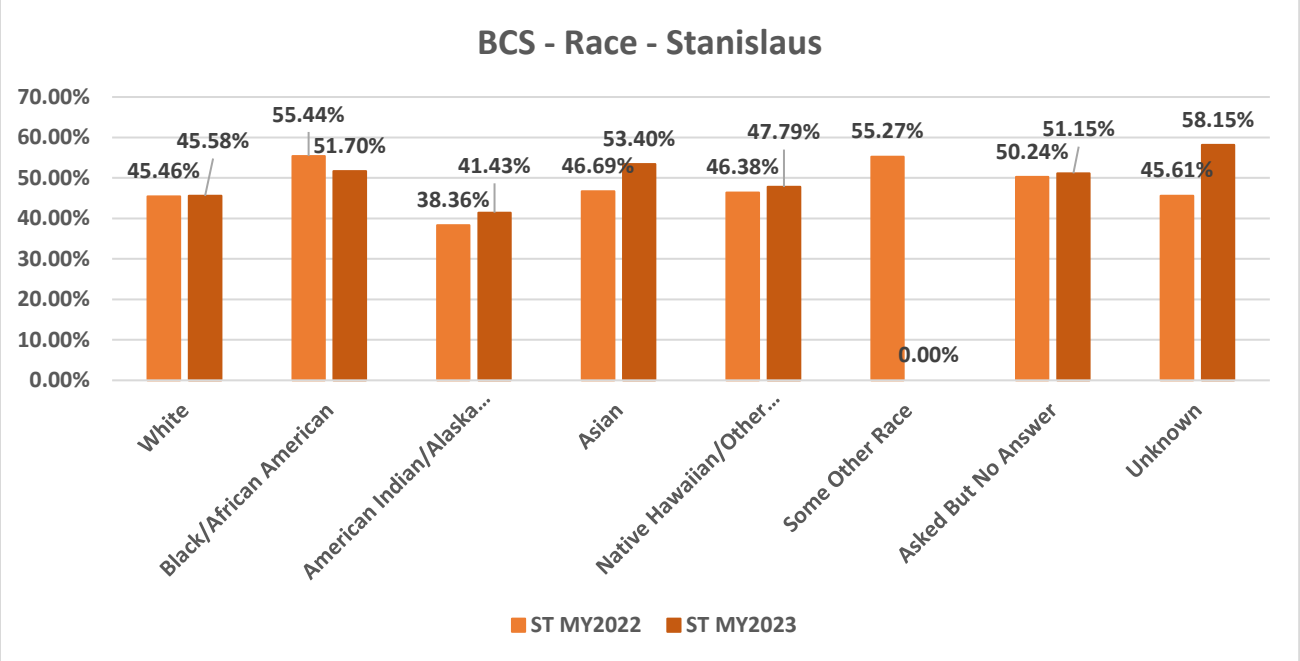
Graphs 59 & 60: AMR – Race – by county





Graphs 61 & 62: BCS – Race – by county

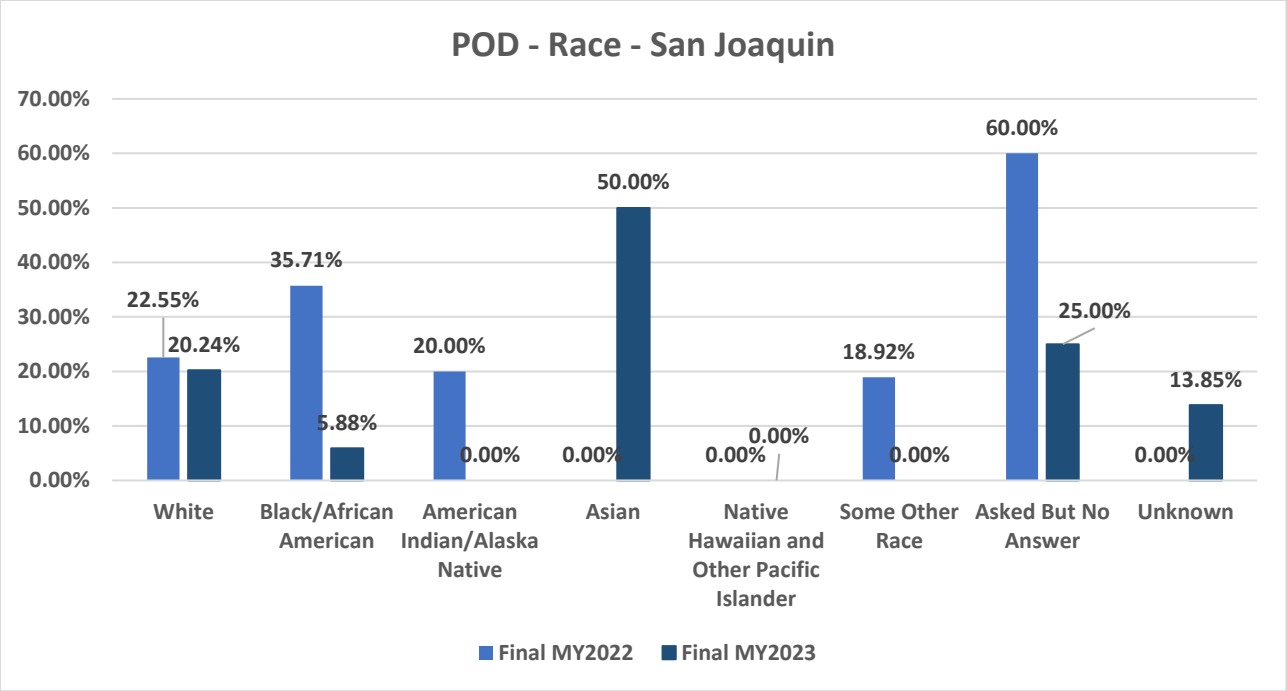


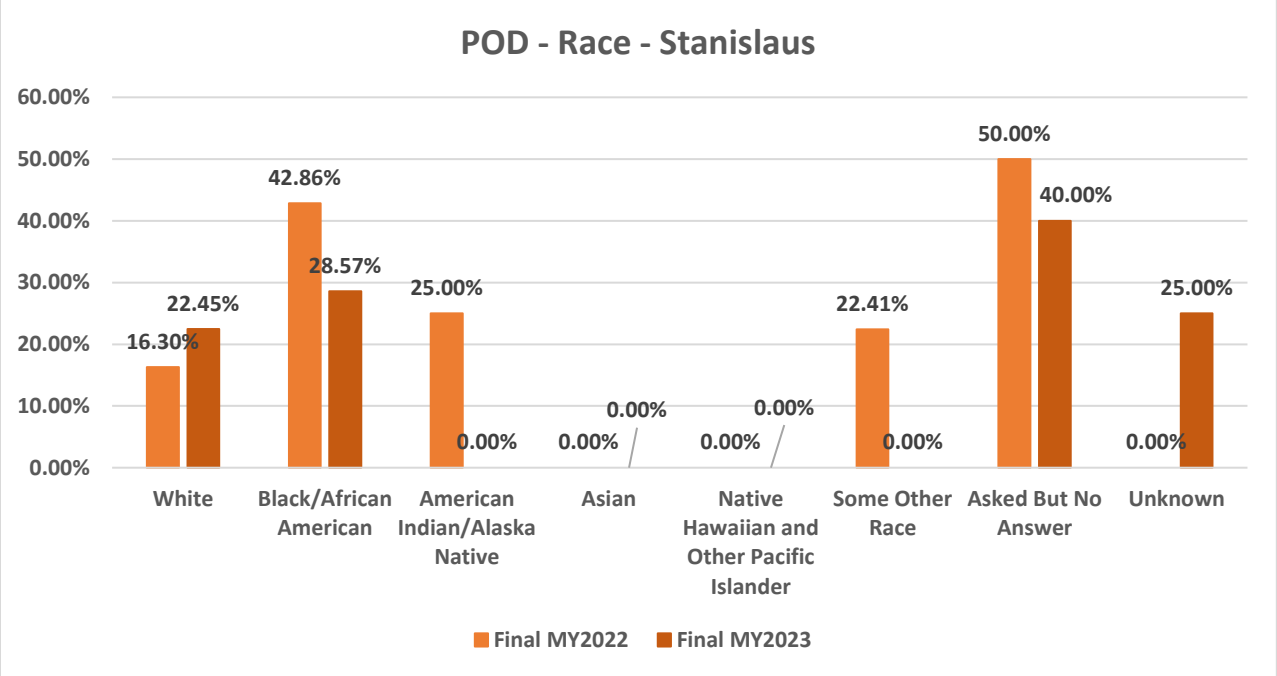


Graphs 63 & 64: POD – Race – by county

Quantitative analysis:

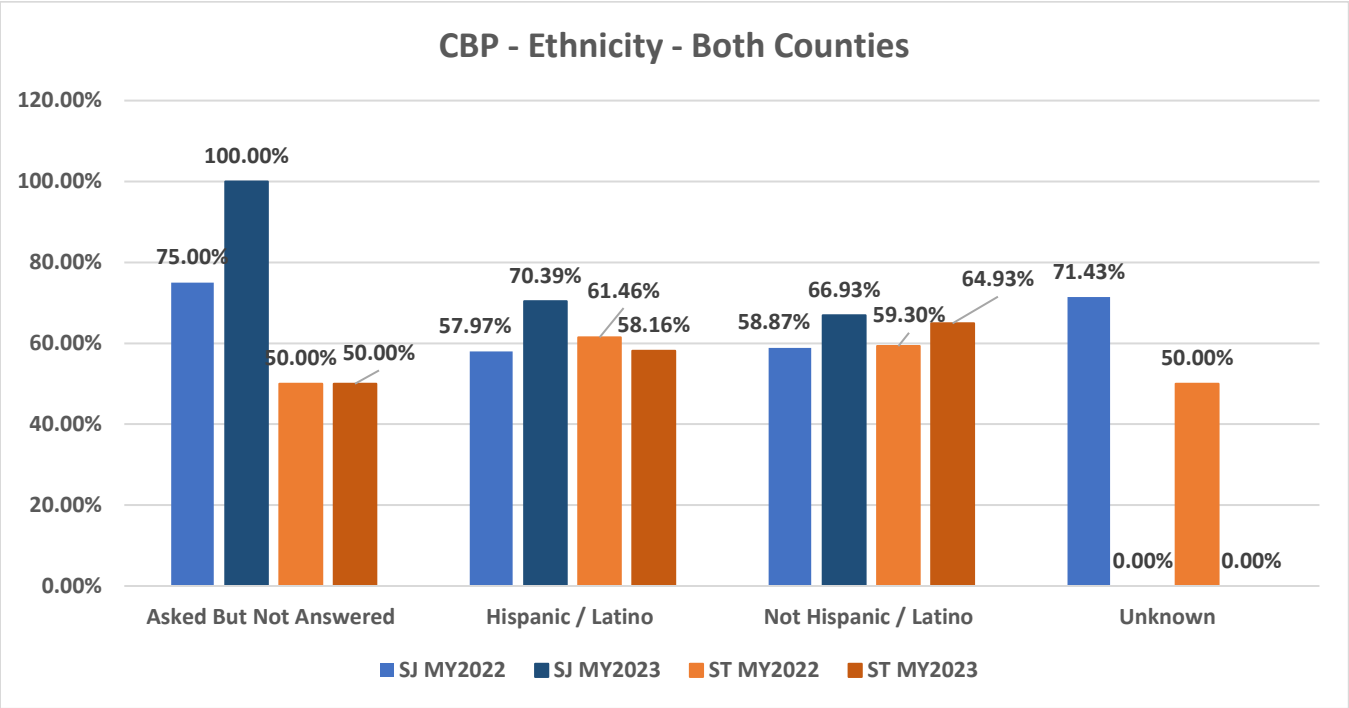
Comparative data appears to be missing for some races depending on the year. It is not possible to analyze data by race and by county.





Ethnicity by County

Graph 65: CBP– Ethnicity – Both counties

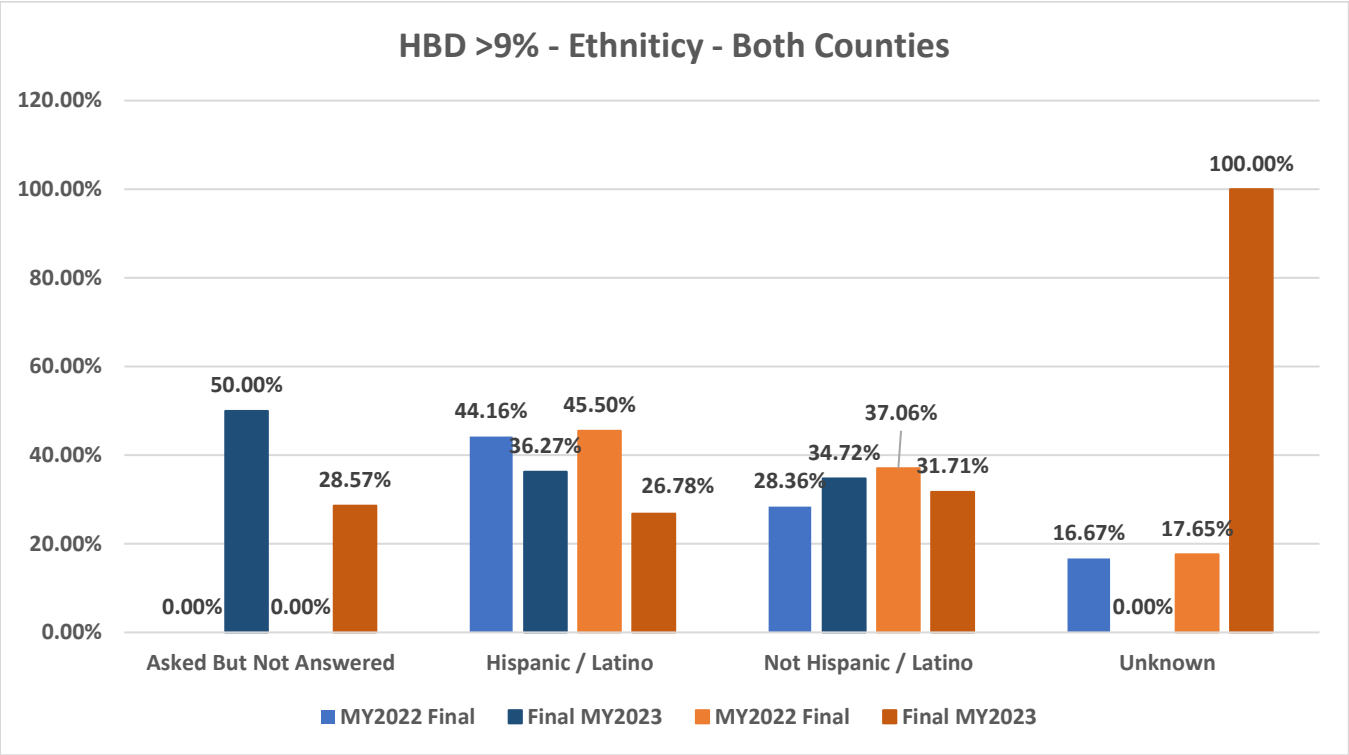


Quantitative analysis:

Hispanic subpopulation rates outperform non-Hispanic in San Joaquin County. In Stanislaus County, Non-Hispanic outperform Hispanic in the current measurement period.

The greatest disparities are noted in the racial comparisons. The ethnic breakouts show comparatively high performance when compared to racial subpopulations.

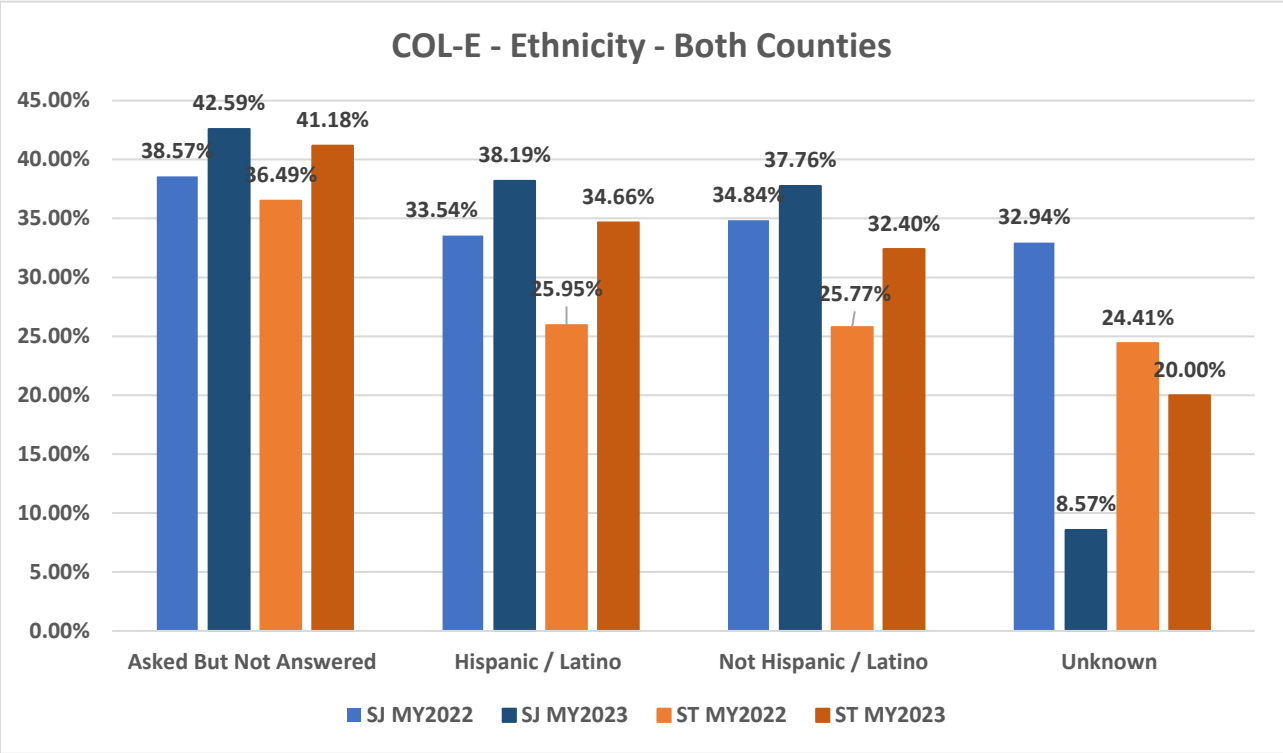
Graph 66: HBD >9% (lower is better)– Ethnicity – both counties



Quantitative analysis:

Hispanics in both counties show dramatic improvement in A1c control. Non-Hispanics in San Joaquin County are not performing quite as well as the previous reporting period. Given the dramatic improvement in A1c control, and the improvements noted in each county, both Hispanic and Non-Hispanic are performing above the MPL except non-Hispanic in San Joaquin County.

Graph 67: COL-E-Ethnicity – both counties

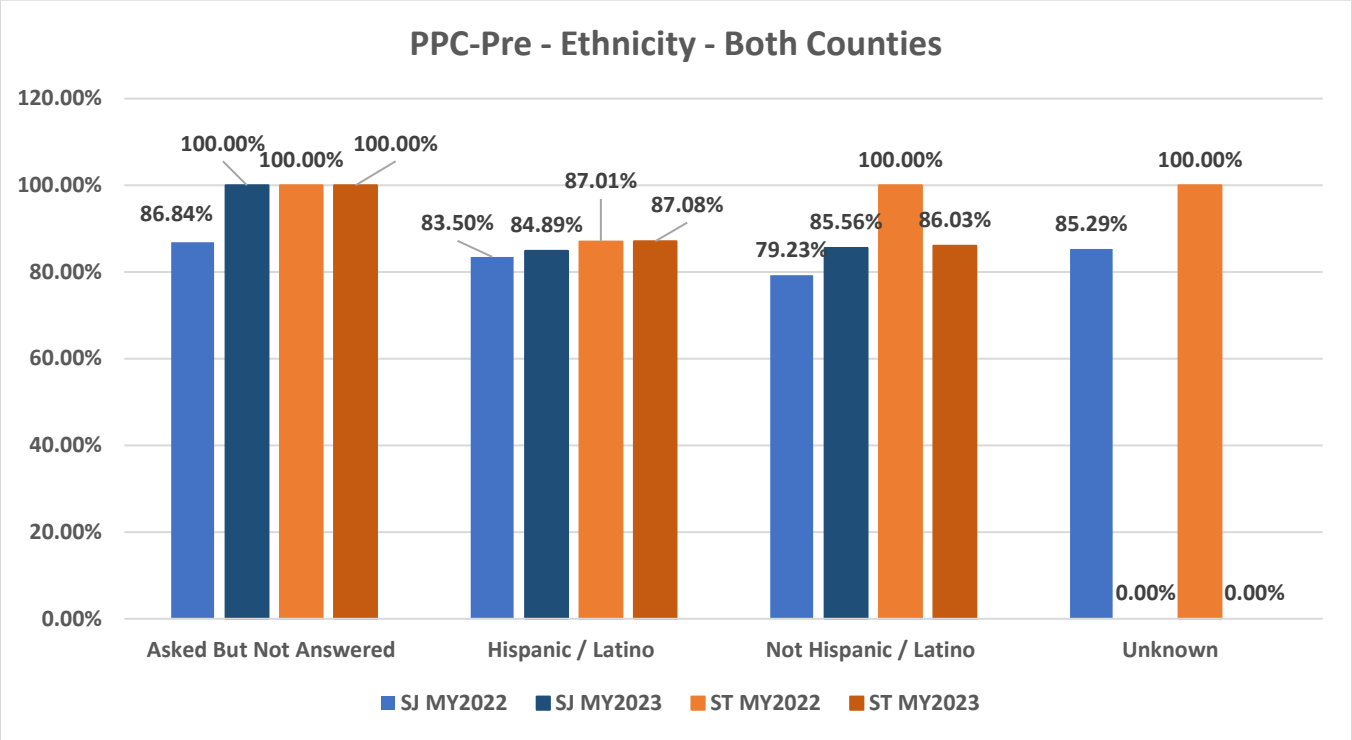


Quantitative analysis:

Both Hispanic and Non-Hispanic subpopulations have increased in both counties. Non-Hispanics are underperforming in both counties both years.

When benchmarks become available, further analysis will be performed.

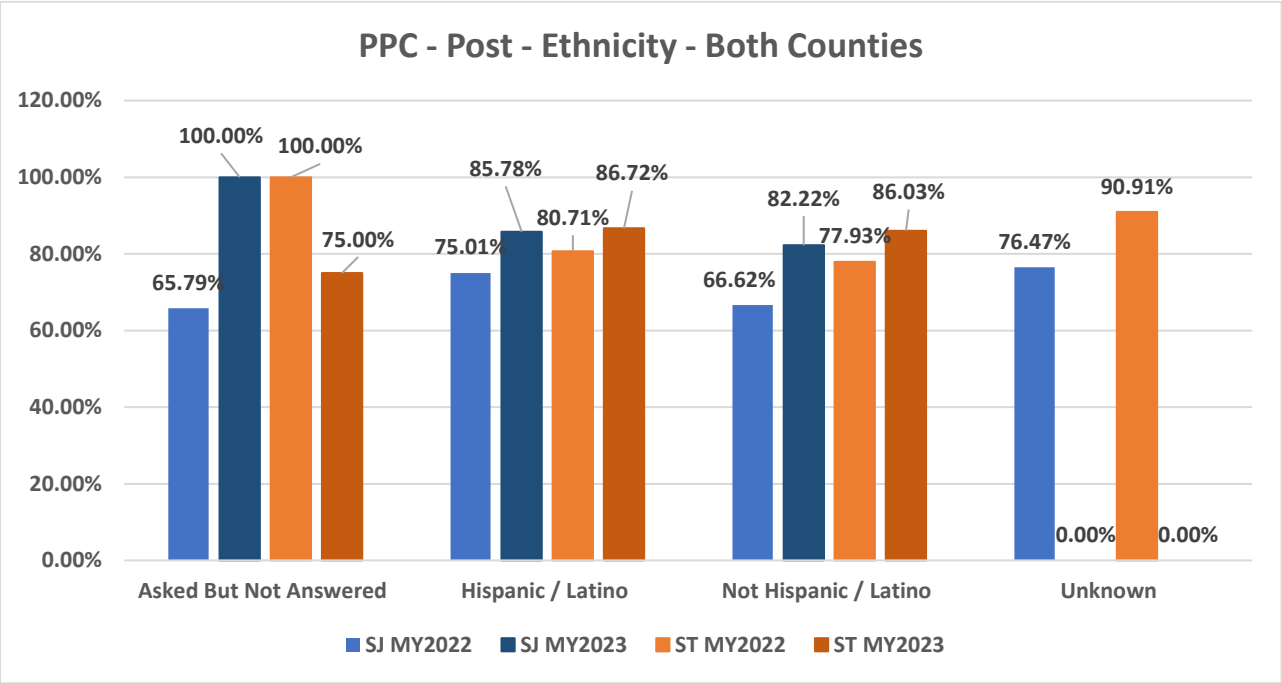
Graph 68: PPC-Pre - Ethnicity – both counties



Quantitative analysis:

Hispanic subpopulations prenatal rates have increased in both counties. Non-Hispanic prenatal rates have improved in San Joaquin County but not in Stanislaus. Both Hispanic and Non-Hispanic are performing well and health disparities by ethnicity are not evident.

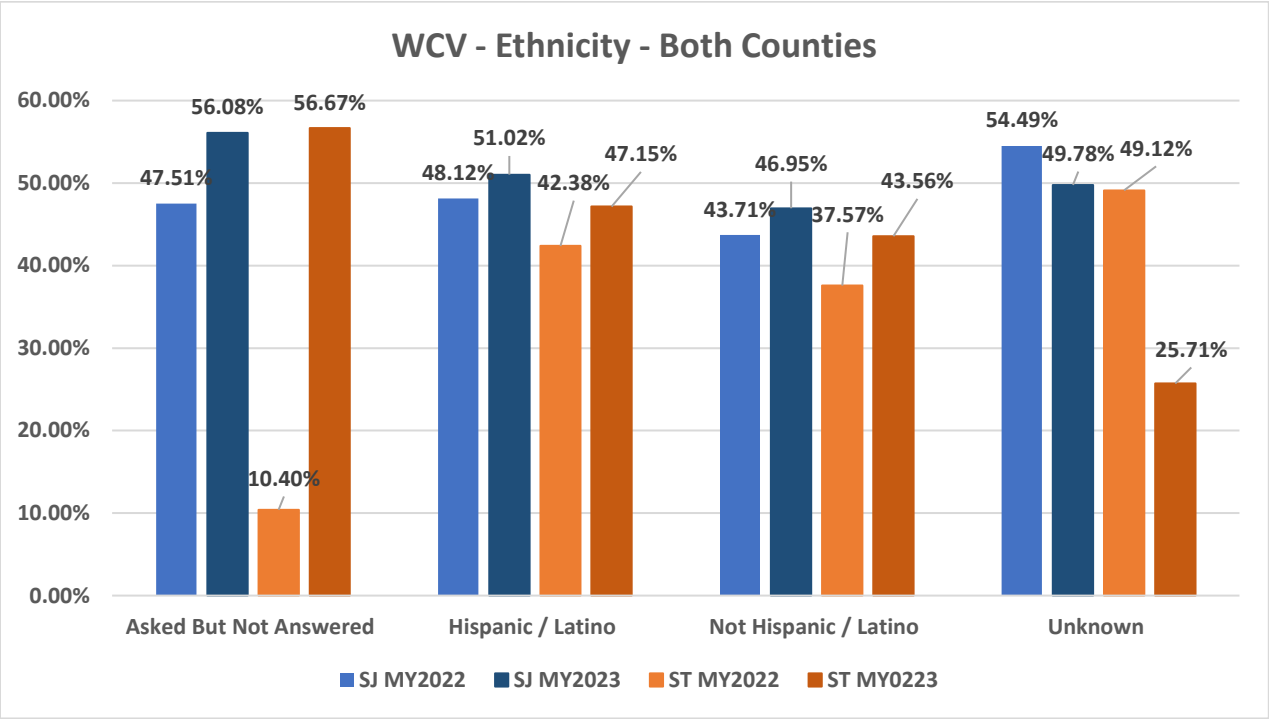
Graph 69: PPC-Post - Ethnicity – both counties



Quantitative analysis:

Both Hispanic and Non-Hispanic postpartum rates have improved in both years and in both counties and no health disparity is evident by ethnic stratification.

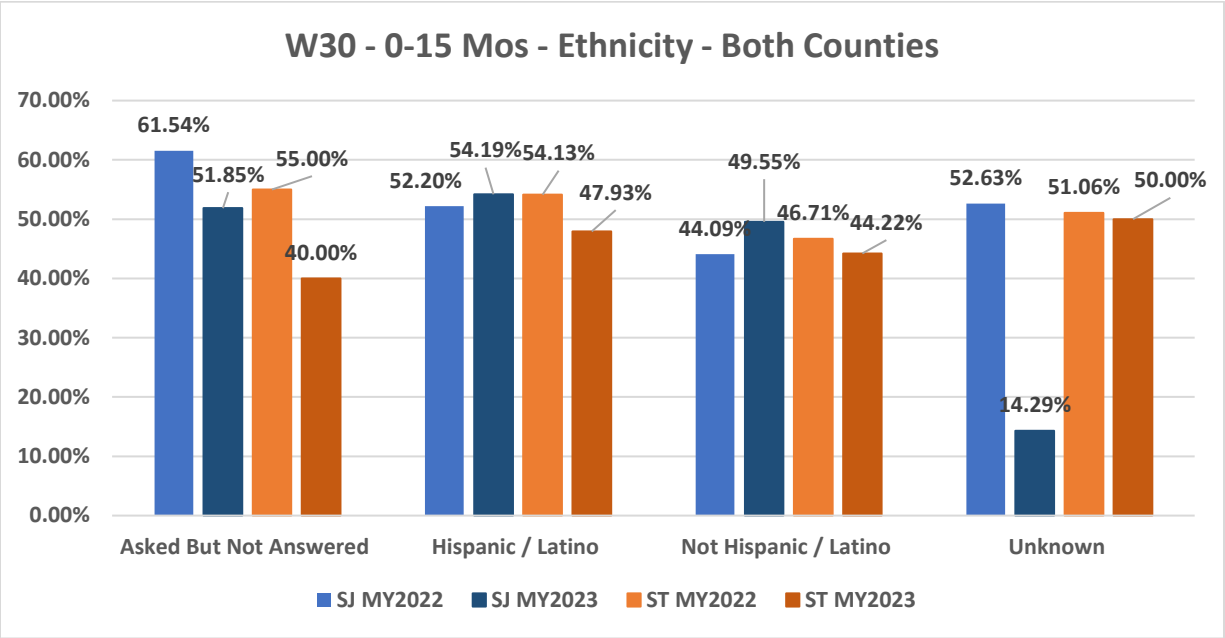
Graph 70: WCV - Ethnicity – both counties



Quantitative analysis:

Both Hispanic and Non-Hispanic well visit rates have improved in both years and in both counties. Non-Hispanic ethnicities are underperforming Hispanic ethnicities in both years and in both counties.

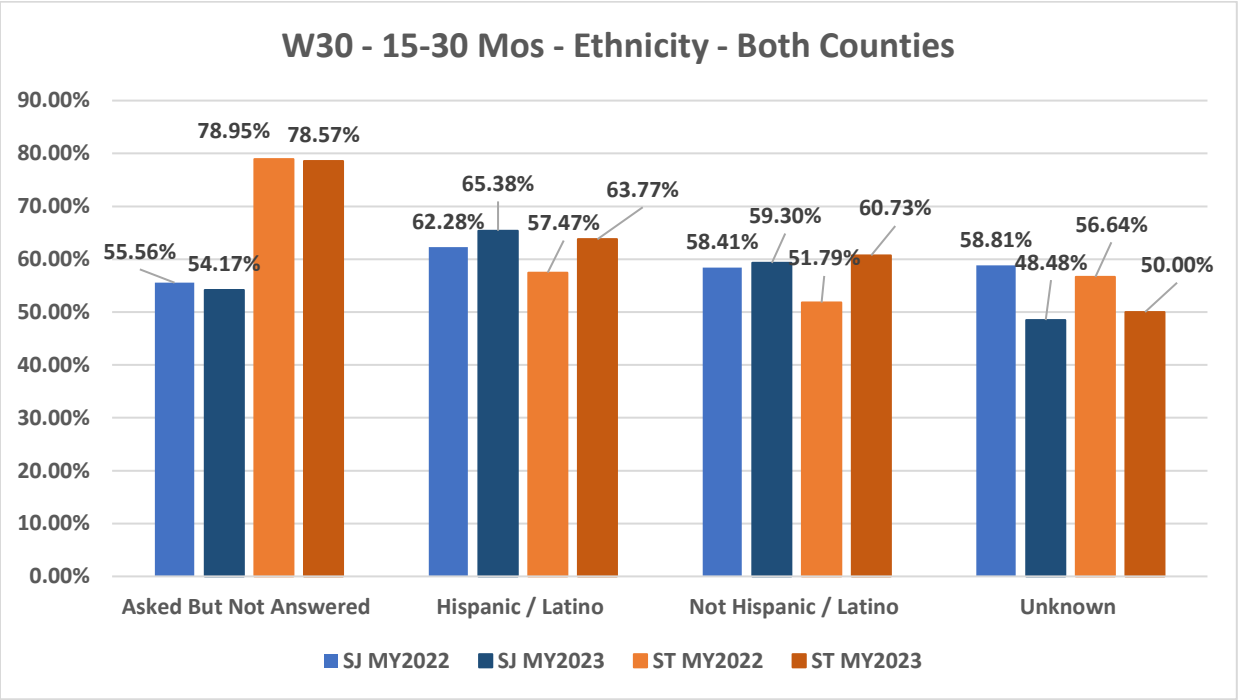
Graph 71: W30 – 0-15 Mos – Ethnicity – Both Counties



Quantitative analysis:

In San Joaquin County, both Hispanic and Non-Hispanic ethnicities improved, in Stanislaus Counties, both declined. Non-Hispanic ethnicities do not perform as well as Hispanic in either county in either year.

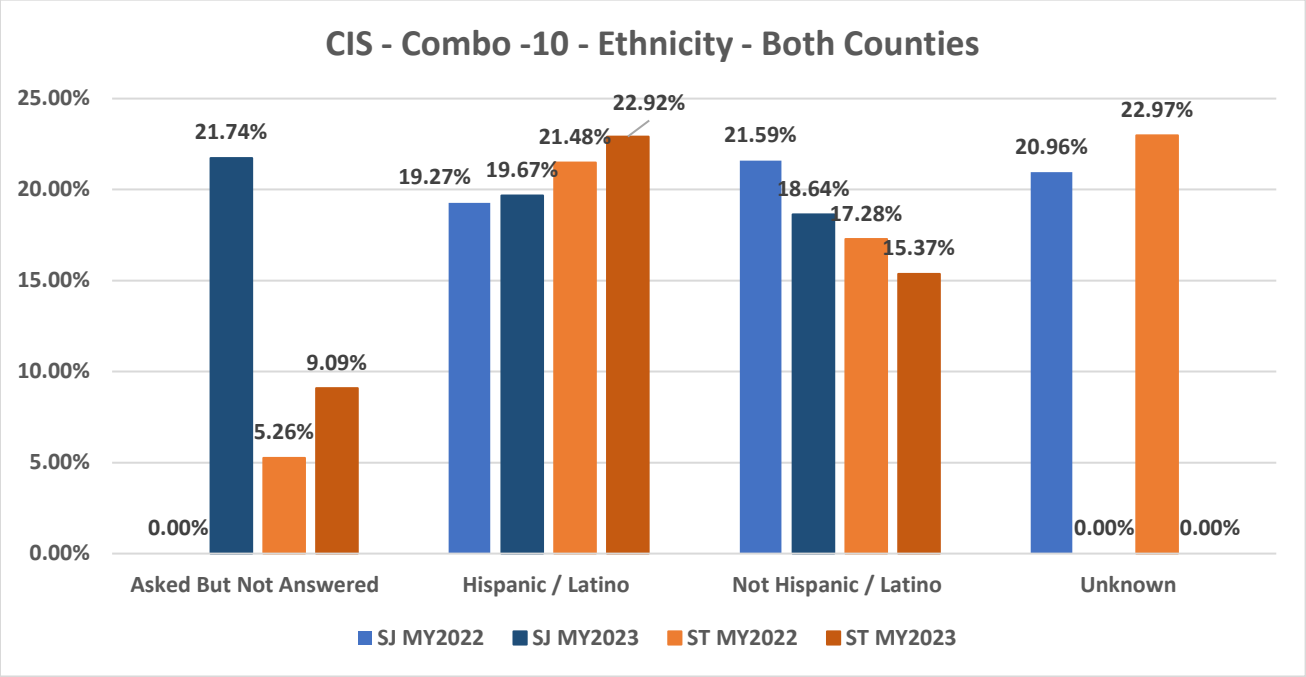
Graph 72: W30 – 15-30 Mos – Ethnicity – Both Counties



Quantitative analysis:

In both counties over both years, rates increased for Hispanic and Non-Hispanic subpopulations. However, in both counties in both years, Hispanic ethnicities outperformed non-Hispanic.

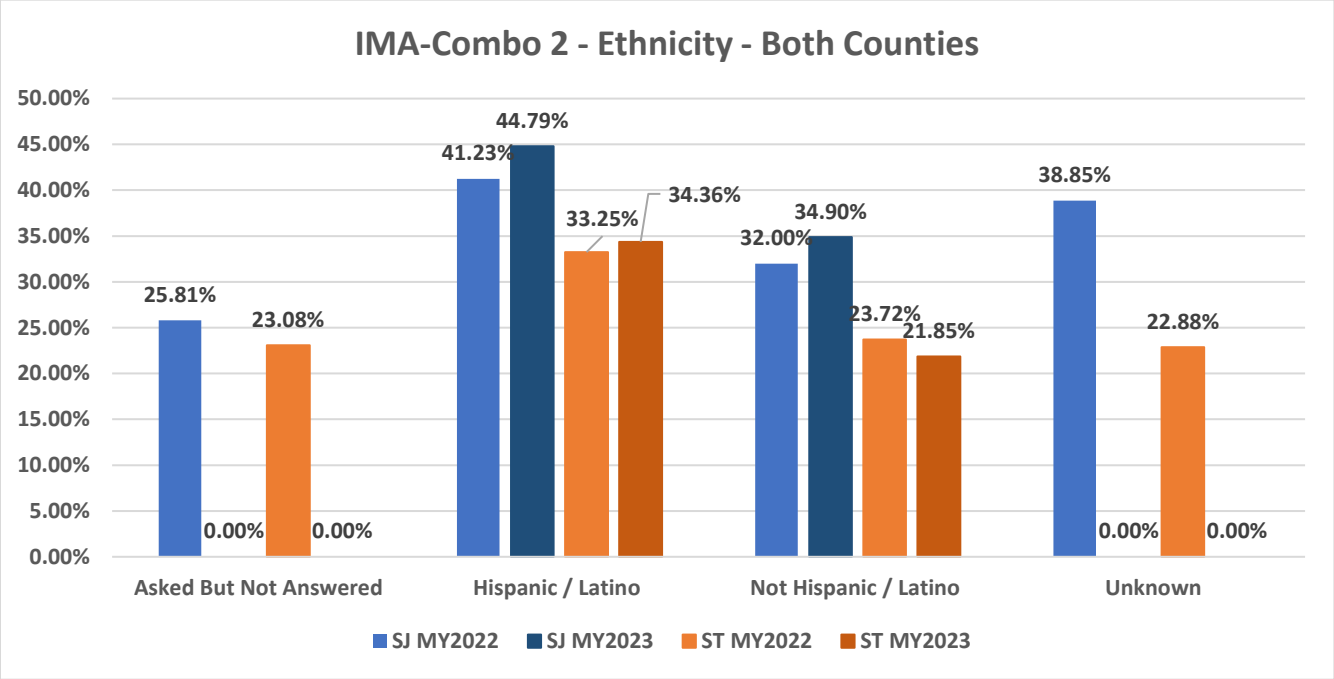
Graph 73: CIS-Combo-10 – Ethnicity – Both Counties



Quantitative analysis:

In both counties over both years, Hispanic rates of vaccination improved compared to prior year. Non-Hispanic ethnicities declined in both counties over both years.

Graph 74: IMA-Combo-2 – Ethnicity – Both Counties



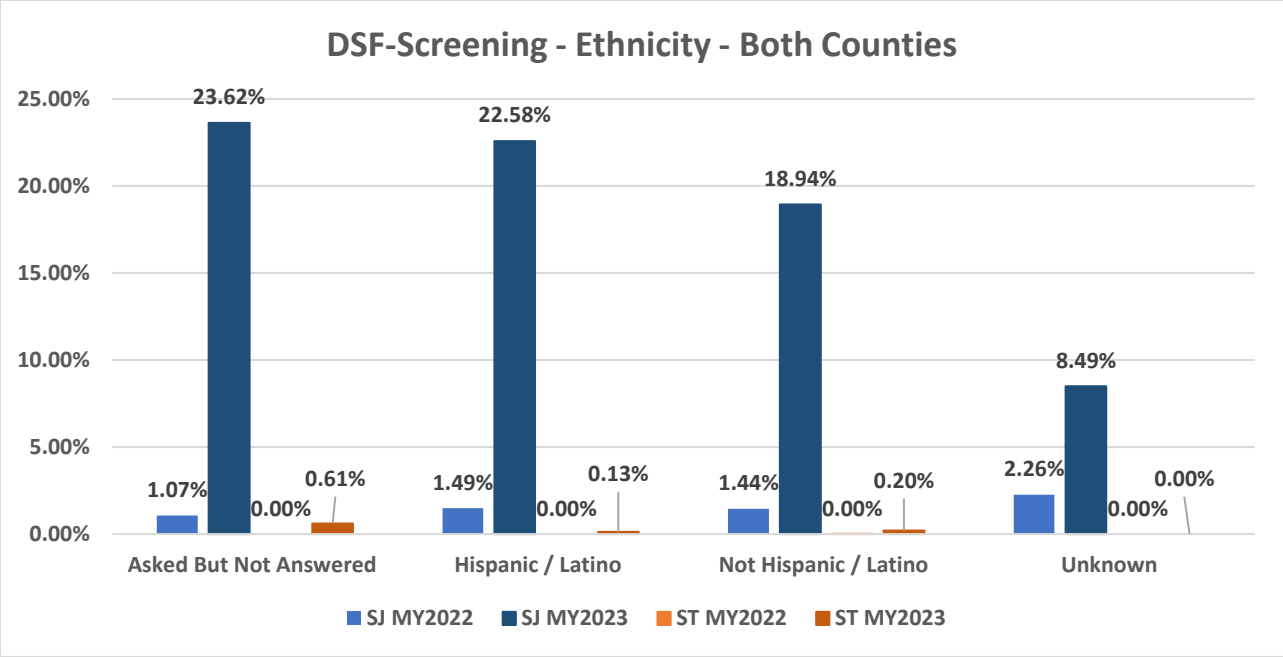
Quantitative analysis:

In both counties in both years, Hispanic rates of vaccination improved compared to prior year. In San Joaquin County Non-Hispanic rates improved, while in Stanislaus Non-Hispanic declined.

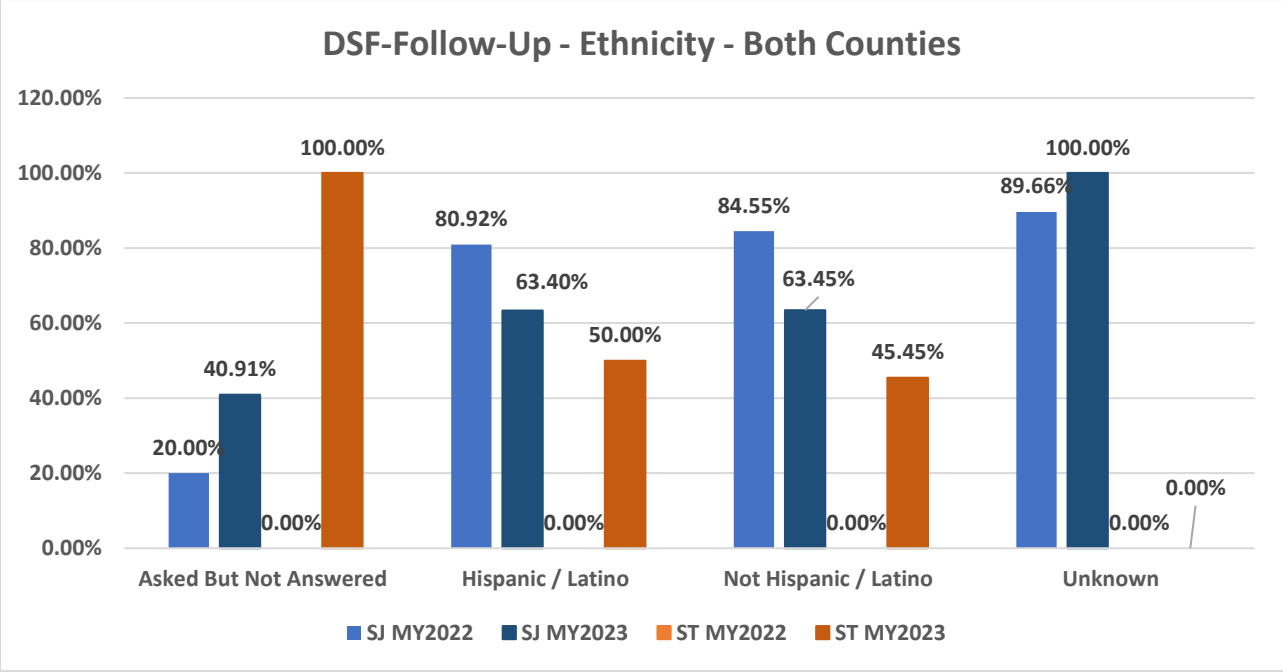
Graph 75: DSF-Screening – Ethnicity – Both Counties

Quantitative analysis:

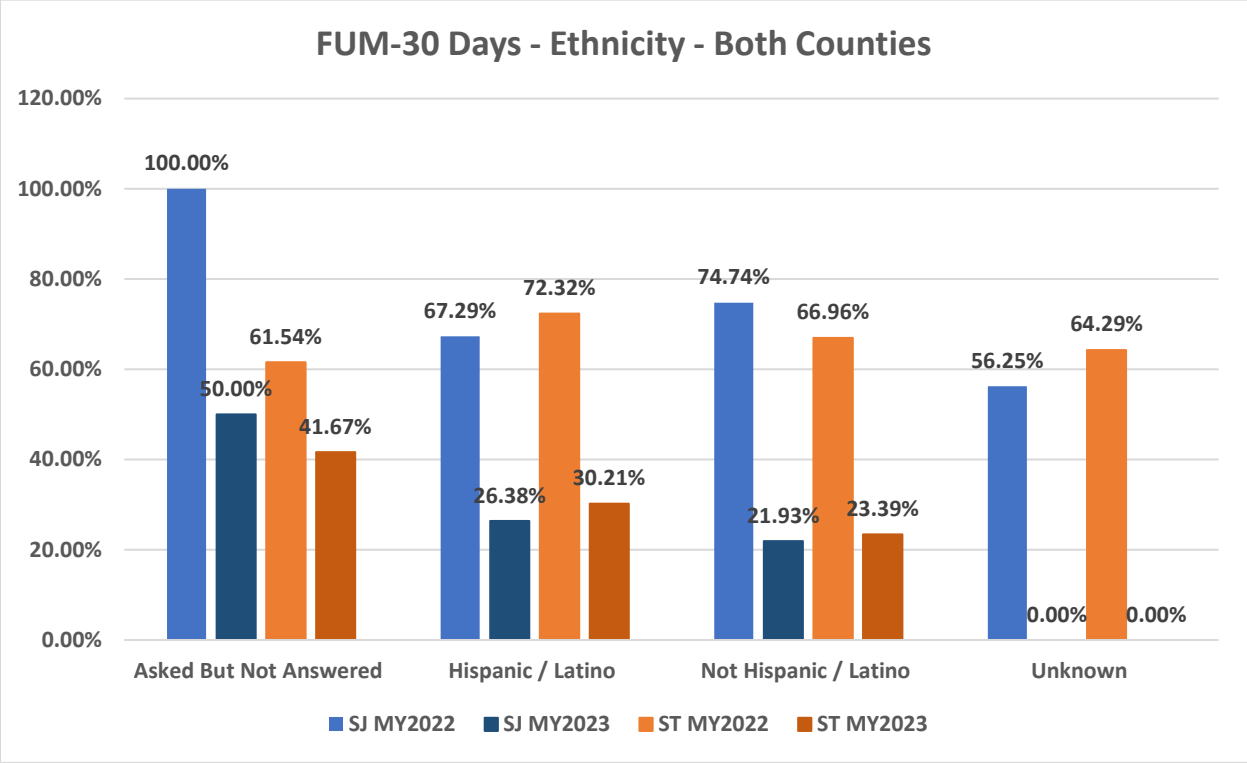
Due to the numerous challenges with collecting and reporting depression screening and follow up data, analysis is deferred until the next reporting period. Data are not reliable.



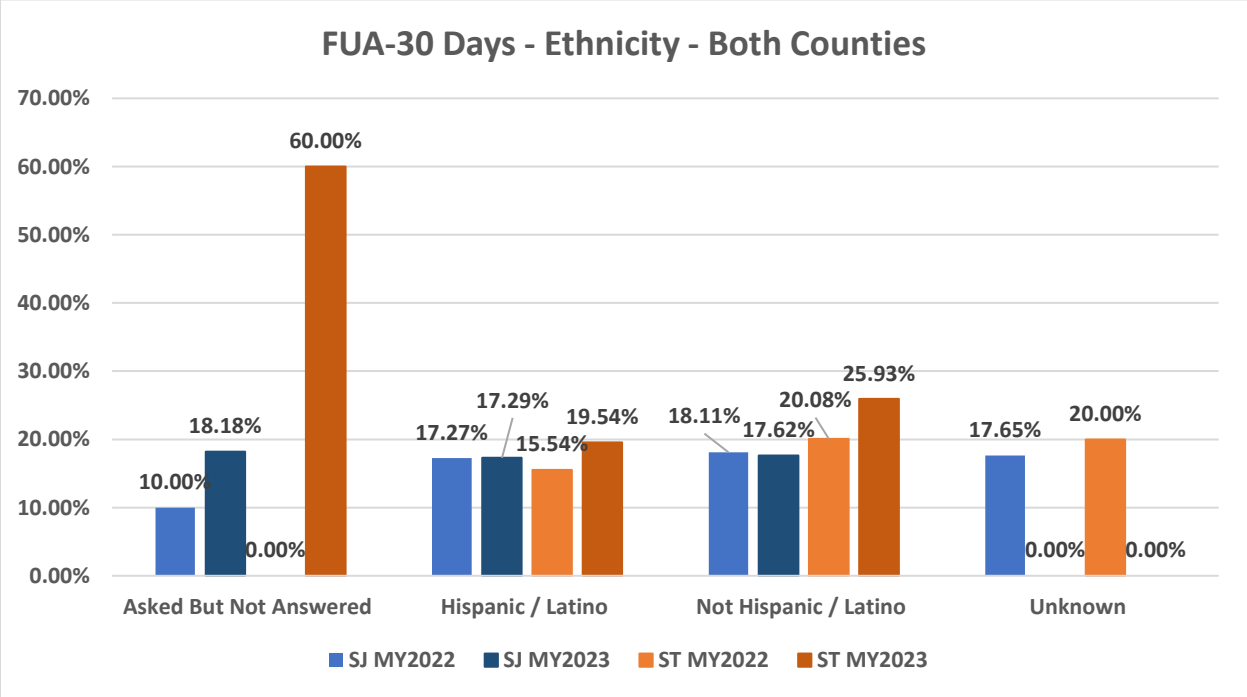
Graph 76: DSF-Follow-Up – Ethnicity – Both Counties



Graph 77: FUM-30 Days – Ethnicity – Both Counties



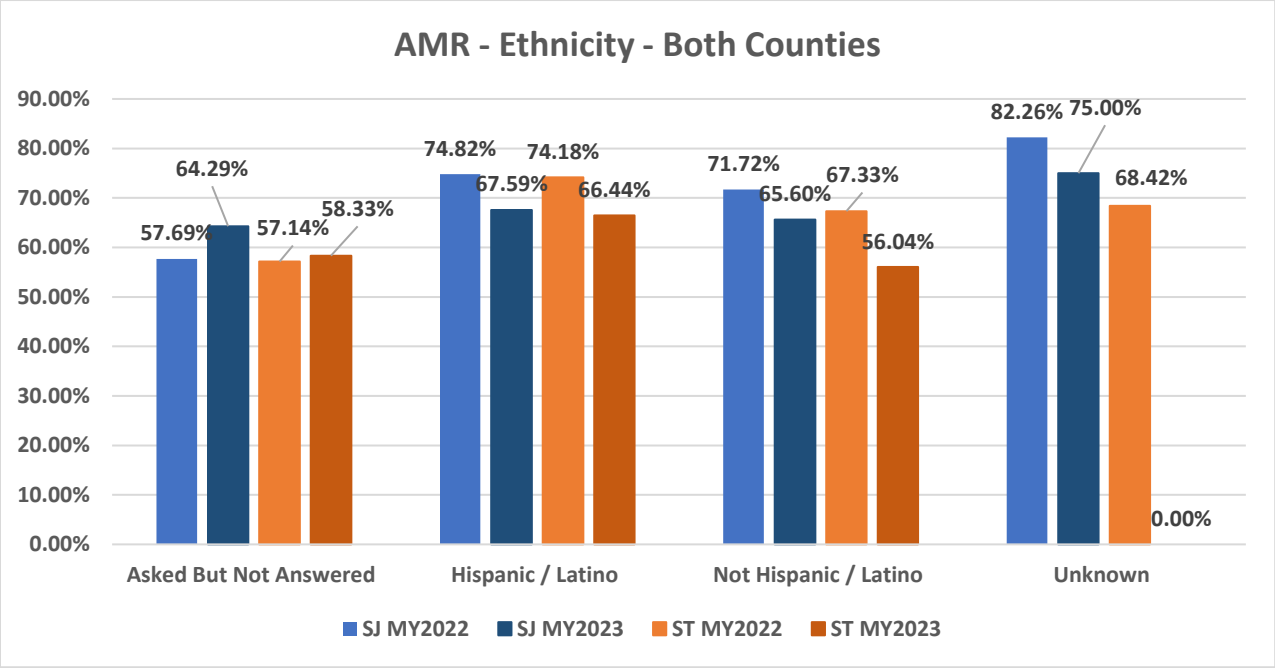
Graph 78: FUA-30 Days – Ethnicity – Both Counties



Quantitative analysis:

Due to the challenges with data capture and reporting with DHCS specialty behavioral health data, the ethnicity data is deferred until the next reporting period due to uncertainties with data reliability.

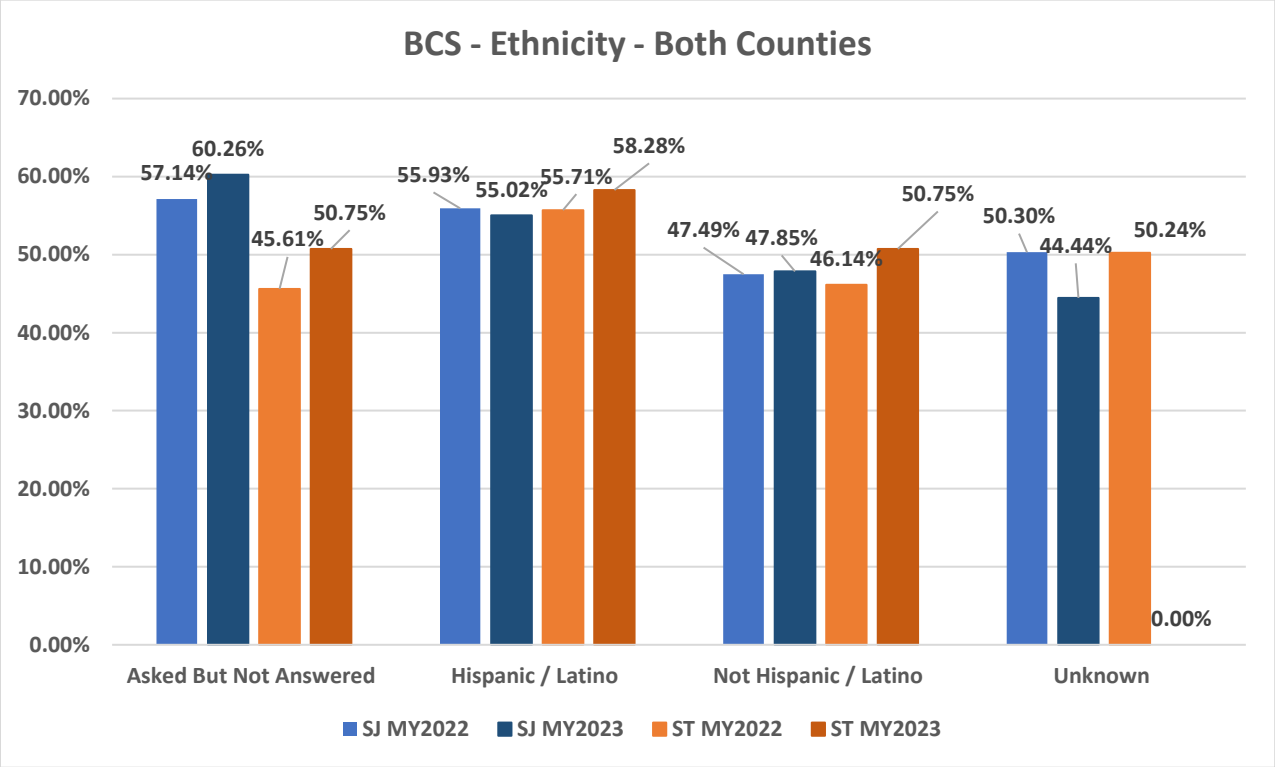
Graph 79: AMR – Ethnicity – Both Counties



Quantitative analysis:

Both Hispanic and Non-Hispanic ethnicities have declined in each county over each year. Non-Hispanic ethnicities underperform Hispanic in every interval. Without knowing the ethnicity of the non-Hispanic subpopulation, it is difficult to identify health disparities.

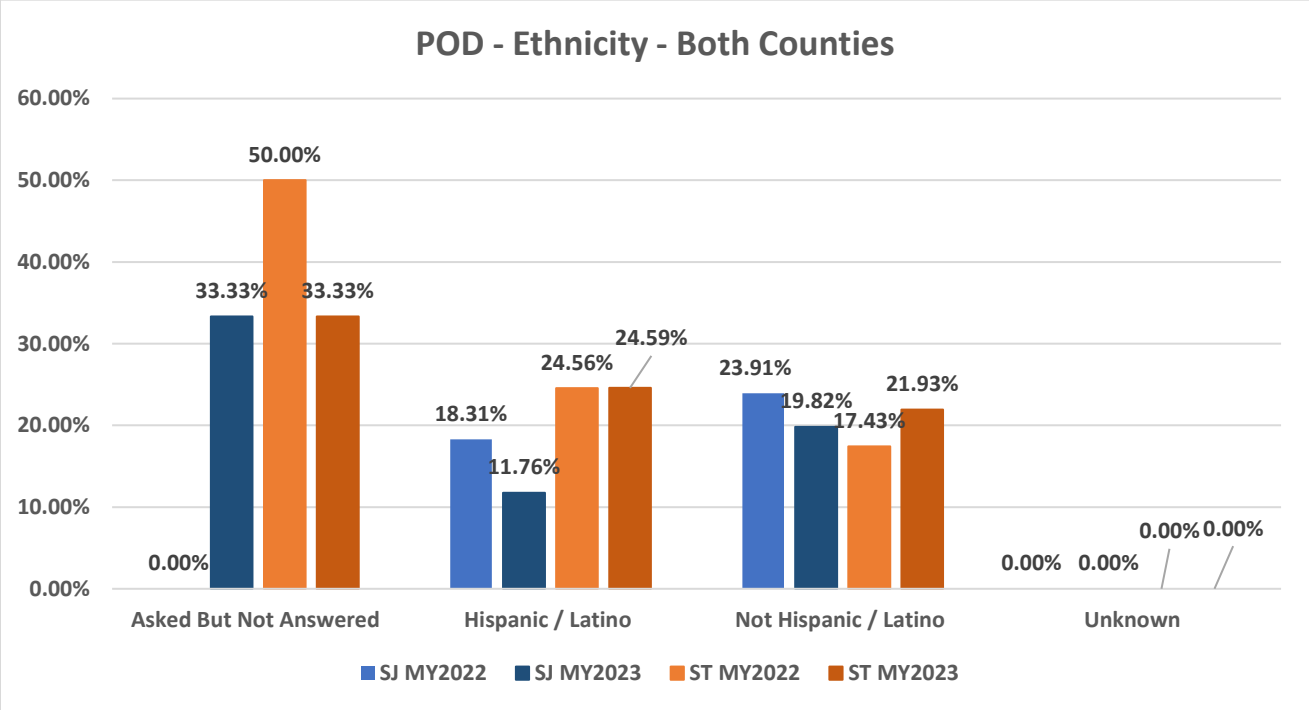
Graph 80: BCS – Ethnicity – Both Counties



Quantitative analysis:

Hispanic subpopulations outperform non-Hispanic in both counties in both years. Without knowing the ethnicity of the underperforming subpopulations, it is difficult to identify health disparities.

Graph 81: POD – Ethnicity – Both Counties



Barriers Identified by Domain

Behavioral Health:

Health Plan was challenged on many fronts to accurately collect and report behavioral health data due to limitations with the quality and quantity of data available to the Plan. Measures that were not held to MPL and reliant upon pharmacy and visit data are much more reliable.

- ADT data is inconsistently populated and not available from all emergency rooms. There are no requirements to populate the fields with consistent nomenclature nor does the data have fields that are required for the fields to be valid. Often these fields are essential to inform the plan about the best course of action for follow-up.
- DHCS All Plan Consolidated Data (APCD) was transitioned to different data source mid-year. Plans were not prepared to consume and utilize the new source in time for reporting. As a result, reported rates were artificially low.
- Memorandum of Understanding with County Behavioral Health data. The MOU template from DHCS was not in place in time to submit to through the HEDIS EQRO audit process.

- Depression screening data, captured on the PHQ-2 and PHQ-9 and transmitted through LOINC codes cannot be submitted on a CMS 1500 form. The CMS 1500 is industry standard, and both claims and encounters are submitted to the health plan on this form. Supplemental data must be used. Not all providers have the resources to submit supplemental data files.
- Race and Ethnicity and disparity data is not reliable for behavioral health measures currently.

Children's Health:

Health Plan noted improvement across nearly all children's health measures. The only exceptions were CIS-10 in both counties and DEV in San Joaquin. These improvements are due in large part to process improvements that address barriers to care. Barriers are associated with member and caregiver social determinants of health and provider access.

- Transportation- members and caregivers often need assistance with transportation.
- Appointment access and availability at convenient times.
- Inconvenient lead screening locations or long wait times at the lab.
- Vaccine hesitancy- members are increasingly more hesitant to fully vaccinate their infants against all diseases for which there are antigens which can protect them. Caregivers are exposed to powerful misinformation campaigns which create fear of vaccinations and mistrust of the health care system.
- Social factors such as competing priorities and lack of familial support.
- Adolescent and young adult members face a lot of peer pressure to participate in unhealthy behaviors and avoid well visits.

Reproductive Health

The greatest barriers to reproductive health have to do with accessing treatment and the deeply personal nature of the care and services in relation to the members paradigm about receiving reproductive care.

- Chlamydia screening is often not performed at the time of the event that makes the member eligible for the measure denominator. As a result, the outreach to the member for follow up must come from the PCP who is often not aware of the event that caused the member to enter the denominator (ER visit, contraception from a confidential clinic, acne medication prescription from a dermatologist, etc.)

- Prenatal care is often delayed due to ambivalent feelings from the pregnant person or access to timely appointments.
- Postpartum care is often either too early or too late. Often the member is enrolled with another plan in the postpartum period and is lost to care.

Cancer Screening

The biggest barrier to cancer screening is convenient access to screening.

- Mammogram access is limited due to the number of radiology units available for screening services. There are insufficient radiology centers in both service areas.
- Many members prefer to have their cervical cancer screening services performed by a practitioner who is both a woman, and a woman that comes from a similar culture or background. There is currently a shortage of OB/Gyn practitioners in the central valley.
- Colorectal cancer screening is best collected in the comfort of one's home with a mail in option for the specimen. Many members are not accustomed to capturing fecal samples, so the type of test and instructions are very important.

Acute and Chronic Care

Acute and chronic care compliance is heavily reliant upon medication adherence and lifestyle changes.

- Controlling blood pressure takes diligent attention to accurate BP monitoring and documenting. Often members are not adherent to BP medications because they are advised to take more than one medication. Medications are often not available at the same time on the same day. Often members do not have an opportunity to return to the pharmacy timely.
- Diabetes A1c control requires adherence to medications that lower blood sugar levels along with lifestyle changes that include reducing simple carbohydrates. Often dietary preferences are tied to cultural preferences and food availability.
- Asthma medications also require members to adhere to a medication protocol that combines both rescue inhalers with asthma controller medications. Members often rely too heavily on their rescue medications, not understanding that the controllers are as effective over time.

Health Disparities

Health Plan identified high priority health disparities which will be the focus of improving equitable care in MY2024.

- Asian Indian, Punjabi speaking members who have hypertension.
- Childhood Vaccination Status, Combo -10 White and Black children
- Well Child Visits for White and Black Adolescents ages 16-21
- Black birthing parents, prenatal and postpartum care
- Participating in the Community Health Needs Assessments and Community Action Plans in each service area
- Improve data collection for behavioral health measures

Improvement Initiatives

Health Plan has implemented many improvement initiatives that address barriers to care.

Data:

- Tip sheets for provider coding possibilities.
- Supplemental data feeds from FQHCs.
- Infant medical record chart pursuits.
- Lead screening grants for point of care lead machines.

Member

- No cost Lyft transportation from home to appointment for all pregnant, postpartum and infant visits up to age 18 months.
- Health education and disease management programs
- Mobile mammography van access.
- Social media campaigns and Spanish radio
- Outreach and incentives for completing care
- Colorectal cancer home screening kits
- Flu screening reminder campaigns

Provider

- Provider Partnership Program
- Custom gap in care lists
- Locum grants to expand access
- Weekend clinics for women's health and well visits
- Direct scheduling and warm transfers for appointments

Table 22 below shows the number of member incentives fulfilled from 2021-2023.

Table 22: Member Incentive Fulfillment

Program	Calendar Year	Rewards Issued
CCS (cervical cancer screening or pap smear)	2021	793
	2022	671
	2023	1245
Diabetic care (HBD, EED)	2021	399
	2022	483
	2023	1203
PPC Post (OB care - postpartum visit)	2021	NA
	2022	195
	2023	582
PPC Pre (OB care - first prenatal visit)	2021	680
	2022	468
	2023	460
WCV – Well Child Visits 3 – 21 years of age (includes counts for retired W34 measure in 2020 and 2021)	2021	6124
	2022	2075
	2023	3511
W30 – Well Visits in the first 30 months (0-30 Months)	2021	557
	2022	202
	2023	644
BCS (Breast Cancer Screening)	2021	327
	2022	282
	2023	680
Lead Screening	2022	123
	2023	373
Flu Vaccine	2022	868
	2023	2521
Adult Preventative Health Visit	2023	1163
Childhood Immunization Status - Combo 10	2023	131
Colorectal Cancer Screening	2023	182

Immunizations for Adolescents	**2023**	215
Postpartum Depression Screening	**2023**	266
Prenatal Immunization Status	**2023**	216

Resources

In MY2023 there was turnover in the staff at the director level responsible for maintaining the quality program. Temporary directors were brought in to fill the leadership needs temporarily. An Executive Director of Quality and Equity role was added but not filled. An additional Quality Manager role was added and filled. A new Director of Special Projects for Quality role was added. If all roles were filled, the resources would be sufficient for the calendar year 2024.

In conclusion, measurement year 2023 HPSJ HEDIS/MCAS rates continued to be impacted by the effects of the Covid-19 pandemic. The pandemic resulted in limited and delayed access to care for many members, this especially shows in the rates for measures with multi-year look back periods. Because of this, only 10 MCAS measures between the 2 counties met the corporate objective goal of meeting the minimum performance level (NCQA 50th Percentile). Continued efforts focused on providers, members, data and a robust member education program can be credited with preventing further rate decline. HPSJ is committed to keeping members engaged and building upon prior successes.

2024 HEDIS/MCAS Priorities

HPSJ considers all improvement efforts to have a positive impact on rates and will continue initiatives year over year when feasible and expand upon all initiatives implemented to create a holistic approach to rate improvement. Ongoing priority is given to measures outlined in the DHCS MCAS reporting requirements, NCQA HEDIS measures for health plan accreditation and measures that continue to fall below goal.

Provider Initiatives:

1. Continue provider alerts focusing on MCAS and Health Plan Ratings measures, behavioral health and medications.
2. Virtual Lunch and Learn related to HEDIS and MCAS.
3. Medication Adherence Programs focusing on acute and chronic conditions.
4. Active messaging for incentive programs.
5. Outreach to low performing providers.
6. Provider HEDIS and MCAS measure Handbook and tip sheets.

7. Proactive measure gap lists.
8. Executive leadership meetings covering comparative quality and incentive programs.
9. Continued provider partnership initiatives including but not limited to gap clinics, standing orders, and contracting with a mobile mammogram program.

Member initiatives:

1. Continue condition specific disease management outreach for Asthma, COPD, Diabetes, HTN and Heart Failure.
2. Direct member outreach and engagement.
3. Member Newsletters.
4. Partnering with community entities.
5. COVID-19 education.
6. Pharmacy outreach to members for antidepression medications.
7. Disengaged member identification.

Data:

1. Recruit new providers to participate in HIE data exchange.
2. Expanding supplemental EMR data feeds from partners to include more measures not being found through the HIE and Administrative claims.
3. Maintain existing data sets.
4. Measure dashboards.
5. Implementation of a new HEDIS vendor with robust reporting capabilities and actionable dashboards.

Continuing Challenges:

1. Engage unseen members.
2. Targeted member outreach to close gaps in care.
3. Gap clinics.
4. Continue current member incentives.
5. Expanding member incentives.
6. Closing future identified health disparities.
7. Collection of member Race, Ethnicity and Language (REaL) data.
8. Implementation of new HEDIS vendor with no overlap to prior HEDIS vendor.

These improvement initiatives are designed to impact a significant number of metrics. All metrics in this report are required by NCQA for health plan accreditation and/or to DHCS as a regulatory requirement for the Managed Care Accountability Set (MCAS). As HPSJ works to address the barriers with

member compliance, provider reporting and data integrity, there is a significant amount of collaboration internally and externally across multiple settings. Some of the collaborative efforts were developed in the previous HEDIS seasons and have continued in the new HEDIS season, while others are new collaborative efforts that were created as a result of ongoing analysis and process improvement efforts. The health plan is committed to our members' health and overall well-being. The opportunities identified are intended to address the barriers identified and improve rates unilaterally.

Quality Improvement Projects

Provider Partnership Program Summary for Calendar Year 2023-2024

The Provider Partnership Program (PPP) has been an ongoing partnership since 2016 between the Health Plan of San Joaquin (HPSJ) and Federally Qualified Health Centers (FQHCs) and provider groups in San Joaquin (SJ) and Stanislaus (ST) counties. The program has also recently expanded to include partners in HPSJ's new territories, El Dorado and Alpine counties.

The primary objectives of the PPP are to:

- Improve communication between HPSJ and provider partners and thereby improve provider engagement with HPSJ's objectives of improving quality care to our members
- Share best practices and gaps in care reports with providers to assist in improving their performance on all the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) performance measures
- Provide a platform for HPSJ's multidisciplinary teams to identify and resolve issues with claims and encounter data, collect supplemental data, and to share important information about other DHCS programs and policies.
- Collaborate with various network providers and groups that participate to carry out special Quality Improvement (QI) projects and implement interventions that not only have improved provider office workflow, but also the quality of claims submissions and patient care during the lifetime of this program.

Participating Providers in the 2023-2024 PPP:

- Community Medical Center (CMC)*
- San Joaquin County Clinics*
- Golden Valley Health Centers (GVHC)*
- Livingston Community Health Services (LCH)*
- Human Services Agency Stanislaus (HSA)*
- Adventist Health – Lodi Memorial
- Dr. Geny Burgos
- Dr. Carmelita Nisperos
- Lodi Children's Clinic
- Dr. Anuradha Dubey
- Dr. Krishnamoorthi
- March Lane Pediatrics
- Pediatric Care of Stockton
- Del Puerto Health District
- Oak Valley Health District (OVHD) Clinics
- Dignity Health Medical Group
- Family First Medical Clinic
- Aspen Family Medical Group
- Newman Medical Group/ Rural Health Center
- Barton Community Health Center
- El Dorado Community Health Centers

* Denotes FQHC

Methodology:

The HEDIS data engine that the Health Plan of San Joaquin (HPSJ) utilizes is Inovalon. Data from all participating providers and FQHCs is received and stored in Inovalon. Data is received on a monthly basis with rates based on claims and encounters data, CAIR registry data, laboratory data, as well as supplemental data submission.

All efforts are supported by the Program Measure Reports provided by HPSJ's HEDIS Vendor. There are member-level reports that are provided that allow HPSJ and providers to pull gaps in care rosters to aid in outreach efforts. These reports are accessible by providers through HPSJ's Inovalon data portal. Providers and their staff are trained periodically on how to review and download the reports for their own records and initiatives. Furthermore, these reports have been utilized to identify member populations for measure improvement during provider projects.

MCAS Measure Performance Trends – County Level: MY2021-MY2023

	MY2021		MY2022		MY2023	
Measure	**Stanislaus**	**San Joaquin**	**Stanislaus**	**San Joaquin**	**Stanislaus**	**San Joaquin**
CCS	59.12%	56.26%	58.15%	56.93%	56.45%	63.99%
CIS-10	29.20%	36.98%	20.92%	36.50%	20.68%	27.98%
GSD >9	41.61%	38.44%	40.63%	35.52%	28.95%	35.52%
CBP	55.96%	57.18%	59.85%	59.37%	61.56%	68.61%
IMA-2	33.33%	39.17%	30.20%	37.55%	30.66%	40.88%
PPC-Pre	87.10%	88.08%	86.37%	87.59%	86.86%	85.40%
PPC-Post	79.81%	78.83%	80.05%	79.08%	86.37%	84.43%
LSC	37.38%	45.90%	41.12%	46.11%	43.55%	46.47%
BCS	49.96%	47.29%	50.42%	50.44%	52.64%	50.54%
WCV	37.71%	46.23%	41.89%	47.26%	46.04%	49.44%
CHL	50.77%	58.54%	52.60%	58.78%	51.72%	59.77%
W30-6+	37.98%	44.63%	35.32%	50.36%	46.21%	51.67%
W30-2+	54.30%	58.30%	56.49%	60.67%	62.67%	62.46%
FUA	5.56%	7.17%	18.06%	17.08%	23.57%	17.49%
FUM	49.18%	59.69%	47.16%	52.39%	26.56%	23.71%
AMR	58.39%	48.07%	60.07%	58.86%	61.9%	66.45%
DEV	NR	NR	16.25%	27.34%	18.6%	25.05%
TFL	NR	NR	0.61%	2.15%	18.73%	19.05%

Qualitative Analysis:

Barriers identified across the partnership include:

- Large panel size and membership – this is an ongoing challenge for FQHCs, whose panel size far exceeds solo and small group practice providers. They have expressed challenges in the areas of call center capacity to address members' needs and in scheduling members for appointments and outreach.
- Data integrity issues – There are persisting issues with providers not submitting the correct CPT II codes to capture critical HEDIS/MCAS related data. For those who do submit these codes, some have clearing houses that may be removing codes that are not covered by MCL or will have a $0 payout due to capitation; both practices negatively impact our data quality.
- In addition, some providers are not submitting codes that are considered capitated. HPSJ's QI nurses' team has been working to remind providers in the partnership program about the need for these codes, even if it is covered contractually under capitation.

- Resistance to change – there is continued resistance to change within the provider network, especially regarding billing and coding information. Providers not wanting to dismiss patients who have "aged out" of their normal care age ranges, and the same patients are still not seeking care elsewhere or are reliant on urgent care/ER visits to manage their health. Some providers are resistant to QI initiatives for a myriad of reasons, including staffing issues and time constraints. Furthermore, regarding EPSDT overlap, conflicting information from DHCS' EPSDT manual regarding periodicity has created reluctance for providers to fully conform to best practice guidelines for well-child periodicity.

Interventions for improving MCAS performance FY2023-2024

Children's Health Measures

- Lead Screening in Children (LSC) – HPSJ QI staff has provided ongoing Provider Education regarding Lead Screening to improve lead screening rates in children. Gap lists for children needing a lead screening test are shared with provider partners each month. Providers are also held more accountable to measure compliance through placement of Corrective Action Plans. Providers have been encouraged to pilot Point of Care (POC) testing for lead screening through grant monies being made available to them to purchase lead screening equipment. Work has also been started to establish LSC blood specimens to be collected by Quest Labs through a small grant program. This will continuously be encouraged and supported moving forward through 2024.
- Child Wellness call campaigns – Proactive call campaigns are being carried out for W15/W30/IMA measures to focus on getting children in for their well-baby visits and/or immunizations before the metric deadlines.
- Customized Care Gap Lists – HPSJ has been sharing customized care gap lists that combine several measures together, as well as add flags for certain services with providers in the partnership program so that providers can maximize their outreach and preventative care visits. These lists are available upon request, aside from care gap lists available on the data vendor site.
- Marketing Coordination – HPSJ's Population Health and Health Education teamwork in conjunction with HPSJ's Marketing team for monthly well visit and incentive fliers distribution/mailing to encourage well visits and immunization compliance.
- Member educational materials – Educational materials to promote well visits and compliance with other preventive services were developed. The

Children's Milestone Booklet has been distributed and is available from ages 0 to 21.

Women's Health Measures

- Focused Care Gap Clinics – HSA has continued the care gap clinics to address multiple care gaps for members who are seen at their clinic. Additionally, San Joaquin County Clinics started offering clinic days to focus on Perinatal and Children's Health services. CMC and Oak Valley Health District have similar initiatives throughout the fiscal year.
- Provider Education – Provider education efforts are continuing, especially regarding billing/coding exclusions if a member meets the criteria.
- Postpartum Follow-up Partnerships – As part of HPSJ's effort to promote postpartum visits, the QI nurses team started partnering with providers in utilizing the MCP's delivery claims report to identify, outreach and follow-up members who were just discharged from hospitals post-delivery.
- Alinea Mobile Mammography Events – Mobile Mammogram events with Alinea began in 2023 in an effort to close Breast Cancer Screening (BCS) gaps. An average of 20 events are held per year, with 30 patients scheduled per day. Moving forward, we are hoping to encourage providers to hold combined BCS/CCS clinics.

Chronic Disease Management Measures

- Diabetes Clinic partnership – HPSJ's CM team has an ongoing partnership with HSA for their Diabetes clinic to provide additional reminders, support, and education to non-compliant diabetic members.
- Hypertension Clinic partnership – SJGH/SJCC has an ongoing hypertension clinic for which our CM team has provided support. This has included facilitating better communication with our capitated DME provider to ensure that patients can get a BP cuff timely.
- Supplemental Data submissions – Most of the FQHCs provide data related to point of care testing for A1c and for CBP via supplemental submissions for HEDIS/MCAS credit. This has positively impacted rates but has room for improvement. Other provider groups in the partnership have opted to either submit supplemental data or make corrections or automations to their billing for rendered services.

Behavioral Health Measures

- Integrated Behavioral Health Programs – GVHC, SJCC, HSA, and CMC have set milestones and goals to address several behavioral health

measures and needs in their member populations. HPSJ is supporting these efforts, and the programs are ongoing.

- Follow Up for Mental Illness/Substance Use Disorder ER Visits (HEDIS measures FUM/FUA) – HPSJ continues to work with major FQHCs on an FUA/FUM project that includes provision and utilization of daily ED discharge claims report to identify and outreach eligible members for these measures and get them in for follow-up within 30 days. HPSJ's social services team has been working closely with partnering providers to maintain an efficient process and support for barriers met by the providers. Expansion of the project to other providers within the Partnership Program is being explored.
- ACEs Screening – Ongoing provider education efforts to remind network providers to take the training and attest for ACEs screenings. Partnership Providers have had this discussion on multiple occasions with their QI Nurse as HPSJ works to ensure an adequate network for members to receive these screenings and follow up.

Additional Partnership Opportunities

- Regular Provider Partnership Program meetings - Partnership between HPSJ and the VIP providers was established and has continued with the goal of improving the delivery of preventive services to the community. The program holds regular meetings to discuss current HEDIS/MCAS standings, best practices, and opportunities for project partnership with the community.
- Equity and Practice Transformation Payment Program (EPT) –Seven of HPSJ's provider partners (Aspen Family Medical, Pediatric Care of Stockton, All for Kids-Dr. Dubey, Barton Health, El Dorado Community Health Centers, Newman Medical, and Livingston Community Health) were selected to participate in the EPT program, a state-wide, multi-year initiative to improve primary care practices. With this program, HPSJ wants to partner with network providers to obtain grant funding and implement practice improvements to better serve patients. HPSJ has partnered with Recast Health to help navigate the EPT program, run an efficient technology vendor selection process, and provide guidance to enable each practice to reach their EPT payment milestones. Support will include hands-on coaching to help providers complete program milestones and prepare deliverables. Support is coordinated with the Provider Partnership Program to align with ongoing quality improvement efforts.
- Patient Transportation Assistance – HPSJ's partnership with Lyft has continued to provide members with greater transportation access in addition to the traditional bus pass services.

- Continued health plan presence at various community events – HPSJ's Community, Retention, and Member Engagement/Community, Marketplace, and Member Engagement [CRME/CMME] team provide HPSJ presence at community events to promote health education and member benefits.
- Member Incentive Program – HPSJ's MyRewards program allows members to digitally request gift card rewards for incentivized measures. These requests are handled by HPSJ's engagement vendor. The incentivized measures are evaluated annually to improve member compliance.
- Provider Incentives – HPSJ continues to update the incentive program for providers to help motivate providers to improve specific quality measures.

Results

MY2023 Goal Performance

Measure	Performance Goal MPL MY2023	Stanislaus	San Joaquin
CCS	**57.11%**	56.45%	63.99%
CIS-10	**30.90%**	20.68%	27.98%
GSD >9	**37.96%**	28.95%	35.52%
CBP	**61.31%**	61.56%	68.61%
IMA-2	**34.31%**	30.66%	40.88%
PPC-Pre	**84.23%**	86.86%	85.40%
PPC-Post	**78.10%**	86.37%	84.43%
LSC	**62.79%**	43.55%	46.47%
BCS	**52.60%**	52.64%	50.54%
WCV	**48.07%**	46.04%	49.44%
CHL	**56.04%**	51.72%	59.77%
W30-6+	**58.38%**	46.21%	51.67%
W30-2+	**66.76%**	62.67%	62.46%
FUA	**36.34%**	23.57%	17.49%
FUM	**54.87%**	26.56%	23.71%
AMR	**65.61%**	61.9%	66.45%
DEV	**34.70%**	18.6%	25.05%
TFL	**19.30%**	18.73%	19.05%

FQHC FY23-24 Measure Results

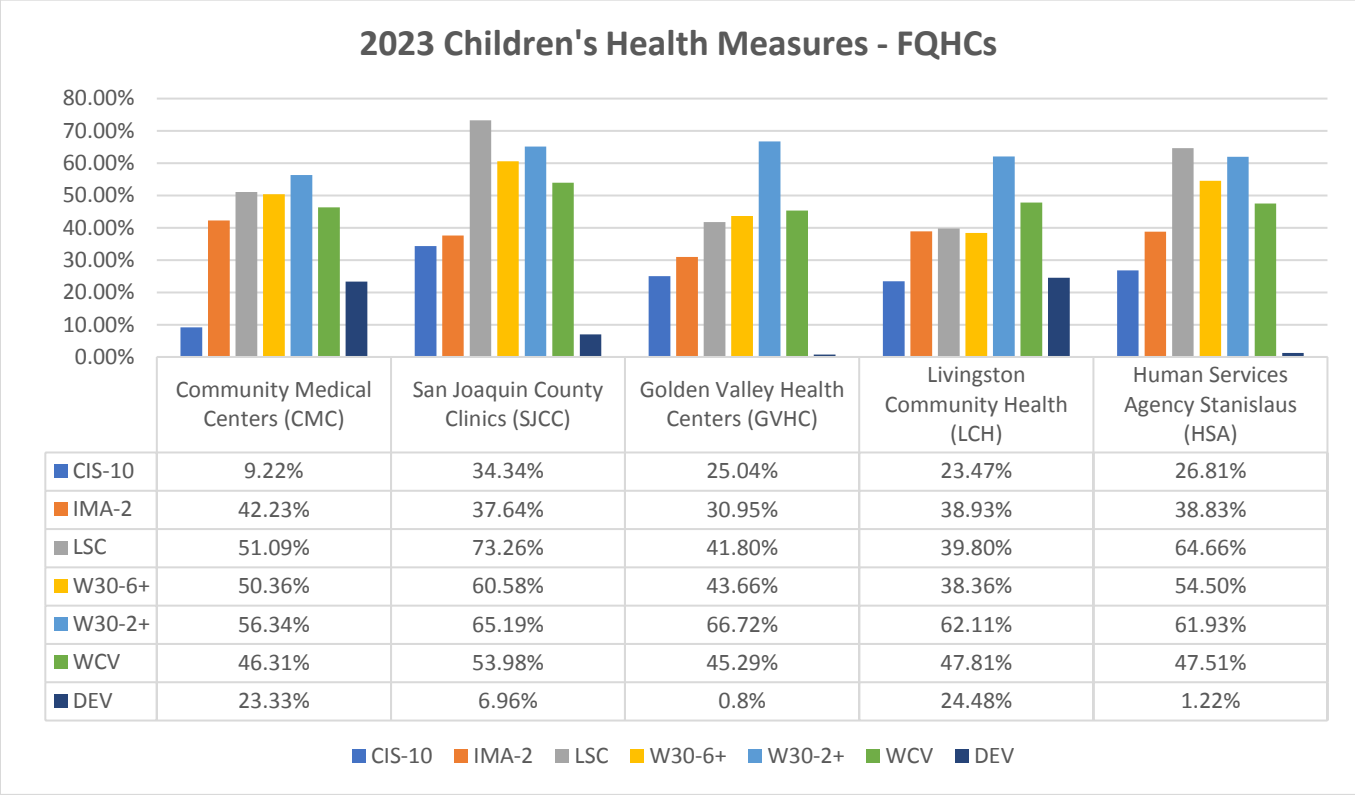
Measure	Performance Goal MPL MY2023	CMC	SJCC	GVHC	LCH	HSA

CCS	**57.11%**	59.40%	51.19%	51.71%	63.11%	57.61%
CIS-10	**30.90%**	9.22%	34.34%	25.04%	23.47%	26.81%
GSD >9	**37.96%**	39.62%	41.27%	57.22%	37.70%	37.65%
CBP	**61.31%**	59.74%	54.43%	46.59%	53.62%	42.39%
IMA-2	**34.31%**	42.23%	37.64%	25.04%	23.47%	26.81%
PPC-Pre	**84.23%**	50.36%	78.53%	78.46%	77.85%	76.85%
PPC-Post	**78.10%**	56.34%	80.98%	72.14%	77.22%	81.48%
LSC	**62.79%**	51.09%	73.26%	41.80%	39.80%	64.66%
BCS	**52.60%**	19.30%	51.43%	45.26%	68.36%	55.65%
WCV	**48.07%**	46.31%	53.98%	45.29%	47.81%	47.51%
CHL	**56.04%**	58.99%	66.52%	46.80%	56.04%	54.25%
W30-6+	**58.38%**	50.36%	60.58%	43.66%	38.36%	54.50%
W30-2+	**66.76%**	56.34%	65.19%	66.72%	62.11%	61.93%
AMR	**65.61%**	65.28%	64.96%	52.04%	50.91%	58.29%
DEV	**34.70%**	23.33%	6.96%	0.8%	24.48%	1.22%

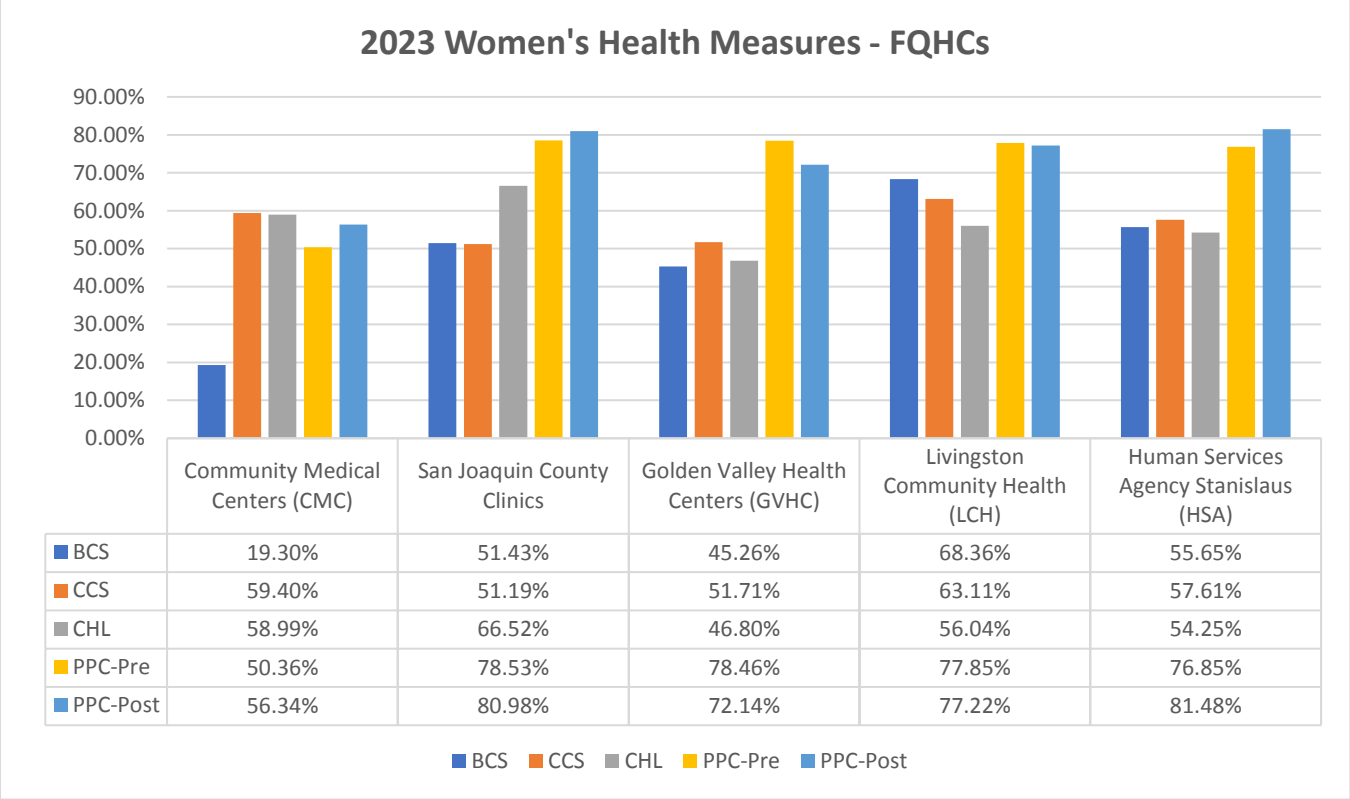
Quantitative Analysis:

- SJCC was the highest performing partnership provider, meeting 7 of the 15 measure performance goals
- CMC and HSA were the next highest performing partnership providers, meeting 4 of the 15 measure performance goals
- LCH and GVHC met 3 and 1 measure performance goals, respectively
- None of the FQHC provider partners met performance goals for the CBP, PPC-Pre, W30-2+, AMR, and DEV measures.

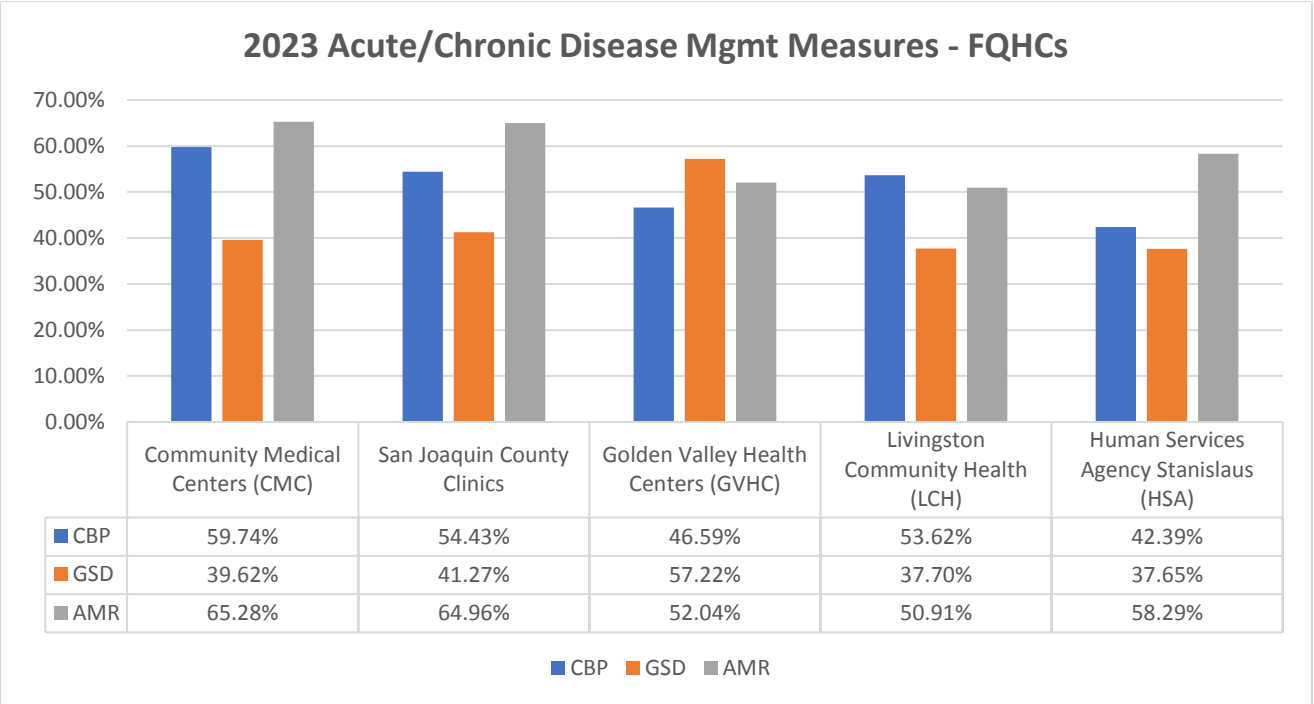
Graph 19: 2023 FQHC MCAS Year-End Data Comparison



	Community Medical Centers (CMC)	San Joaquin County Clinics (SJCC)	Golden Valley Health Centers (GVHC)	Livingston Community Health (LCH)	Human Services Agency Stanislaus (HSA)
CIS-10	9.22%	34.34%	25.04%	23.47%	26.81%
IMA-2	42.23%	37.64%	30.95%	38.93%	38.83%
LSC	51.09%	73.26%	41.80%	39.80%	64.66%
W30-6+	50.36%	60.58%	43.66%	38.36%	54.50%
W30-2+	56.34%	65.19%	66.72%	62.11%	61.93%
WCV	46.31%	53.98%	45.29%	47.81%	47.51%
DEV	23.33%	6.96%	0.8%	24.48%	1.22%

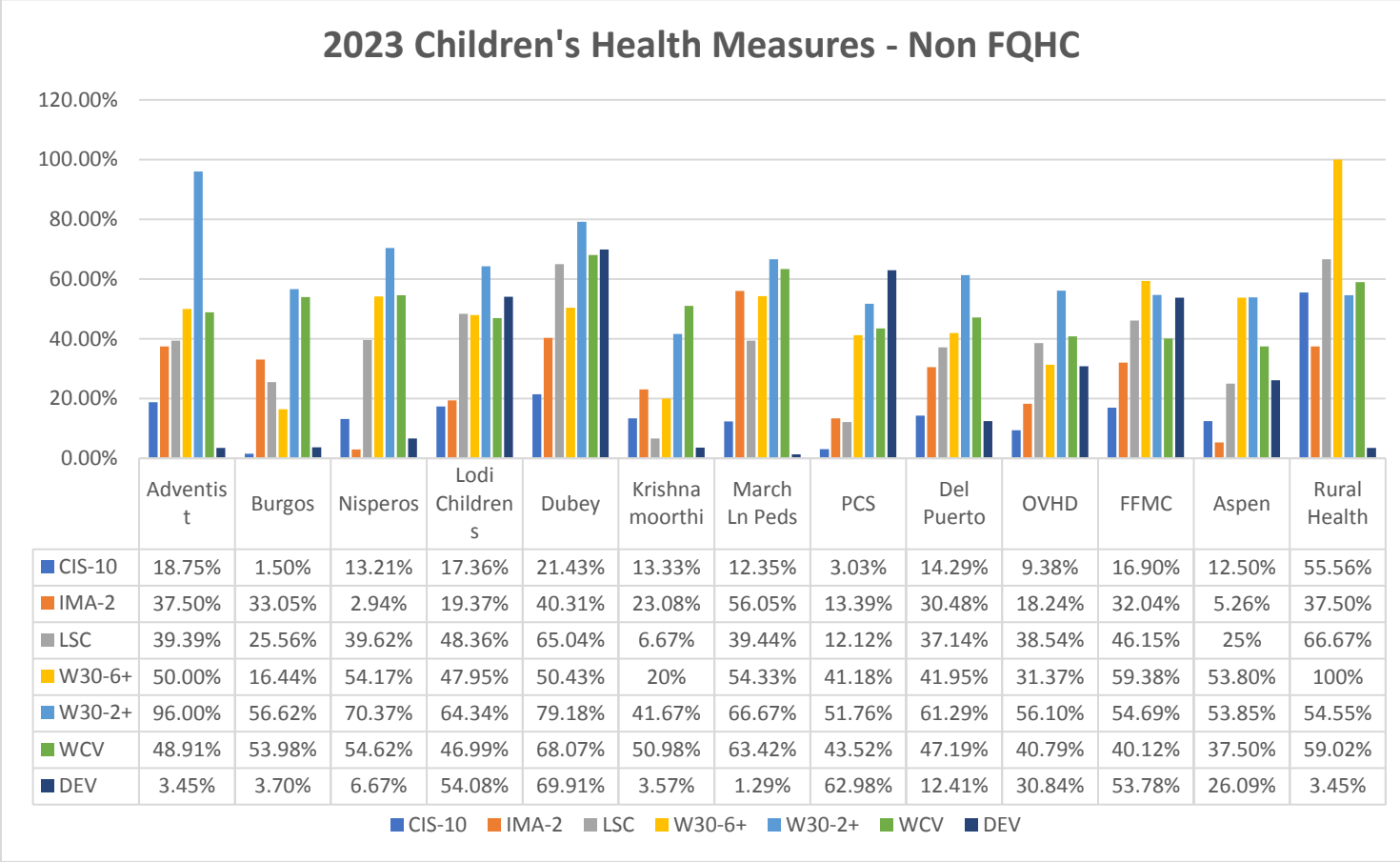


	Community Medical Centers (CMC)	San Joaquin County Clinics	Golden Valley Health Centers (GVHC)	Livingston Community Health (LCH)	Human Services Agency Stanislaus (HSA)
BCS	19.30%	51.43%	45.26%	68.36%	55.65%
CCS	59.40%	51.19%	51.71%	63.11%	57.61%
CHL	58.99%	66.52%	46.80%	56.04%	54.25%
PPC-Pre	50.36%	78.53%	78.46%	77.85%	76.85%
PPC-Post	56.34%	80.98%	72.14%	77.22%	81.48%

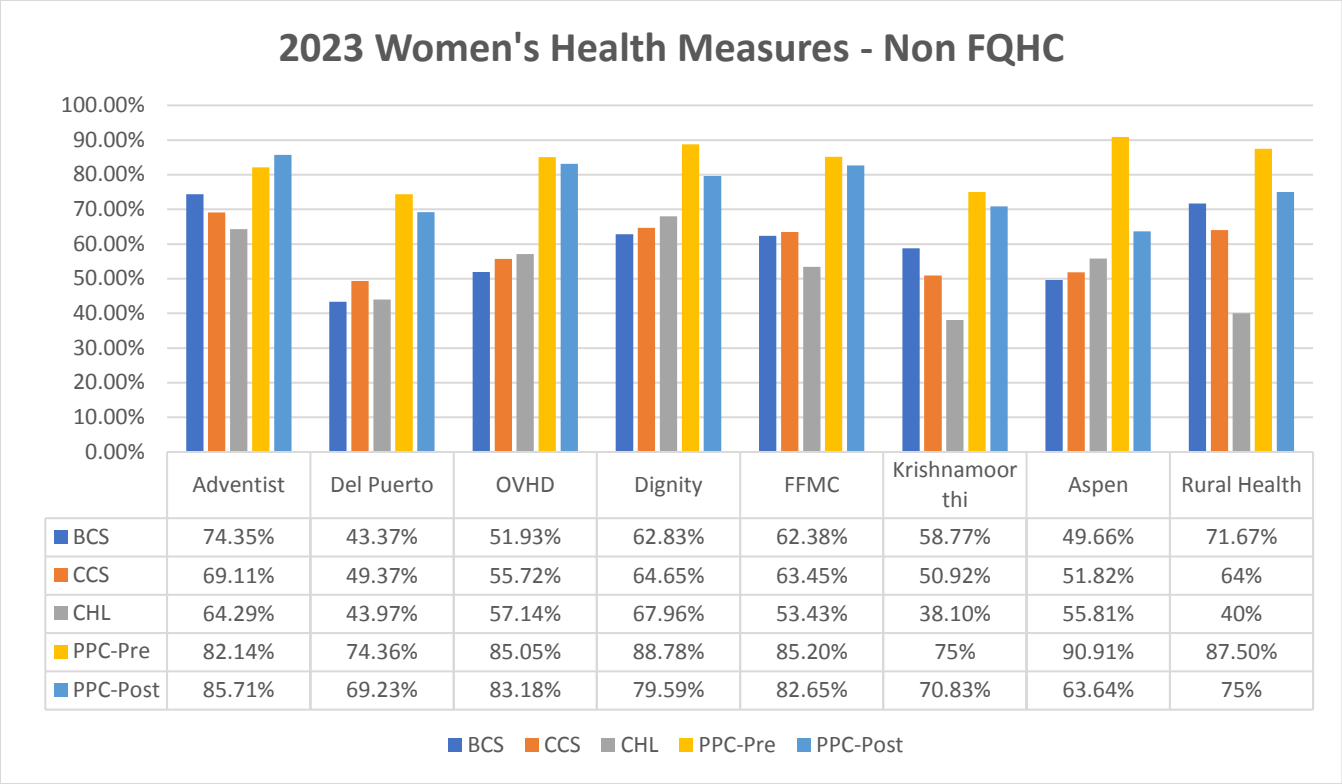


	Community Medical Centers (CMC)	San Joaquin County Clinics	Golden Valley Health Centers (GVHC)	Livingston Community Health (LCH)	Human Services Agency Stanislaus (HSA)
CBP	59.74%	54.43%	46.59%	53.62%	42.39%
GSD	39.62%	41.27%	57.22%	37.70%	37.65%
AMR	65.28%	64.96%	52.04%	50.91%	58.29%

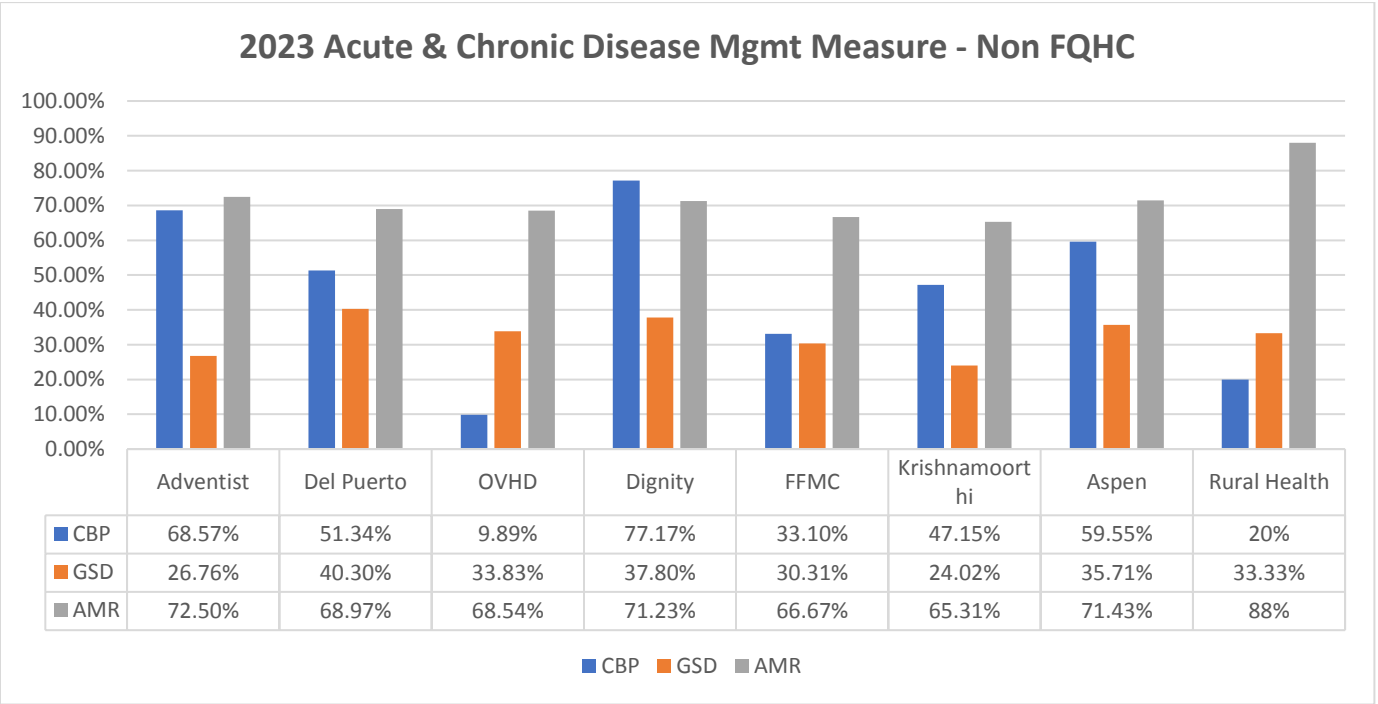
Graph 20: 2023 Non-FQHC MCAS Year-End Data Comparison



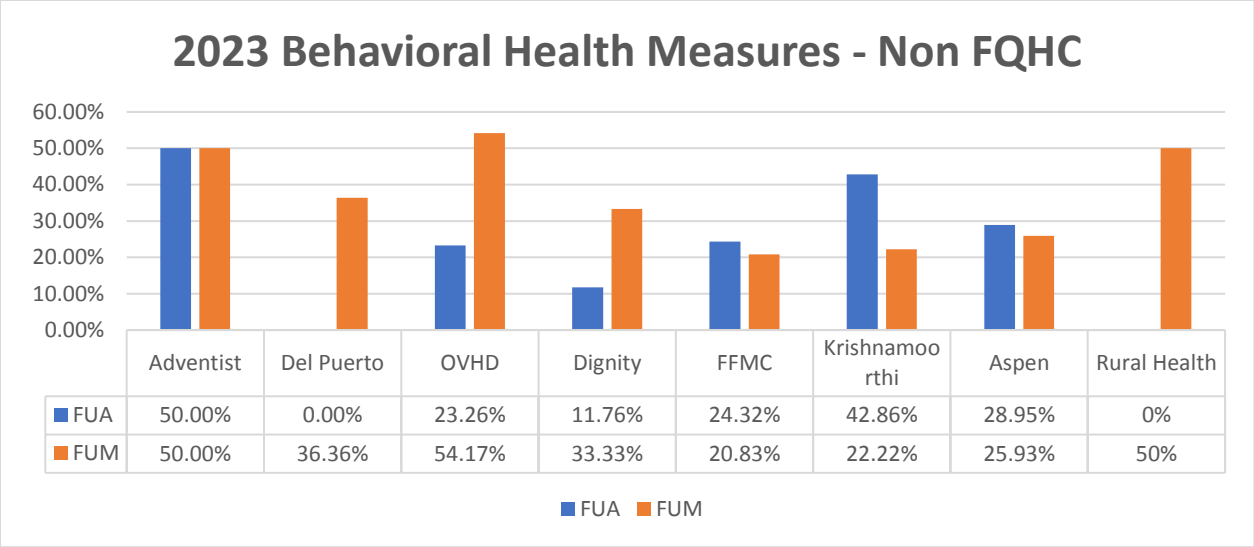
	Adventist	Burgos	Nisperos	Lodi Childrens	Dubey	Krishnamoorthi	March Ln Peds	PCS	Del Puerto	OVHD	FFMC	Aspen	Rural Health
CIS-10	18.75%	1.50%	13.21%	17.36%	21.43%	13.33%	12.35%	3.03%	14.29%	9.38%	16.90%	12.50%	55.56%
IMA-2	37.50%	33.05%	2.94%	19.37%	40.31%	23.08%	56.05%	13.39%	30.48%	18.24%	32.04%	5.26%	37.50%
LSC	39.39%	25.56%	39.62%	48.36%	65.04%	6.67%	39.44%	12.12%	37.14%	38.54%	46.15%	25%	66.67%
W30-6+	50.00%	16.44%	54.17%	47.95%	50.43%	20%	54.33%	41.18%	41.95%	31.37%	59.38%	53.80%	100%
W30-2+	96.00%	56.62%	70.37%	64.34%	79.18%	41.67%	66.67%	51.76%	61.29%	56.10%	54.69%	53.85%	54.55%
WCV	48.91%	53.98%	54.62%	46.99%	68.07%	50.98%	63.42%	43.52%	47.19%	40.79%	40.12%	37.50%	59.02%
DEV	3.45%	3.70%	6.67%	54.08%	69.91%	3.57%	1.29%	62.98%	12.41%	30.84%	53.78%	26.09%	3.45%



	Adventist	Del Puerto	OVHD	Dignity	FFMC	Krishnamoorthi	Aspen	Rural Health
BCS	74.35%	43.37%	51.93%	62.83%	62.38%	58.77%	49.66%	71.67%
CCS	69.11%	49.37%	55.72%	64.65%	63.45%	50.92%	51.82%	64%
CHL	64.29%	43.97%	57.14%	67.96%	53.43%	38.10%	55.81%	40%
PPC-Pre	82.14%	74.36%	85.05%	88.78%	85.20%	75%	90.91%	87.50%
PPC-Post	85.71%	69.23%	83.18%	79.59%	82.65%	70.83%	63.64%	75%



	Adventist	Del Puerto	OVHD	Dignity	FFMC	Krishnamoorthi	Aspen	Rural Health
CBP	68.57%	51.34%	9.89%	77.17%	33.10%	47.15%	59.55%	20%
GSD	26.76%	40.30%	33.83%	37.80%	30.31%	24.02%	35.71%	33.33%
AMR	72.50%	68.97%	68.54%	71.23%	66.67%	65.31%	71.43%	88%



	Adventist	Del Puerto	OVHD	Dignity	FFMC	Krishnamoorthi	Aspen	Rural Health
FUA	50.00%	0.00%	23.26%	11.76%	24.32%	42.86%	28.95%	0%
FUM	50.00%	36.36%	54.17%	33.33%	20.83%	22.22%	25.93%	50%

NOTE:

**Data shown is based on claims through the end of December 2023, MY2023 Final rates used where available.*
**Blanks mean no members assigned to this practice for this measure*
**GSD is inverse-the lower the number, the better*

Measurement of Intervention Effectiveness

Opportunities

- Provider education

Outside of the Partnership Program, HPSJ provides a provider newsletter quarterly that includes information on various topics, including QI/HEDIS/MCAS areas of focus. Ongoing provider network education for these topics can be found in PlanScan as well as periodic Provider Alerts that are sent out to the network providers. During monthly meetings, education on all MCAS measures and best practices is shared, and other departments at the plan are included on the agenda to share information from their respective teams.

    - Member education
        - The QI team works to Ensure the provision of quality and timely preventive health messages shared through newsletters, flyers, posters, and other opportunities to communicate with members when available. The Health Education team attends our monthly Provider Partnership meetings to share new materials that are available for distribution through provider offices. Materials for hypertension, diabetes, and immunizations are regularly

distributed to our members through initiatives with the program in an effort to educate members and thereby improve compliance on related measures.

- Member outreach
  - Monthly gap lists are available for each measure on the data site, Inovalon. Providers are encouraged to use these lists to perform their own member outreach. In addition, the Population Health team performs outreach calls and direct scheduling each month for 6 of the providers in the partnership. For June of 2024, there were a total of 11,463 outreach calls made among these six groups, with 662 booked appointments.

Improvement Actions

Provider coding support

- Equity and Practice Transformation Payment Program (EPT) –Seven of HPSJ's provider partners (Aspen Family Medical, Pediatric Care of Stockton, All for Kids-Dr. Dubey, Barton Health, El Dorado Community Health Centers, Newman Medical, and Livingston Community Health) were selected to participate in the EPT program, a state-wide, multi-year initiative to improve primary care practices. With this program, HPSJ wants to partner with network providers to obtain grant funding and implement practice improvements to better serve patients. HPSJ has partnered with Recast Health to help navigate the EPT program, run an efficient technology vendor selection process, and provide guidance to enable each practice to reach their EPT payment milestones. Support will include hands-on coaching to help providers complete program milestones and prepare deliverables. Support is coordinated with the Provider Partnership Program to align with ongoing quality improvement efforts.

Direct scheduling support

- Direct Scheduling efforts – HPSJ has continued direct scheduling efforts with some providers for their members and/or warm transfer efforts have been used for other FQHCs.

Data Issue

- The transition of HEDIS vendors made it difficult to send out timely gaps in care lists. There also continues to be delays in uploading monthly data refreshes, leading to lags in MCAS rate updates. We hope to strengthen our coordination with the HEDIS team and analytics for future projects.

Adequacy of Resources

- We did not have the full staff of nurses required to handle the load of Provider Partners along with competing QI responsibilities such as PIPs and FSR. For the future of the program, we would like to advocate for enough manpower/human resources to make sure we can be fully invested in the success of the program. We hired two nurses at the end of 2023 and early 2024 who have been training to take on their own provider offices. We are looking forward to the addition of two to three additional staff members by the closing of the year.

Planned Changes for Upcoming Year

1. Continue encouraging expansion of care gap clinics to other provider partnership offices.
2. Continue to encourage providers to correct their billing and coding to correctly capture all the work they do for HEDIS/MCAS.
3. Establish regular supplemental data submission with partner providers as appropriate.
4. Provide coding automation support as needed.
5. Continue gathering and sharing best practices among provider partners.

Children's Health Measures - Strengths, Weaknesses, Opportunities, Threats (SWOT) Summary

The SWOT for Children's Health Measures (CHM) ran from FY 2022-2023 and was completed in December 2023. It was developed to help promote the delivery of preventive health services among the pediatric members in the community. The measures under this domain were adversely impacted by the pandemic and continue to be great areas of focus by the MCP. The Children's Health measures include the following:

- Child and Adolescent Well-Care Visits (WCV)
- Childhood Immunization Status – Combination 10 (CIS-10)
- Developmental Screening in the first 3 Years of Life (DEV)
- Immunizations for Adolescents – Combination 2 (IMA 2)

- Lead screening in Children (LSC)
- Topical Fluoride for Children (TFL-CH)
- Well Child Visits in the First 30 Months of Life – 0 to 15 months, 5 or More Well Child Visits
- (W30 6+)
- Well Child Visits in the First 30 Months of Life – 16 to 30 months, 2 or More Well Child Visits
- (W30 2+)

As the CHM SWOT was developed based on the analysis of the MCP's strengths; weaknesses; opportunities; and threats, the study came up with four major strategies focusing on a multi-disciplinary approach for data, members, providers, and the community. Each strategy encompasses multiple interventions, all geared toward promoting improvement with the targeted measure's performance.

Strategy 1:

Expanding utilization of HPSJ's multi-level data report system for monthly multi-level Care Gap information/data for children's health measures targets, initiative planning and follow-up/evaluation.

The first strategy was geared toward expanding utilization of the MCP's Integrated Reports system for monthly multi-level care gap data for CHM targets, initiative planning, and follow-up or evaluation. This strategy covered the following interventions and sub action items:

1) Continuous education and/or training on the use of HPSJ's Integrated Reports system form monthly multi-level care gap information/opportunities to help with target identification, initiative planning and project evaluation/follow-up.
    - Working with providers in the Partnership Program for continuous use of the monthly proactive lists for member outreach, gap closure, and gap previews on children's health measures.
    - Identification of other providers outside the Provider Partnership Program who may have significant gaps in care on children's health measures and may be willing to utilize proactive lists/reports.
2) Introduction and improvement of proficiency on the upcoming data report system among provider partners.
    - Promotion and provision of training on the upcoming data report system. Training will be done through the following modalities: remote/onsite training with Provider Services Representative, basic

training with QI Nurse or QI coordinator/HEDIS Coordinators, provision/Posting of Report Guide for providers' reference.

3) Continuous driving of providers to close gaps in children's health measures through proactive lists utilization.
    - Continuous Facilitation of virtual QI meetings by HPSJ with target providers to assist with identification, implementation, and evaluation of possible strategies to close gaps in children's health measures.
4) Maximizing utilization of obtained administrative as well as supplemental data to identify population-specific opportunities for more targeted interventions and outcomes.
    - Close collaboration with both HEDIS and Clinical Analytics teams to perform data mining processes for identification of specific age groups within eligible population with the widest gaps in care, specific geographical areas with increased gaps in care, and specific ethnicities with disparities in care.

Strategy 2:

Increasing members' awareness and engagement in required children's health-related well-checks immunizations and other preventive services.

The second strategy was focused on increasing members' awareness and engagement in required children's health related well-checks, immunizations, and other preventative services. Interventions under this strategy include the following main and sub action items:

1) Coordination with Health Education and Marketing teams for any of the following:
    - Promotion and distribution of the MCP's milestone booklet to targeted members and providers (pediatricians /FPs/OBs).
    - Distribution of educational materials for providers and members on the following measures:
        - Fluoride varnish
        - Immunizations
        - Well visits
        - Lead screening
        - Developmental screening
    - Development of educational materials related to WCV and DEV measure. member health materials related to CHM, measure-specific call/text campaigns, health audio-library for members, Community Advisory Committee, social media promotion, and member engagement events.

2) Strengthened, widened, and coordinated member outreach strategies related to children's health measures.
    - General well visit and immunization outreach targeting members with gaps in care under children's health measures, through HPSJ's member outreach vendor, Same Sky.
    - Focused call campaigns by HPSJ's Population Health team, through member outreach with direct scheduling partnership with participating providers and QIP-related calls in collaboration with the QI nurses.
3) Coordination with Health Education team to hold and promote the Community Advisory Committee meetings focused on children's health.
4) Coordination with the Marketing team for children's health-related social media postings throughout the year.
5) Collaboration with CREM team for more opportunities for member outreach and education about children's health and preventive services in the community in 2022 and 2023. This was through these steps:
    - Regular touch base with the team to identify opportunities for CHM promotion through member engagement.
    - Development of tools, talking points, and material content for presentations
    - Planning for promotional items, activities, and opportunities
6) Member engagement opportunities included:
    - Speaking engagements
    - Backpack campaigns
    - Community events
    - School partnerships
    - CHM presentation in community partners' meetings,

Strategy 3:

Increasing provider engagement and participation in HPSJ's initiatives related to children's health through:

1) Provider education
2) Reinforcing provider compliance and best practices related to the delivery of preventive health services to the CHM eligible population
3) Supporting providers' initiatives/projects related to children's health
4) Obtaining and encouraging provider input/feedback on CHM areas of opportunities.
5) Providing opportunities for joint efforts to promote children's health.

The interventions under this strategy were all geared towards driving the providers in and out of the Provider Partnership Program to improve promotion

and delivery of pediatric preventive services. The strategy also aimed to improve provider engagement and participation in HPSJ's initiatives related to children's health through providing opportunities for joint efforts for pediatric health promotion and care. These interventions include:

1) Collaboration with internal businessowners, for provider education and updates related to pediatric health. This consisted of:
    - The QI team working with HEDIS, Provider Services, Health education and Member Development teams for Provider education and updates related to children's health measures which may include one or all of the following:
        - Measure guidance and updates related to children's health.
        - Best practices related to preventive services for children.
        - Related references and resources for support both from the MCP and the community.
    - Provider education may be done through the following modalities:
        - "Children's Health Measure on Spotlight" - A collaborative effort among multiple teams within the MCP focused on highlighting a specific children's health measure on a monthly. This material lays out the following:
            - Key specifications and updates to the children's health measure.
            - Best practices that have worked with other providers in the network.
            - Billing tip
            - Incentives tied up to the measure.
            - Related references and resources for support from the MCP and the community.
        - Provider Alerts
        - Provider Look & Learns
2) Implementation and emphasis on the 2023 Provider Incentive Program to the Provider Partnership Providers through any of the following modalities:
    - Provider education by HPSJ representatives during regular monthly virtual calls/visits.
    - Health plan wide notifications and follow-up through Provider Alert reminders and webinars.
    - Reinforcement of the 2023 Provider Incentive Program during PPP meetings.
3) Increasing and strengthening MCP's support on children's health-related projects/initiatives.
    - Provider support on children's health related projects/initiatives.

- Drive-up Immunization Clinics
- Care Gap Clinics/Care Gap Moonlighting
- Children's Wellness Campaign
- Mobile Van Events
- POC Lead Testing and other innovative strategies promoting the screening.
- Locum Projects
- Immunization Catch-Up days
- Extended office hours for immunization/Immunization Hubs
- Other innovative projects and initiatives to promote children's health and wellness.

- Regular planning meetings with the above providers regarding CHM-focused clinics.
- Collaboration with target providers regarding member-scripted outreach calls to eligible members as well as direct access to provider's EHR for scheduling members right away while they are on the phone.
- Collaboration with target providers regarding member-scripted text messages to eligible members.

4) Providing opportunities for joint efforts with partner providers to promote children's health.
   - Partnership with providers for EMR Feed to allow the capture of EMR data for compliance, if not captured administratively.
   - Collaboration with providers on development and distribution of educational materials related to children's health measures and preventive services.
   - Working with provider partners on workflows related to supplemental data and claims submission.
   - Widening the scope of the Provider Partnership Program by identifying other smaller providers in the network who may have significant pediatric populations and are willing to commit.
   - Pediatric charts coaching by QM, to assess providers' compliance with specifications and standards for children's health measures through HEDIS medical record review. Correlation of documentation to submitted claims to ensure that services are accurately documented and coded for.

Strategy 4:

Leveraging established and new partnership opportunities with providers and the community for the following:

- Reinforcement of compliant member behavior
- Facilitation of access to preventive care for targeted pediatric population
- Targeted health promotion projects/events in collaboration with both providers and community partners
- Promotion of preventive health services on identified populations with disparities in care.

Lastly, the fourth strategy is geared towards driving members to care through leveraging established and new partnership opportunities with providers and the community. This will be done through reinforcement of compliant member behavior, facilitation of access to preventive care for targeted pediatric population, targeted health promotion projects/events in collaboration with both providers and community partners, and promotion of preventive health services on identified populations with disparities in care. Interventions under this strategy included:

1) Targeted health promotion projects/events and facilitation of access to care in collaboration with both providers and community partners.
    - Leveraging partnerships with providers with mobile vans to deliver preventive services to the community.
    - Collaboration with partner providers and community partners for health fairs addressing pediatric health and wellness.
        - Identification of targeted population for the health fair, planning for members outreach and promotions.
        - Encouraging participation from partner providers within the county, establishing services that they can do during the event.
        - Identification of community partners for the health fair for sharing and promotion of resources in the community.
2) Collaboration with Marketing, member engagement and Population Health teams in reinforcing compliance with preventive health services in children by providing incentives through:
    - Backpack Campaign
    - MyRewards Program
3) Promotion of preventive health services on identified populations with disparities in care. This was done through:
    - Health education opportunities focused on Hispanic pediatric population via the following:
        - Radio Catholica
        - Latino Times

- Implementation of focused intervention/s on identified pediatric population with disparities in care.

Progress Towards Goal

Table 1: CHM rates from MY2021-MY2023

	MY2021		MY2022		MY2023	
Measure	**Stanislaus**	**San Joaquin**	**Stanislaus**	**San Joaquin**	**Stanislaus**	**San Joaquin**
CIS-10	29.20%	36.98%	20.92%	36.50%	20.68%	27.98%
IMA-2	33.33%	39.17%	30.20%	37.55%	30.66%	40.88%
LSC	37.38%	45.90%	41.12%	46.11%	43.55%	46.47%
WCV	37.71%	46.23%	41.89%	47.26%	46.04%	49.44%
W30-6+	37.98%	44.63%	35.32%	50.36%	46.21%	51.67%
W30-2+	54.30%	58.30%	56.49%	60.67%	62.67%	62.46%
DEV	NR	NR	16.25%	27.34%	18.6%	25.05%
TFL	NR	NR	0.61%	2.15%	18.73%	19.05%

Table 2: MY2023 Goal Comparison

Measure	**Stanislaus MY2023 Rate**	**San Joaquin MY2023 Rate**	**MY2023 MPL (GOAL)**
CIS-10	20.68%	27.98%	30.90%
IMA-2	30.66%	40.88%	34.31%
LSC	43.55%	46.47%	62.79%
WCV	46.04%	49.44%	48.07%
W30-6+	46.21%	51.67%	58.38%
W30-2+	62.67%	62.46%	66.76%
DEV	18.6%	25.05%	34.70%
TFL	18.73%	19.05%	1.30%

Strategy 1:

- Proactive lists have been distributed less frequently due to changes in data systems and capabilities of the new program. However, Proactive lists continue to be revised/customized based on providers' input or personal requests.
- 11 providers have attended 1 on 1 training sessions for the new data system, Inovalon. There were also 2 Look and Learns held for provider

training on the program. Providers were instructed on how to pull and generate their own gap lists from the system.

- The QI team continues to proactively identify opportunities for partnership and support on the provider initiatives/projects related to CHM promotion and gap closure. All areas are being explored, from outreach, to access as well as data submission. The team makes sure that all MCP initiatives are being shared and offered to each provider partner in the program. Interventions were visited/revisited, regardless of the focus – member, provider, data, community.
- The team also followed-up on proposals to which some providers were not interested in before but can still be feasible and beneficial now. All barriers are explored to ensure they just don't remain as barriers but alleviate challenges over time, until goals are met. The team also seeks best practices that can be shared with other providers.
- African – American members were identified in CHM gap lists with significant gaps in care. Pop health team ensures that these members are being outreached and followed-up multiple times.
- Disparity PDSAs were not reinstated but a similar intervention is being explored for the MCP's Performance Improvement Plan on W30 6+ on African American population.

Strategy 2:

- HPSJ continues to promote its Milestone Booklet, in line with its focus on developmental screening and other children's health-related services. Participating partners include the following:
  - San Joaquin County
    - CMC- PCPs, OBs and WIC Program
    - SJCC
    - SJ WIC
    - Eaton Pediatrics
    - Dr. Wivina Urbano
  - Stanislaus County
    - GVHC
    - HSA – CPSP
    - Dr. Dubey
    - Oak Valley Health District
    - Livingston Community Health
- Scheduled text campaigns for children's health measures are below:
    - October – LSC
    - November – Well visits, Flu, CIS-10

    - December – Well visits, Flu, CIS-10
- Text scripts are shared for consistent messaging. Assistance is rendered to have scripts in multiple languages. MCP is also exploring the provision of outreached members by the MCP to partner providers to prevent duplication of text messages to members.
- The Population Health team and each QM Nurse work closely with each partner provider in identifying priorities, coordinating calls with clinic staffing status and focus, as well as strategizing based on most current rates. Barriers are addressed immediately as much as possible. 8,203 calls were made by PHN in December.

December 2023 PHN outreach data:

Clinic	**Total Calls**	**Appts Booked**
CMC	1672	66
Dr. Dubey	670	62
GVHC	876	21
HSA	686	27
SJCC	4299	262

- HPSJ continues to utilize Facebook, Twitter and Instagram as platforms to socialize some children's health-related messages, including announcements/promotion of events in the community. Postings for the last three months of 2023 highlighted flu shots and lead screening.
- HPSJ 's Partnership with community-based organizations remains to offer great opportunities to promote children's health. For the second quarter, HPSJ met the goal with 26-member engagement opportunities in the community.

Strategy 3:

- The Provider Incentive Program has been reinforced. Incentives are still being offered through two programs- one for small or solo providers, and another program for FQHCs/RHCs. Provider Incentive fliers were sent out/distributed in the network. Provider alerts were sent out as reminders and information was made available on the health plan's website.
- HPSJ also continues to work closely with partner providers that have established or active gap closure initiatives. The QM team regularly touches

base and helps track the progress of each event, helps analyze the data, identify barriers and collaborate for support. Projects/initiatives were expanded within provider's capacity and resources.

- HPSJ maintains EMR feed partnership with 8 providers. For the past two quarters, HPSJ has been able to establish partnership with two more providers. The HEDIS team works continuously to expand the partnership with additional providers.
- A CHM questionnaire / survey was circulated to providers to obtain input on CHM matters including health education topics and other aspects of pediatric health promotion. The survey was closed by the end of June 2023. We were able to obtain input from 12 providers.
- Focused meetings were held focused on supplemental data submission and claims matters. Every provider partner in the program got outreached and supported in aligning their claims/ codes submission aligns with the measure requirements.
- No progress was made on pediatric chart coaching. However, we are looking forward to the data/report our new data system can offer us that can be utilized for the purpose of coaching and record review.

Strategy 4:

- HPSJ is currently contracted with 3 FQHCs who have mobile units in ST County, 2 in SJ. Due to lack of support on this action item during the beginning of this study, there wasn't much relationship and plans that were developed around partnership in mobile van events.
- HPSJ's backpack campaign can be considered more successful this year, as compared to 2022. For 2023, there was a total of 12 providers (44 clinics) within the program participating in the campaign. There was a total of 3,435 backpacks distributed, that led to almost 1500 WCV and/or IMA-2 care gaps being closed.
- The MyRewards program was also expanded for 2023. The program now includes a $25 gift card for the following measures:

  - W30
  - WCV
  - LSC
  - IMA2
  - CIS-10

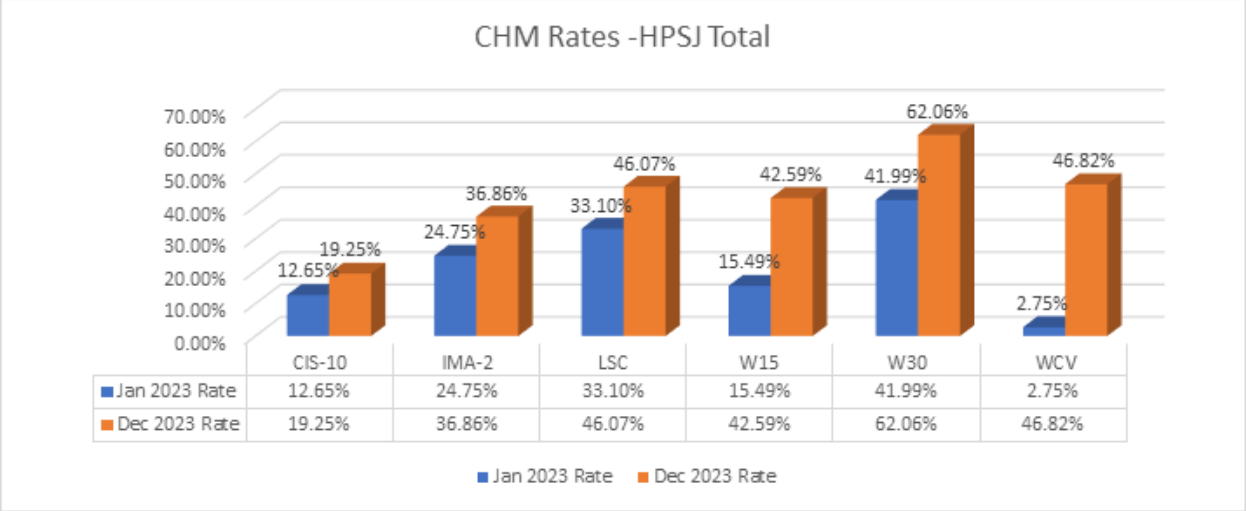
The Same Sky Gift Card Distribution Jan 1-Oct 29, 2023, shows a total of 734 gift cards distributed for CHM related measures, surpassing the goal.

Quantitative Data

The overall progress for 2023 towards CHM SWOT goals is shown below:

FINAL MY2023 HPSJ Total Rates:

Measure	Compliance	Goal (MPL)
CIS-10	23.36%	30.90%
IMA-2	36.83%	34.31%
WCV	48.15%	48.07%



CHM Measure	MPL (Performance Goal)	Jan 2023 Rate	Dec 2023 Rate	% Increase
CIS-10	30.90%	12.65%	19.25%	+6.6%
IMA-2	34.31%	24.75%	36.86%	+12.11%
LSC	62.79%	33.10%	46.07%	+12.97%
W15	58.38%	15.49%	42.59%	+27.1%
W30	66.76%	41.99%	62.06%	+20.07%
WCV	48.07%	2.75%	46.82%	+44.07%

Although only one measure had met the goal by Dec 2023, the table shows that all measures showed significant increases in the compliance rate from January to December.

Qualitative Analysis

- Some interventions were delayed or not provided due to competing priorities
- Delays in materials development
- Staffing turnover and transitions
- Data vendor transition issues
- Lack of provider engagement

Evaluation of Effectiveness of Interventions

While it can be observed in table 1 above that we had a performance increase in the majority of our CHM measures from 2021 to 2023, it remains that we only met the goal for two measures, WCV and IMA, for 2023. There were several challenges met during the implementation of this CHM SWOT which had a negative impact on our ability to meet our performance goals. Due to its scope, the study was labor intensive and demanded much time and resources for business owners. As other competing priorities arose, some of the interventions under each strategy were not pushed through and caused delay in the development of materials. The implementation of the study was also affected by staff turnover and transitions that took place within the QI team as well as with the collaborating teams within the health plan. The complexity of transitioning to a new data vendor also led to significant delays in obtaining updated data, and less gap in care reports were issued/pulled. Lastly, providers' openness to partnership and implementation of new strategies continues to be a barrier, and the struggles of prompt data submission from providers have halted accurate overall CHM compliance picture for the MCP. Lack of benchmarks set for TFL and DEV, as well as the mismatch on the specifications for some measures are factors that also affected the efforts focused on these areas within the SWOT.

Improvement Actions/Opportunities

The strengthened and widened collaboration among internal teams/departments played a very significant role in the success of this study. Each businessowner rose to the occasion and helped with development, implementation, tracking and evaluation of most interventions. Much effort and resources were put in, even on those action items that were challenged. Partner providers have been more open to partnership opportunities with the MCP and even to collaboration with community partners. There has been great support from CBOs to help bring members back to care. In the outset, the implementation of the CHM SWOT has led for the following lessons to be learned

– promptness of intervention and data treatment, interdepartmental collaboration, accountability for tasks and working towards common goal. These factors will be considered in future studies and efforts related to promotion and delivery of children's preventive health services in the community.

Improving Well-Child Visits in the First 30 Months of Life – Six or More Well-Child Visits in the First 15 Months of Life (W30 6+) for HPSJ's Black/African American population during MY2023-2026

The Well-Child Visits in the first 30 Months of Life – Six or More Well-Child Visits in the first 15 Months of Life (W30-6+) Performance Improvement Plan (PIP) is geared toward improving the MY2023-2026 W30 rates for the Health Plan of San Joaquin (HPSJ) Black/African American population. This population is defined as any HPSJ Black African American child member who turns 15 months old during the measurement year.

A barrier analysis was done to determine the most influential factors contributing to poor W30 outcomes and identifying the four main barriers for member completion of this measure. We identified: a) member education b) member motivation c) provider infrastructure issues and d) cultural influences as the top barriers.

By identifying key drivers and implementing targeted interventions, the PIP will help the plan improve compliance to preventive health care services that will help reduce the incidence of preventable medical conditions among African American/Black children, 0-15 months of age.

Interventions

To promote consistency across the development, implementation, and evaluation for overall impact on the objective, a common intervention was planned to promote gap closure among the targeted ethnicity for the W30 measure. A "wrap-around" intervention was created, consisting of a) member outreach, with and without direct scheduling b) member education about the measures c) follow-up calls for missed and cancelled appointments and d) education on assistance on member incentives.

A tracking tool was developed for consistency of intervention and for uniformity of monthly data collection and monitoring. The QI team is coordinating with the Population Health team for directly scheduling calls and will also collaborate with providers who want to do their own outreach and assist with tracking. Call

lists are provided by the PIP team monthly, based on updated gap lists and disparity data stratified.

1. The first intervention is Provider focused by mediating with direct scheduling. We are collaborating with the Population Health Team to conduct member outreach calls. A list of 59 African American members, who are due for the measure, was compiled. A tracking tool was provided to the team of patient health navigators, who conducted the calls and tracked outcomes: whether they could reach the member or schedule an appointment or able to conduct warm transfers.

   We are working with providers and the population health team to follow up on members regarding outreach to assess if the member completed the appointment. The team outreaches a second time for the members for whom messages were left. Feedback regarding the cause of missed appointments, for example transportation issues or available appointment hours, is collected to identify barriers to care and help with management of those barriers. There will be a second call campaign later to include new members who have entered the denominator.

2. The second intervention focuses on member education, specifically for mothers in the 3rd trimester of their pregnancy. The milestone booklet is distributed to mothers at their prenatal appointments as a way of being proactive with education and the importance of the well child visits and help them plan for what to expect at future pediatric visits.

   The milestone booklet is written at a 6th grade level and is a passport to childhood health and preventive screenings. It covers 0-6 years of age for immunizations, developmental milestones, preventive screenings, question(s) to ask at appointments, and notes and space for parents to track progress. For this project, the booklet is tailored to the Black/African American population by including images that are more culturally relevant. A list of 3rd trimester Africa American moms will be generated based on 3rd trimester claims data. A tracker will be created based on the list to make sure members received the Milestone booklet. We plan to partner with a local OBGYN who cares for many members and will distribute the booklets during routine appointments. We have chosen two providers that have 30 or more Black/African American mothers that are in their 3rd trimester. Currently the team is awaiting the Provider's agreement to participate in this intervention. In 3-6 months, the team will track the member's children to assess who went to at least one

appointment with their pediatrician to determine success in this intervention.

3. The third intervention is member focused by providing member incentives in the form of a $25 gift card for each W30 appointment, up to a maximum of $150. For this intervention, we also plan to try to influence mothers in their 3rd trimester before their baby has arrived. We will be partnering with providers to have them distribute MyRewards W30 incentive information to 3rd trimester moms during their prenatal visit. The data we will be tracked for which members received MyRewards flyers or buckslips and which of these mothers actually requested the gift cards for W30. Data from the Health Plan's vendor, SameSky, will be collected to determine the number of total gift cards distributed for the measurement period for W30. This is an ongoing project with The Health Plan. The implementation of this intervention is pending finalization of the intervention process with the chosen providers.

Methodology

Initial baseline data was collected from the final MY2022 HEDIS rates. A remeasurement occurred at the end of MY2023. Data will be re-measured in December 2024, and the final rate comparison will occur December 31, 2025.

Multilevel gaps in care reports will be generated for this data: Health plan level (i.e. county division), Clinic/group level (i.e. FQHC), individual provider or clinic location level reporting, and member level reporting. These reports, which highlight the HEDIS measures, allow HPSJ and our providers to identify where there may be gaps in care. Providers and HPSJ can see which members will not be compliant vs those who are compliant for each measure. To monitor for W30-6 +, the PIP and HEDIS team will be able to query a member level report from our HEDIS vendor for that specific measure. This information can then be filtered by Primary Care Provider, Age, and Compliance. HPSJ level rates will be queried quarterly to monitor and to trend for the annual rate; this is separate from the monthly reports.

Results

Baseline: Final MY2022 W30 0-15 months

African American	Denominator	Numerator	Not Met	Compliance Rate	Performance Goal
HPSJ total	188	61	127	32.45%	55.72%
San Joaquin	159	58	101	36.48%	
Stanislaus	29	3	26	10.34%	

Secondary Baseline: Final MY2023 W30 0-15 months

African American	Denominator	Numerator	Not Met	Compliance Rate	Performance Goal
HPSJ total	279	111	168	39.78%	58.38%
San Joaquin	246	97	149	39.43%	
Stanislaus	33	14	19	42.42%	

2024 Rates: Black/African American Population W30-6+: Performance Goal = 58.38%

	San Joaquin			Stanislaus			HPSJ Total		
	Num	Denom	Rate	Num	Denom	Rate	Num	Denom	Rate
January	30	177	16.95%	6	30	20.0%	36	207	17.39%
February	36	178	20.22%	6	28	21.43%	42	206	20.39%
March	68	275	24.73%	18	60	30.0%	86	335	25.67%
April	50	178	28.09%	9	28	32.14%	59	206	28.64%
May	54	179	30.17%	9	27	33.33%	63	206	30.58%
June	58	177	32.77%	11	27	40.74%	69	204	33.82%

Quantitative Analysis:

- In 2022 and 2023, the compliance rates for the W30-6+ measure were 32.45% and 39. 78%. This shows an improvement of 7.33%.
- As of June 2024, the HPSJ total rate for the measure was 33.82%, needing an additional 24.56% increase before the end of 2024 in order to reach the goal of 58.38%.

Qualitative Analysis:

Several barriers have been encountered from the commencement of this project in 2023. Thus far, member call barriers have included:

- Members not answering phone calls
- Lack of working numbers on file and/or not having alternate contact numbers that can be used
- Members termed and/or switching to other MCPs
- In addition, there were technical challenges related to delayed gap reports from the data analytics department, which delayed follow-up calls and sharing updated member lists for the targeted providers
- Provider unwillingness to participate in the interventions and promptness in the implementation and data submission were also significant barriers.

Measurement of Intervention Effectiveness

The first phase of our call campaign intervention has been completed, while our member incentive intervention is ongoing. Our remaining two interventions have yet to start due to competing priorities and lack of staff. Our department is in the process of onboarding two additional nurses, which we hope will alleviate staffing constraints for the project. It has also been difficult to coordinate with different departments due to competing priorities with their staff as well.

It is not yet far enough into the project to determine if our interventions are effective in helping HPSJ achieve its performance goals. Thus far, we have contributed to scheduling 19 member appointments toward completion of the measure. We plan to do a two-week follow-up with those members who we were not able to reach previously, as well as an additional outreach campaign.

August Outreach Call Data:

Total Calls	59
Appointments Scheduled	19
Left Message	27
Unable to reach	6
Member termed	4
Changing Provider	2
States will Self Schedule	1

Next Steps

Next steps will include a secondary call campaign in the next 3 months to include new members that qualify for the measure. We will also revisit members on the call list that we were not able to reach the first time. We will work with the Population Health team and our provider partners to ensure follow-up is done with all members whose appointments were scheduled to determine if they made it to their scheduled visits. We will also attempt to gain feedback from any members who did not show up to their W30 visits.

The team will continue to connect with providers who we want to work with for the distribution of the milestone booklets. We will reassess and reach out to other providers if we cannot make the current plans come to fruition.

For the MyRewards intervention, we will continue to provide flyers and resources to our Providers so they can share them with our chosen members. We will track which members received the MyRewards information and compare these to the monthly reports provided by the gift card vendor to see which mothers requested gift cards.

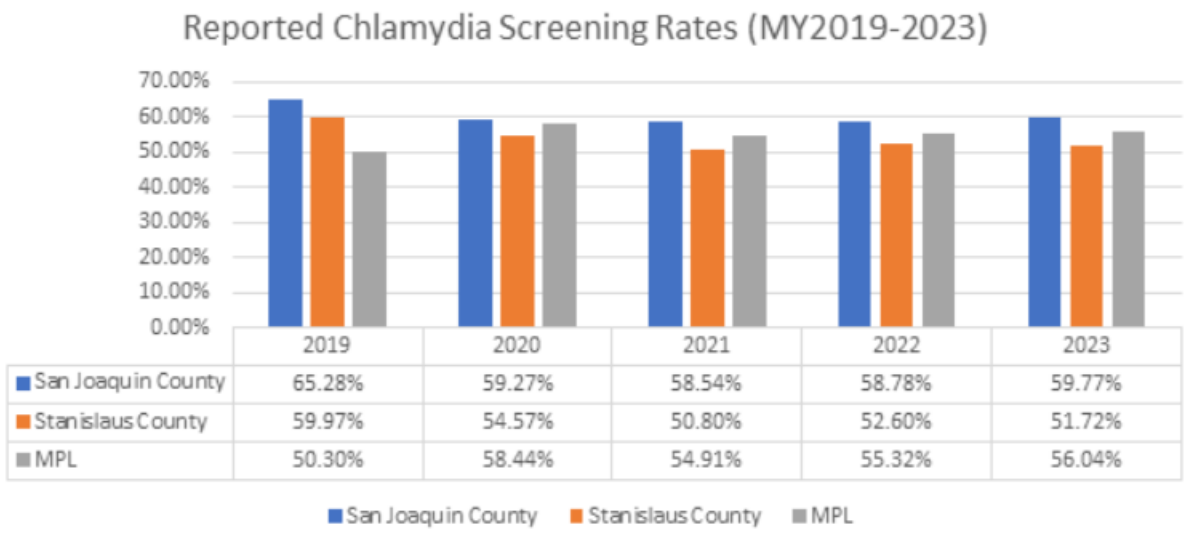
The PIP team continues to request monthly data reports from our analytic team with detailed member demographic information so that we can analyze the data and assess for improvement in compliance for the measures that target the Black/African American population.

Chlamydia Screening PDSA

Chlamydia is a common sexually transmitted infection (ST)I that can cause symptoms among men and women and can also cause permanent damage to a woman's reproductive system, which may adversely impact reproductive health in later years. Chlamydia can also cause a potentially fatal ectopic pregnancy (pregnancy that occurs outside the womb). Chlamydia is most commonly diagnosed among young individuals; two-thirds of new chlamydia infections occur among youth aged 15-24 years. Estimates show that 1 in 20 sexually active young women aged 14-24 years has chlamydia. Chlamydia is also the most frequently reported bacterial sexually transmitted infection in the United States. Most people with the infection have no symptoms and do not seek testing.

The global aim of this PDSA was to improve the Chlamydia screening compliance rate of HPSJ in Stanislaus County. The priority barrier that this PDSA addressed is the lack of proactive testing for Chlamydia during a well child visit check-up. The main reasons being:

a) There is no established workflow that includes a specific step to collect urine samples for chlamydia testing.
b) Chlamydia screening is not usually done in the clinic because providers are not comfortable in discussing and performing the screening due to the sensitive nature of the issue around testing and sexual activity among our 16–20-year-old population.
c) Some members are not completely honest with their sexual activity; thus, several cases remain undetected due to no screening being completed and they eventually get pulled in the denominator.

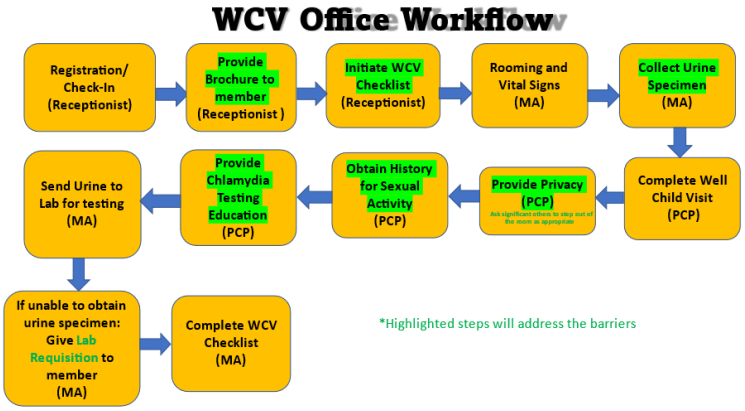


	2019	2020	2021	2022	2023
San Joaquin County	65.28%	59.27%	58.54%	58.78%	59.77%
Stanislaus County	59.97%	54.57%	50.80%	52.60%	51.72%
MPL	50.30%	58.44%	54.91%	55.32%	56.04%

Table 1 shows that there has been a five-year trend in not meeting the minimum performance goal in CHL Screening in women in Stanislaus County. Conversely, San Joaquin County has met or exceeded the performance goal for the last five years. Based on the historical data shown, Stanislaus County was specifically targeted in the testing of the intervention.

Methodology

The intervention tested was to promote the use of a structured "rooming-in" process that addresses the provider barriers that affect compliance of chlamydia screening. The goal of the project was to increase compliance among 16 to 20-year-old female members by utilizing the WCV Office workflow as shown below. The intervention also aimed to capture all eligible women in the roster to get tested regardless of members stated sexual status.



As Chlamydia screening can be a very sensitive issue among the targeted age group (16-20 years old), a provider focused intervention is perceived to be a

more appropriate approach than a member-centered approach. The study provided a structured office workflow to address the following:

a) Establishing a workflow that will include a specific step to collect a urine sample for chlamydia testing during the rooming in process
b) Provision of chlamydia education by the provider
c) Adding a layer of reminder that providers will need to address confidentiality needs of the pediatric patient as appropriate.
d) Need to capture undetected chlamydia infections by universally testing regardless of sexual activity during an annual well care visit.

If utilized on a daily basis, the workflow checklist ensures that providers will remember to assess and document sexual activity, consider member privacy, provide chlamydia education, and most especially test for chlamydia. This will lead to more screenings that will be completed during the well visit, thus increasing member compliance for this measure. The study investigated the provider's compliance in the use of the checklist and how it relates to improved delivery of chlamydia testing among our 16- to 20-year-old members.

Based on the August 2022 data pull for CHL in Stanislaus County, HPSJ identified 95351, 95350, and 95380 as the three zip codes with the greatest number of gaps and identified potential provider groups where the expansion of intervention testing can be applied. The three providers chosen to participate in the study were:

a. Oak Valley Hospital district
b. Stanislaus HSA through their Family and Pediatrics clinic
c. Anuradha Dudey MD Inc.

Process Used to Implement the Intervention

a. The HPSJ team met with the provider staff to discuss the specifics of the PDSA. A slide deck explaining the process was presented to the team for approval and acceptance.
b. A member of the provider's office was identified as the lead or main contact for this study, to help direct the implementation of the project at the provider level. The HPSJ team was led by QI Nurse Anju Aggarwal, who was the main driver of the PDSA.
c. A member list of 16–20-year-old members due for CHL was be provided to the staff for outreach.
d. The list of members was provided to the staff in a tracking tool to facilitate documentation of outreach.

e. Staff reached out to the list of members and documented results of outreach. Staff were given 3 attempts to call the member.
f. Weekly meetings were then scheduled for touch base to discuss progress of the implementation, any barriers encountered, and any insights to improve the implementation of the project.
g. HPSJ was available onsite on the first day of the implementation to monitor and address issues.

Evaluation of Interventions

HPSJ cannot completely determine if the intervention led to improvement because it is difficult to determine whether meeting our goal of completing chlamydia screening of at least 50% of the total number of members seen led to the improvement of the providers overall compliance rate in November. For the 3rd PDSA Cycle, the PDSA intervention's performance was based entirely on the number of checklists that were completed and collected. This was partly a result of the DHCS suggestion to resolve issues relating to claims lag, timely claims submission, etc. that can hinder timely review and submission of the final PDSA results. However, given the chance to successfully expand to the other targeted providers in the area, the use of the structured workflow (checklist) is likely to lead to an improvement. Providers will yield better results if they continue to utilize the checklists as a means of improving compliance with chlamydia screening.

Results

HSA Family and Peds

- On November 1, 2023, a gap list of members was provided. Unfortunately, this provider group did not provide us with an update regarding their progress and a meeting is yet to take place to discuss progress. Results were not included in this PDSA.

Dr. Anuradha Dubey

- On September 7, 2023, the provider's CHL gap list was sent for outreach. Unfortunately, per provider, they attempted to reach out to their list for two weeks but did not have luck in scheduling anybody. When asked, the Provider revealed the issue with scheduling was due to members declining.

Oak Valley

- The SMART Objective for the first cycle of the PDS was for Oak Valley Hospital District in Oakdale to be able to complete Chlamydia urine

testing of at least 50% of the total 16–20-year-old members who will be seen for a WCV routine annual visit, and/or Chlamydia screening visit, utilizing a structured WCV Office Workflow procedure by the end of October 31, 2023.

- On August 23, 2023, the member list was finalized based on OVHD's WCV gap list. The list was filtered down to only include those females 16–20-year-old assigned members only. The list was then transcribed into a tracking tool to help monitor outreach. The tracking tool was provided to OVHD on the same day.
- OVHD started calling members on 8/24/2023. A total of 466 members were on their list:
    a. Combined WCV and CHL list – 80 members
    b. CHL Only – 9 members
    c. WCV Only – 377 members

There was a total of 208 or 45% of members in the list that were outreached out of a total of 466. There were 38 members or 18.27% who were given an appointment. Only 23 patients or 60.52% of the total number of members were seen, and 15 members or 39.48% of members did not show up at their appointment dates.

Variables	Number	Rate
Members Outreached	208	45%
Members successfully scheduled appt	38	18.27%
Members seen	23	60.52%
No Show	15	39.48%

The above table shows the distribution of members who were outreached. There was a total of 208 or 45% of members in the list that were outreached out of a total of 466. There were 38 members or 18.27% who were given an appointment. Only 23 patients or 60.52% of the total number of members were seen, and 15 member or 39.48% of members did not show up at their appointment dates.

Evaluation of Intervention Effectiveness

There was a total of 23 members who were seen for their CHL and/or WCV visits from September 5, 2023, to October 20, 2023. Out of the 23 members, only 1 patient did not have a completed checklist due to the patient's statement that she is not sexually active, and thus provider did not proceed in completing the checklist. Otherwise, all data elements were noted to be over 90% compliant. Because the PDSA measures the effectiveness of the use of the structured

workflow process in Chlamydia screening with the goal of achieving at least 50% of the total number of members seen in the clinic will be screened, we can confidently say that the intervention was a success. It is likely that if the provider/s continue to use the structured workflow, that it can enormously increase compliance rate for this quality measure.

CHECKLIST DATA ELEMENTS	Total	Rate
Initiated WCV checklist	23	100%
Provided labeled Urine Cup to the member	23	100%
Provided Privacy to the member	22	96%
Obtain member's History for Sexual Activity	22	96%
Provided Chlamydia Testing Education	22	96%
Send Urine Specimen to Laboratory for Testing	22	96%
Provide Lab Requisition to the member and instruct to go to laboratory clinic for testing	0	0%

Identification of Opportunities for Improvement

Evaluation of Barriers

- Provider refused to comply with the individual Checklist. However, the provider agreed to make the checklists available and to be posted at their workstations.
- Provider had staffing issues that limited the use of the checklist and outreach. The provider staff did try to accommodate by dividing the list among QI staff members. HPSJ also offered outreach and direct scheduling by our Pop Health Team but was declined.
- Scheduling at the provider's office is based on anniversary dates. So, some members in the list could not be scheduled according to our project timeline. Provider was advised that these appointments can be scheduled prior to their anniversary dates.
- The provider also had issues with billing of what ICD 10 or CPT code they will use for urine screening if under WCV. Updated information on billing and coding.
- Other priority projects hindered continuous weekly tag ups and outreach calls. HPSJ accommodated by asking for continuous submission of the tracking tools.
- Provider expressed that it was helpful when they were able to flag members in their EHR whom they were not able to reach during their outreach. The provider liked the Pop-up alert in the chart as it is their safety net if not connected by phone call when arranging appointment

for WCV. Once member is in the clinic for WCV they will have an alert that member is due for Chlamydia screening.

- Parents are declining appointments within the timeframe.
- Parents are not calling back. Many phone calls are going to voice mail
- Phone numbers are disconnected.
- Staff verbalized it is difficult to schedule members if it is only for Chlamydia screening due to the sensitive nature of the call. They encountered some challenges with this age group since their staff has to ask parents- that is the barrier since it is a sensitive issue
- Lack of existing chlamydia screening member facing education materials
- Not enough time to do claims review due to time constraints and possible claims lag. HPSJ resorted to collated information from the tracking tool.
- There were a considerable number of members from the list that did not show up at the scheduled appt due to parents work schedule or school/ sports.
- Early identification of provider scheduling issues
- Clarity in communications about project expectations
- Inconsistent provider follow up
- Member education materials

Improvement Actions

Areas for improvement were noted to address the identified barriers of implementation. One finding was that providers were unaware of which codes to use when sending urine collection samples to the labs. The QI team was able to provide claims information and educate the provider on necessary coding. We also found that it was to develop processes to identify provider scheduling issues as early as possible and offer additional assistance, such as a process to support consistent provider follow-up. To negate member no-show concerns, the team educated provider staff to follow up and document follow-up attempts. We also strengthened education about leveraging the promotional items and member incentives during outreach. The QI team also suggested having more assigned days, weekend scheduling, or extended hours to assist with access issues. HPSJ offered Population Health Navigators to do outreach of the list and warm transfer members for scheduling.

In addition to improvements on the provider level, we feel that we can enhance initiatives focused on the member and would like to develop more member educational materials related to Chlamydia testing. HPSJ is currently working on making a new Chlamydia piece (i.e. Booklet/Pamphlet). The team also sees a need to improve our system for capturing and updating member information, such as phone number and address, rather than solely relying on the state

reported contact details to address issues related to incorrect or outdated member contact information.

Opportunities

We feel that there are opportunities to improve the implementation of these interventions if additional resources are available. It was noted during the project that HPSJ did not have enough member education materials for Chlamydia screening. HPSJ's education department was in the process of developing materials and having it approved by DHCS. It is planned to distribute additional materials as they become available. Additionally, the team lost one of our QI nurses working on the project. This loss, accompanied with other competing priorities, left the group overwhelmed and limited in their efforts. For future PDSA's we would like to advocate for enough manpower/human resources to make sure these projects are completed, and more time is invested to the successful implementation of the PDSA. Lastly, data issues limited the project, and the transition of HEDIS vendors made it difficult to establish baseline rates and gaps in care lists. We hope to strengthen our coordination with the HEDIS team and analytics for future projects.

HPSJ is adopting the implementation of the new intervention and hopes to continue to expand implementation in the other network providers since the testing of the intervention was successful in meeting the goal. HPSJ will continue with the implementation of the same identified intervention and will ensure that there is proper socialization of the intervention so that the providers and clinical staff will have a better understanding and adherence to the steps of the structured workflow being implemented.

HPSJ Initial Health Assessment (IHA) Compliance, Monitoring, and Improvement

CY 2023

September 2024

Introduction

HPSJ recognizes the importance of the Initial Health Assessment (IHA) for the membership. Members may select a PCP upon enrollment. If a PCP is not selected, one is assigned. All new members receive member materials with information about their PCP assignment, Health Plan benefits and coverage and information about how to access care upon enrollment. Members are encouraged to set up an Initial Health Appointment (IHA) with their assigned

PCP as soon as possible. Annually, HPSJ audits the rate of IHA completion and the required components of an IHA.

Methodology

Annually, HPSJ selects and reviews a random sample of 411 medical records for evidence of completion of the IHA. The randomized sample is selected from a universe of members who are identified as having completed an IHA identified through claims data by CPT and HCPCS codes (see attachment for list of codes). Medical record review is performed to provide confirmation that the IHA's are congruent with claim and encounter data.

The IHA rate for calendar year 2023 was calculated for new enrollees between January 1st– December 31, 2023. Visits that showed claims with acceptable IHA codes (see attachment) within the first 120 days of enrollment are selected. A random sample of 411 is reviewed. Medical records against the following components:

1. Was an IHA completed? (Y/N)
2. Were all components listed in the definition complete? (Y/N)
3. Was a condition or diagnosis identified for follow up? (Y/N)
4. Was a follow-up ordered for those that were complete? Testing or referral (Y/N)

Results:

The following table shows the rates of Initial Health Assessment/Appointment completion for new enrollees within 120 days of enrollment for the past 3 calendar years identified through claims and encounter data. The goal is that all new members complete their initial appointment with their assigned primary care practitioner. The goal is that all new members receive an IHA within 120 days or sooner if they are pediatric members to align with the American Academy of Pediatrics Bright Futures Guideline.

CY2021	CY2022	CY2023
54%	69%	39%

	CY2021	CY2022	CY2023
MRR Confirms IHA Concordance with coding. N= confirmed IHA, D=members with ICD 10 codes indicating IHA.	89.78%	93.70%	79.56%
Condition or Dx identified in the medical record IHA	34.31%	48.40%	65.94%

Referral to specialist or testing in medical record. D= the number of members identified as needing a referral, N=members who received a referral.	29.08%	19.60%	21.40%

Quantitative Analysis:

- Results reflect a decrease of 30 percentage points in the rate of IHA completion from CY2022 to CY2023.
- Of the 411 members sampled, HPSJ confirmed 327 members (79.5%) showed concordance with coding a completed IHA for CY2023. Of the members sampled, 271 (65.94%) had documentation of conditions/diagnoses found. This result is 14.14 percentage points lower than the CY2022 rate. Of the 271 members identified with conditions/diagnoses, 58 (21.40%) members received a referral to a specialist or additional testing was ordered. Of those confirmed through medical record review there was an increase of 17.54 percentage points in documentation of condition was noted from 48.40% in CY2022 to 65.94% in CY2023. Additionally, documentation of referrals saw a small increase of 1.8 percentage points from CY2022 to CY2023.

Qualitative Analysis

- The rate of IHA's completed timely during CY2023 identified through claims and encounter data saw a steep decline from the prior year's completion rate. This decrease in completion rate is attributed to the removal of IHA completion from the incentivized measure list for providers and FQHC/RHCs.
- Medical Record Review for CY2023 did not have as high a rate of confirmed IHA completion as in prior years. This decrease is attributed to incomplete medical records sent to the health plan from provider offices for review. It is not clear from this focus study that all diagnoses were captured because medical records were incomplete.
- Not all individuals who completed an IHA will have a diagnosis identified needing follow-up care, so there is no benchmark available for this measurement. Additionally, not all individuals will receive a referral for a specialist or treatment, some will have authorization requests that go directly to the health plan.

Measurement of intervention effectiveness

Several interventions have been implemented by HPSJ throughout the last 3 years targeting IHA completion.

- Targeted education and materials for providers:
  - Providers education at the time of facility site review.
  - New provider orientation includes IHA instructions.
  - Annual Provider Alert to providers including any changes or updates to the IHA completion requirements.
  - Member lists of patients due for IHA made available for providers each month.
- Targeted education and materials for members:
  - New member packets include IHA education for members.
  - Member incentives for annual wellness and preventative care visits for children and adults.

These interventions were not successful for CY2023 as indicated in by our IHA completion rate. The most notable intervention change for CY2023 was the removal of IHA from the provider and FQHC/RHC incentivized measure list.

Planned Interventions:

The health plan has identified the following interventions for implementation during CY2024 to address the identified barrier to IHA completion.

1. **Provider Education** – Evaluate the frequency of education by Provider Partnership Program and Provider Services visits.
2. **Provider Portal Share File** – Ensure monthly reports to providers of members assigned and identified as needing IHA are refreshed monthly.
3. **Provider Materials and Reviews** – Continue to include IHA in the new Provider orientation and Facility Site Reviews trainings

Adequacy of Resources

The resources are adequate to complete the study. However, additional clinical support is recommended to review the outcome of the conditions identified through the study.

Planned Changes for Next Year

Review and revise the methodology for the IHA focus study to ensure clarity with numerator and denominator populations. Ensure appropriate follow up on opportunities identified through the study. Involve Clinical Operations in the review of fallout cases.

Lead Screening Annual Report

Measurement Year (MY) 2023

September 2024

Introduction

The Health Plan of San Joaquin recognizes the importance of Lead Screening and Anticipatory Guidance as well as notifying providers of assigned enrollees who have not received lead screening up to age 6 years. HPSJ annually monitors compliance with lead screening, anticipatory guidance and caregiver refusal and quarterly monitors members who have not received lead screening up to age 6. The gap members are sent to assigned primary care practitioners quarterly, this is a summary of results from MY 2023 annual review, in accordance with annual Healthcare Effectiveness Data and Information Set (HEDIS) and the Department of Health Care Services All Plan Letter 20-016: Blood Lead Screening of Young Children.

Method 1

Annual HEDIS quality monitoring using administrative data collected on the total population of HPSJ 2-years of age meeting HEDIS specifications for inclusion in the Lead Screening HEDIS Measure.

Results

	Eligible members	Compliant for Lead Screening	Rate	Goal
MY2021	7776	3322	42.72%	N/A
MY2022	7126	3104	43.56%	63.99%
MY2023	7196	3322	46.16%	62.79%

Quantitative Analysis:

- A review of the Lead Screening completion for MY2023 showed there were 7,196 eligible 2-year-old members and of those 3,322 were complaint for receiving lead screening showing a rate of compliance of 46.16% for MY2023.
- Overall compliance has shown a small but steady increase year over year with a notable increase in compliance of 2.6% percentage points from MY2022 to MY2023. Although rates are increasing year over year, rates have not met the Minimum Performance Level which is the National Committee for Quality Assurance Medicaid Managed Care 50th Percentile.

Method 2

A randomized sample of 411 members ages up to 6 years of age was selected for medical record review. Medical records from dates of service January 1 – December 31, 2023, are reviewed for sampled members for documentation of:

- Completed lead screening during the calendar year
- Documentation of Anticipatory Guidance completed for the dangers of lead poisoning
- Documentation of Guardian refusal to complete screening

Results:

	Eligible members	Compliant for Lead Screening	Rate of Lead Screening Completed	Anticipatory Guidance Documented	Rate of Anticipatory Guidance Completion	Guardian refusal documented	Rate of Guardian Refusal
MY2021	411	183	44.53%	6	2.63%	0	0.00%
MY2022	411	167	40.63%	34	13.93%	1	0.24%
MY2023	411	170	41.36%	148	36.01%	0	0.00%

Quantitative Analysis:

- The review sample of 411 selected records shows there were 170 compliant members for a compliance rate of 41.36%, reflecting a .73 percentage point improvement from 2022. There are no performance goals established for blood lead screening for children up to age 6.
- DHCS requires network providers to provide anticipatory guidance about the dangers of blood lead screening at every preventive health visit up to age 6. This guidance at a minimum must include at a minimum that children can be harmed by lead, especially by exposure to decaying lead-based paints. Of the 411 samples reviewed there were 241 non-compliant with 0 refusals documented.
- The reviewed sample also revealed 148 of 411 had documentation of Anticipatory Guidance provided in their records for a rate of 36.01%. This result reflects an increase of 22.08 percentage points from the prior year 22% 2022.
- Of the 411 samples reviewed there were 241 non-compliant with 0 caregiver refusals identified in the medical record documentation.

Method 3

A claims and encounter data report of children ages 6 months to 6 years who had a lead screening with a rate of 3.5 mcg/dl or greater from January 1, 2023 –

December 31, 2023, was reviewed for appropriate follow up care as indicated by the Centers for Disease Control (CDC).

Results:

	Members Identified with High Lead Results	Received follow-up	Rate of Lead Screening Completed Follow-Up
MY2022	125	116	92.80%
MY2023	182	145	79.67%

Quantitative Analysis:

- Of the 3322 children up to age 6 years who received blood lead screening, a total The health plan identified of 182 children with lead screenings had results 3.5 mcg/dl or higher during MY2023, compared to 125 in 2022. An increase of 57 children identified compared to MY2022.
- Of these 145 (79.67%) received appropriate follow-up care. This result reflects a decrease of 13.13 percentage points from 2022. is a decrease from the prior year of 13.13%

Qualitative Analysis:

It is reasonable to expect that the number of children with lead levels that require follow up is increasing along with the rate of blood lead testing. The decrease in appropriate follow-up can be attributed to the lead level requiring follow-up has decreased from 5.0 mcg/dL to 3.4 mcg/dL.

The health plan has identified the following key barriers to improvement for the 2023 measurement year:

1. Patient/Caregiver follow through with physician lab orders.
2. Patient/caregiver fear of the outcome if positive result is identified.
3. Provider follow-up with patients who have not completed labs.
4. Physician documentation –Anticipatory Guidance non-documentation.

The health plan saw an increase in compliance with lead screening testing and documentation of anticipatory guidance from MY2022 to MY2023. The rate of follow-up care decreased, however there was an increase of 57 additional children identified as having high results. This is attributed to the increase in provider compliance with lead screenings.

Measurement of Intervention Effectiveness

While some results declined, some of our lead screening measure results improved and can be These increases are attributed to the many efforts and interventions implemented by the health plan during MY2023. Interventions implemented during MY2023 included:

- **Provider** –
    - Corrective Action Plans (CAP's) were sent to all providers identified through the MY2022 lead screening review as being non-compliant with lead screening completion and anticipatory guidelines.
    - Education was sent to all providers who received a CAP.
    - Lead Screening guidelines and requirements were reviewed during Provider Partnership meetings with all providers who see pediatric patients.
    - Provider Alert was sent to all PCP's and pediatricians outlining lead screening and anticipatory guidance guidelines and requirements.
    - Quarterly Lead gap reports were shared with providers through the health plan provider portal.
    - Providers incentives were offered for lead screening completion.
    - Provider site review—Inclusion in Facility Site Reviews and the Provider orientation.
- **Member –**
    - Member incentives for completed screenings during MY2023 were offered.
    - Reminder Letters for members identified as being due for lead screening were sent.
    - Member education materials included education on the importance of screening for lead exposure and the dangers of lead exposure in young children.

Despite these efforts the health plan continues to struggle to improve compliance with lead screening.

Planned Interventions for MY2024:

The health plan has identified the following interventions to address the identified barriers to lead screening compliance during MY2024.

1. **Provider Education:** – Provider Partnership Program and Provider Services provide specific education given through virtual meetings and look and learns.

2. **CAP'S and CAP'S Training:** –Continue to issue CAP's and training for provider offices identified as non-compliant with lead screening, anticipatory guidance or documented caregiver refusal guidelines and requirements.
3. **Provider incentives:** - Continue to incentivize providers to complete blood lead screenings for members. Additionally, Health Plan is offering lead analyzer grants that providers can apply for on the health plan website.
4. **Provider Alerts:** - Up to date and ongoing materials provided to Provider Services, the Provider Partnership Program, including incentives, HPSJ member plan changes through Health Plan of San Joaquin (HPSJ) Provider Network Provider Alerts.
5. **Monitoring:** – Annual audits of records and rates review of prior measurement year using HEDIS specifications. Quarterly monitoring of lead screening completed for child enrollees ages 0-6 years.
6. **Provider site review: Inclusion** in Facility Site Reviews and the Provider orientation.
7. **Member incentives**: Continue to incentivize members to complete lead screenings.
8. **Member Education:** -Continue to share and make materials available to members with education specific to lead screening and the dangers of lead exposure in young children.

Adequacy of Resources

The resources are adequate to perform lead screening focus studies and provide corrective action education for the providers identified as non-compliant with lead screening, anticipatory guidance and documented caregiver refusal.

Planned Changes for Next Year

The quantitative metrics used to evaluate the prevalence of lead exposure will be reevaluated. Additional focus will be given to promote lead poisoning education and lead screening requirements among the provider network.

Population Health Management Impact:

HPSJ has a robust Population Health Management Program that consists of a model of care and a plan of action designed to meet the needs of its members. HPSJ's Population Health Management Program is comprehensive and addresses the full spectrum of care coordination – including screenings, health assessments, data collection and monitoring, case management, care transitions, communications, governance, and other issues.

HPSJ population management programs are available to all eligible HPSJ members. The following report presents an evaluation of the PHM program performance. The measures included in this report do not represent an exhaustive list of all program metrics that are evaluated, but rather highlight key elements of the PHM program, specifically focused on:

- Clinical Quality
- Member Experience
- Utilization

Comparison of Results to Goal

Section 1: Clinical Measures

Assessing the effectiveness and impact on clinical utilization is instrumental to demonstrating value in addressing gaps in care. Clinical measures include both outcome measures and process measures. Programs for this year with clinical measures for impact include:

- Children's Health – Preventive Services Initiative
- Pregnant and Postpartum Services Initiative

Keeping Members Healthy

Children's Health – Preventive Services Initiative

Relevance Statement

Well-care visits offer members the opportunity to address concerns, identify conditions and risks early, and provide education that can influence health and development. Well-care visits are essential for children and adolescents of all ages to ensure development, nutrition, safety, immunizations and other age-specific health guidance.

Goal 1: Increase the rate of completed well child visits in ages 0-15 months, 15-30 months, and children and adolescents from 3-21 years to above the 50th percentile based on the National Medicaid Managed Care benchmark by 12/31/2023. **This goal was not met.**

Table 2: HEDIS MY2022 Child Well Visit Measures

	MY2020 Rate	MY2021 Rate	MY2022 Rate	Goal	Goal Met
W30-6 San Joaquin	45.82%	44.63%	50.36%	55.72%	N
W30-6 Stanislaus	39.90%	37.98%	35.32%		
W30-2 San Joaquin	46.65%	58.30%	60.67%	65.83%	N
W30-2 Stanislaus	63.40%	54.30%	56.49%		
WCV San Joaquin	40.68%	46.26%	47.26%	48.93%	N
WCV Stanislaus	34.87%	37.71%	41.89%		

Quantitative Analysis

The MY2022 rates for all well visits measures were below the goal of the 50th percentile. Stanislaus was consistently below San Joaquin rates in all measures.

Six visits in the first 15 months of life were 5.36 and 20.4 percentage points below the goal of 55.72% for San Joaquin and Stanislaus Counties, respectively.

Two visits in last 15 months for members who turned 30 months old were below the goal of 65.83% by 5.16 and 9.34 percentage points for San Joaquin and Stanislaus Counties, respectively.

Child and Adolescent Well Care Visits for members 3-21 years of age were below the goal of 48.93% by 1.67 and 7.04 percentage points for San Joaquin and Stanislaus Counties, respectively.

Qualitative Analysis

The Interim Chief Health Equity Officer and NCQA/HEDIS Director reviewed the results. While the goals were not met, the rates of well-visits increased for each measure in San Joaquin County and all but one measure for Stanislaus. Member incentives and outreach and provider incentives may be drivers of these improvements. However, there are barriers to attendance at routine well visits including transportation, conflicts with work schedules, child care for other children, and other social stressors. Further polarization of immunizations may

decrease the perceived benefit of well visits for parents of children 0-30 months, making it difficult to engage parents in attending multiple visits a year. With competing priorities and social stressors, parents of older children may not see the benefit of well visits when their child appears healthy. Barriers to access and social drivers of health are the most impactful to the membership.

Action Items

HPSJ is developing an MOU with the First 5 program to coordinate care and address needs, with particular emphasis on addressing racial disparities in access and health outcomes for pregnant members and children under 5. Additionally, the CalAIM program is expanding to include eligibility criteria for engaging pregnant members. This engagement of high-risk populations is anticipated to have a downstream effect on child well visits after birth. A new platform has been launched that will share provider gap in care lists in a provider-friendly environment and encourage providers to conduct follow up and outreach to engage members more proactively in attending well visits. Lastly, an assessment is being conducted to determine the feasibility of translating health education material into more languages to address any disparities that may be caused by members receiving preventive health care material in a language they cannot easily understand.

Pregnant and Postpartum Services Initiative

Relevance Statement

Timely prenatal and postpartum care are essential for identifying issues or concerns early. Timely care can ensure health education and guidance are provided such as nutrition, exercise and immunizations. Preventive guidelines suggest timeframes for these visits in order to ensure appropriate preventive care.

Goal 1: *Increase rate at which pregnant people receive prenatal care within the first trimester or 42 days of enrollment from above the 50th to above the 75th percentile based on the National Medicaid Managed Care Benchmark by 12/31/2023.* **This goal was met.**

Goal 2: Maintain or increase the rate at which pregnant people receive postpartum care within 7-84 days after delivery to the National Medicaid Managed Care 75th by 12/31/2023. **This goal was met.**

Table 2: HEDIS MY2022 Prenatal and Postpartum Rates

	MY2020 Rate	MY2021 Rate	MY2022 Rate	Goal	Goal Met
Prenatal	90.75%	86.37%	88.56%	88.33%	Y
Postpartum	74.94%	76.89%	82.24%	82.00%	Y

Quantitative Analysis

While prenatal care showed a decrease from MY20 to MY21, there was an improvement in this measure in MY22 of 2.19% and the goal of 88.33%, or the national 75th percentile, was exceeded by 0.23 percentage points.

Qualitative Analysis

The Chief Health Equity Officer and NCQA/HEDIS Director reviewed the results. HPSJ has provided education, engaged providers and allocated staff resources and financial incentives toward improving prenatal and postpartum care. These efforts have shown to be effective in steadily improving rates of timely care.

Action Items

With both rates above the national 75th percentile, HPSJ believes these interventions have been impactful and will continue these programs.

Section 2: Member Experience

Managing Members with Emerging Risk

Relevance Statement

Disease management supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies to improve patient self-management. Disease management continuously evaluates clinical, humanistic and economic outcomes with the goal of improving overall quality of health.

Members at higher risk who have Asthma, Diabetes, Chronic Kidney Disease (CKD), Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD) and Depression are eligible for the disease management program.

The disease management program services are aimed at reducing the risk of future hospitalizations, ED visits, acute care spending and mortality. Risk

stratification for potential program participants is based on modification of best available evidence of risk factors paired with utilization patterns at HPSJ.

Members who complete the disease management program are subsequently called to complete a satisfaction survey specific to their experience with the disease management program.

Goal: *Achieve 80% or greater overall satisfaction with all Disease Management programs by 06/30/2023.* **This goal was met.**

Table 3: Disease Management Member Experience

	FY2021 Rate	FY2022 Rate	FY2023 Rate	Goal	Goal Met
Was the program helpful	92.9%	100.0%	95.5%	80%	Y
Are you better able to manage your condition now?	96.6%	94.1%	82.1%	80%	Y
Overall Rating of the Program (9 or 10)	95.0%	90.5%	95.0%	80%	Y

Quantitative Analysis

The goal of 80% was met for all member experience measures for the disease management program. 95.5% of members found the program helpful, exceeding the goal of 80% by 15.5%. 82.1% of members reported being better able to manage their condition after completing the program. This rating decreased by 12 percentage points from the prior year but was still above the goal of 80%. Overall satisfaction exceeded the 80% goal by 15 percentage points, with 95% of members rating the program a 9 or 10 out of 10.

Qualitative Analysis

The Chief Health Equity Officer and NCQA/HEDIS Director reviewed the results. The Case Management department at HPSJ strives to provide member focused, equitable, and holistic care to all members. Case Management engages in routine and ad hoc training, creation of new member education material specific to their healthcare needs, and coordination and collaboration with

providers and community services to address holistic needs. These interventions appear to be appreciated and impactful for members who engage with these services.

Next Steps

Maintain disease management programs and monitor member experience results to ensure member needs continue to be met.

Patient Safety Across Settings

Relevance Statement

The Me and My Baby program provides outreach, health education and care coordination for pregnant and postpartum members. In order to ensure that members Coordination of perinatal care is essential for identifying issues or concerns early. Adequate perinatal care can prevent adverse outcomes and maternal death, as well as lay the foundation for lifelong health for parents and babies.

Members who complete the Me and My Baby program are subsequently called to complete a satisfaction survey specific to their experience with the disease management program.

Goal: Achieve 80% or greater overall satisfaction with the Me and My Baby program by 06/30/2023. **This goal was met.**

Table 3: Me and My Baby Member Experience

	FY2021 Rate	FY2022 Rate	FY2023 Rate	Goal	Goal Met
Are you better able to manage now?	100.0%	95.8%	100.0%	80%	Y
Overall Satisfaction of the Program (Good & Very Good)	96.8%	100.0%	100.0%	80%	Y

Quantitative Analysis

The goal of 80% was met for both member experience measures for the Me and My Baby program. 100% of members reported they were better able to manage their pregnancy and health concerns after completing the program. Overall satisfaction exceeded the 80% goal by 20 percentage points, with 100% of members rating the program Good or Very Good.

Qualitative Analysis

The Chief Health Equity Officer and NCQA/HEDIS Director reviewed the results. The Me and My Baby Program strives to meet members needs through proactive outreach to pregnant members and member-centered care coordination. All members are provided with health education and are connected to services such as HPSJ Social Workers if they need additional emotional or social support. Registered Nurses provide case management, and all members receive outreach after delivery to ensure coordination with appropriate providers. These services appear to be appreciated and impactful for members who engage with services.

Next Steps

Maintain Me and My Baby program and monitor member experience results to ensure member needs continue to be met.

Section 3: Utilization Measures

Managing Multiple Chronic Illnesses

Relevance Statement

Effective Case Management focuses on moving members to the appropriate level of care, coordinating a treatment plan across multiple providers, preventing complications, restoring maximum functional capacity during the Member's recovery period, and ultimately helping members and their families live as independently as possible.

Utilization measures "capture the frequency of services provided by the organization", per NCQA. This includes measures such as number of ER admissions and number of prescriptions. Asthma is a prevalent disease that is associated with increased ER visits, inpatient admissions and missed school and work. The AMR measure is used as an indicator of asthma control and how well members are managing this disease.

Goal: Increase the rate of members with a ratio of controller to total asthma medications (AMR) of 0.5 or more by 12/31/2022. **This goal was met.**

Table 4: HEDIS MY2022 Utilization Measures

	MY2020 Rate	MY2021 Rate	MY2022 Rate	Goal	Goal Met
AMR	57.73%	52.47%	59.38%	>52.47%	Y

Quantitative Analysis

The goal to increase the rate for the HEDIS AMR measure from MY2021 was achieved. The rate increased 6.91 percentage points in MY2022 to exceed the goal of 52.47%.

Qualitative Analysis

The Chief Health Equity Officer and NCQA/HEDIS Director reviewed the results. Case Management provides intensive one-on-one advocacy, care coordination, education, and intervention for the extremely complex, high-risk, or high-cost members. By focusing on these members for services, it appears to have effectively impacted pharmacy utilization. The goal seems to have been achieved by engaging the Member in the care process and removing barriers to care. Case Managers, (CM)s, work closely with the Member's primary care physician (PCP) and other members of the healthcare team to identify and close any gaps in care.

Next Steps

Maintain Complex Case Management program and monitor utilization results to ensure member needs continue to be met.

Population Health Management Impact

In 2023, HPSJ's Population Health Management (PHM) Program expanded beyond the framework of the NCQA HPA Standards and Guidelines for PHM and Quality Improvement (QI) to encompass a more strategic alignment with the DHCS Comprehensive Quality Strategy, DHCS Population Health Strategy and the DMHC Health Equity and Quality Measure Set (HEQMS) requirements.

The current PHM program seeks to create a cohesive framework which will serve as the cornerstone of transformation in the care provided to HPSJ enrollees.

Overall, the PHM Program has had the desired impact, with many of the goals being met. Notably, members engaged in HPSJ programming report high satisfaction and usefulness of those programs. HPSJ has achieved the goal of being above the 75th percentile nationally in timely prenatal and postpartum care. Utilization of controller medication in relation to emergency inhalers has increased by an impressive 6.91 percentage points, demonstrating better management of asthma for the HPSJ membership as a whole. There remain improvement opportunities for keeping members healthy related to well visits.

Results of Actions Identified in FY2023

The improvements and achievements seen in FY2023 can be attributed to the allocation of staff and resources, provider engagement and incentives, and data driven goals and interventions toward meeting the population's needs. The following were actions identified in the prior PHM Impact report that were taken the past year:

1) For child well visits for members 0-21 years old, HPSJ offered enhanced transportation alternatives for care givers of infants in order to assist with completing well visits. While this is beneficial to address access and transportation barriers, this does not appear to be sufficient to address the needs of the population.
2) For disease management, case managers improved communication techniques using integrated multidisciplinary approaches when engaging members. Techniques included member centric care plans, a focus on member goals, engagement and integrated care.
3) For Me and My Baby, the Case Management department continued to conduct proactive outreach and care management and coordination along with performance monitoring.

While the goals for well visits were not met, many additional actions were taken during the year in addition to those identified during last year's review of the PHM program, the full effect of which may not be realized yet. Child well visits were incentivized for providers through the Pay for Performance program and routine data sharing was conducted through the Quality Department during site specific Provider Partnership meetings. Members were also offered incentives through letters and phone call outreach to receive a gift card upon completion of well visits. This outreach also included member education, the importance for well visits and assistance to schedule visits for members.

Improvement and Action for FY2024

HPSJ will continue to address population level needs through FY24 as outlined in the Population Health Management Strategy. There remains an opportunity to improve well visits for children 0-21. In order to address the unmet needs of child and adolescents in receiving well visits, HPSJ has a number of interventions in process and planned. HPSJ is developing an MOU with the First 5 program to coordinate care and address needs, with particular emphasis on addressing racial disparities in access and health outcomes for pregnant members and children under 5. Additionally, the CalAIM program is expanding to include eligibility criteria for engaging pregnant members. This engagement of high-risk populations is anticipated to have a downstream effect on child well visits after birth. A new platform has been launched that will share provider gap in care lists in a provider-friendly environment and encourage providers to conduct follow up and outreach to engage members more proactively in attending well visits. Lastly, an assessment is being conducted to determine the feasibility of translating health education material into more languages to address any disparities that may be caused by members receiving preventive health care material in a language they cannot easily understand. By the end of FY, it is hoped that these additional resources and activities will help HPSJ members achieve the national 50th percentile for these measures.

Population Health Management Program – Population Needs Assessment

Responsible Staff: Health Education and/or Cultural and Linguistics

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Population Needs Assessment Overview

Introduction

Health Plan of San Joaquin's Population Needs Assessment (PNA) was conducted using data from national and state public health sources, health plan specific data, Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

data, The California Department of Managed Healthcare (DMHC) Timely Access Compliance regulatory filing data, comprehensive cultural and linguistic detailing, and community focused key informant interviews. Key findings were identified for Quality Improvement, Health Education, and Cultural Linguistics programs. The findings were related to interpreting services, member access to routine care for both children and women and accessing health education classes.

This evaluation serves as the annual PNA evaluation update.

Objectives

The objectives included in the PNA Action Plan were developed through data analysis, internal discussions, and community feedback. These interventions seek to address issues related to:

- Community and member engagement
- Population level chronic disease management and health education
- Cervical Cancer Screening Compliance among eligible members
- Members' needs based on culture and language
- Completion of health forms

Objective 1

Increase overall interpreted encounters for members by 35% and interpreted encounters vs. membership preferred spoken language ratio by 15%, by June 30, 2024. This will be accomplished by continuing outreach to provider groups and members to spread awareness of the availability and importance of qualified interpreter resources, as well as assisting where possible with the roll out of new language access services (e.g. OPI, VRI, onsite interpreting). We will also conduct a targeted campaign to increase interpreted encounters among our Hmong, Khmer, and Chinese LEP groups by 3% each. HPSJ's Cultural and Linguistics Department utilized the FY23 Interpreter Services Utilization Report and Membership Spoken Languages report for determining this coming fiscal year's goal.

Objective 2

Increase the rate of completed well child visits in ages 0-15 months, 15-30 months, and children and adolescents from 3-21 years to above the 50th percentile based on the National Medicaid 50th percentile by 12/31/2024 by implementing children's health milestone initiatives focused on developmental milestones and incentivizing preventive care.

Objective 3

Increase enrollment and retention in Diabetes Prevention Program by 5% as compared to baseline established June 1, 2022, by June 30, 2024.

Objective 4

By June 30, 2023, to increase the rate of compliance for cervical cancer screenings among White/Caucasian women ages 24-64 years of age at GVHC's West Modesto Clinic and residing in Stanislaus County from 49.52% to 55.73%.

Conclusion

HPSJ will continue to assess the needs of its members through active engagement and provide comprehensive, innovative, and equitable care. As the local managed care health plan, HPSJ partners with the community to raise awareness of the health services available to its members and actively seeks feedback from members, community partners, and providers to improve the measurable impact within communities served.

Data Sources

Multiple data sources were used throughout all sections of this report including:

- The 2022 Consumer Assessment of Healthcare Providers and Systems (CAHPS) data
- MY2020 Department of Health Care Services (DHCS) HPSJ health disparities data
- 2022 Community & Cultural Detailing Report by HPSJ's community engagement vendor
- HPSJ internal reports highlighting member demographic data, current enrollment rates, interpreter services utilization, and claims
- External reports developed by local health departments and statewide health research groups

National or state curated sources provided county level data. The sources and methodologies are as follows:

Overview of Data Sources

Internal Sources

DHCS MCP specific health disparities data

Cited as: (DHCS Disparities, 2020)

DHCS provides annual health disparities data to all MCP's. Health Disparities data highlights the utilization of preventive health services by age, race/ethnicity, language spoken, and county of residence.

2023 Community & Cultural Detailing Report

Cited as: (Community & Cultural Detailing, 2023)

HPSJ Community Engagement Consultant compiled a Community Detailing Report. This report analyzed a combination of data sources which include:

- Kaiser Family Foundation
- Journal of Community Health
- American Community Survey: US Census Bureau
- Pew Research Center's Social & Demographic Trends Project
- Journal of Health and Social Behavior

Data was collected and analyzed to better understand access to care, language needs, cultural and linguistic competency, health education and gaps in quality improvement efforts at the county and plan level.

External /Local Sources

2022 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

Cited as: (CAHPS, 2022)

HPSJ contracted with a National Committee for Quality Assurance (NCQA) accredited survey vendor to complete the CAHPS surveys. These surveys assessed members' satisfaction with the health plan.

2022 Community Health Needs Assessment San Joaquin County

Cited as: (SJC CHNA, 2022)

The 2022 Community Health Needs Assessment (CHNA) offers a comprehensive community health profile that encompasses the conditions that impact health in San Joaquin County. In order to identify health needs, a mixed-methods approach was utilized, examining existing data sources (secondary data), as well as speaking with community leaders and residents to solicit their opinions and conducting a survey of residents (primary data). Guided by the understanding that health encompasses more than disease or illness, the 2022 CHNA process continued to place emphasis on the social, environmental, and economic factors— "social determinants"— that impact health. Thus, the CHNA process identified top health needs by analyzing a broad range of social, economic, environmental, behavioral, and clinical care factors that may act as contributing factors to each health issue.

2020 Community Health Assessment Stanislaus County

Cited as: (Stanislaus CHNA, 2020)

This report is the third Stanislaus County Community Health Assessment (CHA). The CHAs are designed around broad, social determinants of health. The broad determinants are non-medical factors that affect health, such as income, educational attainment, housing, and community safety, among others. Each assessment has both primary and secondary data components. To examine geographic differences, the County was divided into nine regions, each with one or more zip codes.

Interpreter Utilization Tracking FY23

Cited as: (Interpreter Utilization Tracking FY23)

Month to month sum and fiscal year total of interpreted encounters supported by HPSJ-arranged over-the-phone, video-remote, and onsite interpreting services at provider locations across the service area.

Member Spoken Language Tracking FY22 Year-End, Member Spoken Language Tracking FY23 Year-End

Cited as: (Spoken Languages FY22, Spoken Languages FY23)

Sum of fiscal year-end totals of member languages across members who have been assigned a PCP, live in select zip codes, and have primary Medi-Cal enrollment with HPSJ.

Encounter Language Study FY23

Cited as: (Encounter Language Study FY23)

Month-to-month Study of interpreted encounters stratified by languages throughout FY23

Khmer, Hmong, Chinese Study FY23

Cited as: (Khmer, Hmong, Chinese Study FY23)

Month-to-month Study of interpreted encounters stratified by Khmer, Hmong, and Chinese throughout FY23, and compared to memberships count respective to these languages, as well as total all LEP membership and total membership.

Key Data Assessment Findings

A.1.a Membership/Group Profile

Local county data was reviewed in addition to HPSJ membership data. This provided details on the demographic makeup of both service areas which include San Joaquin County and Stanislaus County. There are many factors that affect how community members interact within various systems of care that

make up safety net services. Better data collection and data sharing are essential in the positive progression of the larger system, including partners, that serve our members.

Geography

HPSJ had a total of 389,720 enrollees as of December 31, 2022. Serving two counties in the central part of California with roughly 61% of membership living in San Joaquin County and 39% living in Stanislaus County. HPSJ is one of two plan options for eligible individuals and families to choose from. The largest concentration of membership is within Stockton and Modesto, which can be described as more urban areas in their respective counties. Local programs and services including community service agencies, major hospitals, social services, community centers, and homeless shelters are primarily located in these two cities. Please note that data in the tables below were collected using membership data from 2022.

Table 1: Top 10 Cities by # of Members (HPSJ Member Data, 2022)

The following listed cities contain the highest number of HPSJ members within the two counties served as of 2022. This information helps to inform HPSJ where members reside to provide services that are easily accessible based on geographical location.

City	# of Members	%Total	County
STOCKTON	150,778	39%	San Joaquin
MODESTO	78,850	20%	Stanislaus
TRACY	22,108	6%	San Joaquin
LODI	21,612	6%	San Joaquin
TURLOCK	20,938	5%	Stanislaus
MANTECA	20,735	5%	San Joaquin
CERES	14,006	4%	Stanislaus
PATTERSON	7,376	2%	Stanislaus
LATHROP	6,360	2%	San Joaquin
RIVERBANK	5,330	1%	Stanislaus

Table 2: Most Populated Zip Codes by HPSJ Members (HPSJ Member Data, 2022)

San Joaquin county has a larger HPSJ membership concentrated in Stockton, whereas in Stanislaus County membership spans multiple geographic areas. The following table demonstrates the 5 zip codes with the highest populations of HPSJ members. Zip code level data provides a clearer picture as to what types of services are available to community members such as access to clinics,

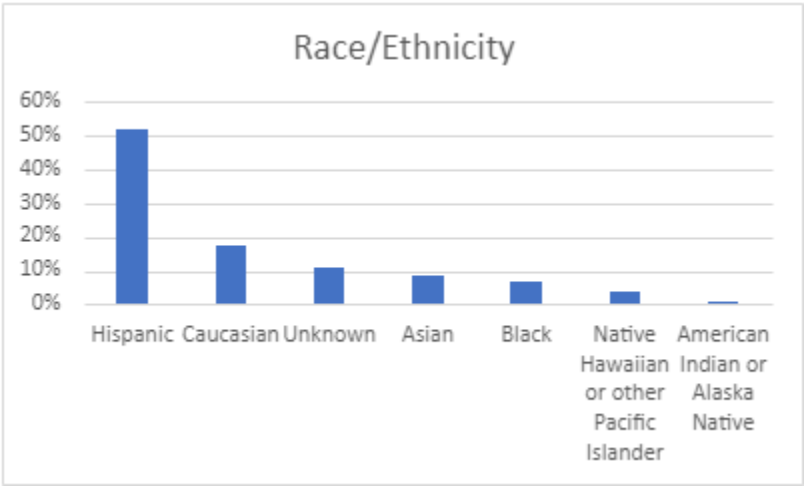
transportation, food, and other items that contribute to social determinants of health.

Zip Code	# of Members	County
95206	29,360	**San Joaquin**
95205	20,562	**San Joaquin**
95351	19,560	**Stanislaus**
95210	18,054	**San Joaquin**
95207	17,753	**San Joaquin**
95240	16,476	**San Joaquin**
95307	14,770	**Stanislaus**
95350	14,011	**Stanislaus**
95380	13,922	**Stanislaus**
95376	**12,898**	**San Joaquin**

Race/Ethnicity

HPSJ continues to serve a diverse population with many ethnicities and languages. To identify cultural and linguistic needs it is important for us to identify the race/ethnicity and primary language in our counties. The largest race/ethnicity category was Hispanic with 50% of members, followed by White at 19% of members. In the table below is the breakdown by race/ethnicity.

Figure 1: HPSJ Membership Race Ethnicity (HPSJ Member Data, 2022)



Primary Language

Within San Joaquin County and Stanislaus County, 31% of members have Limited English Proficiency. The number of members who reported English as their primary language was also at 31% Members who speak Spanish were identified as 26%. We have members who have neither identified nor indicated

a preference at 38%. To better assist us with our efforts of practicing cultural competency we looked at the prevalent languages spoken by HPSJ members, and top languages can be found in the following table. In total, HPSJ members listed over 55 non-English, spoken-language preferences in FY23.

Table 3: Most Prevalent Languages (Spoken Languages FY23)

Language	Percentage	# of Members
No Language	38%	152,708
English	31%	126,510
Spanish	26%	106,728
Punjabi	1%	3,139
Khmer (Cambodian)	1%	2,842
Vietnamese	1%	2,578
Farsi	1%	2,139

Language Access by Overall Interpreted Encounters and Encounters vs. Membership Language Preference

Members with Limited English Proficiency are able to request an onsite interpreter for upcoming appointments through HPSJ Customer Service, or they can request a phone or video interpreter on demand at their appointment and all key points of contact. HPSJ continues to monitor utilization of interpreter services across phone, video, and onsite modalities for members across Stanislaus and San Joaquin counties, and to compare the encounter volume with separate member preferred language reports. This is done by compiling and reviewing utilization data from contracted vendor reports that identifies the number of interpreted encounters for all serviced languages within a given period of time. That utilization data is then compared to our membership language data to come up with a ratio expressed by percentage to illustrate how encounters compare to either individual or overall non-English membership languages.

Our objective for FY23 was to increase the overall utilization of interpreting services to total LEP members by 8%. To assist with these efforts and decrease the barrier of having to schedule interpreting services and give providers instantaneous access, we rolled out video interpreting services to the last of three FQHCs for whom we'd set up interpreting services just before the start of the fiscal year, and have continued to meet with all three entities quarterly regarding utilization and member/provider experience, while also reaching out

to other FQHCs to either gather data on their existing services or assist them with arranging services. Additionally, we provided resources and informing materials on language assistance and interpreting services via our CAHPs and PlanScan newsletters.

The table below is a fiscal year comparison which demonstrates that we have reached our goal of increasing the total number of interpreted encounters vs. total LEP membership for the fiscal year by 10% (actual result: 19%).

Table 3: Utilization of Language Assistance Services FY2022 vs FY2023 (Spoken Languages FY22, Spoken Languages FY23, Interpreter Utilization Tracking FY23)

Month	**FY2022**	**FY2023**
July	2629	4738
Aug	2833	5687
Sept	3252	5079
Oct	2171	5319
Nov	2849	5221
Dec	3062	5486
Jan	2081	6117
Feb	3046	5570
Mar	3903	6913
April	4594	6086
May	4790	6132
Jun	5068	5906
Total Utilization	**40,278**	**68,254**
% Diff from Prev FY	+67%	+69%
Total LEP Membership*	**114,249**	**127,513**
% Diff from Prev FY	+13%	+12%
Utilization vs. LEP Membership Ratio	**35%**	**54%**
% Diff from Prev FY	+10%	+19%

*Total LEP Membership is determined by count of member languages across members who have been assigned to a PCP, live in select zip codes, and have primary Medi-Cal enrollment with HPSJ.

Cultural and Linguistic Profile

The Cultural and Linguistic program at Health Plan of San Joaquin follows the National Culturally and Linguistically Appropriate Services Standards to guide us in improving the quality of services provided to all our members. HPSJ seeks to

improve the health care quality and health equity of HPSJ's eligible members with Limited English Proficiency (LEP), those with disabilities or cognitive impairments, and those whose cultural beliefs about health care are different from the majority of the populations in the region. We continue to closely examine and consider the views on healthcare and cultural insights organized by different racial and ethnic groups as indicated by the Community and Cultural Detailing, 2023 (select excerpts shared below).

Insights regarding the Khmer Population:

- The lack of access to behavioral and psychological professionals can contribute to adverse mental health outcomes like depression and PTSD for some Cambodians.
- Based on historical trauma, several Cambodian American refugees experience poor mental health like depression and PTSD. They are less likely to receive mental health services than other Asian groups and non-Asians.
- Medication management is highly important for Cambodian communities. Some might receive medication from close relatives and friends because of the lack of access to a primary care provider who can prescribe the appropriate medication.
- Some Cambodian women who migrated from Cambodia might be unfamiliar with family planning and reproductive health and are less likely to use birth control, because it was ingrained from past generations to have large families.
- Many older Cambodians might prefer to shop only at local Asian grocery stores, compared to their children and grandchildren who also shop at Asian markets in addition to large chain grocery stores like Safeway.
- Among Asian Americans, Cambodian Americans have the highest economic and social barriers, such as living in poverty, increased dependence on social services like welfare, and low educational attainment.
- Cambodians generally have healthy balanced diets that include calcium-rich foods (fish and milk, protein (fish, meat, and eggs}, and abundant fruits and vegetables.

Insights regarding members of Mexican Descent:

- Some Mexican Americans might decline their medication adherence because they believe it is unnecessary or too costly to take their medication for diabetes every day. Many Mexican communities in the US are experiencing high rates of type 2 diabetes, with some contributing factors being diet, cost, language barriers, and lack of healthcare access.

- One-third of Mexican American adults and 8% of Mexican American children lack health insurance coverage.
- Some estimates suggest 20% of Mexican Americans live in poverty.

- Trust is hard to generalize in Mexican Americans, with some studies showing high trust overall in major institutions of the US government, but other studies show higher distrust in the medical establishment specifically. Trust (confianza) is a major element of Hispanic culture, and the cultural idea of personalismo (the desire to cultivate closer relationships with providers) means that deep trust can be established between a Mexican patient and a provider.

Insights regarding the Asian Indian (Punjabi) Population

- There are over4 million Asian Indians in the US as of 2019, and with large communities found in metropolitan areas like New York. Chicago, San Francisco, and New Jersey. In Yuba and Sacramento there is also a sizable community of Punjabis (most of whom identify as Sikhs). Still, the size of this community is often underreported and counted as Asian Indian or South Asian.
- Type 2 diabetes is a serious health issue among the South Asian community, including among those who identify as Sikh-practicing Punjabis. About 11% of Asian Indians have type 2 diabetes, compared to a prevalence rate of 4% in Chinese communities, 9% in Filipinos, and 8% in other Asian American groups.

Insights regarding the African American Population:

- Many African Americans have a fear of receiving a negative health diagnosis and would rather not seek medical attention.
- Black/African American adults may hold low levels of trust in the healthcare system. A Kaiser Family Foundations survey found that only around50% of the Black/African American adults trust their local hospital to provide them with high quality healthcare services. Furthermore, close to 40% of African American mothers of children under age 18 reported in the survey experiencing discrimination based on their race when getting health care for themselves or a family member.
- Compared to the white population in the US, Black/African Americans have suffered 3 times the hospitalization rates and 2 times the death rates from COVID-19. In most states, Black/African Americans have received less than their relative share of vaccinations, based on the proportion of the population.

- African American populations are more likely to be uninsured and suffer from worse health outcomes when compared to their non-Hispanic white counterparts; some African Americans may not see a doctor due to cost and falling behind on receiving basic preventative care due to experiencing significant social drivers of health-related barriers.
- A USDA survey found close to 90% of Black/African Americans did not eat leafy vegetables, and most Black/African Americans did not intake the daily recommended amounts of key vitamins. Many Black/African Americans are struggling with health food choices because of high costs of low-calorie food options. Some neighborhoods have fewer supermarkets with minimum healthy food options like fresh fruits, vegetables, and whole grains. Some traditional food is prepared with high amounts of sodium, fat, cholesterol, and starches, which can cause heart disease, diabetes, high blood pressure, obesity, stroke, and certain cancers.

Insights from the Filipino Population

- Verbal communication with elderly Filipinos is characterized by using the words "po" and "opo" to signify respect and deference to "hierarchy."
- Family members are essential players in one's healthcare. They can be a source of support rather than a burden and can also be vital in helping a member monitor their medication or other necessary health measures. Filipino patients may defer medical decisions to an authoritative family member to maintain group harmony.
- Filipino adults tend to utilize alternative medicine like traditional Chinese medicine, homeopathic, and naturopathic therapies to treat health conditions (e.g. herbal teas, herbal paste, and health supplements to manage hypertension)
- The traditional Filipino diet is higher in saturated fat, which can affect cholesterol levels. The diet features carbohydrates (rice), with low intake of fruits, vegetables, and dairy products. Filipino immigrants tend to increase their intake of dairy, meat, fruits, salads, fat, and sugar and experience an overall increase in caloric intake resulting in higher rates of obesity and chronic diet-related illnesses.

Age, Gender, Seniors, & Persons with Disabilities

A small percentage (6%) of HPSJ's overall population can be assigned the Seniors and Persons with Disabilities (SPD) category of aide. This includes older people, people with disabilities and people that are blind. This data can be

used to prioritize certain populations based on various demographic data in the provision of holistic care.

Membership by Aid Code

Category of aid codes (COA) help identify the types of services for which Medi-Cal and Public Health Program recipients are eligible. A recipient may have more than one aid code and may be eligible for multiple programs and services. Reviewing membership by aid code establishes a baseline of member needs based on the descriptor of that category. For example, SPD refers to category, "Seniors, and Persons with Disabilities." Members in this category may need additional support and targeted interventions based on their medical history or current ability to care for themselves.

Figure 2: Overall Membership by COA

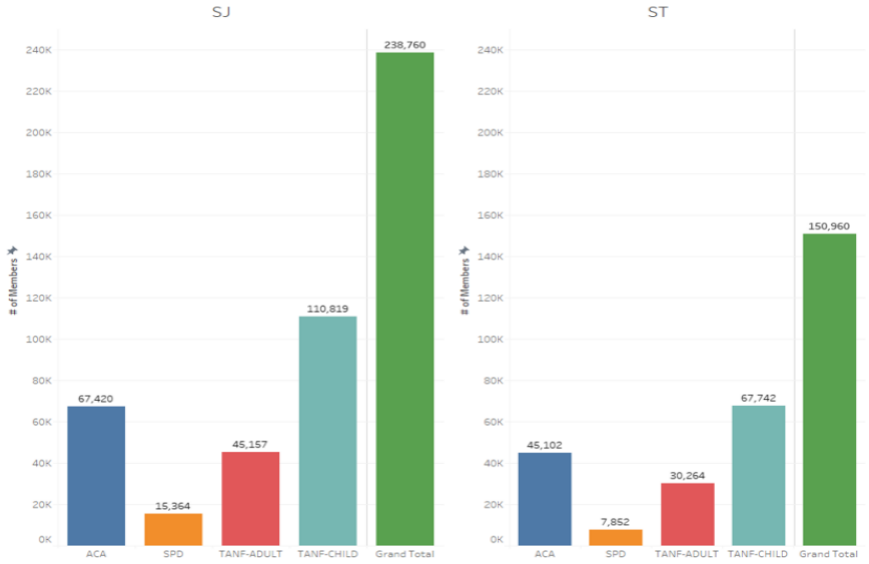
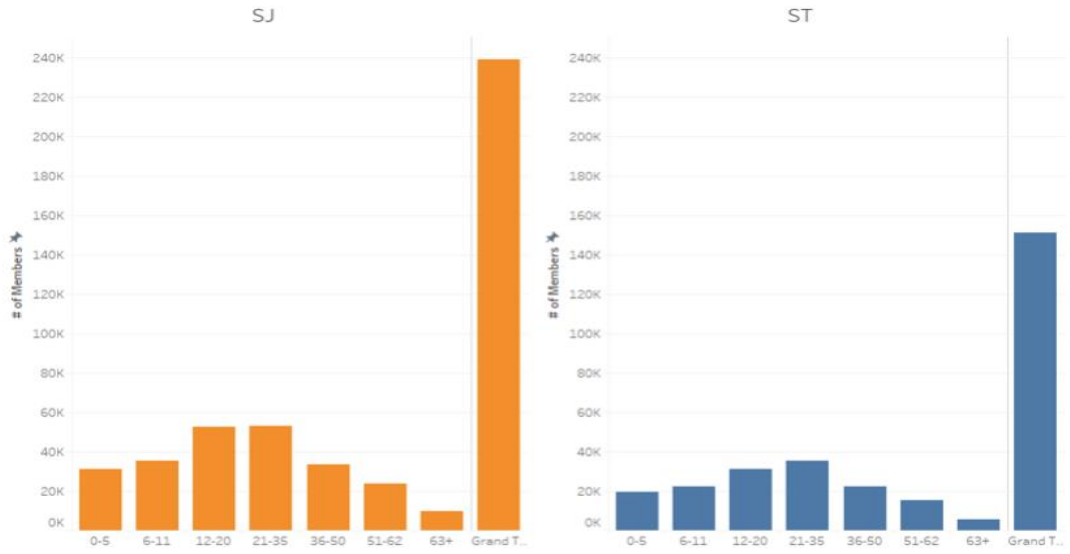


Figure 3: HPSJ members by age

The chart below illustrates the distribution of HPSJ members by age. A large portion of HPSJ membership includes children and young people.



Age Table

County	Age (Group) 0-5	6-11	12-20	21-35	36-50	51-62	63+	Grand Total
San Joaquin	30,982	35,453	52,594	53,005	33,345	23,636	9,745	238,760
Stanislaus	19,502	22,164	31,085	35,171	22,100	15,502	5,436	150,960
Grand Total	50,484	57,617	83,679	88,176	55,445	39,138	15,181	389,720

Health Status and Disease Prevalence

Chronic conditions are known to disproportionately impact Medi-Cal (Medicaid) individuals due to factors such as chronic stress, and other social determinants of health that create barriers in accessing health care or participating in healthy behaviors. In addition to those concerns, COVID-19 continues to affect Medi-Cal members at higher rates than other populations. while vaccine COVID-19 vaccination rates remain low. The top 10 conditions impacting across HPSJ membership were identified by Claims and Encounter data between January 1, 2022-December 31, 2022.

Figure 4: Top 10 Conditions Among Members Who Reside in San Joaquin County by Race/Ethnicity

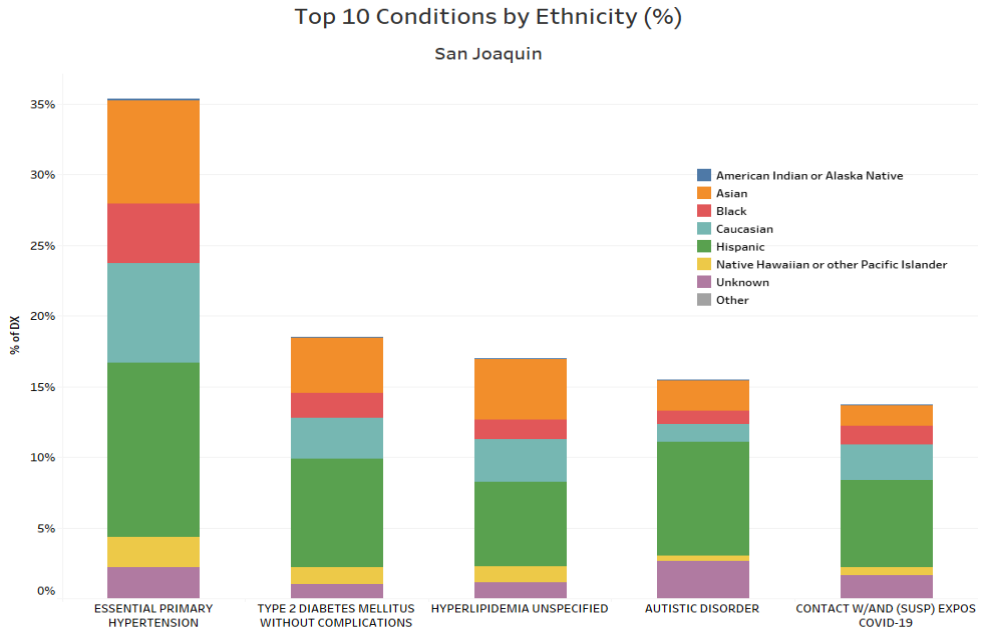
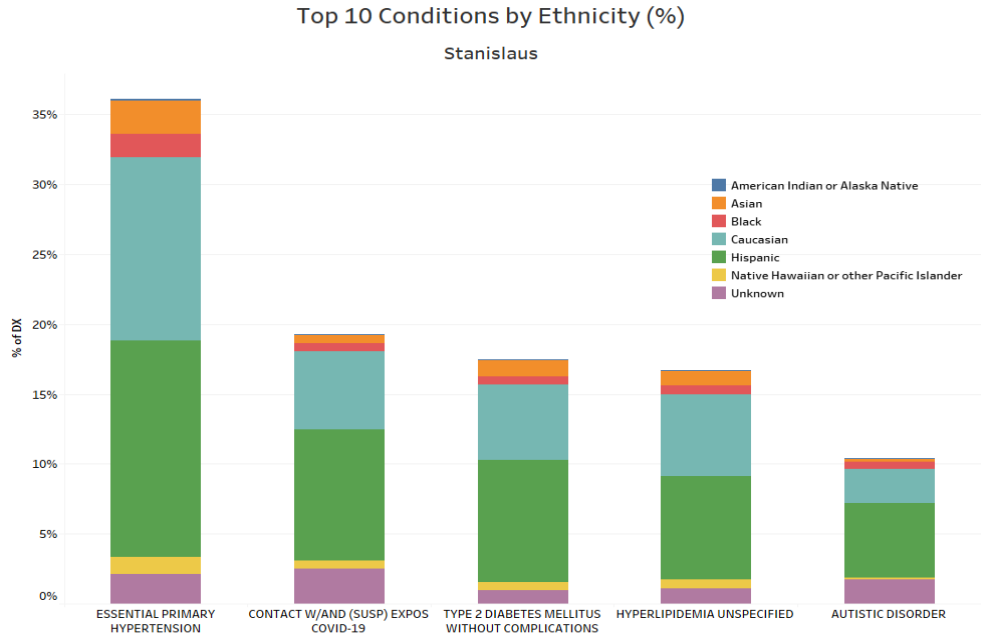


Figure 5: Top 10 Conditions Among Members Who Reside in Stanislaus County by Race/Ethnicity



Access to care involves physician and health services availability, cost of care, location, and other factors that impact the ability to get appropriate health care in a timely manner. The trend in health care access is seen in local reported data for the service area of both San Joaquin and Stanislaus Counties.

Identified barriers related to health care access in both counties include:

- Physician shortage,
- Dentist shortage,
- Mental health provider shortage,
- Medically underserved areas, and
- Health insurance coverage.

HPSJ contracted with an NCQA accredited survey vendor to complete the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This instrument is designed to provide insight into enrollee experience and care. This analysis helps HPSJ identify opportunities to improve enrollees' member experience.

Adult Member Experience:

Table 6: Summary Rate Scores – Adult CAHPS Survey Experience

MEASURE	SUMMARY RATE 2022	SUMMARY RATE 2023	CHANGE	2023 PG BOOK OF BUSINESS BENCHMARK PERCENTILE DISTRIBUTION (0 20 40 60 80 100)	PERCENTILE RANK	BoB SRS
Health Plan Domain						
Rating of Health Plan *% 9 or 10*	61.8%	58.0%	-3.8		19th	63.6%
Getting Needed Care *% Usually or Always*	74.3%	73.9%	-0.4		6th	82.0% ▼
Customer Service + *% Usually or Always*	86.7%	86.8%	0.1		18th	89.8%
Ease of Filling Out Forms + *% Usually or Always*	96.7%	93.8%	-2.9		18th	95.3%
Health Care Domain						
Rating of Health Care *% 9 or 10*	49.8%	50.3%	0.5		13th	56.8%
Getting Care Quickly *% Usually or Always*	70.1%	68.8%	-1.3		<5th	81.5% ▼
How Well Doctors Communicate + *% Usually or Always*	88.8%	84.7%	-4.1		<5th	92.8% ▼
Coordination of Care + *% Usually or Always*	79.3%	69.0%	-10.3		<5th	85.6% ▼
Rating of Personal Doctor *% 9 or 10*	58.5%	55.8%	-2.7		<5th	69.2% ▼
Rating of Specialist + *% 9 or 10*	59.5%	68.3%	8.8		57th	67.4%

Table 6: Summary Rate Scores – Child CAHPS Survey Experience

MEASURE	SUMMARY RATE 2022	SUMMARY RATE 2023	CHANGE	2023 PG BOOK OF BUSINESS BENCHMARK PERCENTILE DISTRIBUTION (0 20 40 60 80 100)	PERCENTILE RANK	BoB SRS
Health Plan Domain						
Rating of Health Plan *% 9 or 10*	69.7%	69.3%	-0.4		30th	72.0%
Getting Needed Care *% Usually or Always*	75.4%	78.7%	3.3		22nd	83.1%
Customer Service + *% Usually or Always*	86.1%	88.6%	2.5		47th	88.7%
Ease of Filling Out Forms + *% Usually or Always*	96.2%	93.9%	-2.3		14th	95.8%
Health Care Domain						
Rating of Health Care *% 9 or 10*	61.5%	62.2%	0.7		8th	69.6% ▼
Getting Care Quickly *% Usually or Always*	77.3%	73.4%	-3.9		<5th	85.8% ▼
How Well Doctors Communicate + *% Usually or Always*	89.5%	91.3%	1.8		11th	94.0%
Coordination of Care + *% Usually or Always*	81.6%	82.8%	1.2		39th	84.2%
Rating of Personal Doctor *% 9 or 10*	70.9%	68.5%	-2.4		<5th	76.5% ▼
Rating of Specialist + *% 9 or 10*	73.6%	70.0%	-3.6		38th	72.3%

HPSJ plans to send more information to members, starting a shorter survey that will be sent to random members after they have a visit with their doctors to get more information about specific offices as a way to determine potential barriers to care or issues with individual provider offices.

The Health Plan of San Joaquin (HPSJ) Community & Cultural Detailing Report of 2023 indicates the following about recent primary care visits:

- The ratio of primary care providers to the general population lags state and national averages.

Figure 7: California Public Health Data- Recent PCP Visit within the Past Year

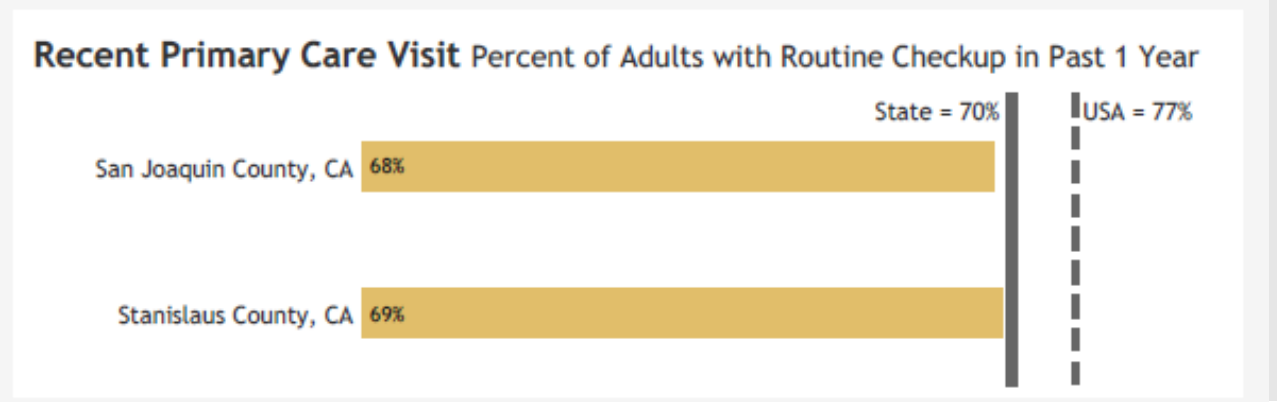


Figure 8: California Public Health Data- Federally Qualified Health Centers per 100k People

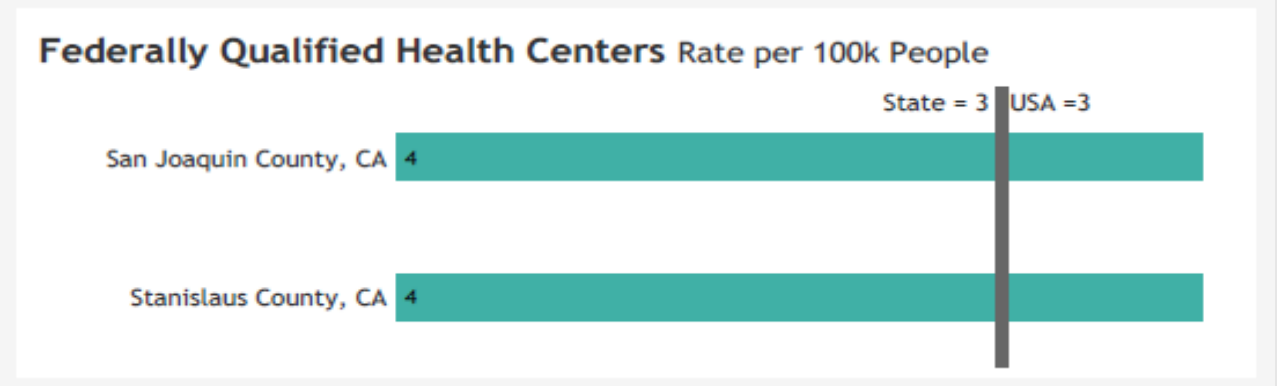
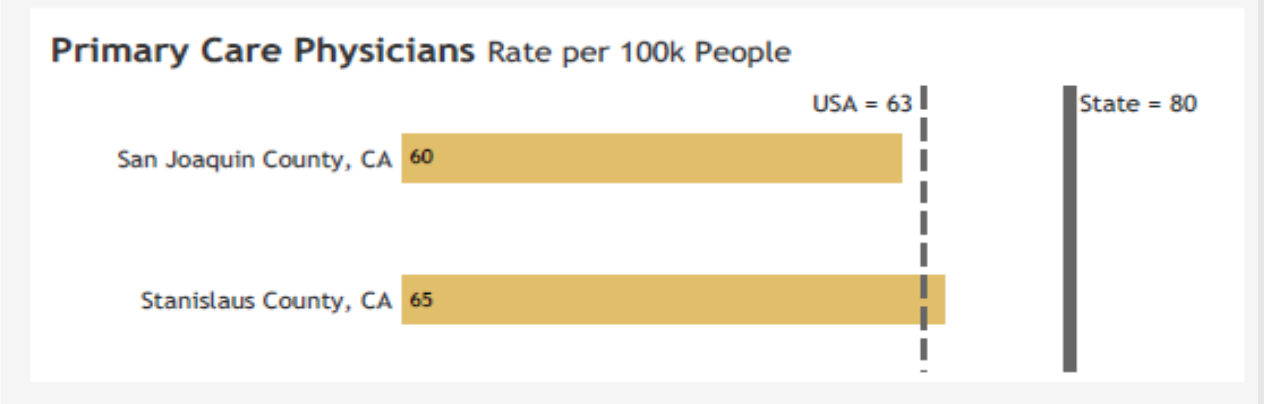


Figure 9: California Public Health Data- Primary Care Physicians per 100k People



Barriers contributing to access to care are:

- Poor access to affordable health and dental insurance,
- Few high-quality health care providers (including urgent care and mental health),
- Living in rural areas,
- Lack of transportation,
- Lack of knowledge of available services,
- Language and cultural barriers to health care,
- Perception that doctors don't understand the community's culture,
- Fear of prejudice from providers,
- Inadequate interpretation services at clinics, and
- Low physician, dentists, and behavioral health providers to population ratios.

Qualitative Analysis

National County Health Rankings data demonstrates a community wide access to care issue across Stanislaus and San Joaquin Counties. In both counties the population to PCP ratio is higher than ratio in California and the United States meaning there are less PCP's available to meet the needs of residents in the area.

Table 7: National County Health Rankings: Population per PCP Ratio, San Joaquin County

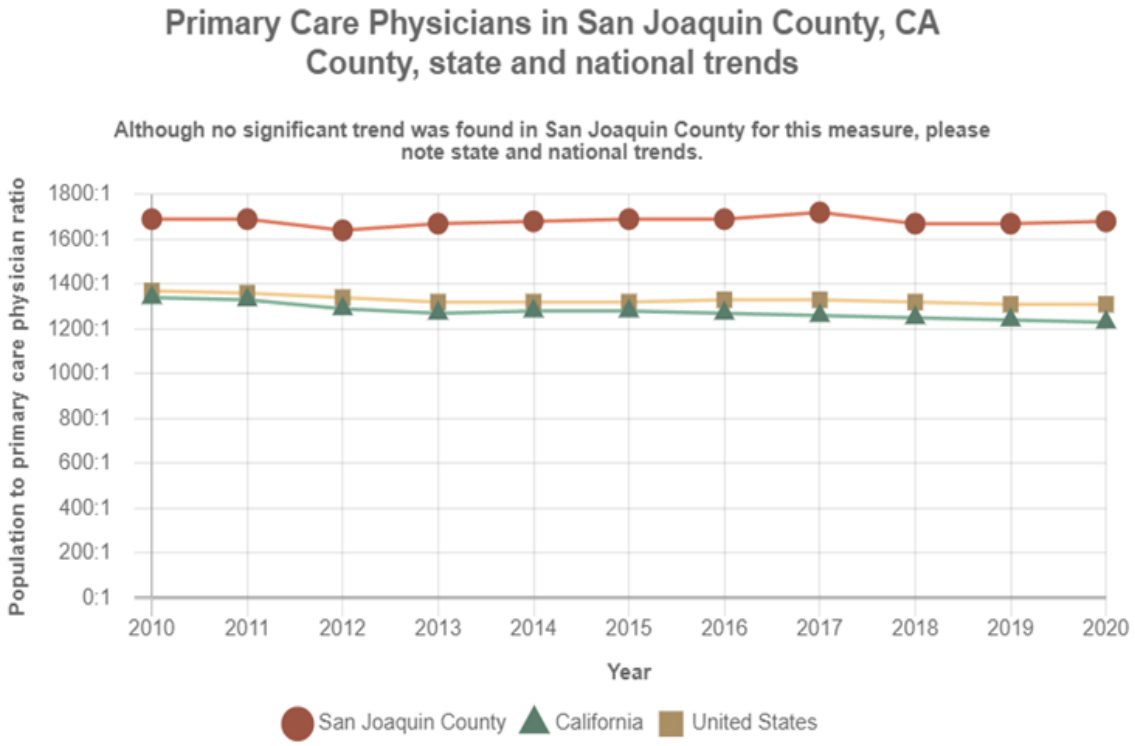
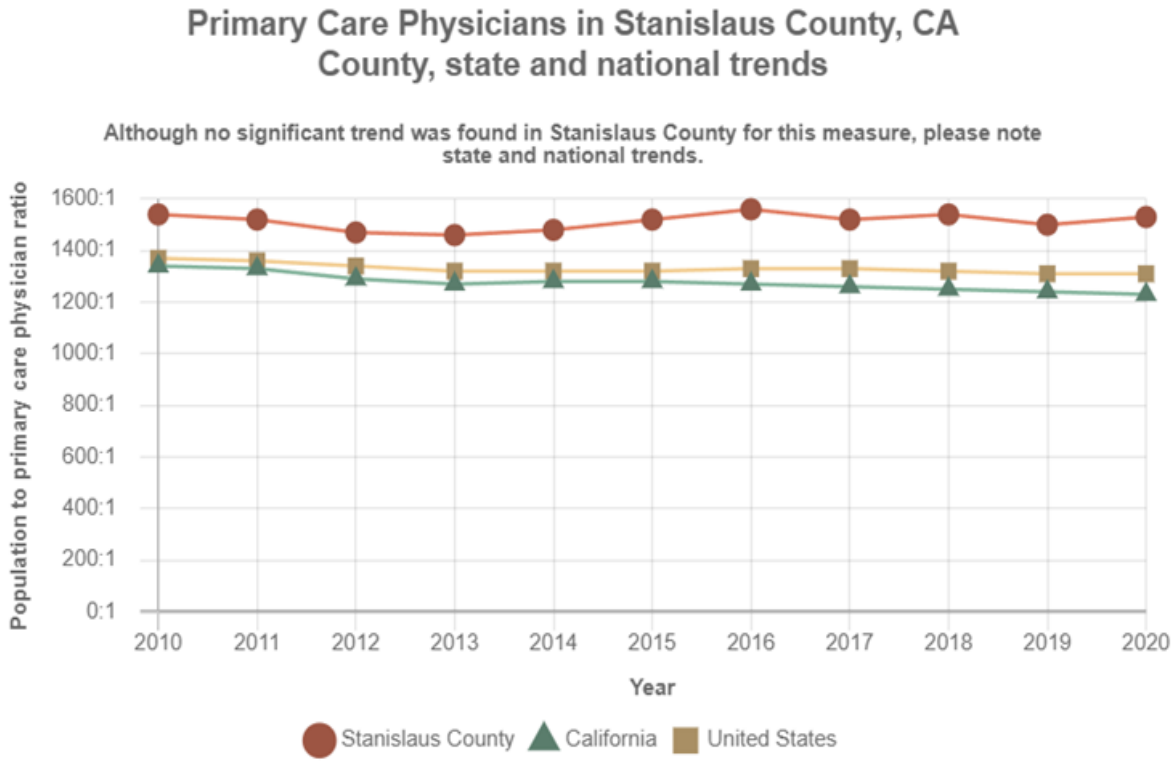
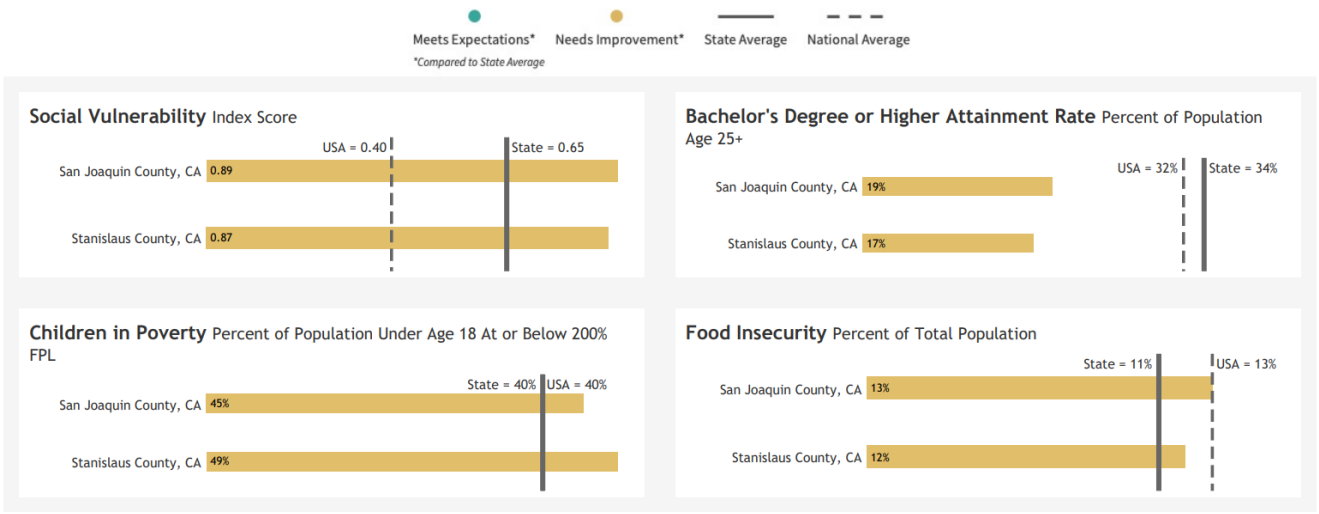


Table 8: National County Health Rankings: Population per PCP Ratio, Stanislaus County



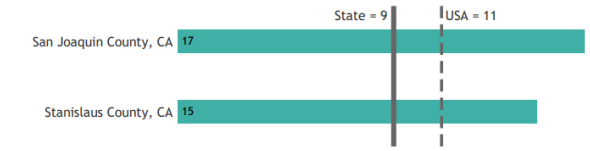
Health Disparities

Health disparities were evaluated through a Community Detailing report completed by HPSJ's Community Engagement Vendor, SameSky Health. SameSky Health prepared a report highlighting social determinants of health which includes access to care, education, food insecurity, overall poverty level, and other socioeconomic factors. The following tables represent results of those findings in comparing San Joaquin and Stanislaus Counties to California State rates. Health Plan uses this data to tailor improvement initiatives to achieve the most desirable impact.



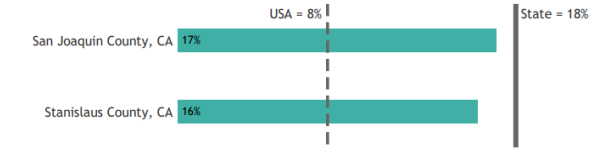
Grocery Stores Establishments per 100k People

Head Start Programs Rate per 10k Children

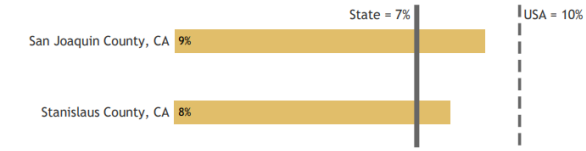


Health Professional Shortage Area Percent of Population Living in HPSA

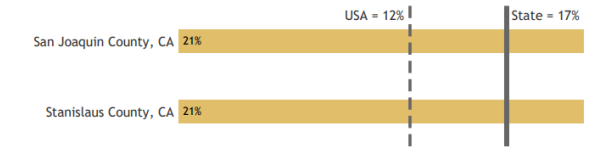
Limited English Proficiency Percent of Population Age 5+



No Computer Percent of Households

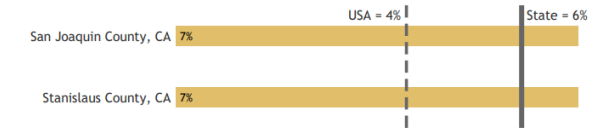


No High School Diploma Percent of Population Age 25+

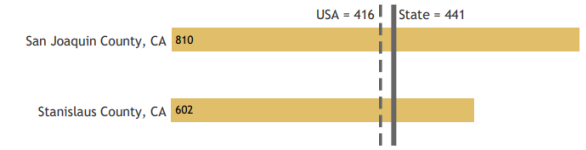


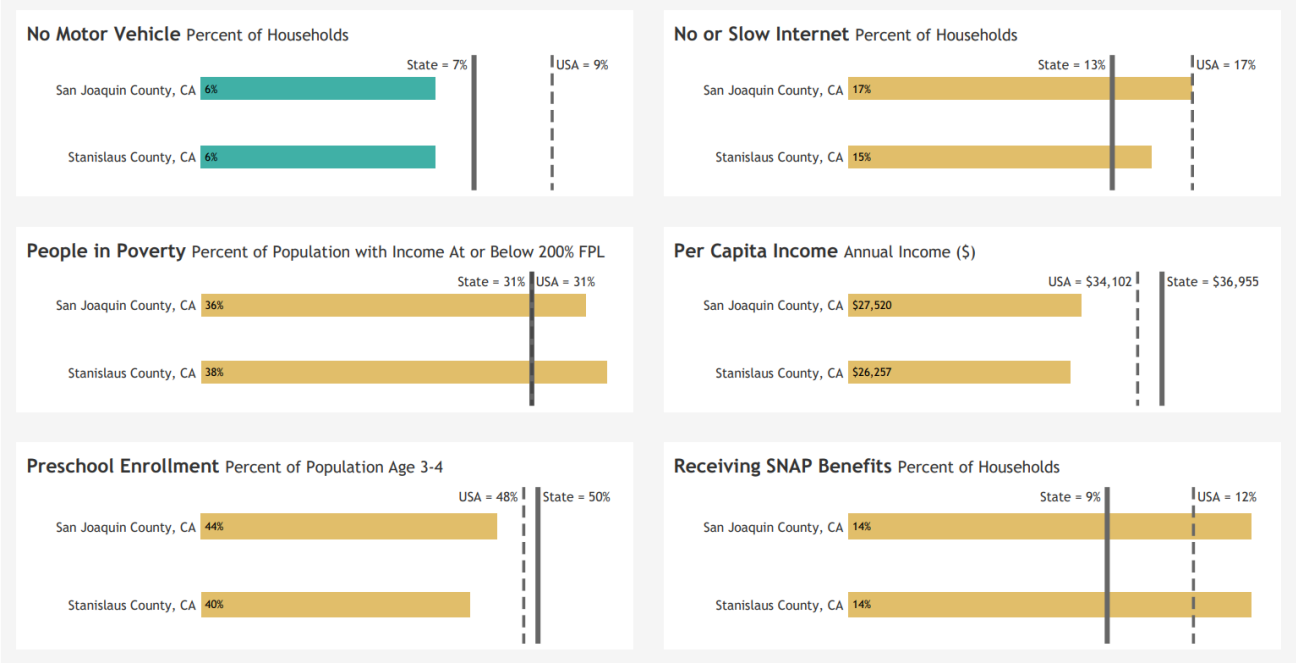
SNAP-Authorized Retailers Rate per 10k People

Unemployment Rate



Violent Crime Annual Rate per 100k Population





Health Education, C&L, and/or Quality Improvement Program Gap Analysis

Key Data Assessment Findings noted in this report provide insight into areas that need improvement across HPSJ membership. It is important to analyze these findings to address any weaknesses or shortcomings in internal processes that may affect how members access and receive care. This gap analysis seeks to prioritize the needs of HPSJ membership and informs the PNA action plan that serves as a guide on how to deploy resources and focus internal efforts.

Health Education:

Diabetes Prevention Program (DPP):

In April 2023, HPSJ received communications from Melon Health DPP vendor that they would no longer be providing DPP as a program. As of May 1, 2023, HPSJ members would lose access to DPP through Melon health. The following is a reflection of DPP members through Melon Health from January 1, 2023, through April 30, 2023:

2023 Engagement:

- Total number of enrollments: 33
- Total number engaged in Melon program: 30
- Number of people who agreed to participate but did not complete registration from their end): 18

Members had a recorded weight loss as high as 24 pounds since starting the program with others reporting 10, 14, and 18 pounds with an average weight loss of 8.5 pounds.

4 participants completed the 12-month DPP program. One continues to use the platform even after completing because she found it so helpful.

As of September 1, 2023, HPSJ is working with Inspiring Communities as the new DPP provider.

Outreach initiatives

The goal over the next 3 months is to relaunch DPP under the new DPP provider. HPSJ will work with Inspiring Communities to identify potentially eligible beneficiaries for the program. Together, Inspiring Communities and HPSJ will be responsible for collaborating and administering enrollment campaigns through phone, email, or any other communication channels to which HPSJ and Melon agree, using beneficiary contact information provided by HPSJ in a HIPAA compliant manner. Current initiatives have been focused on a phone enrollment campaign.

Cultural and Linguistics:

Although the overall goal of increasing our Interpreted Encounters vs. LEP Membership Ratio for 2022-23 was met, there is still disparity in some LEP groups, and the goal of increasing the interpreted encounters vs. LEP membership ratio for Hmong and Khmer was not met More education and more awareness about language assistance will be provided to the community (i.e. providers and members) in order to increase awareness of qualified interpreter services and the benefits in order to continue improving this metric. Khmer (Cambodian) and Hmong, for example, were identified as groups with higher members but lower utilization. A magnet campaign (refrigerator magnet with onsite interpreter scheduling instructions) was developed with intention to launch in FY23 but was not launched until July of FY24 (Chinese was identified and added as well). Utilization in these and other low interpreted encounter languages will be monitored carefully in FY24, and strategies will continue to be evaluated. Without direct the targeted intervention of the magnet campaign, Hmong and Khmer interpreted encounters did increase, but the Hmong encounter ratio to Hmong membership remained about the same, and Khmer increased by only about 1%. The data below shows the breakdown.

Table 9: Utilization of Language Assistance Services Among Khmer and Hmong Members FY2022 (Encounter Language Study FY23, Khmer, Hmong, Chinese Study FY23)

Month	Hmong Encounters	Hmong Membership	Khmer (Cambodian) Encounters	Khmer (Cambodian) Membership
Jul 2021	16	1323	19	2709
Aug 2021	13	1325	21	2713
Sep 2021	7	1326	23	2722
Oct 2021	2	1318	16	2723
Nov 2021	14	1316	18	2721
Dec 2021	5	1315	29	2722
Jan 2022	5	1242	33	2572
Feb 2022	6	1244	18	2567
Mar 2022	11	1305	33	2712
Apr 2022	8	1247	9	2709
May 2022	9	1311	22	2704
Jun 2022	9	1303	22	2689
Average totals	**9**	**1303**	**22**	**2687**
%	**1%**		**1%**	

Table 10: Utilization of Language Assistance Services Among Khmer and Hmong Members FY2023 (Encounter Language Study FY23, Khmer, Hmong, Chinese Study FY23)

Month	Hmong Encounters	Hmong Membership	Khmer (Cambodian) Encounters	Khmer (Cambodian) Membership
Jul 2022	10	1309	56	2811
Aug 2022	15	1304	51	2817
Sep 2022	11	1294	66	2822
Oct 2022	19	1289	79	2816
Nov 2022	9	1298	69	2811
Dec 2022	9	559	60	1134
Jan 2023	23	1286	77	2799
Feb 2023	13	1295	81	2839
Mar 2023	19	1309	77	2843
Apr 2023	14	1312	91	2834
May 2023	30	1311	67	2833
Jun 2023	27	1308	79	2842
Average totals	**17**	**1240**	**71**	**2700**

Ave Encounter vs. Membership Ration %	**1.4%**		**2.7%**	

Action Plan

Objective 1: Objective was brought forward from reporting year 2020. The objective was to increase the overall utilization of language assistance by 8% by June 30, 2023. Categories included members, providers, internal staff. Baseline for 2021 changed from 22.5% to 24%, HPSJ used Member interpretation Utilization Report to establish focus goal for 2022-23.

Though HPSJ has met the overall focus goal for 2022-23 and overall Interpreter Encounters vs. LEP Membership is at 54%, there are still disparities identified in LEP populations that require focused strategies for spreading awareness and importance of language assistance services. Based on member utilization data, the number of interpreted encounters in certain LEP groups does not reflect the membership populations of those groups.

Objective 1	Increase language access to member interpretation Request by this group	2022 Increase Hmong 1% - 3%	2023 No Change
Objective 2	Increase language access to member interpretation Request by this group	Increase Cambodian (Khmer) 1% - 3%	~1%+

The FY24 goal will remain to increase utilization in these languages, with a goal of 3% increase in interpreted encounters vs LEP membership by 3% by fiscal year end. The magnet campaign has been launched for these languages and Chinese, and progress will be monitored on a monthly basis.

Overall FY24 goal is to Increase overall utilization of interpreted encounters for members language assistance by 358% by June 30, 2023, and interpreted encounters vs. membership preferred spoken language ratio by 15% by June 30, 2024.

Strategies	Progress Discussion

1. Disseminate culturally relevant resources to members to inform them of interpreting services that could assist them in understanding the health forms and other member informing materials so they can make informed decisions.	So far this is accomplished primarily through the Language Assistance Notice that is sent out with certain member-informing materials. Will also share in CAC in FY24Q2.
2. Share complaints and grievance data with providers to communicate opportunities for improvement, educate on best practices to ensure availability and access to qualified language assistance tools and resources. Monitor grievances related to language assistance and interpretive services.	Strategy and implementation in 2023 for dissemination of complaint and grievance data under development. Complaints and grievances are currently carefully monitored by C&L and Grievance team.
3. Expansion of C&L Services, making video interpretation available to providers. Decrease the barrier having to schedule interpretive services and give providers instantaneous access. Three FQHCs have VRI/OPI systems implemented	Will continue this campaign in FY24 in existing counties, and in two new counties.
4. Perform annual member satisfaction survey to gather feedback on language assistance services. Including CAHPS survey on ease of understanding written materials and ease of filling out forms.	Strategy and implementation ongoing into FY24.

Objective 2: Increase the rate of completed well child visits in ages 0-15 months, 15-30 months, and children and adolescents from 3-21 years to above the 50th percentile based on the National Medicaid 50th percentile by 12/31/2024 by implementing children's health milestone initiatives focused on developmental milestones and incentivizing preventive care.

Strategies	**Progress Discussion**
1. Create myHealth health education campaign inclusive of health education materials, website and supporting items.	Children's Milestone Booklet completed and sent to WIC Agencies, FQHC partners.
2. Engage and test campaign with community partners including Black Infant Health, local FQHC's and MCAH programs.	Booklet tested with BIH team. 500 copies sent to BIH for use.
3. Educational mailing inclusive of well child message and incentive information for members.	Mailings completed. Reached over 100,000 members.

4. Work directly with providers and FQHC's to complete outreach calls for well child visits based on HEDIS gaps in care lists for key providers.	Completed outreach calls for 4 clinic partners.

Objective 3: Increase enrollment and retention in Diabetes Prevention Program by 5% as compared to baseline established June 1, 2022, by June 30, 2024.

Data Source: Melon Health Diabetes Prevention Program KPI Report

Strategies	Progress Discussion
1. Collect member emails for email campaign of DPP services through	
2. Increase opportunities for outreach inclusive of calls, mailing, and newsletter	
3. Promote DPP among providers/partners and engage them in direct referral processes to increase referral sources across member touchpoints.	
4. Work with Promotora network in Stanislaus County to engage community in DPP referrals.	

Objective 4: Objective 4 is a project brought forward from 2020. By December 31, 2022, to increase the rate of compliance for cervical cancer screenings among White/Caucasian women ages 24-64 years of age at (Golden Valley Health Center) GVHC's West Modesto Clinic and residing in Stanislaus County from 49.52% to 55.73%.

Data Source:

•Care Gap Finder Reports; Baseline 12/2020

- DHCS EQRO indicates a decrease in rates from 2015 [57.18%] through 2017 [2016=49.39%.

2017=47.20%] for Stanislaus County

- DHCS 2016 Health Disparities Report [published May 2019]; CCS – 4 Health Disparities were identified for CCS indicator: Asian, Black/African Americans, Hispanic/Latino, and "Other" groups were better than the rate for Whites.
- The 2019 DHCS Disparities report was not included in the data set due to DHCS not including CCS in the analysis.
- Our overall data still shows this disparity in ST county

Strategies	Progress Discussion
Continue to partner with the FQHC with the largest population for this measure to leverage the best impact; this FQHC must have the disparity mirrored in their population. After reviewing the data mentioned above. HPSJ Partnered with GVHC to select the West Modesto GVHC clinic as a target population for this activity.	Final comparison of rates demonstrated a 2.31% decrease in rates for this objective. Based on this decrease we can conclude that the intervention implemented for this study was not successful.
Warm transfer through population health team utilizing targeted gaps in care lists for specific women's health one day a week as agreed upon by the FQHC partner. This Is centered around cervical cancer screening calls but includes messaging around breast cancer screening and colorectal cancer screening when applicable.	Although the intervention did not impact the rate as we hoped for, there are other barriers that could have possibly affected the rate change. These include member-related challenges, as well as provider related factors. The study had very limited implementation period. Calls started in April of 2022 and needed to be concluded by October. The combination of all the factors impacted the outcome of the study.

Share monthly gaps in care lists with FQHC partners to engage in quality improvement discussions and provide ongoing process evaluation. Gap lists are specific to the clinic and include gaps specific to women's health (BCS, CC S).	Gap lists were utilized and shared on an ongoing basis.
Facilitate ongoing meetings to provide opportunities for planning and discussion around gaps in care clinic days. Monthly or bi-monthly meetings allow HPSJ and GVHC to identify barriers and discuss other opportunities to outreach and connect with members experiencing this disparity.	Positive outcome includes GVHC finding value add to call campaign despite decrease in rates. Partnership helped to facilitate discussion around direct scheduling and opened opportunities to address other MCAS measures.

References

Department of Health Care Services (DHCS) (2020). MY2020 CA DHCS Health Disparities HPSJ Rate Sheet. [Excel File]

San Joaquin County Community Health Assessment Collaborative (SJC2HAC). (2020). *San Joaquin County 2019 Community Health Needs Assessment*. Healthier San Joaquin. Retrieved from: https://www.healthiersanjoaquin.org/download.htm

HPSJ Community Engagement Vendor. (2023). *HPSJ Community and Cultural Detailing Report.* San Joaquin County, Stanislaus County. [PDF File].

Lucile Packard Foundation for Children's Health. (2021). *KidsData.org Platform*. Retrieved from https://www.kidsdata.org/?site=full

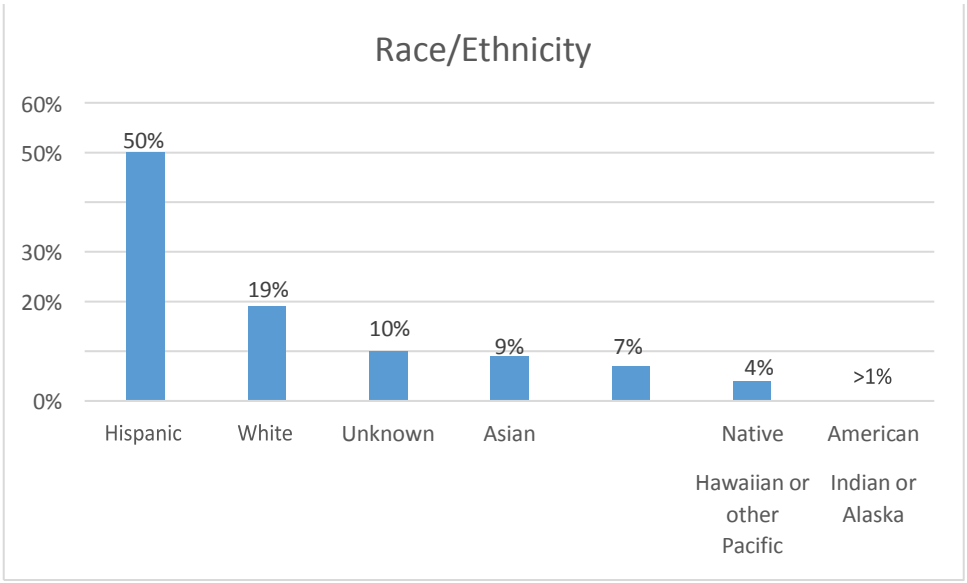
UCLA California Health Information Survey. (CHIS). (2011-2012). *AskCHIS Neighborhood Edition.*

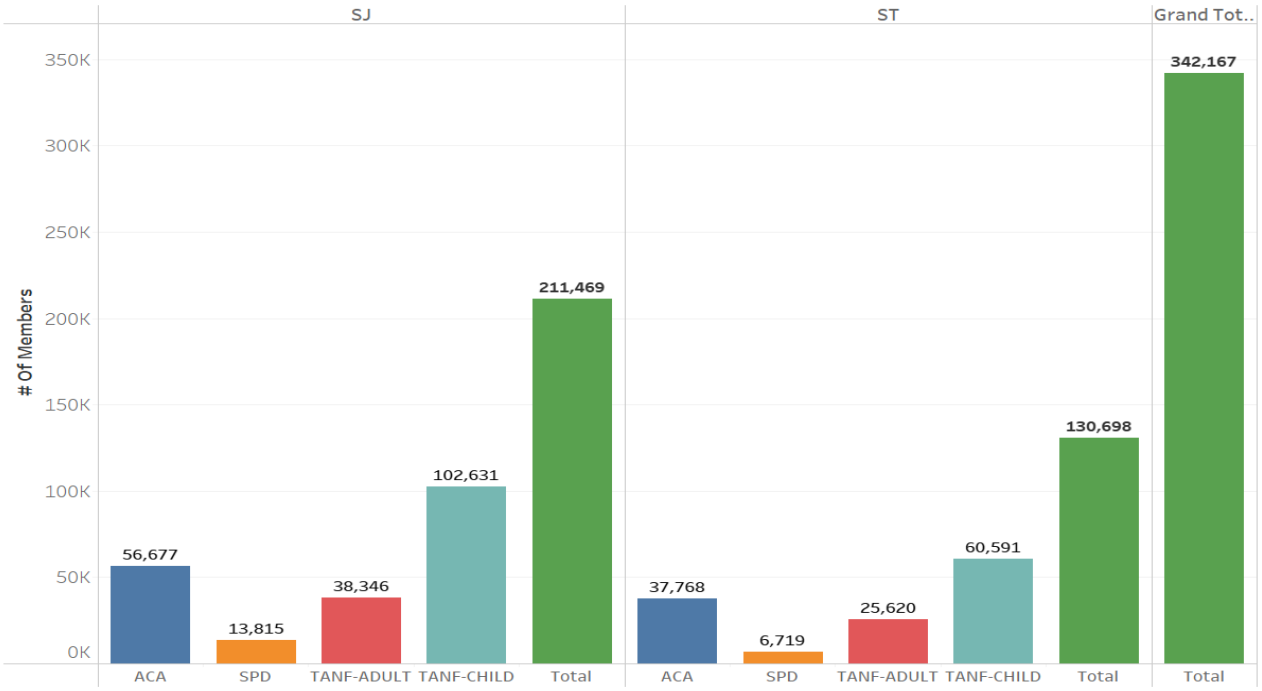
Retrieved from: http://askchisne.ucla.edu/

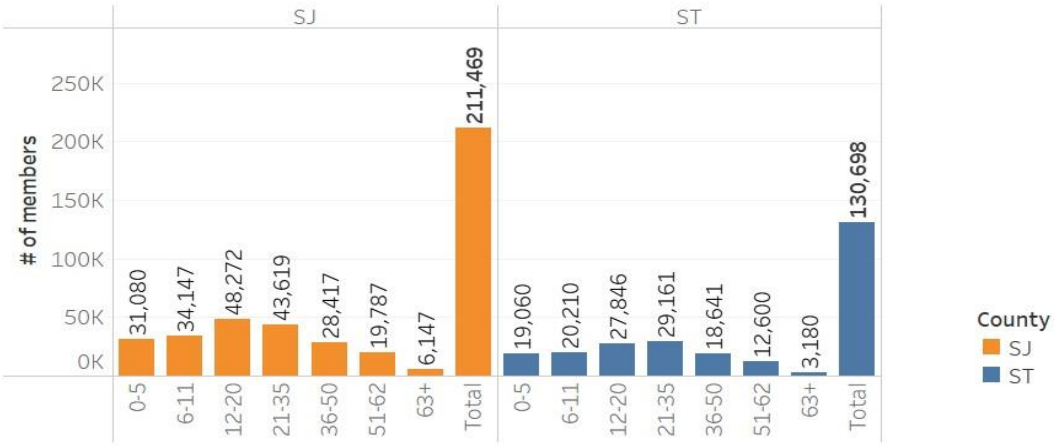
(2020). *Stanislaus County Community Health Assessment*. Stanislaus County Health Services Agency, Data and Publications.

Symphony Performance Health (SPH). (2023). *2023 CAHPS Medicaid Final Report: Health Plan of San Joaquin*. Consumer Assessment of Healthcare Providers and Systems Survey.

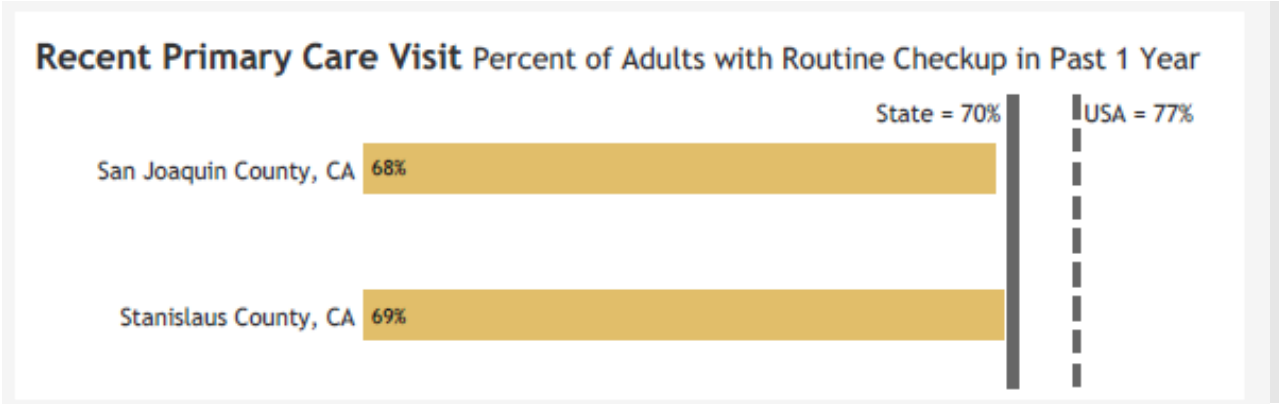
Stanislaus County Health Services Agency, Public Health Division. [PDF File]

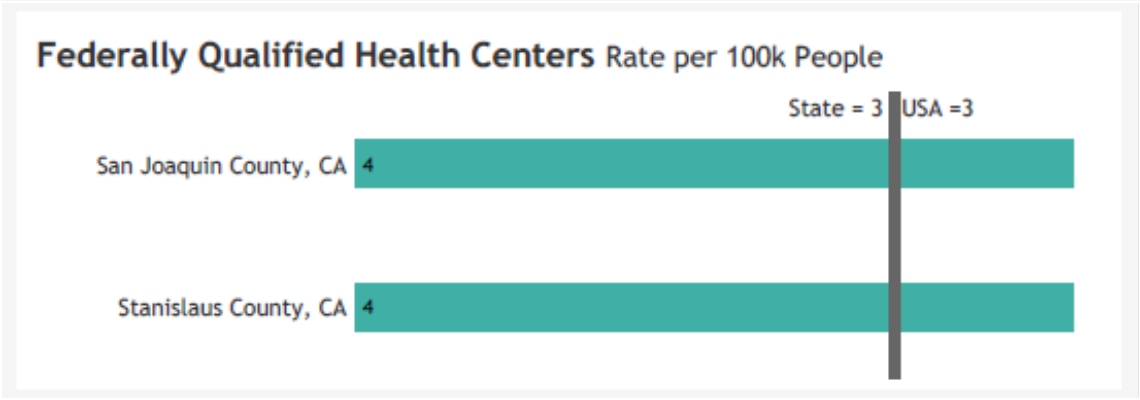


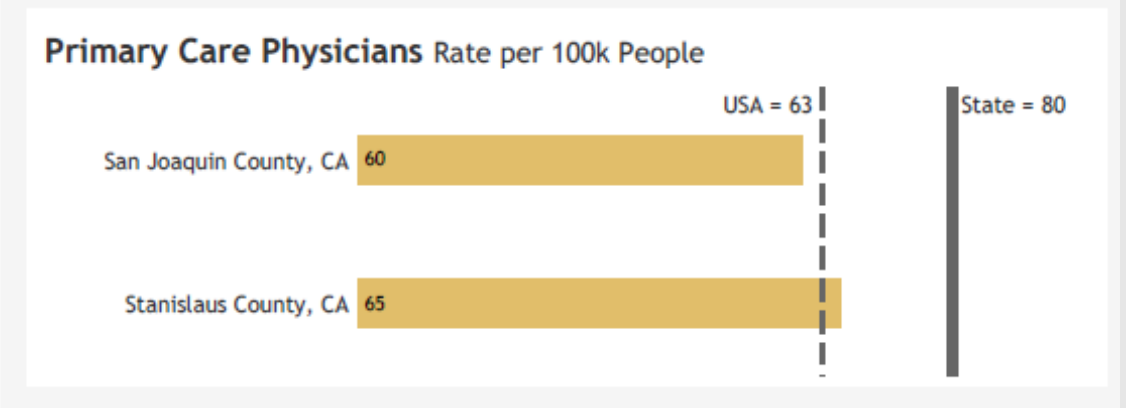


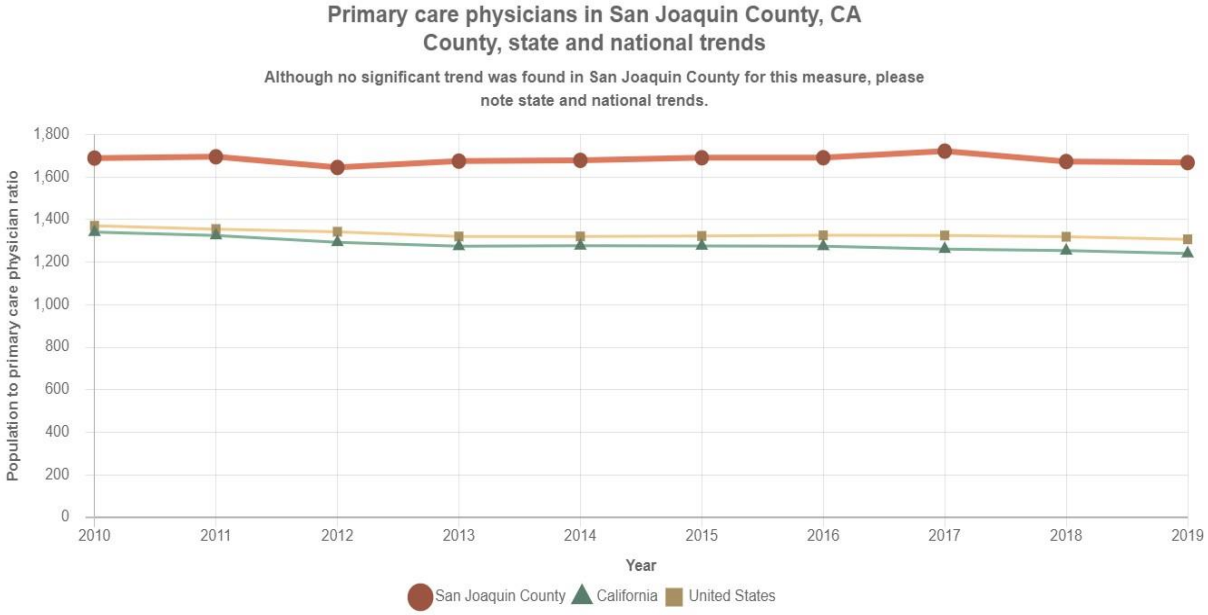


County	0-5	6-11	12-20	21-35	36-50	51-62	63+	Grand Total
SJ	31,080	34,147	48,272	43,619	28,417	19,787	6,147	**211,469**
ST	19,060	20,210	27,846	29,161	18,641	12,600	3,180	**130,698**
Grand ..	**50,140**	**54,357**	**76,118**	**72,780**	**47,058**	**32,387**	**9,327**	**342,167**

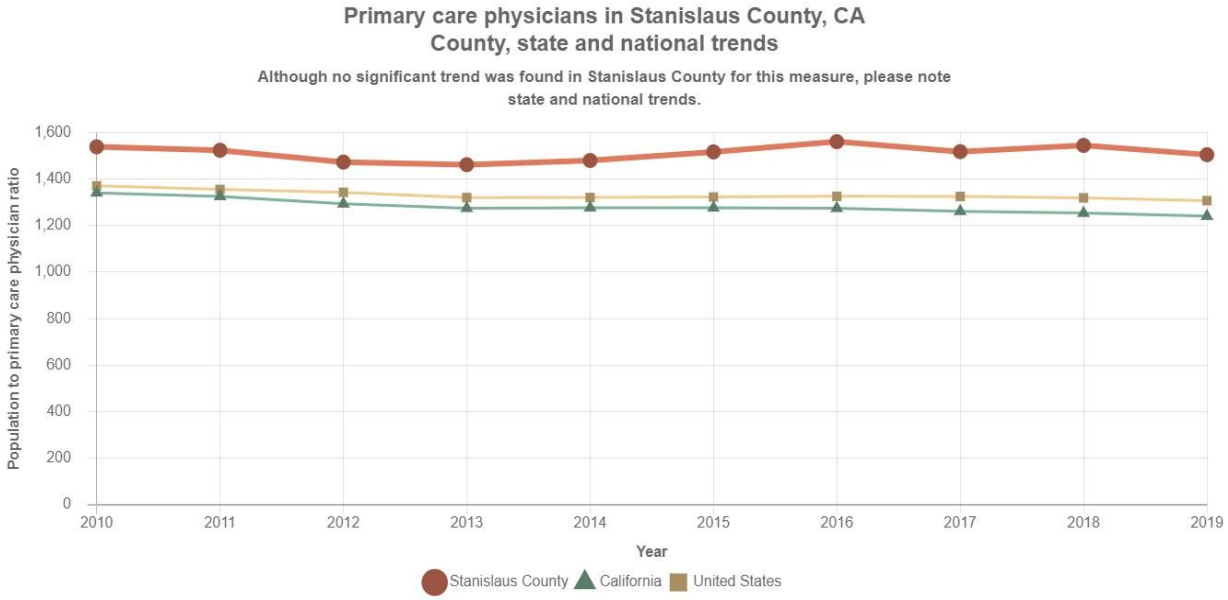








Notes:
The data in this table reflect the average population served by a single primary care physician.



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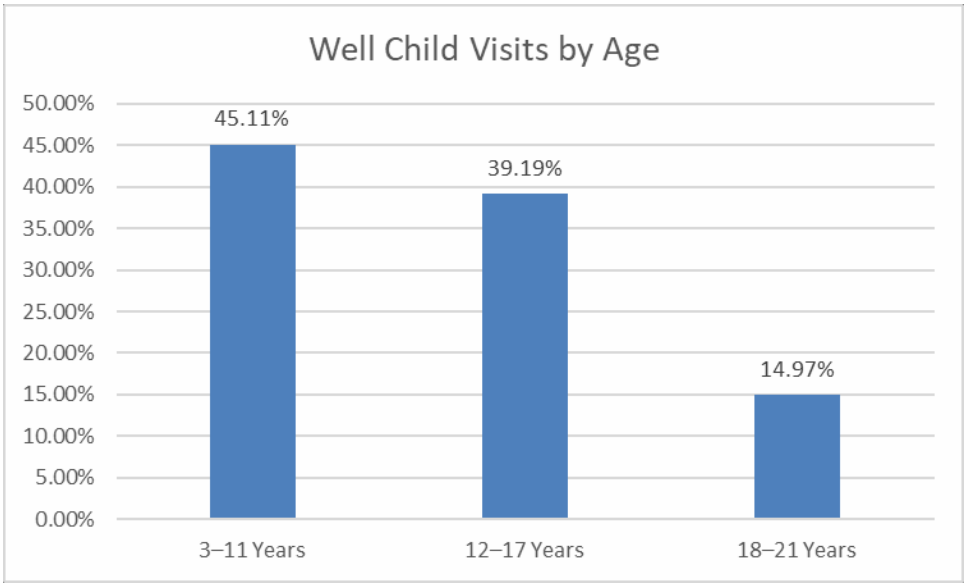
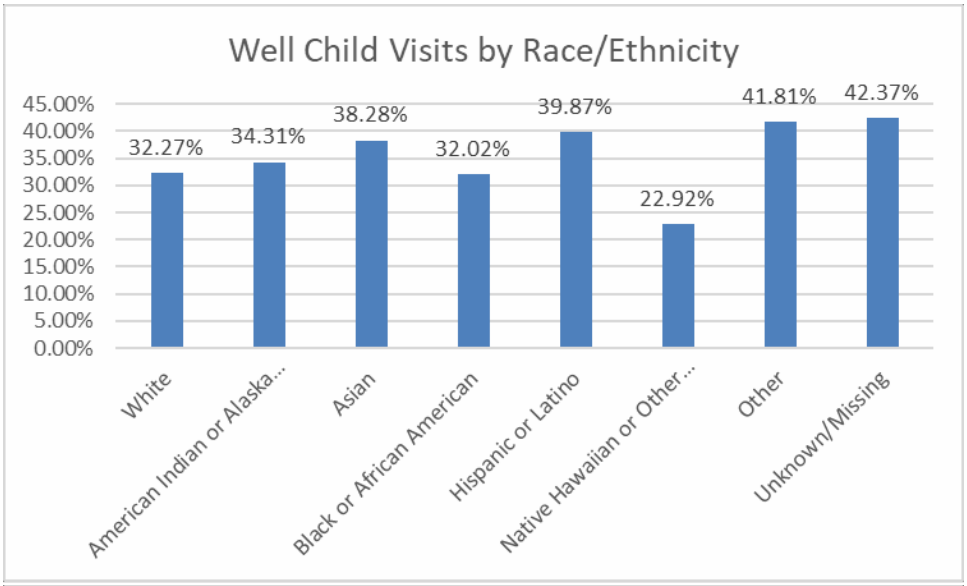
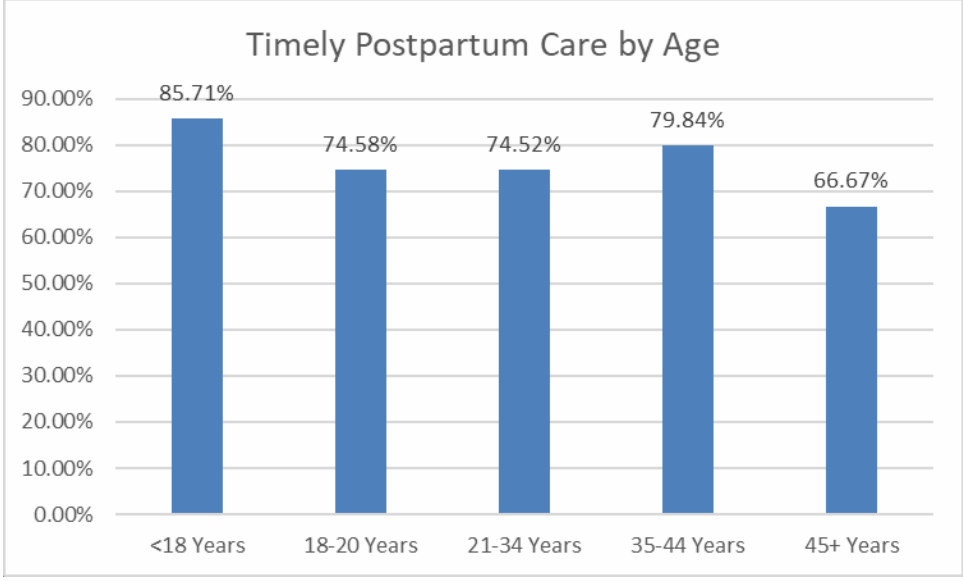
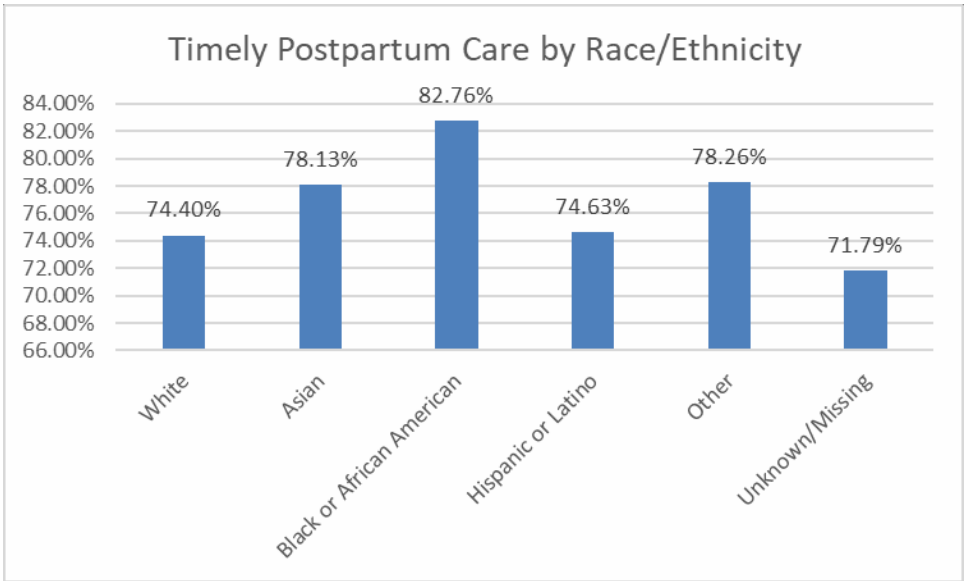
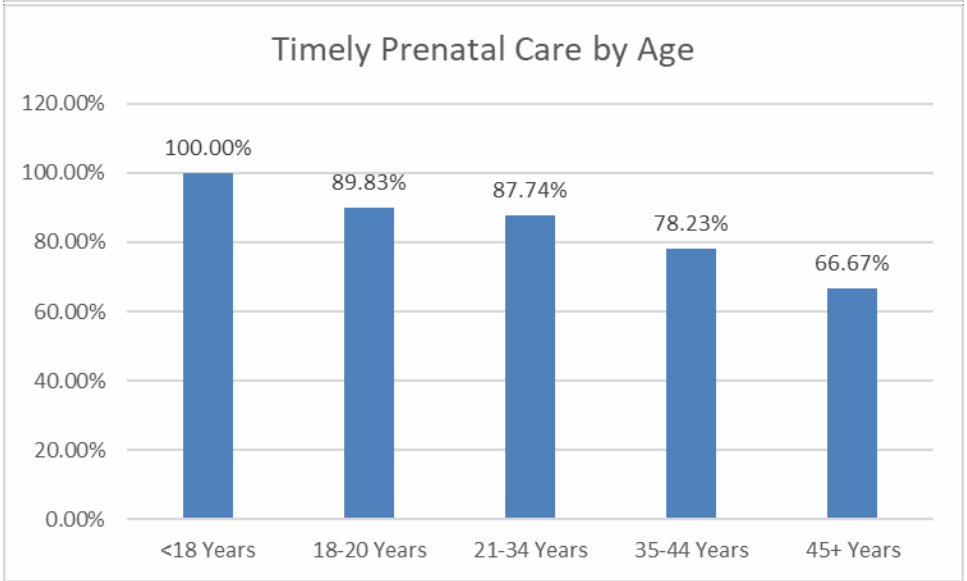
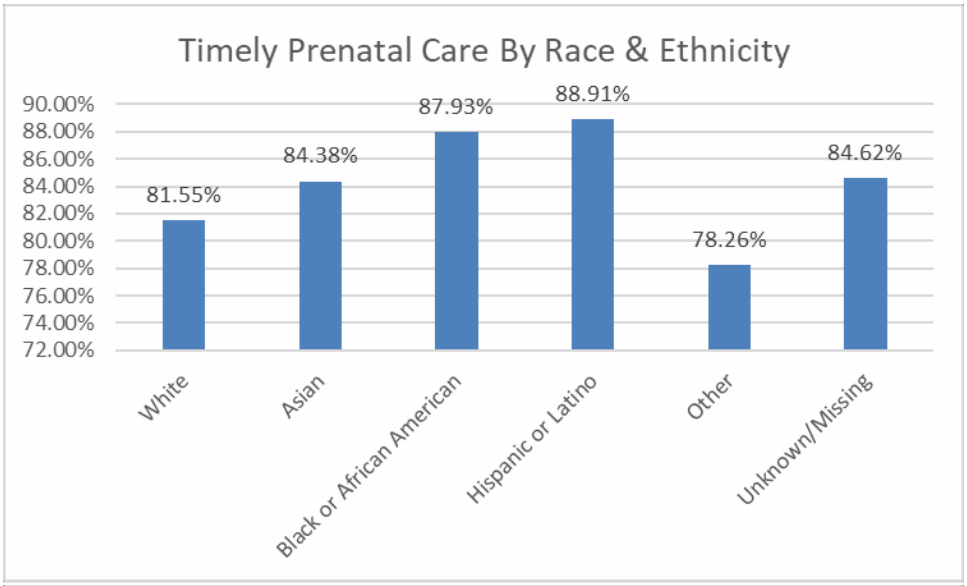


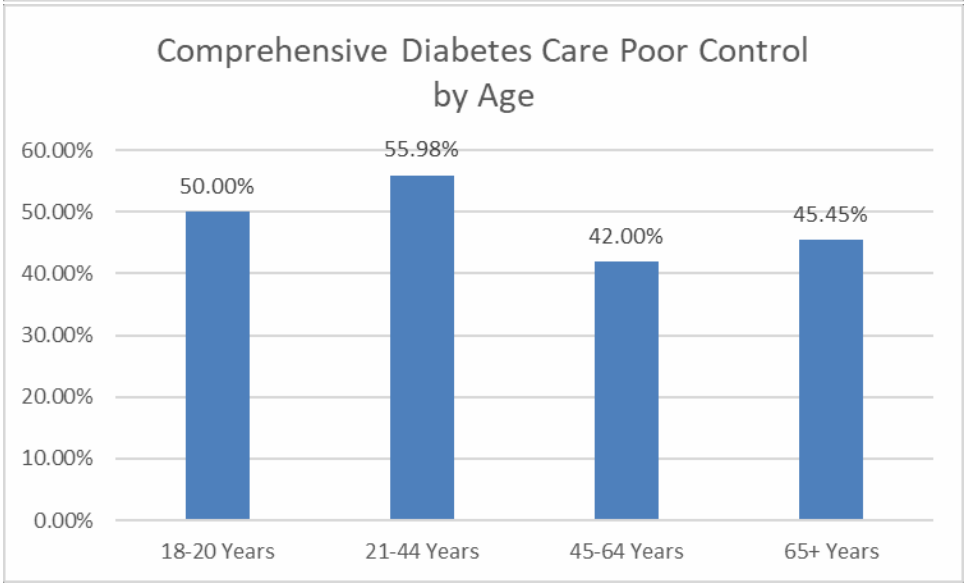


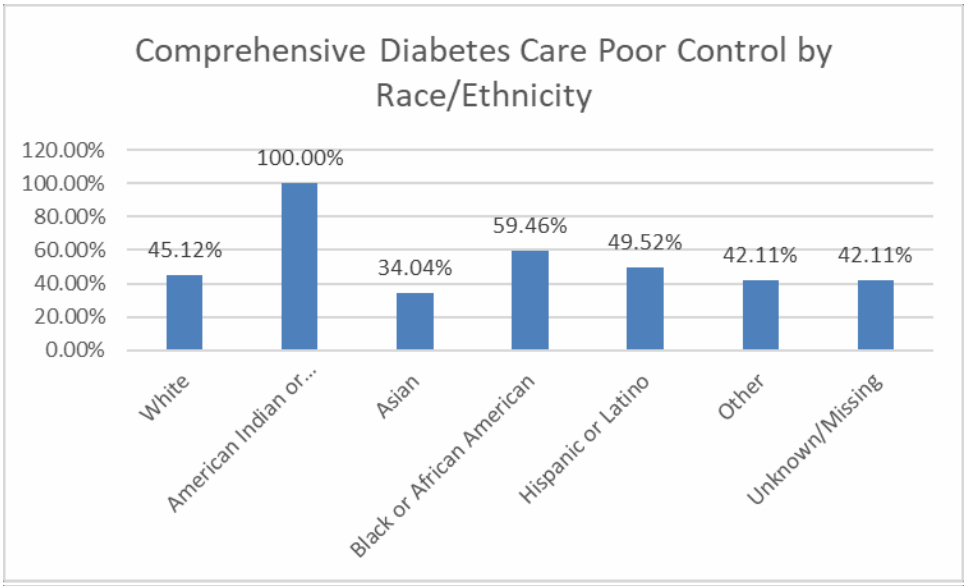


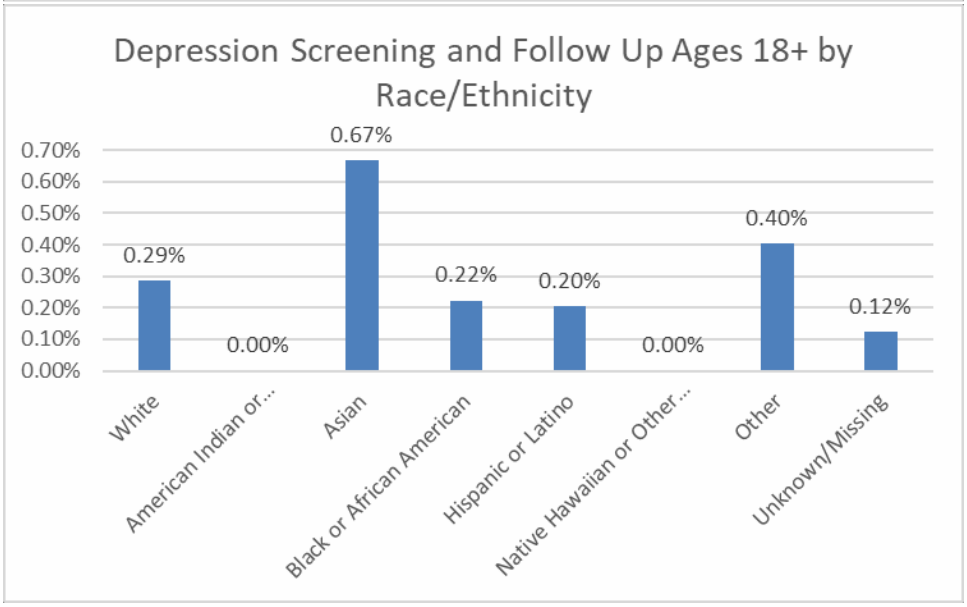












Equity Evaluation

DHCS Quality Metrics for Equity with Benchmarks

Race Stratifications by Measure

	Race Stratifications by Measure for MY2022 & MY2023								
	White	Black or African American	American Indian/ Alaska Native	Asian	Native Hawaiian/ Other Pacific Islander	Some Other Race	Two Or More Races	Asked But No Answer	Unknown
Measure	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
CBP MY2022	62.56%	55.32%	40.00%	54.42%	65.22%	0.00%	0.00%	66.67%	60.43%
CBP MY2023	63.33%	67.86%	44.44%	58.16%	75.00%	0.00%	0.00%	72.22%	65.83%
HBD >8% MY2022	45.28%	43.29%	45.75%	59.90%	49.91%	44.09%	0.00%	55.52%	44.64%
HBD >8% MY2023	42.70%	37.50%	42.50%	51.98%	40.27%	41.82%	0.00%	50.43%	42.86%
HBD >9% MY2022	32.26%	39.47%	53.85%	24.03%	51.85%	0.00%	0.00%	15.38%	43.40%
HBD >9% MY2023	35.29%	51.35%	75.00%	26.32%	44.44%	0.00%	0.00%	40.00%	34.92%
COL MY2022	24.86%	26.63%	25.70%	33.27%	25.58%	0.00%	0.00%	32.57%	26.90%
COL MY2023	24.33%	26.02%	23.72%	31.18%	23.77%	0.00%	0.00%	35.75%	25.88%
BCS-E MY2022	39.30%	48.80%	38.66%	51.52%	42.34%	52.44%	0.00%	48.17%	55.97%
BCS-E MY2023	43.07%	51.87%	41.12%	52.00%	45.03%	55.17%	0.00%	52.23%	53.24%
PPC-Pre MY2022	85.71%	82.76%	66.67%	88.31%	81.82%	0.00%	0.00%	100.00%	87.87%
PPC-Pre MY2023	85.62%	79.66%	75.00%	87.36%	90.00%	0.00%	0.00%	88.89%	86.23%
PPC-Post MY2022	70.78%	70.69%	66.67%	80.52%	72.73%	0.00%	0.00%	80.00%	83.50%
PPC-Post MY2023	90.20%	76.60%	66.67%	84.38%	66.67%	0.00%	0.00%	100.00%	85.40%
WCV MY2022	37.61%	41.85%	47.30%	48.94%	43.13%	0.00%	0.00%	50.63%	46.51%
WCV MY2023	42.95%	42.57%	51.34%	50.13%	44.74%	0.00%	0.00%	54.35%	51.48%
W30-0-15 MY2022	34.94%	32.45%	54.55%	54.27%	39.62%	0.00%	0.00%	45.45%	45.46%

	Race Stratifications by Measure for MY2022 & MY2023								
	White	Black or African American	American Indian/ Alaska Native	Asian	Native Hawaiian/ Other Pacific Islander	Some Other Race	Two Or More Races	Asked But No Answer	Unknown
Measure	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
W30-0-15 MY2023	50.70%	39.43%	29.41%	59.93%	40.54%	0.00%	0.00%	56.25%	52.56%
W30-15-30 MY2022	53.67%	47.18%	63.33%	72.02%	64.76%	0.00%	0.00%	64.15%	59.22%
W30-15-30 MY2023	59.00%	50.70%	47.83%	67.62%	56.96%	0.00%	0.00%	61.70%	63.56%
CIS MY2022	25.33%	26.92%	25.00%	36.96%	50.00%	0.00%	0.00%	0.00%	28.59%
CIS MY2023	13.88%	13.01%	10.00%	27.62%	16.46%	0.00%	0.00%	11.63%	20.37%
IMA MY2022	24.37%	27.43%	36.00%	38.18%	32.24%	0.00%	0.00%	18.97%	37.58%
IMA MY2023	23.42%	29.30%	23.68%	39.78%	33.70%	0.00%	0.00%	27.88%	40.34%
DSF-E-S MY2022	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DSF-E-S MY2023	9.29%	16.66%	15.88%	15.51%	13.23%	0.00%	0.00%	13.85%	12.94%
DSF-E-F MY2022	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DSF-E-F MY2023	66.51%	61.06%	80.00%	56.82%	58.82%	0.00%	0.00%	50.00%	63.93%
FUM 30D MY2022	50.43%	43.79%	50.00%	50.00%	43.48%	0.00%	0.00%	65.63%	50.25%
FUM 30D MY2023	22.96%	14.36%	21.43%	26.37%	31.58%	0.00%	0.00%	34.78%	28.50%
FUM 7D MY2022	50.43%	43.79%	50.00%	50.00%	43.48%	0.00%	0.00%	65.68%	50.25%
FUM 7D MY2023	12.58%	7.73%	14.29%	16.48%	15.79%	0.00%	0.00%	21.74%	17.55%
FUA 30D MY2022	19.85%	12.55%	25.93%	17.28%	12.00%	0.00%	0.00%	14.29%	16.67%

	Race Stratifications by Measure for MY2022 & MY2023								
	White	Black or African American	American Indian/ Alaska Native	Asian	Native Hawaiian/ Other Pacific Islander	Some Other Race	Two Or More Races	Asked But No Answer	Unknown
Measure	**Rate**	**Rate**	**Rate**	**Rate**	**Rate**	**Rate**	**Rate**	**Rate**	**Rate**
FUA 30D MY2023	24.79%	11.72%	20.00%	15.91%	5.56%	0.00%	0.00%	28.57%	18.32%
FUA 7D MY2022	19.85%	12.55%	25.93%	17.28%	12.00%	0.00%	0.00%	14.29%	16.67%
FUA 7D MY2023	16.69%	6.69%	12.50%	10.23%	0.00%	0.00%	0.00%	14.29%	11.96%
AMR MY2022	67.09%	67.24%	80.00%	72.41%	80.00%	72.14%	0.00%	72.22%	0.00%
AMR MY2023	69.62%	67.87%	77.78%	72.75%	77.46%	74.04%	0.00%	69.23%	68.42%
POD MY2022	20.54%	22.73%	14.29%	0.00%	0.00%	19.49%	0.00%	30.00%	0.00%
POD MY2023	19.59%	38.10%	22.22%	0.00%	0.00%	20.45%	0.00%	55.56%	0.00%
PCR MY2022	NR	NR	NR	NR	NR	NR	NR	NR	NR
PCR MY2023	11.13%	11.40%	12.12%	9.59%	9.21%	0.00%	0.00%	14.36%	8.64%

Ethnicity Stratification by Measure

	Ethnicity			
	Asked But Not Answered	Hispanic / Latino	Not Hispanic / Latino	Unknown
Measure	**Rate**	**Rate**	**Rate**	**Rate**
CBP MY2022	62.50%	60.00%	59.06%	62.16%
CBP MY2023	77.78%	65.41%	63.58%	50.00%
HBD >8% MY2022	0.00%	44.16%	28.36%	16.67%
HBD >8% MY2023	0.00%	45.50%	37.06%	17.65%
HBD >9% MY2022	39.34%	42.02%	35.89%	33.19%
HBD >9% MY2023	25.00%	41.20%	35.75%	17.65%
COL MY2022	38.03%	30.18%	31.75%	29.67%

COL MY2023	38.62%	30.78%	30.82%	25.09%
PPC-Pre MY2022	88.06%	83.23%	77.85%	82.67%
PPC-Pre MY2023	100.00%	86.09%	85.76%	0.00%
PPC-Post MY2022	70.15%	78.48%	71.07%	80.00%
PPC-Post MY2023	90.00%	86.29%	83.86%	0.00%
WCV MY2022	51.05%	47.11%	48.05%	54.92%
WCV MY2023	56.32%	49.44%	45.82%	46.56%
W30-0-15 MY2022	55.00%	46.94%	40.48%	44.10%
W30-0-15 MY2023	48.65%	51.77%	47.71%	18.75%
W30-15-30 MY2022	63.64%	60.48%	56.28%	57.87%
W30-15-30 MY2023	68.29%	64.74%	59.83%	58.14%
CIS MY2022	2.22%	20.06%	20.27%	21.86%
CIS MY2023	15.56%	20.64%	18.67%	5.26%
IMA MY2022	25.00%	38.19%	29.61%	31.52%
IMA MY2023	0.00%	39.27%	29.10%	0.00%
DSF-E-S MY2022	0.66%	0.87%	0.97%	1.38%
DSF-E-S MY2023	14.48%	13.03%	12.76%	7.32%
DSF-E-F MY2022	20.00%	80.92%	84.55%	89.66%
DSF-E-F MY2023	43.48%	63.35%	63.32%	100.00%
FUM 30D MY2022	75.00%	69.91%	71.08%	60.00%
FUM 30D MY2023	29.41%	28.24%	22.75%	20.00%
FUM 7D MY2022	65.00%	62.70%	62.07%	50.00%
FUM 7D MY2023	13.64%	17.82%	12.65%	0.00%
FUA 30D MY2022	8.33%	16.57%	18.99%	19.05%
FUA 30D MY2023	38.10%	10.31%	21.09%	0.00%
FUA 7D MY2022	8.33%	10.37%	13.29%	9.52%
FUA 7D MY2023	19.05%	11.94%	13.76%	0.00%
AMR MY2022	57.50%	74.49%	70.01%	75.63%
AMR MY2023	62.50%	67.01%	62.06%	60.00%
BCS-E MY2022	52.48%	55.83%	47.03%	50.28%
BCS-E MY2023	55.86%	56.48%	47.74%	40.00%
POD MY2022	25.00%	21.09%	21.05%	0.00%
POD MY2023	33.33%	17.83%	20.89%	0.00%
PCR MY2022	NR	NR	NR	NR
PCR MY2023	16.67%	8.74%	10.85%	16.66%

Insert finding about equity and underutilization of childhood preventive care or any patterns of underutilization

Equity Delegates

Health plan ensures that delegates adhere to equity requirements outlined in regulations.

Upon review of delegate activities, there is no equity delegation…

NCQA Health Equity Accreditation

Health Plan is committed to ensuring all members have a fair and just opportunity to reach their full health potential. Quality care is not possible without equitable care, in which personal characteristics do not impact the care, service, or access received. In recognition of systemic barriers that have historically and currently impact member care, in FY2024 Health Plan adopted the NCQA Health Equity Accreditation (HEA) framework as a roadmap for operationalizing concrete steps toward identifying disparities, addressing social risk factors, and working toward dismantling the systemic and structural barriers that generate disparate outcomes.

In order to accomplish Health Equity Accreditation by 7/1/2025, Health Plan dedicated resources toward adopting HEA Standards. These resources include the assignment of the HEDIS & NCQA team to project manage the operationalization of required changes. The team dedicated to Health Equity Accreditation consists of the Director of HEDIS & NCQA, Accreditation Manager, and two HEDIS & NCQA Coordinators. A consultant group was engaged with expertise in NCQA Health Equity standards and financial resources were dedicated to leveraging consultant support. These staffing and consultant supports were adequate during the fiscal year.

Additional resources provided include a priority adoption of ADOS with consultant and staff support for adapting the project requirements into the Agile framework. Technical assistance was provided to guide this transition. Additional analytic support is also available for the data requirements including stratification of HEDIS and CAHPS measures through vendor contracts and Clinical Analytics support for ad hoc reporting needs. In Fiscal Year 2024, these technological and analytic supports were adequate for accreditation needs.

Leadership has taken an active role in ensuring appropriate resources and oversight through making Health Equity Accreditation a Corporate Objective. This oversight includes a monthly update to Health Plan leadership and tracking of milestones. All barriers and delays are escalated to the highest level with full transparency. In addition, direct oversight for project management is done by the Interim Chief Health Equity Officer and the Chief Medical Officer. Weekly updates are provided and the CHEO and CMO are available to provide feedback and direction frequently. This leadership involvement has been adequate to ensure timely implementation and adequate and appropriate resources for these initiatives.

The HEDIS & NCQA team also reports progress and initiatives through the Quality Improvement and Health Equity Oversight Committee which reports up to the Quality Improvement and Health Equity Committee. Committee oversight during Fiscal Year 2024 was adequate to provide oversight and support as needed.

Overall, the Health Equity Accreditation project was initiated in FY24 and appropriate resources including staffing, leadership, oversight, technology, and consultant support were allocated to ensure a successful trajectory towards achieving HEA timely.

Caregivers and members involvement in Health Equity

In March 2024, the Department of Health Care Services partnered with the Institute for Healthcare Improvement to kick off a Child Health Equity Collaborative (CHEC). This collaborative was a required initiative for Health Plans to identify and act on disparities related to Well Child Visits in partnership with a network clinic. Health Plan engaged Golden Valley Health Centers (GVHC) for this effort. In June 2024, Health Plan and GVHC reviewed data for W30-6, W30-2 and WCV stratified by race, ethnicity, language and zip code to identify disparities in completion of well visits. This review of data discovered a disparity in Ceres, CA where there is a large Hispanic community. A population of focus was determined, and a goal established to improve the well child completion rates for 15–18-year-olds by 10 percentage points from 35.81% to 45.81% by March 31, 2025.

In Fiscal Year 2025, the collaborative will continue. Next steps include supplementing quantitative data with qualitative understanding through engaging members and their caregivers to better understand the barriers to well child visit completion for this population of focus. IHI has created interview questions that are intended to gather both barriers and strengths for the population of focus and better understand actionable pain points that can

support the Health Plan and partner clinic in improving. The feedback gained from interviews will be used to develop journey maps that can identify where process changes can be made to improve completion of well visits.

Reinvestment in Health Equity

Health Plan partners with DHCS allocate funding through the Equity and Transformation (EPT) Grant process. The EPT grants are designed to support providers who are historically not eligible for the financial supports that larger Federally Qualified Health Centers are eligible for. The EPT grants will provide financial support to chosen practices for achieving equity and practice improvements milestones. Health Plan recruited many providers and ultimately 7 practices were selected by DHCS for participation. The selected EPT participants provide care for all members in all represented service areas. They completed population health readiness assessments and continue to be involved in learning sessions, goal setting, and are actively involved in Health Plan collaborative activities. As the program progresses, there will be ongoing guidance and support to the practices to ensure continued engagement which will drive improvement for known health disparities at the practice level.

Health Plan is also committed to investing in initiatives that reduce health disparities using reserve funding. Health Plan funding has been allocated to access, service and community engagement. Throughout the 2025 fiscal year, strategic partnerships will be developed to further strengthen marginalized groups and promote health equity.

Access has been expanded at health centers serving high numbers of women and children by funding locums to increase capacity for preventive care and screenings, expanding mammography access by funding mobile mammography and wellness mobile vans. In calendar year 2023, locums provided over 19,300 services to members. The mobile mammography vans granted access to over 360 mammogram appointments in 2023. Providing additional access to care helps reduce health disparities in the membership.

Health Plan is also actively reinvesting in the community by providing funding to communities with members who have a high proportion of the population living in poverty. Reinvent South Stockton (RSSC) is a Health Plan partner focused on improving the lives of individuals historically abandoned through red lining practices and by the funding streams that ensure investment in communities. Health plan provides funding for street medicine, lactation rooms and housing and homeless shelters.

Activities that Reduce Health Disparities

Health Plan partners with culturally sensitive and aligned community groups that support healthy pregnancy outcomes for women of color. Health Plan provides condition management for birthing individuals through the Me and My Baby Program, CMS/DHCS Affinity Learning Collaboratives, Black Infant Health, Doulas, and Health Plan sponsored Baby Showers.

Me and My Baby is a program that provides prenatal education and resource connections for pregnant individuals. Mailers, milestone booklets and health education are provided.

The CMS/DHCS Affinity Learning collaborative supports birthing individuals with navigating the health care delivery system by providing checklists for newborn infant enrollment, finding a Pediatric care provider and health education about newborn milestones, transportation and interpreter services.

Health Plan informs Black birthing individuals about the Black Infant Health (BIH)Program. BIH provides a welcoming community for Black women and their partners to support healthy pregnancy, delivery and infant care.

Additionally, Health Plan offers a safe space to hold community baby showers. Health Plan provides gifts, health education and information about health plan services to birthing members.

Through these partnerships, Health Plan is lifting up populations to attain a higher level of health and well-being in methods that address members needs and preferences which leads to healthier and happier lives.

Member Experience and CAHPS, Language Access

Equitable care can be evaluated through the lens of the member's experience. Their experience with their health care journey is key. Their perception is at the forefront of engagement with care, treatment and adherence to care plans.

Health plan member experience is declining year after year as measured by the Consumer Assessment of Health Plan Providers and Systems (CAHPS). CAHPS is fielded annually from February through May each year. Surveys are sent to 2600 randomly selected members. Interestingly when, asked about the experience of members in their preferred language about the rating of their health plan and language services, their experience is far more favorable. Each year language access surveys are sent to about 2,000 members in their preferred language from January through March each year.

The Composite results for the measurement year 2024 CAHPS compared to the Language Access Survey for Rating of Health Plan are below.

Survey	Rating of Health Plan- Percentage of members scoring 8, 9 10
CAHPS	70.60%
Language Access	88%

Equity Findings from CAC

The Community Advisory Committee (CAC) has informed equity, by ensuring there is an opportunity for members and community partners to engage in meaningful discussions about their experiences, navigating the health care ecosystem, and Health Plan benefits, programs and services. The CAC is diverse and ensures diversity in membership. CAC recruits from the membership service areas with specific emphasis on persons who represent diverse backgrounds, genders, gender identity and sexual orientation and disabilities. The CAC provides feedback through focus groups, and review of health plan materials and policies.

SDOH Initiatives

As part of Health Plan's 2023-2026 strategic roadmap to improve health for residents in San Joaquin, Stanislaus, El Dorado and Alpine counties, we have launched our Community Reinvestment Program. Through an investment of $100M over the next three years, Health Plan aims to transform care delivery, expand provider access, and improve the quality of health care in our communities.

Principles for our Community Reinvestment Program:

- Access to barrier-free quality care
- Support for local innovation
- Strategic & Transparent Spending
- Beneficial to our Members
- Partnership with community
- Integrity

Some of our initial investments include:

- Community Health Worker Recruitment Workforce
- Community Health Worker Training Certification Program
- HIE Grants Incentive Program
- Mobile health clinics

Cultural and Linguistic Services FY24 QIHETP Evaluation and FY25 Planned Improvements

Cultural and Linguistic Services Program

The Cultural and Linguistic Services Program (the Program) is based on the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards or NCLAS) developed by the US Department of Health & Human Services, Office of Minority Health (OMH). The Program relies on the Health Plan's staff, providers, policies, and organizational infrastructure to meet the diverse cultural and linguistic needs of our members, clients, & patients, including:

- People with Limited English Proficiency (LEP). This includes members whose primary language is a language other than English, as well as native English speakers who are not fully literate.
- People with disabilities or cognitive impairments that affect communication abilities and use of health services.
- People whose cultural beliefs about health are different from the dominant culture in the United States of America.

The Program is managed by the Cultural & Linguistic Services Manager, in collaboration with Quality, Health Education, Population Health, Compliance, and other relevant departments. C&L is built into the overarching Health Equity department, with the C&L Manager reporting directly to the Chief Medical Officer (CMO). The C&L Manager reports to the Quality Improvement and Health Equity Committee (QIHEC) on a regular basis regarding C&L workplan objectives and updates.

Cultural and Linguistic Services Data and Resources

The C&L department relies on various reporting sources to understand the effectiveness of the services provided by the department, and to identify opportunities for quality improvement. These sources are primarily:

- Interpreter services utilization tracking
- Interpreted encounter language and member language studies
- Language access quality metric tracking
- Staff language tracking
- Written translation utilization tracking
- Press Ganey California Timely Access Enrollee Experience Survey – Focus on Language Access
- Community and Cultural Detailing, 2023

Cultural and Linguistic Services FY24 Quality Improvement Results

The Cultural and Linguistic Services department establishes quality improvement efforts on a fiscal year timeline. In the fiscal years leading up to and through FY24, quality regarding cultural and linguistic services had primarily been measured by comparing engagement with interpreting services with member-reported preferred language, which can be indicative of the likelihood that members with limited English proficiency are having quality encounters with either the Health Plan or their providers, in that interpreter services are essential for those with limited English proficiency to understand and actively engage in their care. The FY24 measurement table and analysis below are reflective of that framework. While the FY25 framework will still include utilization metrics that are reflective of access, availability, and utilization of language access services, which are indicative of quality encounters, the FY25 framework has been modified to include many more measurable indicators that pertain to the quality of the language access services (primarily interpreter services) themselves.

C&L FY24 Quality Indicator and Performance Goal for Increasing Interpreter Services Utilization

C&L FY24 Quality Indicator and Performance Goal for Increasing Interpreter Services Utilization				
Quality Indicator	**Performance Goal**	**Results**		
		FY24	FY23	FY22
1. Increase Monthly Average Hmong Interpreting Encounters vs Monthly Average Membership Ratio	+3% (4%)	+0% (1%)	+0% (1%)	1%
2. Increase Khmer Monthly Average Interpreting Encounters vs Monthly Average Membership Ratio	+3% (6%)	-1% (2%)	+2% (3%)	1%
3. Increase Monthly Average Chinese interpreting Encounters vs Monthly Average Membership Ratio	+3% (18%)	-5% (10%)	15%	N/A
4. Increase Overall Interpreter Services Encounters	+35% (92,021)	+17% (79,856)	+69% (68,164)	+67% (40,278)
5. Increase ratio of total fiscal year interpreted encounters vs average monthly fiscal year LEP member count	+15% (69%)	+2% (56%)	+19% (54%)	+10% (35%)
6. Increase average ratio of interpreting	+5% (12%)	-1% (6%)	N/A%	N/A%

encounters vs same quarter end Top 14 member LEP languages by 5% on average				

Methodology:

C&L compiles monthly utilization data from language access vendors into utilization report trackers, which are then used to generate charting, trending, and reporting. This reporting is reviewed no less than quarterly, reported to the Executive Team quarterly, and pertinent elements are used to form and report semiannually on the QIHEC annual work plan, as well as to guide and inform the development of other C&L projects. Interpreter services utilization data is compared to membership data reporting received from DHCS. The aim is always to increase interpreted encounters, and likewise the ratio of interpreted encounters to LEP members. The reporting allows for focus on both collective and precise languages.

Quantitative Analysis:

- **Performance Goals 1-3:** Increase Monthly Average Hmong, Khmer, and Chinese Interpreting Encounters vs Monthly Average Membership Ratio
    - The Hmong result was a 0% increase, which did not meet the performance goal of increasing by 3%. We have not achieved a significant ratio increase for this language the last three fiscal years.
    - The Khmer result was a 1% decrease, which did not meet the performance goal of increasing by 3%. We have not achieved a significant ratio increase for this language the last three fiscal years.
    - The Chinese result was 5% decrease, which did not meet the performance goal of increasing by 3%. We have not seen as low a ratio with Chinese utilization as we have with Hmong and Khmer over the last three fiscal years, but it was added as a focus language since we do see lower utilization for Chinese than what we would like, being that it is a DHCS concentration language.

Qualitative Analysis:

- During Q1 of FY24, C&L discovered that an internal systemic reporting error was resulting in lower reporting of members with limited English proficiency. The reporting was refined beginning with FY24 Q2 data (October 2023), and the new reporting captured 3% more members for Hmong speakers, 16% more members for Khmer

speakers, and 35% more for Chinese speakers. This change, coupled with the fact that true membership in all three of those languages declined steadily from the onset of the fiscal year onward, made this objective more difficult to achieve with a larger denominator than what was originally used to plan the objective, but with fewer members each month to utilize services. It is likely that this decline in membership, along with the greater overall reporting capture of membership in these language groups, contributed to lower utilization of interpreter services (numerator) while contending with a higher-than-previously-reported, albeit declining membership count for these languages.

- Being that the magnet campaign was an overt measure to ensure the reason for low utilization of interpreter services in these languages was not due to a lack of awareness, there is a stronger feeling now that lack of awareness of the services is not the cause of low utilization. It is helpful to know what has *not* been effective in increasing utilization, and we have identified a need for direct member feedback from one or more of these populations in order to better identify the root cause of the low utilization. Gathering direct member feedback from one or more of these language groups will be incorporated into the FY25 C&L QIHEC workplan.

Measurement of Intervention Effectiveness:

- In FY23, C&L established a goal of increasing interpreter services utilization for Hmong, Khmer, and Chinese. It was determined that a Magnet Campaign – a project in which simple messaging around requesting onsite interpreting would be translated, placed on magnets, and mailed out to members who prefer these three languages – would be an effective way to encourage members of these languages to rely more readily on qualified, onsite interpreter services, and that they would also have those instructions handy on their refrigerator or any other magnetic surface. The launch of the campaign was delayed in FY23, owing in large part to department turnover, but was launched during July 2023, the first month of FY24. The goal of increasing utilization in these languages was therefore carried over into FY24, with monitoring for these languages to remain throughout the entire fiscal year.
- After the first two quarters of FY24, it was clear that the magnet campaign had been almost entirely ineffective, and this trend continued throughout FY24. The magnet campaign provided a crucial lesson: that the cause of low utilization in these languages

was not likely due to lack of sufficient awareness of the availability of the services; it's likely that members who speak these languages are choosing not to engage with them. FY25 will aim to dive deeper into this trend, as explained further in the FY25 planning section below.

- **Performance Goals 4-6:** Increase overall interpreter services encounters, increase ratio of total fiscal year interpreted encounters vs average monthly fiscal year LEP member count, and increase average ratio of interpreting encounters vs same quarter end Top 14 member LEP languages by 5% on average.

Quantitative Analysis

- The performance goal of increasing overall interpreter services encounters by 35% (92,021 total) was not met. Interpreter services encounters increased only by 17%, about half of the target. The target itself of 35% was practically half of what the previous fiscal year's increase had been, so the FY24 result is much lower than anticipated and very different from the preceding two fiscal years.
- The performance goal of increasing the ratio of total fiscal year interpreted encounters vs average monthly fiscal year LEP member count by 15% (69% total) was not met. The result was a 2% increase to 56% overall, which was much smaller than the preceding two fiscal years.
- The performance goal of increasing the average ratio of interpreting encounters vs. same quarter end top 14 member LEP languages by 5% (12% total) was not met. This ratio actually decreased by 1%, from 7% total to 6% total. FY24 was the first fiscal year that this measure was introduced.

Qualitative Analysis:

- Regarding performance goals 4-6, which all had to do in part with increasing interpreter services encounters, the latter two relying on the ratio to members with limited English proficiency for measure, the preceding two fiscal years had seen exponential increases in interpreter services, owning primarily to robust roll outs of video remote interpreting services at multiple provider entities leading into and during those preceding fiscal years. During FY24 planning, we did not have a provider entity identified to whom a similar-sized roll out could be planned, and while we made it an objective to do another roll out in FY24, we halved the amount that we anticipated being able to increase interpreter services throughout the fiscal

year. During the fiscal year we surveyed providers throughout the service area, and were unable to identify any provider entities that were in need or had interest in a VRI roll out until the end of FY24, and we were unable to deploy these services during the fiscal year itself, although we did deploy two small-scale VRI roll outs at the beginning of FY25.

- Beyond the factor of not having executed a VRI roll out in FY24, overall LEP membership increased by 4%, and improved internal reporting on LEP member language resulted in a ~12% higher LEP member capture beginning in Q2 of FY24, both of which contributed moderately to decreasing the ratios of interpreted encounters vs LEP membership, since both of those factors increase the denominator of the measure.

Measurement of Intervention Effectiveness:

- The absence of any roll out of VRI services during FY24 has been determined to be the primary differentiator between FY24 and previous fiscal years in terms of increasing interpreter services utilization.
- Beyond the effort made to find opportunities to increase VRI availability, which would have likely increased interpreter services utilization and the ratio of interpreting encounters to LEP membership, C&L also ensured standard language assistance and nondiscrimination notifications were still going out with member-informing materials, that the providers that received outreach for potential VRI roll outs were aware of the onsite and phone interpreter services available to them aside from video, that C&L presented on interpreter services at the Community Advisory Committee, QIHEC, and quarterly meetings with select provider entities to ensure direct dialogue and awareness of the availability of language access services. A notification to Providers in the Plan Scan newsletter, as well as a separate notification to members in the FOCUS newsletter, were also made during the fiscal year. All of these efforts likely contributed to the FY24 17% increase in interpreted encounters.

Adequacy of C&L Resources:

- The C&L department is comprised of a manager and two specialists, and the department currently reports to the Chief Medical Officer (CMO), who receives operational and project updates from the C&L manager on a weekly basis. Being a smaller

department means having to carefully plan and execute projects throughout the course of defined timelines, accounting for as much of the unexpected as possible among given projects and standard operational activities. During FY24, owing to several competing initiatives, C&L was not able to agilely address observed and predicted gaps in achieving the above performance objectives after new gaps were identified. The magnet campaign is a good example of this reality, in that we knew early on in the fiscal year that the campaign was not having the desired effect, but we did not have the staffing bandwidth with other competing projects to meaningfully circle back and dive deeper into the "why" prior to the end of year evaluation, owing primarily to projects that had tighter timelines and higher prioritization. C&L will take this lesson into consideration when creating the FY25 workplan.

- During FY24, C&L increased frequency of communication with other Health Plan departments that are critical to carrying out its objectives, in particular Quality, Grievances and Appeals, Health Education, Population Health, Customer Service, Provider Relations, and Marketing, now meeting regularly with all of these teams to fulfill project and operational objectives. These improved connections will continue to be leveraged for FY25 objectives.
- C&L maintains a strong contingent of vendors for over-the-phone, video remote, and onsite interpreting, as well as written translation and alternative format preparation. C&L meets regularly with internal member-facing teams, as well as external provider entities, to identify service issues and opportunities for improvement.

Cultural and Linguistic Services FY24-25 Quality Improvement Planning and Refinements

Being that all performance goals for FY24 were not met, C&L has carefully evaluated the effectiveness of measures taken during FY24 to achieve performance goals and made the following observations and strategy adjustments.

- Two small scale video remote interpreting (VRI) roll outs were performed at the onset of FY25, and there are a couple of additional requests for small roll outs that will likely take place throughout the fiscal year. Being that these are small, C&L will set a performance goal of increasing interpreter services utilization by 10% during FY25 and increasing the ratio

of interpreted encounters to average monthly fiscal year LEP membership by 5% during FY25.

- While utilization of interpreter services and comparison of that utilization to LEP membership to create the ratio described above is a helpful indicator of the likelihood that the encounter the member had with their provider or health plan staff was a quality encounter (i.e. not having interpreter services would indicate a risk for communication issues, and a lower quality interaction, and therefore, degraded outcomes), this measure doesn't really share much insight into member and provider perceptions of the true quality of the language access services themselves, nor insight into the overall perceived quality of the interaction. To mitigate this reality, C&L has developed additional measures that can be used as indicators of quality. These measures and indicators, along with the efforts to support their improvement, are described briefly in the following list and tables, and will be used to form the FY25 QIHETP workplan:
    - **Timely Access Survey – Language Access Focus:** A member timely access survey with a focus on the limited English proficient population was launched for the first time in Q3 of FY24 and is planned to be launched each year moving forward. The results from the survey were very positive overall, but members rated the plan and providers lower in several important categories. C&L will form a goal around increasing satisfaction for each of the lower measures identified by 1% on overall average by the time the survey is relaunched in Q3 of FY25, and an additional 2% on average by FY26 in measures identified the table below titled C&L FY25-FY26 Timely Access for LEP Survey Benchmarks.
    - **Focus Language:** Since informing speakers of Hmong, Khmer, and Chinese about the availability of language access services and encouraging them to engage in these services via the magnet campaign was largely ineffective, it is apparent that a deeper dive is needed into the "why" of the reality that these members do not engage with these services. Rather than try to get these answers from all three language populations, and because of C&L's limited bandwidth with other FY25 planned projects, C&L will choose one of three focus languages upon which to focus further in FY25, reaching out to this community more directly to gain insight into their perceptions of language access, and to identify more tangible opportunities to increase reliance on interpreter services. C&L has already made contact with a service area community-based organization who may be able to support this effort.

- **Awareness and Training:** C&L will continue to promote interpreter services through language access and non-discrimination notifications, as well as announcements in provider and member newsletters. As a FY25 project, C&L is also developing new language access training for providers, members, and health plan staff in order to increase overall awareness and accessibility of the services. The Community Advisory Committee will also be leveraged for comment from members and community partners on any improvements that could be made to the program.
- **Clinical Outcomes:** The Health Plan aims to achieve NCQA Health Equity Accreditation by 2026. A part of accreditation is tying C&L efforts to a clinical outcome. At the onset of FY25, the Quality Improvement team at the Health Plan identified an opportunity to improve blood pressure results for Punjabi speakers, an effort that C&L will support from the perspective of culturally and linguistically appropriate methods, ensuring that pertinent materials are translated into Punjabi, that Punjabi interpreter services are available at key points of contact, and that any pertinent cultural nuances are identified and accounted for in the strategy. The benchmark for improvement is still being calculated, but this will be a part of the FY25 QIHEC workplan.
- **Utilization Goals:** Utilization metrics similar to those examined through FY24 will continue to be tracked and utilization-related performance goals will continue to be centered around them, but the number of individual performance goals will be reduced to the most meaningful as shown in the below table titled C&L FY25 Quality Indicators and Performance Goals for Increasing interpreter Services Utilization, and a much higher emphasis will be placed on goals that are more indicative of quality, as illustrated in the Quality Goals section.
- **Quality Goals:** During FY24, C&L had a workplan project that involved the creation of a quality tracker and the establishment of quality benchmarks that went beyond simple utilization of services. This project was completed, with many benchmarks established, most of which C&L will plan to roll into the FY25 performance objectives, as shown below in the Table called C&L FY25 Quality Benchmarks.

C&L FY25 Quality Indicators and Performance Goals for Increasing interpreter Services Utilization

C&L FY25 Quality Indicators and Performance Goals for Increasing interpreter Services Utilization				
Quality Indicator	**Performance Goal**	**Results**		
		FY25	FY24	FY23
Increase Interpreting Encounters vs Membership Ratio by 3% for Khmer	5%		-1% (2%)	+2% (3%)
Increase Overall Interpreter Services Utilization by 10%	+10% (87,842)		+17% (79,856)	+69% (68,164)
Increase ratio of total fiscal year interpreted encounters vs average fiscal year LEP member count by 5%	+5% (61%)		+2% (56%)	+19% (54%)

C&L FY25 Quality Benchmarks

C&L FY25 Quality Benchmarks				
Quality Indicator	**Performance Goal**	**Results**		
		FY25	FY24	FY23
Grievances related to language access vendors	<2/mo ave		1	N/A

Potential Quality Issues (PQIs) related to language access vendors	<3/mo ave		3	N/A
Video Remote Interpreting Star Rating by provider entity for interpreter quality	>/= 4.8/5.0 monthly average		4.8	N/A
Video Remote Interpreting Star Rating by provider entity for video quality	>/= 4.8/5.0 monthly average		4.8	N/A
Vendor Written translation timeliness	>/= 99%		99%	N/A
Internal staff qualified bilingual contingent (% of member-facing staff)	>/= 35%		N/A	N/A
Onsite Interpreting Request vs Fulfillment rate	>/= 90% per mo monthly average		N/A	N/A

C&L FY25-FY26 Timely Access for LEP Survey Benchmarks (incremental 2-year timeline)

C&L FY25-FY26 Timely Access for LEP Survey Benchmarks					
Quality Indicator	**FY26 Performance Goal**	**FY25 Performance Goal**	**Results**		
			FY25	FY24	FY23
Regarding written information from doctors, increase % of respondents who felt that doctors gave	+2% (91%)	+1% (89%)		88%	N/A

them written information they needed in their language quickly.					
Regarding verbal interpreting from doctors, increase % of respondents who believed they got the same information as an English speaker would.	+2% (94%)	+1% (92%)		91%	N/A
Regarding written information from the Health Plan, increase % of respondents who felt that if information was not available in their language, the Health Plan was able to translate it for them.	+2% (92%)	+1% (90%)		89%	N/A
Regarding verbal interpreting from the health plan, increase % of respondents who believed the health plan told them the same information they would have given to an English speaker	+2% (91%)	+1% (89%)		88%	N/A

Safety of Clinical Care

Annual Evaluation FY23-24: Facility Site Review (FSR) and Medical Record Review (MRR)

The purpose of conducting Facility Site Review (FSR) audits is to ensure that all primary care provider sites utilized by the Health Plan of San Joaquin /Mountain Valley Health Plan for delivery of services to members have sufficient capacity to:

- Provide appropriate, safe primary healthcare services.
- Carry out processes that support continuity and coordination of care.
- Maintain patient safety standards and practices; and operate in compliance with all applicable federal, state, and local laws and regulations.

Medical records Reviews are conducted to review medical records for:

- Format, legal protocols and documented evidence of the provision of preventive care and coordination and continuity of services.

Primary Care Providers are required to have an initial FSR just prior to signing a contract with Health Plan of San Joaquin. A Medical Record Review (MRR) is completed within 6-9 months of members being assigned to the provider. The provider will then be required to have an FSR/ MRR every three years thereafter.

Methodology

The primary data source is from the Healthy Data System, HPSJ's third party vendor in maintaining the database for audit results. Data for audit results from both FSRs and MRRs completed during FY 2022 to 2023 and FY 2023-2024 were generated and presented below. Certified site reviewers conduct the FSR and MRR audits using the mandated DHCS audit tools.

Results

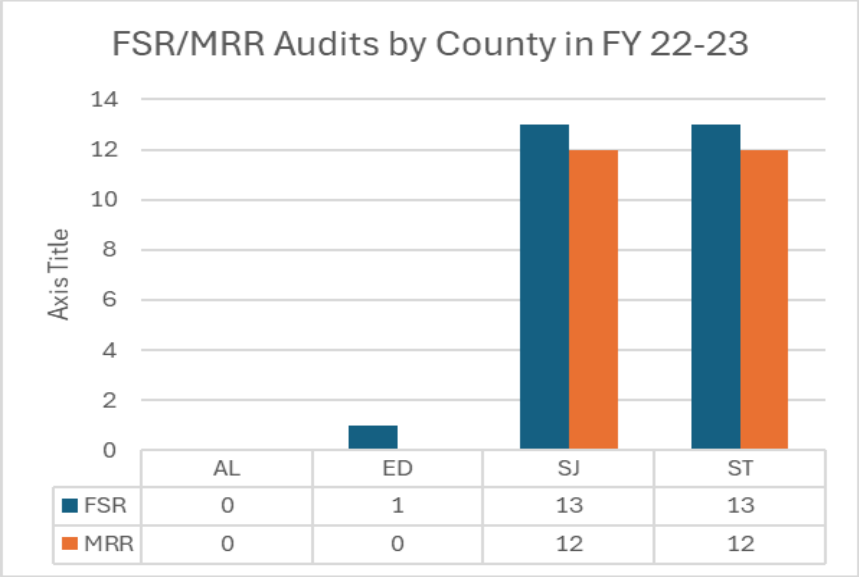
FY22-23				
	Initial	**Periodic**	**Annual**	**Total**
FSR	5	16	3	24
MRR	5	20	2	24
Total	10	36	5	51

FSR/MRR FY23-24				
	Initial	**Periodic**	**Annual**	**Total**
FSR	12	25	1	38
MRR	9	25	1	35
Total	21	50	2	73

Overall, there were 124 combined FSR and MRR audits completed over the last two fiscal years. The total number of FSR and MRR audits increased from 51 in FY 22-23 to 73 in FY 23-24. This was mainly driven by:

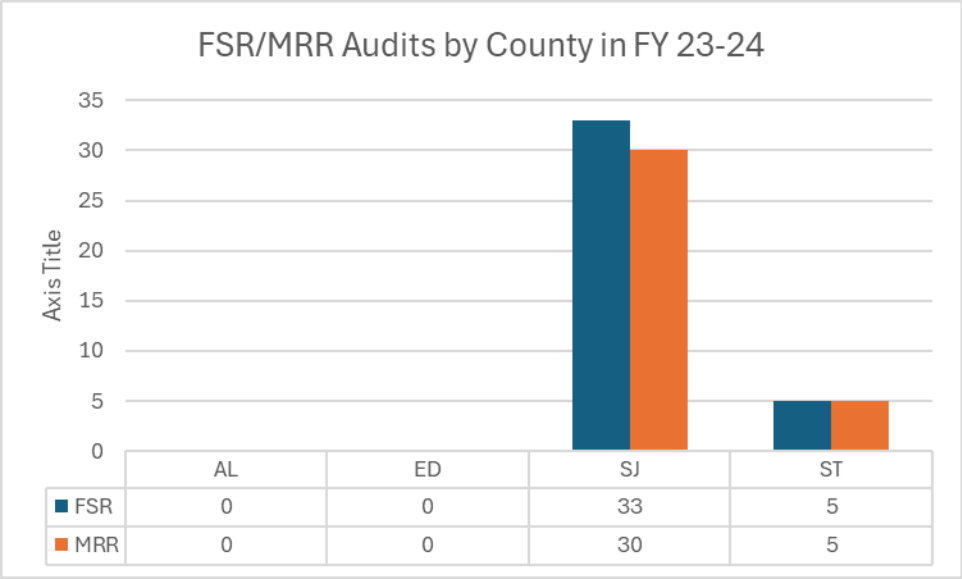
a. Continued network expansion resulting in an increase in initial FSRs conducted as part of the initial contracting process.
b. Higher number of periodic reviews due during FY 23-24 compared to FY 22-23.
c. Additional FSR/MRR audits (annual audits) as follow up to the failed audits in FY 22-23.

County Breakdown



	AL	ED	SJ	ST
FSR	0	1	13	13
MRR	0	0	12	12

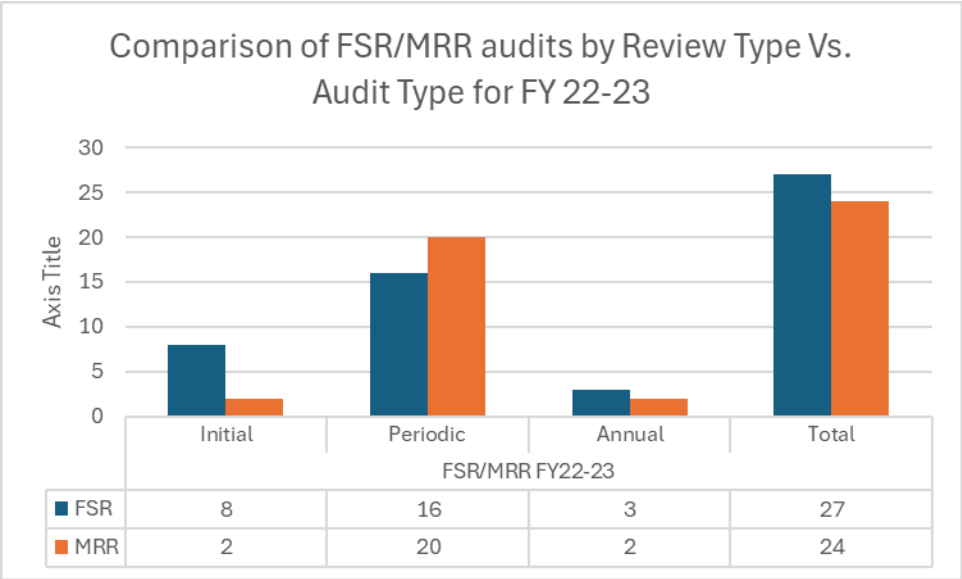
In FY 22-23, there were equal number of FSRs and MRRs completed between San Joaquin (SJ) and Stanislaus (ST) Counties. There was one audit completed in El Dorado (ED)County while no audit was completed in Alpine County. Health Plan of San Joaquin began conducting FSR in the ED County as part of its early phase of its expansion activities into the Mountain Valley region in FY 22-23. This explains the low number of audits completed in the said counties as shown above.



In FY 23-24 however, most of the FSR/MRR audits were completed in the San Joaquin County with a total combined audits of 63, followed by Stanislaus County with 10 audits. This is due to the MCPs more established network in the SJ County compared to the ST County. The increase in SJ County audits can also be attributed to new PCP sites and PCP relocations prompting initial audits as required by the Department of Health Services (DHCS).

It is worth noting that although the graph above does not show any audits conducted in both AL and ED Counties, the most current FSR/MRR data were collected from collaborating health plans under the direction of DHCS. This aligns with the DHCS' requirement for new PCP sites to be added to the MCPs network.

Comparison by Review Type Versus Audit Type



The tables above show that in both FY 22-23 and FY 23-24, there were more FSRs completed compared to MRRs. This can be related to:

a. The increase in initial FSRs where initial MRRs are only conducted 90 to 180 days after initial member assignment.
b. The strict implementation of the enhanced MRR guidelines requires that a separate MRR be completed for each PCP with his/her own assigned panel of members. This resulted in multiple MRRs to be completed in PCP sites with multiple non-sharing providers. This also explains why FSRs are completed faster compared to MRRs.

The above graph also shows continuous expansion of the MCPs network as evidenced by an increase of 4 initial audits in FSRs in FY 23-24 as compared to FY 22-23.

Review Date Compliance FY 22-23				
	Conducted before due date	**Conducted past due date**	**No Scheduled Due Date**	**Total**
FSR	11	8	8	27
MRR	7	10	7	24
Total	18	18	15	51
Review Date Compliance				

FY 23-24				
	Conducted before due date	**Conducted past due date**	**Conducted w No Applicable Due Date**	**Total**
FSR	16	9	13	38
MRR	12	14	9	35
Total	28	23	22	73

Comparison of Review Date Compliance by Audit Type and FY

In FY 22-23, there were 11 FSRs and 7 MRRs conducted timely which accounts to 40% and 29% of the total audits respectively. While 8 FSRs and 10 MRRs or 30% and 42% of the total audits were completed past their due dates. On the other hand, there were 8 FSRs and 7 MRRs or 30% and 29% respectively did not have due dates primarily because the audits were conducted for the first time. Most of the MRR reviews did not have scheduled due dates, especially in the case of provider sites with multiple medical record reviews.

Qualitative Analysis

Some of the reasons why FSRs and MRRs were not completed within their due dates are (HPSJ or Provider related):

a. Staffing issues
    - Lingering effects of COVID – some office sites struggle with staffing issues due to COVID.
    - Personal emergencies like death in the family, or medical emergencies
    - Provider staff with competing priorities.
    - Limited availability of certified site reviewers.

b. EHR Issues and Technology Challenges
    - Delays related to the need to complete a PHI confidentiality agreement prior to screen sharing or provision of an EHR remote access
    - Some providers were having an issue with the use of internet screen sharing platforms

In FY 23-24, there were 16 FSRs and 12 MRRs completed timely or 42% and 34% respectively out of a total of 38 FSRs and 35 MRRs. While 9 FSRs and 14 MRRs or 24% and 40% respectively were completed outside their due dates. Again, there are more audits, primarily for MRRs that were completed past their due dates related to the provider sites capacity to accommodate more audit dates. For

FSRs, there were 13 audits or 34% that did not have a due date. While for the MRRs, there were 9 audits or 26% that did not have due dates because of additional MRRs that are required for non-sharing providers.

Comparison of FSR/MRR Audits by Outcome

HPSJ/MVHP complies with the DHCS scoring criteria:

FSR scoring is based on the following:

a. Exempted Pass: 90% or above *without deficiencies* in Critical Elements, Pharmaceutical or Infection Control
b. Conditional Pass: 80-89%, or 90% and above with deficiencies in either Critical Elements, Pharmaceutical or Infection Control. A CAP is required.
c. Fail: 79% and below. CAP and follow-up audits are required.

MRR scoring is based on the following:

1. The minimum passing score is 80%.
2. A corrective action plan (CAP) is required for a total MRR score below 90%.
3. Also, any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score.

The above table shows that in FY 22-23, there were 17 sites, or 63% of total FSR audits completed, that were on conditional pass and received CAPs. While 7 sites, or 26%, were Exempted. Three sites or 11% received Failed scores. These sites required CAPs and follow-up audits.

For MRRs, majority of the audits were conditional passes which account for 17 audits, or 71% of the total MRR audits completed. There were 6 audits, or 25% that scored an exempted pass. One MRR or 4% of the total MRR failed. Sites that earned conditional and failed audit scores were also required CAPs. The failed audit required multiple follow-up reviews.

The above table shows that in FY 23-24, there were 30 sites or 79% of the total FSRs earned a conditional pass and received CAPs. There were 8 sites, or 21% were exempt. No FSR audits failed during this FY.

For MRRs, majority of the audits were exempt passes which accounts to 17 audits or 49%, followed by conditional pass for 12 audits or 34% of the total MRRs. CAPs were placed on these sites. There were 6 audits or 17% of the total reviews that failed, requiring both CAPS and more frequent reviews.

Since the new requirements for both FSR and MRR were implemented in the later part of FY 22-23, there were more conditional passes and failed audits that can be noted in FY 23-24. The implementation resulted in longer and more complex site reviews.

Opportunities for Improvement

Opportunities for improvement were identified for the following areas:

a. Audit timeliness compliance can be improved through the following:
   - Additional staff training and certification for conducting site reviews
   - Allotting more time for scheduling 1 FSR and possibly multiple MRRs for provider sites.
   - Planning for provider staff training on virtual medical record reviews.

b. Audit outcomes can be improved through the following:
   - Improved pre-audit preparations.
   - Global provider education on new requirements on FSR and MRR
   - Identification of trends in FSR/MRR deficiencies for quality improvement.

Improvement Actions

Due to the limitations in the MCPs FSR/MRR staffing, with competing QI opportunities, there were limited improvement actions implemented that included the following:

a. Collaboration with HealthNet for education of bigger provider groups
b. Development of an FSR website dedicated to the provision of resources and updates.
c. Training in additional site reviewers

All improvement activities identified above will be greatly considered for future improvement activities this coming FY.

Practitioner Credentialing and Recredentialing

Introduction

HPSJ conducts credentialing and recredentialing of practitioners to ensure that HPSJ's criteria and standards for participation are met and to ensure compliance with DHCS and NCQA requirements. HPSJ verifies the credentials and information about practitioners to ensure that practitioners meet and continue to meet the required standards to provide care to members.

Each provider is presented to the Peer Review and Credentialing Committee for review, discussion, and disposition. The Peer Review and Credentialing Committee is made up of community providers representing several provider specialty types. The committee makes recommendations to either approve or deny the providers application for Credentialing with the plan. The committee also makes recommendations on the term of the provider's initial credentialing. The standard approval is for 3 years.

Practitioners undergo recredentialing every 3 years, or more frequently based on the PRCC recommendations, along with continuous monitoring and follow-up (as applicable) for any license sanctions/limitations/restrictions, Medicare/Medicaid sanctions, grievances, and adverse events.

Credentialing and Recredentialing Results

	CREDENTIALING			RECREDENTIALING		
Outcome	**2023-2024**	**2022-2023**	**2021-2022**	**2023-2024**	**2022-2023**	**2021-2022**
Approved: 3 Years	445	231	243	361	448	348
Approved: 1 Year	13	13	2	96	16	21
Termination - Involuntary	0	2	2	0	0	0
TOTALS	458	246	247	457	464	369

- Credentialing volume increased 86.02% from FY 2022-2023 to FY 2023-2024, which will have a substantial impact on future recredentialing volume
- Recredentialing volume remained essentially the same from the previous fiscal year
- Despite the substantial increase in credentialing volume, all provider verification and recredentialing timeliness requirements were met, please see audit results section (below) for details
- There were no involuntary terminations during the fiscal year

- Of the 457 providers recredentialed, none met a category threshold for grievances or had their recredentialing applications denied due to exceeding the grievance and PQI point totals

Credentialing and Recredentialing Audits

Methodology

A random sample of credentialing and recredentialing files processed by the Credentialing Specialists is selected each quarter for audit. Throughout 2023, an average of 11 credentialing files were audited each quarter, with a total of 44 completed file audits; and an average of 10 recredentialing files were audited each quarter, with a total of 42 completed file audits.

Results

HPSJ Credentialing Audit Results				
Audit Indicator	**Performance Goal**	**2023**	**2022**	**2021**
Credentials Verification	100%			
License		100%	98%	100%
DEA or CDS		100%	97%	100%
Education		100%	98%	100%
Board Certification		100%	100%	100%
License Sanctions/Restrictions		100%	100%	100%
Medicare-MediCal Sanctions		100%	98%	100%
Hospital Privileges		100%	95%	100%
Application				
Inability to Perform		100%	100%	100%
Illegal Drug Use		100%	100%	100%
History of Loss of License		100%	100%	100%
Felony Convictions		100%	100%	100%
Loss of Hospital Privileges		100%	100%	100%
Malpractice Coverage / Federal Tort Letter		100%	100%	100%
Signed Attestation		100%	100%	100%
Credentials Verification Timeliness		100%	100%	100%

Green = goal met; Red = goal not met

Quantitative Analysis

- All credentialing quality indicator results met the performance goal in 2023 and results are consistent with 2021 performance

- Results for credentials verification for licensure, DEA or CDS, education, Medicare – MediCal sanctions, and hospital privileges reflect improvements in scores ranging from 2-5 percentage points
- Overall, our results have stabilized over the past 3 years with consistent performance at 100% throughout the year

Qualitative Analysis

- Qualitative analysis is not indicated, as quarterly and aggregate results met the performance goal
- Measurement of Intervention Effectiveness of interventions: Our results reflect an improvement for five audit indicators and all indicator results met the performance goal, which demonstrates that our ongoing auditing, feedback loop, and coaching/training of Credentials staff has been effective at improving our performance.

Opportunities

- No opportunities for improvement were identified, as quarterly and aggregate results met the performance goal

Improvement Actions

- No improvement actions were needed in 2023, as quarterly and aggregate results met the performance goal

HPSJ Recredentialing Audit Results				
Audit Indicator	**Performance Goal**	**2023**	**2022**	**2021**
Credentials Verification	100%			
License		100%	98%	100%
DEA or CDS		100%	97%	100%
Board Certification		100%	98%	100%
Malpractice History (NPDB)		100%	100%	100%
License Sanctions/Restrictions		100%	100%	100%
Medicare-MediCal Sanctions		100%	98%	100%
Hospital Privileges		100%	95%	100%
Application				
Inability to Perform		100%	100%	100%
Illegal Drug Use		100%	100%	100%
History of Loss of License		100%	100%	100%
Felony Convictions		100%	100%	100%
Loss of Hospital Privileges		100%	100%	100%

HPSJ Recredentialing Audit Results				
Audit Indicator	**Performance Goal**	**2023**	**2022**	**2021**
Malpractice Coverage / Federal Tort Letter		100%	100%	100%
Signed Attestation		100%	100%	100%
Performance Monitoring		100%	95%	100%
Recredential Cycle Timeliness		100%	100%	100%
Credentials Verification Timeliness		100%	100%	100%

Quantitative Analysis

- All recredentialing quality indicator results met the performance goal in 2023, and results are consistent with 2021 performance
- Similar to the credentialing audit results, our results for credentials verification related to licensure, DEA or CDS, education, Medicare – MediCal sanctions, and hospital privileges reflect improvements in scores ranging from 2-5 percentage points. Results for the Performance Monitoring indicator improved 5 percentage points from 2022.
- Overall, our results have stabilized with consistent performance at 100% throughout the year

Qualitative Analysis

- Qualitative analysis is not indicated, as quarterly and aggregate results met the performance goal
- Measurement of Intervention Effectiveness: Our results reflect an improvement for six audit indicators and all indicator results met the performance goal, which demonstrates that our ongoing auditing, feedback loop, and coaching/training of Credentials staff has been effective at improving our performance.

Opportunities

- No opportunities for improvement were identified, as quarterly and aggregate results met the performance goal

Improvement Actions

- No improvement actions were needed in 2023, as quarterly and aggregate results met the performance goal

Adequacy of Credentialing Resources

- Due to the network expansion in El Dorado County, HPSJ contracted with Calibrated Healthcare to provide five credentialing support staff over a six-month period to assist with provider credentialing
- Internal and external physician support continued to be vital and adequate to support HPSJ's credentialing processes

Priorities for Next Fiscal Year

- Revise credentialing and recredentialing processes to support NCQA's new and tighter primary source verification timeframes, and ongoing monitoring requirements, as well as the revised Information Integrity requirements
- Expansion of facility and ancillary provider assessment and verification processes
- Behavioral health credentialing insourcing project, to include approximately 246 behavioral health telehealth providers
- DSNP network support

Quality of Service

Annual Evaluation of Nonbehavioral & Behavioral Healthcare Grievances and Appeals

Date: September 10, 2024

Introduction

Health Plan collects, analyzes, and trends all member grievances. Grievance is defined as a written or oral expression of dissatisfaction regarding the plan and/or provider including quality of care concerns. If the plan is unable to distinguish between a grievance and an inquiry it shall be considered a grievance. Health Plan grievances are received via telephone, fax, in person, email or online. Health Plan is committed to monitoring, promoting, and maintaining the quality of care, and services that its members receive. Health Plan thoroughly investigates all complaints regarding dissatisfaction with services or delivery of care. In order to comprehensively evaluate member grievances, several policies were updated and changed. These included:

- Grievance scoring and severity methodology were developed and implemented.
- Definition of Clinical Grievances vs. Non-Clinical Grievances were developed.
- All clinical grievances are reviewed and closed by a Health Plan Medical Director Case Reviewer.
- Category thresholds were developed for the DHCS highest reported categories statewide.

Health Plan regularly collects performance data on areas affecting member experience. All sources of non-behavioral and behavioral health-related grievances and appeals are categorized into five distinct standards and measured against a goal to evaluate their performance and to identify gaps. This report discusses the results from the annual evaluation of grievances and appeals, identifies barriers to member satisfaction, and interventions to close these gaps.

The five performance areas are:

1. Access
2. Attitude and Service
3. Billing and Financial Issues
4. Quality of Practitioner Office Site
5. Quality of Care

Data Sources

- Grievance and appeals database: Essette is the electronic system that grievances and appeals are housed and worked in.

Methodology

All grievances and appeals received and processed by Health Plan are assigned a category pertaining to one of the five NCQA performance areas. All member demographic data, grievant information and grievance information is stored in the grievance database. On an annual basis, the Grievance Team aggregates all grievance and appeals data received during the fiscal year. A report is generated that summarizes both behavioral health and non-behavioral health into the NCQA categories for the previous and current fiscal year for analysis. The formula for calculating complaints and appeals per 1000 Members rates is:

- Annual Rate per 1000 Members = (Total Number of grievances or appeals /Average Membership for the Year) x 1000

The data provided below is reported in terms of rates defining the number of grievances by 1000 member months and in terms of actual grievance counts by product and by category to allow for a drill-down into the issues.

For both appeals and grievances, Health Plan has set an overall goal to have less than 5 grievances/1000 members for each category.

Non-Behavioral Health Analysis

Grievances

Annual grievances are calculated for San Joaquin (SJC), Stanislaus (SC), El Dorado (ED) and Alpine (AP) counties.

Annual SJC, SC, ED, AP Grievances	FY July 1, 2022 - June 30, 2023			FY July 1, 2023 - June 30, 2024			Goal per 1000 members	Goal Met
Category	Total Grievances	Grievances per 1000	% of Total Grievances	Total Grievances	Grievances per 1000	% of Total Grievances		
FY22-23 Membership	431,964			FY23-24 Membership		438,783		
Access	1272	2.94	31.75%	1048	2.39	28.24%	≤5	Yes
Attitude & Service	809	1.87	20.19%	1005	2.29	27.08%	≤5	Yes
Billing & Financial	21	0.05	0.52%	36	0.08	0.97%	≤5	Yes
Quality of Care	1895	4.39	47.29%	1622	3.70	43.71%	≤5	Yes
Quality of Practitioner Office Site	10	0.02	0.25%	22	0.05	0.59%	≤5	Yes
Total	4007	9.27	100.00%	3711	8.46	100.00%	**N/A**	**N/A**

Green text = goal met; Red = goal not met

Quantitative Analysis:

- Overall, for FY23-24, a total of 3,711 grievances per 1000 members were received. The ≤5.00 grievances/1000 members goal was met for each category and results have been fairly consistent from the previous FY, with variations in results across some categories, described below.
    - **Access** received 1048 grievances and had a rate of 2.39 grievances per 1000 members, a decrease of .51 grievances/1000 from FY22-23

- **Attitude & Service** received 1005 grievances and had a rate of 2.29 grievances per 1000 members, an increase of 6.89 grievances/1000 from FY22-23.
- **Billing & Financial** received 36 grievances and had a rate of 0.08 grievances per 1000 members, an increase of 0.03 grievances/1000 from FY22-23.
- **Quality of Care** received the highest number of grievances, with 1622, and had a rate of 3.70 grievances/ 1000 members, a decrease of 0.69 grievances/1000 from FY22-23.
- **Quality of Practitioner Office Site** received 22 grievances and had a rate of 0.05 grievances per 1000 members, an increase of 0.03 grievances/1000 from FY 22-23.

Non-Behavioral Health Qualitative Analysis-Grievances

Qualitative Analysis:

In addition to the annual evaluation of the trends, barriers, and improvement activities, the Appeals & Grievances team presents trends, barriers, and improvement activities on a quarterly basis for discussion in collaborative forums. The committee discussions include representation from Customer Services, Provider Services, Quality Improvement, Claims, Case Management, Utilization Management, Behavioral Management, and Compliance. The data is also presented to the governing body and Community Advisory committee.

While goals were met for each grievance category, in the spirit of continuous quality improvement, HPSJ continues to monitor trends and root causes in an effort to further reduce grievance rates and improve the member's experience of care and service. The **trends** and root causes for non-behavioral grievances noted during FY23-24 are described below as per category:

Trends	Root Causes
Quality of Care	
• Delays in referrals processing (PCP to specialty in network) • Delays in care with PCP and specialty providers	• Provider office's lack of follow and monitoring to ensure the referrals were received

Trends	Root Causes
• Delay in medication refills or issues with prescribing meds (PCP) • Lack of provider's response or additional responses • Delays in submitting prior authorizations timely • Member's not in agreement with provider's plan of care	• Initial receiving provider denied the referral upon review or members requested redirection to alternate provider • Lack of clarity in order specifications. • Insufficient training for clear communication. • Longer than usual wait times for appointment availability • Staffing shortages within the provider • Providers with limited availability for specialty providers • Lack of prior authorization submitted to Medical-Rx for prescription • Lack of submissions for prescriptions timely to the pharmacy
Access	
• Timely access for routine appointments (PCPs & specialists) • Providers cancelling & rescheduling appointments outside the Timely access standards (PCPs & specialists) • Access related issues with transportation vendors (NMT) d/t cancelled rides, drivers showing up late or not showing up • Issues with setting up transportation services by customer service which in turn cause an access component • Telephone Access issues	• Limited availability with providers or preferred providers • Members are cancelling and/or not showing to the timely appointment • Providers reporting not receiving calls or requests for appointments • Provider office not returning phone calls timely • Staffing shortages reported by provider • Lack of available optometry offices in the area accepting Medi-Cal members • Members are not prepared for the pickups within the 5-minute time frame • Rerouting of the ride after the initial driver cancels the ride • HPSJ staff setting up rides with incorrect address • CSR not properly completing the PCP change request • Clinic name change/member were not aware of the change despite notification • QNXT configuration is not updating timely for closed panel/provider panel
Attitude and Service	

Trends	Root Causes
• Delays in receiving gift cards or links not working • Drivers, HPSJ staff, or provider staff with attitude & service issues • Customer Service staff incorrectly scheduling rides or flex link issues • Return ride issues, rides being re-routed, and ride long wait times • Advice nurse line call handling	• Members did not correctly activate the card due to a problem/missed step with the activation process. Token number code was difficult to find in the message • Lack of funding to the gift card vendor • Lack of response from the vendor's sub-delegated vendor • Members not allowing the additional 4-6 week waiting period despite the message in the portal • Members' incorrect demographics information listed in the profile • Members do not submit gift card requests timely, which in turn causes them to be ineligible • Inadequate number of staff to schedule transportation ride requests • Increase in transportation ride requests • Issues with training for customer service staff on how to set up transportation • Rides are re-routed when the initial driver cancels the initial pick up • The drivers receive the incorrect location for the return ride • Members are not prepared for the pickups within the 5-minute time frame • 5-Minute wait time frame is not long enough for the members to reach the car
Billing and Financial	
• Billing issues related to providers balance billing members	• Claims not being properly processed for the full refund • Providers' staff lack of knowledge regarding bill processing
Quality of Practitioner Office Site	
• There were no trends identified in the quality of practitioner office site.	

Measurement of Intervention Effectiveness:

The quality improvement activities have had a positive impact on two categories of grievances. Access to care and quality of care. The corrective actions placed on transportation vendors have lessened the grievances for transportation related grievances and the improvements made in handling specialty care and services have had a positive impact on quality of care grievances.

Opportunities:

- Educated providers' staff about using ensuring the referrals are tracked and monitored
- Promote better and timely communication with members if issues with referrals arise
- Staff utilization of wait list to outreach to members for sooner appointments
- Redirection to alternate specialist
- Staff education on timely prescription submissions to the pharmacy
- Staff education on timely submission for authorization to Medi-Cal Rx timely
- Education to provider offices to ensure they schedule appointments within TAS
- Offered walk-in clinic as an alternative option, seek services at urgent care
- Locum projects continued for more accessibility
- Clinics are offering appointments with alternate providers or walk-in clinics
- Education to members regarding the importance of keeping their appointments
- New staff are being hired to alleviate shortages.
- VSP is attempting to recruit more providers in the area
- Alternate process to authorize out of network providers for VSP
- Some providers offered alternative telehealth appointments
- Education to members about Lyft's 5-minute cancellation policy
- The rider is matched with 3 other different drivers
- Lyft monitors cancellation rates and will remove drivers from their platform if they meet thresholds
- CSR coached on properly completing the PCP changes
- Communicating with Configuration team

- The CSR reschedules the ride with the correct address
- Feedback was provided to Claims department regarding EOC guidelines
- Education to provider staff about balance billing and PDR process
- Customer service staffing
- Customer service retraining/coaching
- Additionally training all CSR staff to assist with transportation load
- Real-time monitoring of rides by CSR staff
- Member education regarding activating the gift cards, timely submissions, and processing times
- Re-requested gift cards from the HEDIS team, if there is still an issue with receiving or errors retrieving
- Timely and consistent gift card funding

Actions Taken:

Will prioritize and implement interventions based on the above analysis including:

- Monitoring grievance trends, monthly grievance audits done by G/A team and results presented in Quarterly Grievance Committee.
- Quarterly audit for grievances/appeals is performed by CMO about appropriate documentation by MD, case leveling and scoring by MD, and appropriate case escalation to CMO or PRCC (Peer Review and Credentialing Committee) if needed, and appropriate feedback is provided to the Medical Directors as needed.
- A random sample of resolution letters are audited daily by the QI Supervisor.
- The Grievance team collaborates with internal depts; and quarterly grievance reports are sent to Providers Services dept., Behavioral Health dept, and Cultural and Linguistics team to drive continuous improvement.
- Grievances and Appeals meetings are held regularly with Utilization Management leadership team to address G/A grievances and trends related to UM and to further enhance and/or develop additional interventions.

- Health Plan participates in Community Advisory Committee meetings to provide grievance and appeals updates and address members' concerns.

- The following Corrective Action Plans (CAPs) were placed, see below:

Provider/ Vendor Name	Start Date	Reason for the CAP	Open/ Closed	Other Relevant Information
Lyft-NMT vendor	3/7/2019	**Initial Issues**: • Fifteen grievances identified as Quality of Service were related to transportation issues which included the following: members being denied transportation services prearranged by HPSJ, Lyft drivers refusing to take and bring back members to doctor's appointments, Lyft drivers showing up late to pick up members to and from appointments, Lyft drivers leaving members and not picking up members from their appointments in out of town locations, Lyft drivers being rude and unprofessional towards members. • The access-related case was related to the member missing their appointments with specialist for an out-of-town location due to Lyft drivers refusing to transport the member. **Ongoing issues:** • Provider has continued to meet thresholds for grievances with 48 cases with leveling of C0-S0 and with 12 cases of C1-S1 in a rolling 12month period. • The number of rides has drastically increased over the years since 2022. The number of rides per month requested from NMT vendor has almost tripled since 2022 as compared to 2024(from 3,000 to 11,000). We have also seen a decrease in grievances in October 2023 as compared to previous months in CY2023. • The Peer Physician Reviewer has recommended continuing the CAP for ongoing monitoring, and because the provider has continued to meet the rolling 12-month thresholds.	Open	Monthly meetings were set up to discuss grievances and trends
Palm Haven Care/St. Jude Center (single case)	9/9/2022	**Initial Issues:** • No response was received for the member grievance • Gaps in care and services the member complained about (PT sessions, wound care and meals not being provided). **Ongoing issues:** • Multiple attempts were made by the QI nurse to attempt to receive a CAP response	Open	

		• A referral to Provider Services to assist with the CAP response, provided direct contact to assist.		
Western Drug Medical Supply	6/8/2023	**Initial Issues:** • Back-order issues or delays in delivering the supplies. • Member receiving incorrect supplies. • Delays on processing prescriptions and Prior Authorizations. • Communication issues with the office informing members of the status of their supplies or orders, staff not following up on member's current PCP for re-certifications (e.g.: oxygen supplies), phone access issues and staff not returning voice messages from members or staff. **Ongoing issues:** • Provider has continued to meet thresholds for grievances with 48 cases with leveling of C0-S0 and with 12 cases of C1-S1 in a rolling 12month period. • Issue types (delays with medical supplies, incorrect supplies, delays in processing Rx or PA, and communication issues) trends have remained the same over time.	Open	Quarterly meetings were set up to discuss grievances and trends
Lorenzo Aguilar Jr. Neurologist	9/19/2023	• Telephone Access issues and no return calls after leaving a voicemail.	Closed	Health Plan's contract with Dr. Aguilar ended, it was recommended by the MD to close the CAP.
Lincoln Square Post Acute Care (single case)	10/26/2023	**Initial Issues:** • Preventable incident • Lack of detailed fall risk policy and procedure provided **Ongoing issues:** • Continue to monitor grievances and trends	Open	

Shou-I Lin (single case)	12/15/2023	**Initial Issues:** • Lack of missing Vitals documented in the medical record • Lack of denials regarding illnesses: location of illnesses, color, symptoms etc. • Lack of missing physical assessments • Lack of missing plan /treatment plan • Poor legibility of clinical documents/chart notes **Ongoing issues:** • Continue monitoring and implementation of the corrective actions needed • Pending a review of 5 medical charts (Health Plan) members to ensure proper documentation	Open	An initial meeting was set to discuss grievance and plan of care with provider and Medical Director.
Lincoln Square Post Acute Care (single case)	1/8/2024	• No admission fall risk assessment submitted for review of the PQI • Lack of detailed fall risk policy and procedure provided • No plan of care for high fall risks provided	**Closed**	N/A
CMC-Waterloo (single case)	1/11/2024	**Initial Issues:** • A quality-of-care and access-to-care issues were found, office failed to follow up with one of our members that requested a seizure medication refill. • The member called the office and was never called back by the staff or any provider. • A response from the office the staff did not assign the task to a provider or Care Team after receiving a call from the member requesting seizure medication refill. • The member went to the Emergency Room due to having more episodes of seizures as the member was out of seizure medication for three days. **Ongoing issues:**	Open	

		• Escalated to Peer Review Committee for further recommendations • Continuing monitoring grievances, pending an updated policy and procedure for medication refills		
Carmelita Nisperos	1/10/2024	**Initial Issues:** • Provider not responding to grievances • Members unable to get ahold of the provider office staff or phone access issues • Provider not returning calls to members • Provider scheduling appointments outside of the standard timeframes, which mostly resulted in members changing their providers and delays in referrals. **Ongoing issues:** • The provider was referred to Provider Services a second time to work on improving access issues found d/t no significant improvement seen with the current strategies the provider initially implemented.	Open	
Samesky Health	3/7/2024	**Initial Issues:** • Gift card not received • Gift card reflects $0 balance • Invalid link/code **Ongoing issues:** • Provider has continued to meet thresholds for grievances with 48 cases with leveling of C0-S0 and with 12 cases of C1-S1 in a rolling 12month period	Open	
San Joaquin Health Center	3/26/2024	**Initial Issues:** • Delay in processing referrals • Delay in scheduling timely appointments with specialty providers and timely communication. • Lack of detailed responses (addressing issues listed in grievance)	Open	Quarterly meetings were set up to discuss grievances and trends

		• Members being unable to follow up with PCP after ER discharge timely. • Appointments scheduled outside of timely access standards • In office excess waiting times. • Telephone access related to telehealth appointments **Ongoing issues:** • Provider has continued to meet thresholds for grievances with 48 cases with leveling of C0-S0 and with 12 cases of C1-S1 in a rolling 12month period		
St. Joseph Medical Center (single case)	4/9/2024	**Initial:** • ER physician/team did not consult Urologist/Specialist for Urologic emergency (in this case, member with infected and obstructed kidney stone) • Lack of detailed fall risk policy and procedure provided • ER physician/team did not address member's persistent elevated blood pressure • HTN was not addressed in the patient's discharge paperwork. **Ongoing issues:** • Pending in-service proof of completion	Open	

Community Medical Center	5/3/2024	**Initial**: Access-to-Care issues related to: • Phone access issues (i.e. Unable to get hold of staff, prolonged phone wait times, not returning calls/voice messages from members) • Prolonged in-office wait times • Cancelling appointments due providers not available • Scheduling and rescheduling appointments outside Timely Access • Standards for urgent and non-urgent appointments • Incorrectly filling up PCS Forms or not sending PCS Forms Timely to Health Plan Quality-of-Care issues related to: • Delays in processing medication refills or request • Delays in processing specialist referrals • Delays in submitting Prior Authorization Request to Health Plan • Delays in following up with members regarding lab or diagnostic results • Delays in care related to access issues Quality-of-Service issues related to: • Staff rude attitude • Incorrectly filling up or issues with disability form **Ongoing issues:** • Provider has continued to meet thresholds for grievances with 48 cases with leveling of C0-S0 and with 12 cases of C1-S1 in a rolling 12month period	Open	Quarterly meetings were set up to discuss grievances and trends
Carenet Health	6/13/2024	**Initial Issues**: • Transportation related issues (setting up rides/incorrect bookings/canceling rides) • Complaints of being placed on hold for long periods of time • Complaints of no return calls by the staff	Open	An initial meeting was set to discuss grievances and trends.

Resource Adequacy Assessment:

- Limited capacity within our grievance management system, Essette. Transitioning to a new system to ensure grievance cases are resolved within regulatory timeframes.
- Staffing to process grievances has been adequate to ensure timeliness of grievance processing and follow-up on evidence of non-compliance with grievances.

Plans for Upcoming Year:

- Migration to a new grievance management system (Jiva)
- Continue to monitor resources for upcoming year
- Continue to perform monthly audits and provide feedback and retraining to employees as needed
- Review any new regulations which might apply to grievances

Appeals

The information below is representative of all counties and includes coverage and non-coverage-related appeals.

Annual SJC, SC, ED, AP Appeals	FY July 1, 2022 - June 30, 2023			FY July 1, 2023 - June 30, 2024			Goal per 1000 members	Goal Met
Category	Total Appeals	Appeals per 1000	% of Total Appeals	Total Appeals	Appeals per 1000	% of Total Appeals		
FY22-23 Membership	431,964			FY23-24 Membership		438,783		
Access	0	0.00	0.00%	1	0.00	0.42%	≦5	Yes
Attitude & Service	0	0.00	0.00%	12	0.03	5.00%	≦5	Yes
Billing & Financial	0	0.00	0.00%	0	0.00	0.00%	≦5	Yes
Quality of Care	277	0.64	100.00%	227	0.52	94.58%	≦5	Yes
Quality of Practitioner Office Site	0	0.00	0.00%	0	0.00	0.00%	≦5	Yes
Total	**277**	**0.64**	**100.00%**	**240**	**0.55**	**100.00%**	**≦5**	**Yes**

Green text = goal met; Red = goal not me

Quantitative Analysis:

- Overall, a total of 240 appeals per 1000 members were received. The ≤5.00 appeals per 1000 members goal was met for each category and performance has been fairly consistent from FY22-23.
    - **Access** received 1 appeal and had a rate of 0.00 appeals per 1000 members, which is essentially consistent with FY22-23 results.
    - **Attitude & Service** received 12 appeals and had a rate of 0.03 appeals per 1000 members, an increase of 0.03 grievances/1000 from FY22-23.
    - **Billing & Financial and Quality of Practitioner Office Site** received 0 appeals and had a rate of 0.00 appeals per 1000 members, consistent with FY22-23 results.
    - **Quality of Care** received 227 appeals and had a rate of 0.52 appeals per 1000 members, a decrease of 0.12 grievances/1000 from FY22-23.

Non-Behavioral Health Qualitative Analysis - Appeals

All goals regarding Access, Attitude and Service, Billing and Financial, Quality of Care, and Quality of practitioner Office Site were met across all counties. Subject matter experts identified the following trends: Physical therapy, Back braces and power wheelchairs. While goals were met for each appeal category, in the spirit of continuous quality improvement, HPSJ continues to monitor trends and root causes in an effort to further reduce appeal rates and improve the member's experience of care and service.

Appeal trends were physical therapy, back braces and power wheelchairs

Measurement of Intervention Effectiveness:

The actions taken below decreased the appeals for physical Therapy and back braces for Q3 and Q4.

We will continue to monitor the effectiveness of these interventions.

Opportunities/Actions Taken:

There were 2 opportunities based on appeals data during this time. See actions taken below. Health Plan will continue to monitor appeals to maintain and improve this standard.

Trends	Improvement Actions	Outcome
Physical therapy	Utilization Management changed the policy from requiring prior authorization for physical therapy to not requiring prior authorization.	Significantly reduced the number of physical therapy appeals
Back Braces	Medical Director had meeting with Pain Mgt clinic and reviewed the criteria for Back Orthotics and process.	Reduction in number of back braces appeals
Gift Cards	SameSky Health was placed on a CAP due to members not receiving gift cards.	Will continue to monitor through the CAP process.

Behavioral Health Analysis

Grievances

All Counties

Annual BH Grievances SJC, SC, ED, AP	FY July 1, 2022 - June 30, 2023			FY July 1, 2023 - June 30, 2024			Goal per 1000 members	Goal Met
Category	Total Grievances	Grievances per 1000	% of Total Grievances	Total Grievances	Grievances per 1000	% of Total Grievances		
FY22-23 Membership	**431,964**			**FY23-24 Membership**		**438,783**		
Access	37	0.09	43.02%	97	0.22	54.49%	≦5	Yes
Attitude & Service	5	0.01	5.82%	2	0.00	1.12%	≦5	Yes
Billing/Financial	1	0.00	1.16%	1	0.00	0.56%	≦5	Yes
Quality of Care	43	0.09	50.00%	78	0.18	43.83%	≦5	Yes
Quality of Practitioner Office Site	0	0.00	0.00%	0	0.00	0.00%	≦5	Yes

Total	**86**	**0.19**	**100.00%**	**178**	**0.40**	**100.00%**	**N/A**	**N/A**

Green text = goal met; Red = goal not met

Quantitative Analysis:

- Overall, a total of 178 grievances per 1000 members were received. The ≤5.00 appeals per 1000 members goal was met for each category, however increases were noted in the access and quality of care categories.
    - **Access to Care** received the highest number of grievances, with 47, resulting in a rate of 0.22 grievances per 1000 members, and an increase of 0.13 grievances/1000 from FY22-23.
    - **Quality of Care** received 78 grievances and had a rate of 0.18 grievances per 1000 members, an increase of 0.09 grievances/1000 from FY22-23.
    - **Attitude & Service** received 2 grievances and had a rate of 0.00 grievances per 1000 members, which is essentially consistent with FY22-23 results.
    - **Billing & Financial** received 1 grievance and had a rate of 0.00 grievances per 1000 members, which is essentially consistent with FY22-23 results.
    - **Quality of Practitioner Office Site** received 0 grievances and had a rate of 0.00 grievances per 1000 members, consistent with FY22-23 results.

Behavioral Health Qualitative Analysis - Grievances

Qualitative Analysis:

In addition to the annual evaluation of the trends, barriers, and improvement activities, the Appeal & Grievance team presents trends, barriers and improvement activities on a quarterly basis for discussion in collaborative forums. The committee discussions include representation from Customer Services, Provider Services, Quality Improvement, Claims, Case Management, Utilization Management, Behavioral Management,

and Compliance. While goals were met for each grievance category, in the spirit of continuous quality improvement, HPSJ continues to monitor trends and root causes in an effort to further reduce grievance rates and improve the member's experience of care and service.

The **trends** for non-behavioral grievances noted during FY23-24 are described below as per category:

Trends	Root Causes
Quality of Care	
• Delay in care to for BH/MH care services due to staff not outreaching within TAS (10 business days)	• Lack of provider specialties • Staffing shortages with Carelon
Access	
• Appointments scheduled outside of the Timely Access Standards	• Providers no longer contracted with Carelon as of 5/1/2024 • Staff shortages with Carelon • Lack of outreach within TAS (10 business days)

Measurement of Intervention Effectiveness:

Opportunities:

- New hiring process to alleviate the staffing shortages
- Redirection to alternate specialist

Actions Taken:

Will prioritize and implement interventions based on the above analysis including:

- Corrective Action Plans (CAPs)
- The Grievance team collaborated with compliance department to ensure the corrective actions taken by the provider were appropriate

Corrective Action Plan

Provider/ Vendor Name	Start Date	Reason for the CAP	Open/ Closed	Other Relevant Information
Carelon Behavioral Center	2/5/2024	**Initial Issues:** • Delays in initial outreach for mental health referrals • Members are unable to receive ABA services within timely access standards **Ongoing Issues:** • Provider was referred to provider services due to the provider's staffing shortages, and lack of timely outreach for MH care and services.	Open	Collaboration with Compliance to monitor the CAP

Resource Adequacy Assessment:

- Limited capacity within our grievance management system, Essette. Transitioning to a new system to ensure grievance cases are resolved within regulatory timeframes.

Plan for Upcoming Year:

- Migration to a new grievance management system (Jiva)
- Continue to monitor resources for upcoming year
- Continue to perform monthly audits and provide feedback and retraining to employees as needed
- Review any new regulations which might apply to appeals

Behavioral Health Appeals

The information below is representative of all counties and includes coverage and non-coverage-related appeals.

Annual BH Appeals SJC, SC, ED, AP	FY July 1, 2022 - June 30, 2023			FY July 1, 2023 - June 30, 2024			Goal per 1000 members	Goal Met
Category	**Total Grievances**	**Appeals per 1000**	**% of Total Appeals**	**Total Appeals**	**Appeals per 1000**	**% of Total Appeals**		
FY22-23 Membership	431,964			FY23-24 Membership		438,783		
Access	0	0	0	0	0	0	≦5	Yes
Attitude & Service	0	0	0	0	0	0	≦5	Yes
Billing & Financial	0	0	0	0	0	0	≦5	Yes
Quality of Care	277	0.64	100.00%	9	0.02	100.00%	≦5	Yes
Quality of Practitioner Office Site	0	0	0	0	0	0	≦5	Yes
Total	**277**	**0.64**	**100.00%**	**9**	**0.02**	**100.00%**	**N/A**	**N/A**

Green text = goal met; Red = goal not met

Quantitative Analysis:

- Overall, a total of 9 appeals per 1000 members were received. The 5.00 appeals per 1000 members goal was met for all categories. Overall performance is consistent with FY22-23, with the exception of the decrease in quality-of-care appeals described below.
    - **Quality of Care** received 9 appeals and had a rate of 0.02 appeals per 1000 members, a decrease of 0.62 appeals/1000 from FY22-23.
    - Zero appeals received for the other four categories, consistent with FY22-23 performance

Behavioral Health Qualitative Analysis - Appeals:

All goals regarding Access, Attitude and Service, Billing and Financial, Quality of Care, and Quality of practitioner Office Site were met across all counties. Health Plan subject matter experts do not identify any barriers to processing grievances at this time. Health Plan will continue to monitor appeals to maintain and improve this standard.

Qualitative Analysis:

In addition to the annual evaluation of the trends, barriers, and improvement activities, the Appeal & Grievance team presents trends, barriers and improvement activities on a quarterly basis for discussion in collaborative forums. The committee discussions include representation from Customer Services, Provider Services, Quality Improvement, Claims, Case Management, Utilization Management, Behavioral Management, and Compliance. The data is also presented to the governing body and Community Advisory committee.

The **trends** for non-behavioral grievances noted during FY23-24 are described below as per category:

Quality of Care: 9

Trends Identified

Six out of the nine appeals received were attributed to a single provider that separated from their contractor group and established their own independent practice. They worked with Health Plan to secure a separate contract and LOA's were conducted for CoC. This is due to members already being under the care of this provider and meeting the continuity of care guidelines.

Actions Taken:

Will continue to monitor.

Resource Adequacy Assessment:

- Limited capacity within our grievance management system, Essette. Transitioning to a new system to ensure appeal cases are resolved within regulatory timeframes.

Plan for Upcoming Year:

- Migration to a new appeal management system (Jiva)
- Continue to monitor resources for upcoming year
- Continue to perform monthly audits, and provide feedback to employees

Annual EvaluationFY23-24-Potential Quality Issues

A potential quality issue (PQI) is defined as a suspected deviation from expected member behavior, provider performance, clinical care, or outcome of care, which requires further investigation to determine whether an actual quality issue or opportunity for improvement exists. Not all PQIs represent quality of care problems. PQIs may be identified through a systematic review of a variety of data sources, including but not limited:

- Referrals by Health Plan staff
- Providers or Subcontractors
- Grievance/Appeal reviews
- Concurrent reviews
- UM reviews

All PQI's are investigated by QI Nurses and reviewed by a Medical Director/Peer Physician Reviewer. The Medical Director or designee levels and scores the PQI, that indicates the next step actions needed for the case. Additional action may be indicated by the QI Nurse, or the case may be closed or referred to Peer Review Committee (PRCC) for further recommendation. The PQIs must be resolved within 180 days of receipt.

PQI for All Counties		FY July 1, 2022 - June 30, 2023			FY July 1, 2023 - June 30, 2024		
Category	**Performance Goal**	**Total PQI**	**PQI's per 1000**	**% of Total PQI**	**Total PQI**	**PQI per 1000**	**% of Total PQI**
FY Membership		431,964			438,783		
Access	≤ 5/1000	5	0.01	5.1%	31	0.07	25.0%

Quality of Service		2	0.004	2.0%	6	0.01	4.8%
Quality of Care		92	0.21	92.9%	87	0.20	70.2%
Total		99	0.22	100.0%	124	0.28	100.0%

Quantitative Analysis

- The ≤ 5/1000 PQI goal was met for all three categories.
- Access: Reflects 19.5 percentage point increase (from 5.5% to 25.0%) in volume from the previous year
- Attitude & Service: Reflects a 2.8 percentage point increase in volume from the previous year
- Quality of Care: Continues to reflect the highest number of PQI's, with 87, with a slight decrease in volume and rate from the previous year
- The total number of PQI's increased in FY23-24 as compared to FY22-23 by 25.3%

Qualitative Analysis

In addition to the annual evaluation of the trends, barriers, and improvement activities, the quality improvement team presents trends, barriers, and improvement activities on a quarterly basis for discussion in collaborative forums. The committee discussions include representation from Customer Services, Provider Services, Quality Improvement, Claims, Case Management, Utilization Management, Behavioral Management, and Compliance. The data is also presented to the governing body and Community Advisory committee.

Health Plan continues to monitor trends and root causes in an effort to further reduce PQI rates. The trends and root causes for PQI noted during FY23-24 are described below as per category:

Trends	Root Causes
Quality of Care	
• Complications after surgery • Unwitnessed falls • Quality of Care issues • Delay in care • Inappropriate provider care	• Members failed to follow up after discharge • Lack of assessment for fall risk • Lack of discharge planning process • Lack of timely referral submissions • Lack of scheduling timely follow up post-op after procedures

• Unsafe Discharge	• Lack of timely submission for prescription refills that lead to adverse outcomes • Lack of timely evaluation or activation by trauma surgeon due to high volume of traumas or due to not following proper trauma protocol • Known complications not due to negligence • Members non-compliant with plan of care • Lack of timely intervention • Lack of specialty providers • Medical record deficiency • Providers closing their panel not accepting new patients
Access	
• Interpreter issues with understanding and translating • Interpreter disconnecting the calls too soon • Vendors not able to interpret certain dialects • Difficulty contacting and scheduling appointments with the specialty provider	• Lack of Assyrian dialect interpreter • Lack of Dutch interpreter • Lack of Hindko interpreter • Lack of Kannada interpreter • Lack of Taishanese interpreter • Interpreters not appropriately following proper protocols and adherence to client's protocol for translation • Providers not accepting or seeing new members
Attitude and Service	
• Translating service issues during calls with Health Plan's Customer Service Representatives	• Interpreters' poor customer service or unacceptable behavior • Lack of active listening and engagement

Measurement of Intervention Effectiveness

Improvement actions implemented during the measurement period included enhanced oversight of grievance processes by the CMO, audits of Medical Director determinations by the CMO, and regular meetings with the C&L Manager to remediate cultural and linguistic related grievances. All interventions are relatively new and

sufficient time has not elapsed to fully evaluate the effectiveness of these interventions. Ongoing measurement and evaluation will continue throughout the 24-25 fiscal year to monitor effectiveness of interventions.

Opportunities:

Quality of Care

- Member education to ensure they complete and attend their post op visits or contact provider for any concerns of complications
- Provider education on treatment of urgency, and emergency as well as management of patients in the ED
- Staff education on timely submission for medication prescriptions timely
- Improvement training for timely interventions post falls (such as x-rays), and fall prevention interventions
- Member education to request staff assistance with ADL to prevent falls

Access

- Deactivated the interpreter access to platform
- Coaching and feedback were provided to the interpreter (adherence to client's instructions)
- Prescheduling the specific language interpreter ahead of time due to the rare needs
- Interpreter coached on ethics and professionalism, and the prohibition of intentionally putting a call on hold.
- Redirected members to alternate providers in the area

Attitude and Services

- Interpreters were coached on properly and professionally handling translation services
- Ongoing monitoring of the interpreters to ensure they follow proper protocols when providing translation services

Improvement Actions:

Quality of Care

- Provider to implement changes to their discharge process and member discharge education regarding reporting adverse s/s post-surgery and procedures

- Providers to update policies and procedures for high risk fall patients that include fall prevention and interventions (enhanced safety of the environment)
- Provider to review their medication refill process and systems
- Escalation to the Peer Review Committee for further actions and recommendations
- Corrective Action Plans submitted to the providers for corrective actions (Hospitals/SNF/LTC facilities or individual providers).
- Root cause analysis request from providers for improvement opportunities
- Peer to Peer calls to discuss the issues and trends
- Provider Service referrals internally with Health Plan for support with access to care issues
- DHCS reporting for Provider Preventable Conditions of Health Acquired Conditions and Other Provider Preventable Conditions

Access

- A list of languages that need to be pre-scheduled for rare languages was provided for reference to Health Plan's Customer Service Representatives

QOS

- Continued coaching and feedback to be provided to the interpreters

Resource Adequacy Assessment:

- Limited capacity within our management system Essette. Transitioning to a new system to ensure PQI cases are resolved within regulatory timeframes.

Plans for Upcoming Year:

- Migration to a new PQI management system (Jiva)
- Continue to monitor resources for upcoming year

2024 Annual Assessment of Non-Behavioral Health Member Experience and Complaints and Appeals

Date: August 29, 2024

Introduction:

Health Plan of San Joaquin (HPSJ) is committed to ensuring enrollees experience with HPSJ health plan providers and systems are evaluated annually. Once evaluated, opportunities to improve coordination of care and access to care, tests and treatment are identified and acted on. The methods used to evaluate member experience are an annual survey of member experience for both adult and child populations (CAHPS) as well as an annual evaluation of grievance and appeal trends by quarter. All survey results are reflective of measurement year 2023, fielded and reported in 2024.

CAHPS Survey Methodology:

The CAHPS survey is a nationally recognized and validated member experience survey tool. CAHPS surveys follow scientific principles in survey design and development. The survey focuses on matters that members/patients themselves say are important to them and for which members are the best and/or only source of information. HPSP utilizes an external NCQA-certified vendor, Symphony Performance Health (SPH), to conduct the annual Medicaid Adult and Child CAHPS surveys. The survey results are analyzed to identify opportunities for improving member experience and are correlated with other member experience data including grievances and appeals to identify any trends in member experience opportunities.

The survey sample frames are drawn from a list of members (adults age 18 and older, or children 17 and younger) enrolled in HPSJ. The Medicaid survey target time frame, or look-back period, is 6 months and is intended to make the sample frame as inclusive as possible and to standardize data collection for comparisons of results. Adults and children must have been enrolled in the plan for the full look-back period or longer, with no more than one 30-day break in enrollment during that time period.

HPSJ analyzed the responses to the CAHPS 5.1H composites and questions to assess member experience with health plan providers and systems as well as identify opportunities for improvement. The 5.1H survey instrument added telehealth to access questions.

It is clear that prolonged aftermath of conditions surrounding COVID-19 shelter in place, the subsequent public reaction thereto, telehealth visits as an alternative

means by which to seek services, as well as an overall change in how people approach the receipt of healthcare services and everyday life as well, collectively continues to negatively impact the response rates.

Medicaid Adult CAHPS Survey Response Rate:

- In 2024 a total of 2700 surveys were sent to enrollees in San Joaquin and Stanislaus counties. Ineligible survey responses are removed before response rates are calculated. For this survey period there were 21 ineligible responses.

Survey responses by percentage	2024	2023	2022	2021
Completed Surveys	243	274	351	377
Overall Response Rate	9.1%	11.7	13.1%	14.10%

Demographics of Respondents:

Of the 243 respondents, the following demographics are noted with Health Equity of the Medicaid adult population of HPSJ in mind. 174 English surveys were returned and 69 Spanish.

- There were 155 female and 85 males 3 undisclosed responding and of those respondents the largest population (44 %) (107) were 55 years or older in age.
- Most respondents were Latino 51.5%, Those who declared Not Hispanic Latino, reported identifying as White, Asian, Black/African American, American Indian or Alaska Native, Native Hawaiian/Pacific Islander. It is challenging to form a solid race and ethnicity stratification because multiple selections may be checked by the respondents. To exemplify this, it is noted that the third most prevalent stratification is "other" which comprised 27.5% of the responses.
- Of the adult respondents, 62.1% have a high school education or less.
- Self-reported physical health status of respondents: 31.8% report excellent or very good health, and the remaining respondents were split between good 39.8% and fair to poor health 28.4%.
- Self-reported mental health status of respondents: 39.9% report excellent or very good emotional/behavioral health, the remaining respondents report good 33.9% and 26.2% fair to poor.

Health Equity - *The tables below show disparities among key demographic groups across key metrics.*

Health Plan of San Joaquin

HEALTH EQUITY

MEDICAID ADULT

Group is performing...
- Above the plan score by 5 or more points
- Above the plan score
- Below the plan score
- Below the plan score by 5 or more points
- Above/below plan score but has low base (<30)

The infographic below highlights disparities in health equity among key demographic groups across the key metrics. Darker shading indicates a larger disparity.

Accreditation Measure | Other Measure

Demographic	Category	Total	Rating of Health Plan SRS	Rating of Health Plan Δ	Rating of Health Care SRS	Rating of Health Care Δ	Getting Needed Care SRS	Getting Needed Care Δ	Getting Care Quickly SRS	Getting Care Quickly Δ	Rating of Personal Doctor SRS	Rating of Personal Doctor Δ	Rating of Specialist + SRS	Rating of Specialist + Δ
			56.6%		46.4%		72.2%		73.6%		61.5%		63.7%	
Gender	Male	n = 85		-1%		-5%		3%		5%		-6%		1%
	Female	n = 155		0%		1%		-1%		-2%		2%		0%
Age	18 – 34	n = 53		-9%		-17%		-22%		-18%		-38%		-9%
	35 – 44	n = 30		-8%		-18%		-6%		-21%		-16%		-14%
	45 – 54	n = 44		-10%		4%		-5%		-10%		10%		-6%
	55 or older	n = 107		10%		8%		7%		14%		9%		6%
Overall Health	Excellent/Very Good	n = 75		16%		18%		11%		8%		8%		5%
	Good	n = 94		-2%		-6%		4%		8%		2%		11%
	Fair/Poor	n = 67		-17%		-12%		-13%		-15%		-10%		-17%
Mental Health	Excellent/Very Good	n = 93		18%		15%		14%		12%		14%		24%
	Good	n = 79		-20%		-16%		-10%		-9%		-15%		-19%
	Fair/Poor	n = 61		-3%		-1%		-7%		-4%		-3%		-7%
Education	HS Grad or less	n = 146		8%		5%		6%		6%		4%		2%
	Some college or more	n = 89		-14%		-10%		-10%		-9%		-8%		-5%
Race/ Ethnicity	White	n = 105		-5%		-1%		-3%		-9%		2%		-3%
	Black/African-American	n = 18		-10%		-2%		11%		5%		-2%		-1%
	Asian	n = 40		3%		-6%		1%		7%		3%		5%
	Native Hawaiian/Pacific Islander	n = 4		-32%		-46%		28%		-74%		-62%		36%
	American Indian or Alaska Native	n = 11		-11%		-13%		-26%		-54%		5%		-14%
	Other	n = 60		-4%		5%		17%		13%		-1%		10%
	Hispanic/Latino	n = 120		1%		1%		2%		2%		-1%		2%

Health Plan of San Joaquin

HEALTH EQUITY

MEDICAID ADULT

Group is performing...
- Above the plan score by 5 or more points
- Above the plan score
- Below the plan score
- Below the plan score by 5 or more points
- Above/below plan score but has low base (<30)

The infographic below highlights disparities in health equity among key demographic groups across the key metrics. Darker shading indicates a larger disparity.

Accreditation Measure | Other Measure

Demographic	Category	Total	Coordination of Care + SRS	Coordination of Care + Δ	Customer Service + SRS	Customer Service + Δ	How Well Doctors Communicate + SRS	How Well Doctors Communicate + Δ	Ease of Filling Out Forms + SRS	Ease of Filling Out Forms + Δ
			67.1%		84.0%		88.7%		96.0%	
Gender	Male	n = 85		9%		-2%		0%		2%
	Female	n = 155		-3%		1%		0%		-1%
Age	18 – 34	n = 53		-37%		-13%		0%		-4%
	35 – 44	n = 30		-7%		4%		-4%		4%
	45 – 54	n = 44		0%		-4%		-2%		2%
	55 or older	n = 107		8%		6%		2%		0%
Overall Health	Excellent/Very Good	n = 75		1%		14%		2%		1%
	Good	n = 94		12%		-1%		5%		-2%
	Fair/Poor	n = 67		-12%		-9%		-8%		1%
Mental Health	Excellent/Very Good	n = 93		13%		10%		5%		2%
	Good	n = 79		-12%		-4%		-3%		-3%
	Fair/Poor	n = 61		1%		-7%		-4%		1%
Education	HS Grad or less	n = 146		7%		2%		1%		1%
	Some college or more	n = 89		-13%		-4%		0%		-2%
Race/ Ethnicity	White	n = 105		-4%		-10%		-3%		0%
	Black/African-American	n = 18		-17%		0%		-8%		-9%
	Asian	n = 40		-14%		2%		1%		-4%
	Native Hawaiian/Pacific Islander	n = 4		-67%		-84%		-14%		4%
	American Indian or Alaska Native	n = 11		-17%		-14%		11%		4%
	Other	n = 60		33%		14%		8%		4%
	Hispanic/Latino	n = 120		10%		2%		4%		1%

Disparity Analysis by metric:

When evaluating sub-populations, the following analysis shows responses that may point to potential disparities in receiving care and services when compared to the plan averages.

- Rating of Health Plan:
  - Lowest responses came from members aged 35-44. And members of fair and poor health.
  - Higher responses: members who reported good health overall and notably those who reported Excellent/Very good Mental Health, irrespective of age.
- Getting Needed Care – In 2024 (72.2%) and 2023 (75.7%) a decline of 3.5%
- Getting Care Quickly:
  - The 2024 response rate of 73.6% is favorable when compared to 2023 response rate of 72.2%
  - By Gender, the number of Males who reported Getting Care quickly was more than double of that reported by women.
- Rating of Personal Doctor:
  - Lower responses: members ages 18-34, members in fair or poor health, Native American members
  - Higher responses: members ages 45+, members in excellent or very good health, white members
- Coordination of Care:
  - Lower responses: members in overall fair or poor health, members with some college
  - Higher responses: members with good health, those who reported being HS graduates or less and those who are reportedly Hispanic or Latino
- Customer Service:
  - Lower responses: members with Excellent/very good health, which may suggest that there was no interaction.
  - Higher responses: members who report Excellent/Very good mental health
- How Well Doctors Communicate:
  - Lower responses: members in fair or poor overall health
  - Higher responses: members who reported good overall health and excellent mental health, and Hispanic or Latino members

Medicaid Adult CAHPS Results and Analysis

The following table summarizes the results from RY 2022 through RY 2024. These rates are presented along with the vendor book of business and the RY 2023 Quality Compass rating for benchmarking purposes.

Medicaid Adult CAHPS Summary Rate Scores						
	Performance Goal (2024)	**2022**	**2023**	**2024**	**2024 PG BoB**	**2023 QC**
Rating Questions *(% 8, 9, or 10)*						
Q28. Rating of Health Plan	77.71%	75.6%	73.9%	70.6%	78.7%	77.7%
Q8. Rating of Health Care	74.8%	67.3%	66.7%	66.9%	75.8%	74.6%
Q18. Rating of Personal Doctor	82.66%	72.0%	69.1%	79.7%	83.9%	82.4%
Q22 Rating of Specialist	81.49%	76.3%	82.2%	75.8%	82.7%	81.4%
Getting Needed Care *(% Usually or Always)*		74.3%	73.9%	72.2%	82.1%	81.0%
Q9. Getting care, tests, or treatment	84.62%	81.5%	75.5%	75.7%	85.1%	84.2%
Q20. Getting specialist appointment	78.85%	67.1%	72.4%	68.8%	79.1%	78.3%
Getting Care Quickly *(% Usually or Always)* 81.49%		70.1%	68.8%	73.6%	81.2%	80.4%
Q4. Getting urgent care	82.97%	71.8%	71.8%	74.7%	82.7%	82.0%
Q5. Getting routine care	80.00%	68.4%	65.9%	72.4%	79.7%	79.2%
Effectiveness of Care (% Sometimes, Usually, or Always)						
Q31. Flu Vaccine 18-64 (%Yes)	N/A	43.2%	41.5%	N/A	N/A	N/A
Q33. Advised to quit smoking 2 YR	73.01%	52.2%	60.7%	55.4%	73.7%	72.8%
Q34. Discussing cessation meds 2YR +	50.37%	35.1%	39.1%	37.8%	53.4%	51.2%
Q35. Discussing cessation strategies 2YR +	46.37%	30.1%	39.3%	26.5%	47.1%	45.4%
Customer Service *(% Usually or Always)* 89.57%		86.7%	86.8%	84.0%	89.8%	89.2%
Q24. Provided information or help	83.81%	81.7%	83.0%	78.3%	84.7%	83.7%
Q25. Treated with courtesy and respect	95.41%	91.7%	90.5%	89.8%	94.8%	94.7%
How Doctors Communicate *(% Usually or Always)*	92.73%	88.8%	84.7%	88.7%	93.2%	92.5%
Q12. Dr. explained things	92.73%	89.2%	86.5%	88.1%	93.2%	92.6%
Q13. Dr. listened carefully	92.69%	88.6%	84.4%	88.0%	93.3%	92.6%
Q14. Dr. showed respect	94.51%	92.4%	86.4%	92.3%	94.9%	94.4%
Q15. Dr. spent enough time	90.53%	84.9%	81.6%	86.4%	91.4%	90.3%
Q17. Coordination of care	85.29%	79.3%	69.0%	67.1%	86.0%	84.6%
Q27. Ease of filling out forms	95.54%	96.7%	93.8%	96.0%	94.8%	95.4%

Green text = goal met; Red text = goal not met

Key Drivers

Key driver modeling uses statistical methodology to identify key drivers behind the health plan ratings. This model takes into account results and weighted importance of each measure to members' overall experience.

The statistics suggest that members had responses favorable to the health plan when asked if they were 1) treated differently by doctors when asked if, 1) (Q50) Treated differently by Drs. Because of race /culture/economic status, and 2) Treated unfairly by health plan due to cultural differences. Members rated the ease of filling out forms as highly favorable.

Health Plan of San Joaquin

MEASURE SUMMARY

MEDICAID ADULT

TOP THREE Performing Measures

Your plan's percentile rankings for these measures were the highest compared to the 2024 PG Book of Business.

MEASURE	2024 Valid n	PLAN SUMMARY RATE SCORE			2023 QC			2024 PG BoB		
		2023	2024	CHANGE	SCORE	GAP	PERCENTILE	SCORE	GAP	PERCENTILE
Rating of Specialist + *(% 9 or 10)*	91^	68.3%	63.7%	-4.6	66.2%	-2.5	27th	68.5%	-4.8	20th
Rating of Health Plan *(% 9 or 10)*	235	58.0%	56.6%	-1.4	61.2%	-4.6	20th	63.1% ▼	-6.5	12th
Rating of Personal Doctor *(% 9 or 10)*	148	55.8%	61.5%	5.7	67.9%	-6.4	8th	70.3% ▼	-8.8	8th

BOTTOM THREE Performing Measures

Your plan's percentile rankings for these measures were the lowest compared to the 2024 PG Book of Business.

MEASURE	2024 Valid n	PLAN SUMMARY RATE SCORE			2023 QC			2024 PG BoB		
		2023	2024	CHANGE	SCORE	GAP	PERCENTILE	SCORE	GAP	PERCENTILE
How Well Doctors Communicate + *(% Usually or Always)*	117	84.7%	88.7%	4.0	92.5%	-3.8	6th	93.2%	-4.5	<5th
Getting Needed Care *(% Usually or Always)*	124	73.9%	72.2%	-1.7	81.0% ▼	-8.8	<5th	82.1% ▼	-9.9	<5th
Coordination of Care + *(% Usually or Always)*	82^	69.0%	67.1%	-1.9	84.6% ▼	-17.5	<5th	86.0% ▼	-18.9	<5th

Significance Testing: Current score is significantly higher/lower than the 2023 score (▲/▼) or benchmark score (▲/▼).

^Denominator less than 100. NCQA will assign an NA to this measure.

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Adult CAHPS Quantitative Analysis:

Ratings are taken from result responses 8, 9 and 10 on a scale of 1-10 or capture the percentage of respondent who reported an experience as "Always or Usually".

- Performance goals to achieve 50th percentile performance for the vendor book of business were not met for any of the CAHPS results with the

exception of Q27 Ease of Filling Out Forms. This result was .46 percentage points above its performance goal.

- The following measures declined in performance from MY23 to MY24
  - Getting needed care declined 1.7 percentage points from 73.9% to 72.2%.
  - Rating of health plan declined 1.4 percentage points from 58.0% to 56.6%.
  - Customer service declined by 2.8 percentage points from 86.8 to 84%
  - Customer service declined by 2.8 percentage points from 86.8 to 84%
- The following measures improved in performance from MY23 to MY24:
  - How well doctors communicate improved 4.0 percentage points from 84.7% to 88.7%.
  - Rating of personal doctor improved 5.7 percentage points from 55.8% to 61.5%.

The top three performing measures are Rating of Specialist, Rating of Health Plan and Rating of Personal Doctor. The bottom three Performing Measures are How well Doctors Communicate, Getting Needed Care and Coordination of Care. The Bottom three reporting measures are of particular interest because the 2024 rates are called out as significantly lower than the Quality Compass rate for 2023, AND the plan rate for 2023. It should be noted that the rates are Higher than most- so the low rate is not as low as one would expect.

Adult CAHPS Qualitative Analysis:

The HEDIS and NCQA Director, Accreditation Manager and Accreditation Coordinator conducted a qualitative analysis of the Adult CAHPS results. HPSJ members are not pleased with their access to services or the personal doctors themselves. Getting the needed care and getting it quickly is an area that HPSJ will focus on from a network development perspective. Driving factors for this dissatisfaction include:

- Members experience limited appointment availability, there are scheduling demands that exceed the provider's capacity.
- Patients equate lack of appointment availability with Plan inefficiency – not the provider offices themselves.
- Members are pleased with the interactions with specialty providers, even though the appointments may occur long after the referral has been made.
- Providers do not have sufficient education on communicating to members varying levels of need, including the diverse cultural and linguistic makeup

of the HPSJ member population and ensuring culturally and linguistically appropriate services and resources at the time of visits.
- Providers have many competing priorities and lack the resources and time to achieve all the demands on them, creating a stressful environment that impacts providers ability to focus on the patient experience.

Opportunities

- In addition to provider facing materials and meetings the importance of the doctor/patient relationship, there continues to be the need to refer members for specialty care when appropriate, having the right care available at the right time for HPSJ enrollees.
- Increased emphasis on the delivery of reporting that creates heightened provider awareness with respect to care gaps that are experienced by members will slowly shift the pendulum towards better comprehensive care, and hopefully a better experience.
- Additional opportunities involve expansion of the provider network and educating those providers with respect to the unique needs of this member population.
- Sensitivity training and cultural awareness is in line for optimization

Improvement Actions

- Continue with Provider Partnership meetings, these are becoming a stronger delivery system for provider awareness and education
- Utilize state sponsored programs and partnerships between the plan and the physician groups, as these are becoming a bridge to understanding, and thinking about the member needs in different ways

Intervention	Barrier Addressed	Timeframe	Responsible
Employee and Provider Education on Health Equity	Providers do not have sufficient education on communicating to member's varying level of need, including the diverse cultural and linguistic makeup of the HPSJ member population.	2024	HEDIS & NCQA Department, C&L Manager
Health Equity Accreditation	The workforce at a plan for marginalized and disenfranchised individuals should reflect the faces of the individuals served	2024/2025	NCQA Accreditation Team.

Intervention	Barrier Addressed	Timeframe	Responsible
Network expansion	Providers have many competing priorities and lack the resources and time,	2024/2025	Provider Services
Leverage grants to implement practice improvements to create operational efficiencies.	Providers have many competing priorities and lack the resources and time to achieve all the demands on them, creating a stressful environment that impacts providers ability to focus on the patient experience.	2024	Health Equity Department, HEDIS & Accreditation Director
Priority: Development of Interdepartmental Task Forces for Improvement of Member Experience	The member experience collaboration has been launched and will have held 6 meetings as of October 1, 2024. The attendance and interest is growing with each of the key departments bringing forth and describing their roles and the ways that what they do effect the member. The meeting has been successful in that the contributors are re-imagining the impact of the experience of the member, as they report on what they do. As the staff experiences the collaboration there is a different level of ownership, synergy and connectivity with the departments who present each week. Information is shifting to action as of October. It is not expected that rates will suddenly be better, it is expected	2024	HEDIS & Accreditation Director, with Support of CMO

Intervention	Barrier Addressed	Timeframe	Responsible
	that the shift in thinking, interacting and reflecting will form a collective and a momentum.		
Priority: CG CAHPS Survey Launch	HPSJ does not have real time detail regarding member/provider interactions to make meaningful partnerships for change and improvement.	2024	HEDIS & Accreditation Director/ Team, with Support of CMO

Medicaid Child Survey

In 2024, 3300 surveys were sent to the caregivers of child enrollees in San Joaquin and Stanislaus counties. Ineligible survey responses are removed before response rates are calculated. The Qualified Respondents are Parents or guardians of those 17 years and younger (as of December 31st of the measurement year) with respect to a population of children that were continuously enrolled in the plan for at least five (5) of the last six (6) months of the measurement year. In 2024, HPSJ received the lowest response rate over the three-year period.

Medicaid Child CAHPS Survey Response Rate:

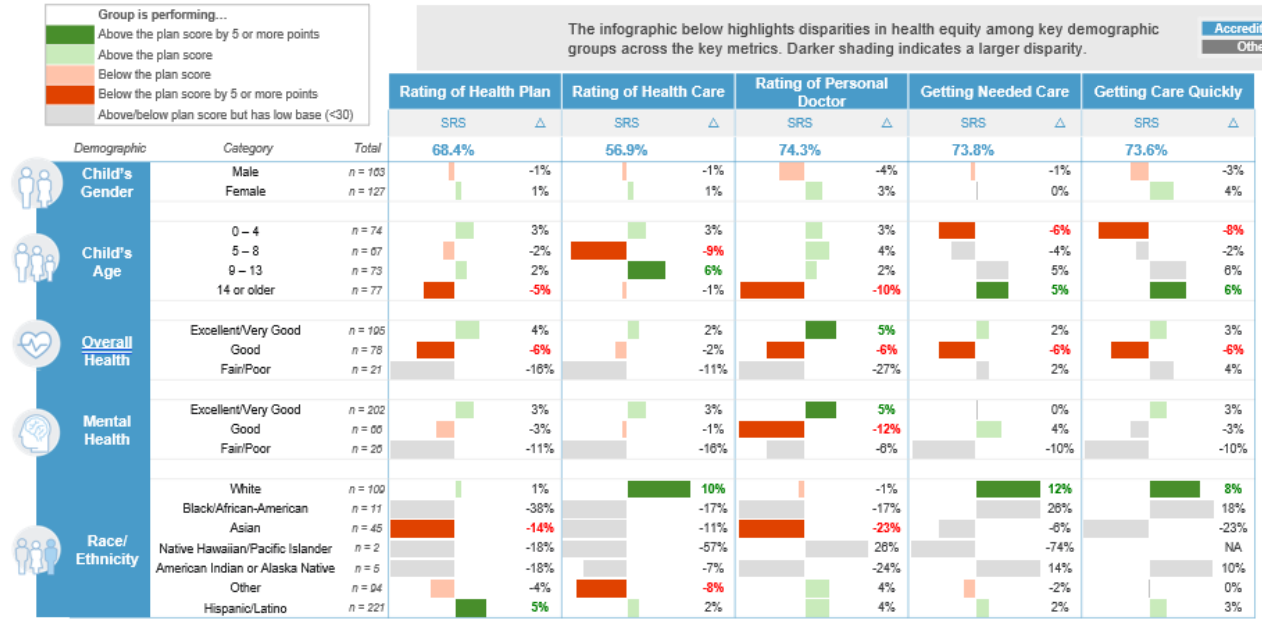
Survey responses by percentage	2024	2023	2022
Completed Surveys	299	336	358
Overall Response Rate	9.1%	12.7%	10.9%

- The survey respondents represented an equal cross section of ages of children. The age category stratification was 0-4, 5-8, 9-13, 14 or older. 56.2 % of the population represented Male. 43.8% was representing female members.
- The caregiver-reported physical health status excellent or very good, of the child(ren) enrollees, was 66.3%.
- The caregiver-reported mental/emotional health status indicating Excellent/Very good, of the child(ren) enrollees, was 68.7%, with 8.8% in fair or poor health mental health.
- Of note, the respondents spoke on behalf of a population of children that were 78.4% Hispanic or Latino.

Health Equity - The tables below show disparities among key demographic groups across key metrics.

HEALTH EQUITY

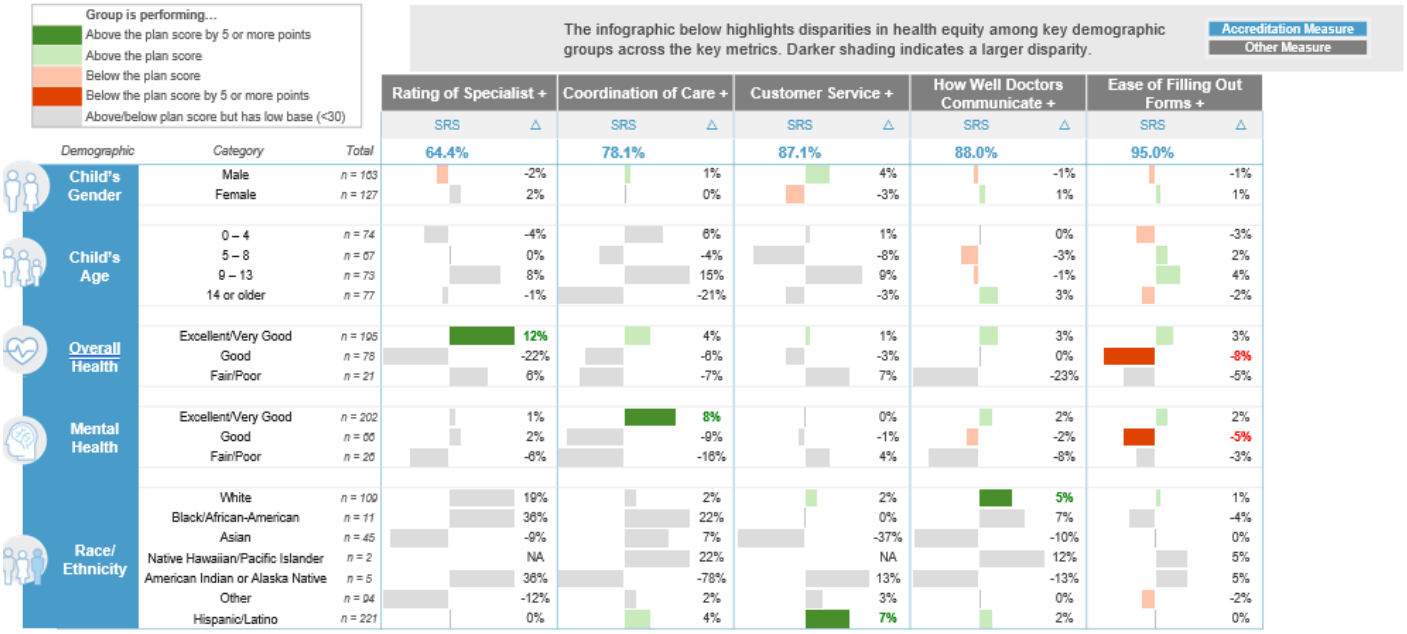
MEDICAID CHILD



Demographic	Category	Total	Rating of Health Plan SRS	Rating of Health Plan Δ	Rating of Health Care SRS	Rating of Health Care Δ	Rating of Personal Doctor SRS	Rating of Personal Doctor Δ	Getting Needed Care SRS	Getting Needed Care Δ	Getting Care Quickly SRS	Getting Care Quickly Δ
			68.4%		56.9%		74.3%		73.8%		73.6%	
Child's Gender	Male	n = 163		-1%		-1%		-4%		-1%		-3%
	Female	n = 127		1%		1%		3%		0%		4%
Child's Age	0 – 4	n = 74		3%		3%		3%		-6%		-8%
	5 – 8	n = 67		-2%		-9%		4%		-4%		-2%
	9 – 13	n = 73		2%		6%		2%		5%		6%
	14 or older	n = 77		-5%		-1%		-10%		5%		6%
Overall Health	Excellent/Very Good	n = 195		4%		2%		5%		2%		3%
	Good	n = 78		-6%		-2%		-6%		-6%		-6%
	Fair/Poor	n = 21		-16%		-11%		-27%		2%		4%
Mental Health	Excellent/Very Good	n = 202		3%		3%		5%		0%		3%
	Good	n = 66		-3%		-1%		-12%		4%		-3%
	Fair/Poor	n = 26		-11%		-16%		-8%		-10%		-10%
Race/ Ethnicity	White	n = 109		1%		10%		-1%		12%		8%
	Black/African-American	n = 11		-38%		-17%		-17%		26%		18%
	Asian	n = 45		-14%		-11%		-23%		-6%		-23%
	Native Hawaiian/Pacific Islander	n = 2		-18%		-57%		26%		-74%		NA
	American Indian or Alaska Native	n = 5		-18%		-7%		-24%		14%		10%
	Other	n = 94		-4%		-8%		4%		-2%		0%
	Hispanic/Latino	n = 221		5%		2%		4%		2%		3%

HEALTH EQUITY

MEDICAID CHILD



Demographic	Category	Total	Rating of Specialist + SRS	Rating of Specialist + Δ	Coordination of Care + SRS	Coordination of Care + Δ	Customer Service + SRS	Customer Service + Δ	How Well Doctors Communicate + SRS	How Well Doctors Communicate + Δ	Ease of Filling Out Forms + SRS	Ease of Filling Out Forms + Δ
			64.4%		78.1%		87.1%		88.0%		95.0%	
Child's Gender	Male	n = 163		-2%		1%		4%		-1%		-1%
	Female	n = 127		2%		0%		-3%		1%		1%
Child's Age	0 – 4	n = 74		-4%		6%		1%		0%		-3%
	5 – 8	n = 67		0%		-4%		-8%		-3%		2%
	9 – 13	n = 73		8%		15%		9%		-1%		4%
	14 or older	n = 77		-1%		-21%		-3%		3%		-2%
Overall Health	Excellent/Very Good	n = 195		12%		4%		1%		3%		3%
	Good	n = 78		-22%		-6%		-3%		0%		-8%
	Fair/Poor	n = 21		6%		-7%		7%		-23%		-5%
Mental Health	Excellent/Very Good	n = 202		1%		8%		0%		2%		2%
	Good	n = 66		2%		-9%		-1%		-2%		-5%
	Fair/Poor	n = 26		-6%		-16%		4%		-8%		-3%
Race/ Ethnicity	White	n = 109		19%		2%		2%		5%		1%
	Black/African-American	n = 11		36%		22%		0%		7%		-4%
	Asian	n = 45		-9%		7%		-37%		-10%		0%
	Native Hawaiian/Pacific Islander	n = 2		NA		22%		NA		12%		5%
	American Indian or Alaska Native	n = 5		36%		-78%		13%		-13%		5%
	Other	n = 94		-12%		2%		3%		0%		-2%
	Hispanic/Latino	n = 221		0%		4%		7%		2%		0%

- Rating of Health Plan:
    - Lower responses: members in fair/poor overall health and mental health,
    - and Black members
    - Higher responses: children ages 0-4, excellent and very good health, other and Hispanic or Latino member.
- Rating of Health Care:
    - Lower responses: male, ages 5-8, fair/poor overall and mental health
    - Higher responses: female, ages 9-13, White and/Hispanic /Latino.
- Getting Needed Care:
    - Higher responses: female, ages 14+. Those reporting good mental health. and White
    - Lower responses: male, ages 0-4, good health, fair/poor mental health
- Getting Care Quickly:
    - Lower responses: male, ages 0-4, members with good overall health
    - Higher responses: ages 0-4, 14+, and white members.
- Rating of Personal Doctor:
    - Lower responses: ages 0-4, good mental health
    - Higher responses: on behalf of female members, ages 5-13, excellent and very good overall and mental health, Hispanic/Latino and those classified as other members.
- Rating of Specialist:
    - Members with Overall Health that is excellent offered ratings above the plan score.
- Coordination of Care:
    - Members with Excellent/Very Good Mental Health offered ratings above the plan score.
- Customer Service:
    - High responses: Hispanic/Latino Population
- How well Doctors Communicate:
    - Lower responses: ages 9-13, good overall health
    - Higher responses: 14 and older, excellent and very good health. White members.
- Ease of filling out forms:
    - No disparities identified

Medicaid Child CAHPS Results and Analysis

Domain Performance	2022	2023	2024	22-23 Rate Change	2023 Compass 25th Percentile (Goal)	Percentile Rank
Rating of All Health Care	78.6%	81.1%	76.4%	2.6	84.1%	<5th
How Well Doctors Communicate Composite	89.5%	91.3%	88.%	1.8	92%	<5th
Getting Care Quickly Composite	77.3%	73.4%	73.6%	-3.9	82.3%	<5th
Getting Needed Care Composite	75.4%	78.7%	73.8%	3.3	79.2%	5th
Rating of Health Plan	83.1%	85.4%	85.9%	2.3	84.2%	36th
Rating of Personal Doctor	84.9%	85.4%	85.3%	0.5	87.9%	6th
Rating of Specialist Seen Most Often	87.5%	90.0%	78.0%	2.5	83.2%	5th
Customer Service Composite	86.1%	88.6%	87.1%	2.5	85.9%	35th

Child Medicaid Benchmarks:

HPSJ target goal is the annual Quality Compass (QC) All Plans benchmarks at the 25th percentile.

Quantitative Analysis

- When compared to all plan types, HPSJ Child CAHPS scores perform below the QC 25th percentile target goal in all domains
- HPSJ 2024 Plan Scores perform equal to or better than the 2023 Quality Compass 25th percentile in the following categories:
  - Rating of Health Plan: result was 85.9%, which is 1.7 percentage points higher than the QC score of 84.2%
  - Customer Service Composite: result was 87.1%, which is 1.2 percentage points higher than the QC score of 85.9%
- Results for all other categories did not meet the 25th percentile scores
- Results for Rating of Personal Doctor were relatively steady in 2024 at 85.3% from 2023 85.4% and the 2022 score of 84.9%, however 2024 results are 2.6 percentage points below the QC 25th percentile
- Results for Getting Care Quickly improved a slight .2 percentage points from 73.4% in 2023 to 73.6% in 2024, however results are 8.7 percentage points below the QC 25th percentile

Top Three Performing Measures

Your plan's percentile rankings for these measures were the highest compared to the 2024 PG Book of Business.

MEASURE	2024 Valid n	PLAN SUMMARY RATE SCORE			2023 QC			2024 PG BoB		
		2023	2024	CHANGE	SCORE	GAP	PERCENTILE	SCORE	GAP	PERCENTILE
Customer Service + *(% Usually or Always)*	93^	88.6%	87.1%	-1.5	87.6%	-0.5	35th	88.8%	-1.7	26th
Rating of Personal Doctor *(% 9 or 10)*	218	68.5%	74.3%	5.8	75.6%	-1.3	34th	77.2%	-2.9	23rd
Rating of Health Plan *(% 9 or 10)*	291	69.3%	68.4%	-0.9	70.9%	-2.5	25th	72.0%	-3.6	22nd

Bottom Three Performing Measures

Your plan's percentile rankings for these measures were the lowest compared to the 2024 PG Book of Business.

MEASURE	2024 Valid n	PLAN SUMMARY RATE SCORE			2023 QC			2024 PG BoB		
		2023	2024	CHANGE	SCORE	GAP	PERCENTILE	SCORE	GAP	PERCENTILE
How Well Doctors Communicate + *(% Usually or Always)*	167	91.3%	88.0%	-3.3	93.6% ▼	-5.6	<5th	94.4% ▼	-6.4	<5th
Rating of Health Care *(% 9 or 10)*	174	62.2%	56.9%	-5.3	68.3% ▼	-11.4	<5th	70.5% ▼	-13.6	<5th
Getting Care Quickly *(% Usually or Always)*	124	73.4%	73.6%	0.2	85.5% ▼	-11.9	<5th	87.0% ▼	-13.4	<5th

Significance Testing: Current score is significantly higher/lower than the 2023 score (↑/↓) or benchmark score (▲/▼).

^Denominator less than 100. NCQA will assign an NA to this measure.

MY 2023 Medicaid Child CAHPS Report - 15

Child CAHPS Survey Quantitative Analysis:

- Three Child Survey measures met the goal of the Quality Compass 25th percentile in MY23:
  - Rating of Health Plan improved 2.3 percentage points from MY22 to MY23 and was 1.3 percentage points above the goal rate of 84.1%.
  - Rating of specialist seen most often improved 2.5 percentage points from the prior measurement year and was above the goal rate of 84.8% by 5.2 percentage points. Customer service improved 2.5 percentage points from MY22 to MY23 and was 2.4 percentage points above the goal rate of 86.2%.
- Five Child Survey measures did not meet the goal of the Quality Compass 25th percentile in MY23:
  - Rating of all health care increased by 2.5 percentage points but was below the goal rate of 85.3% by 4.2 percengate points.
  - How well doctors communicate improved 1.8 percentage points but was belwo the goal rate of 92.5% by 1.2 percentage points.
  - Getting care quickly was the the only measrue that declined in the Child Survey in MY23. This measure declined 3.9 percentage points and was below the goal rate of 84.0% by 10.6 percentage points.
  - Getting needed care improved 3.3 percentage points but was below the goal rate of 81.2% by 2.5 percentage points.

- Rating of personal doctor improved 0.5 percentage points but was below the goal rate of 88.7% by 3.3 percentage points.

Child Member Key Opportunities:

In the table below, SPH survey key opportunities to improve member experience are evaluated by question and by national Medicaid percentile ranking. Opportunities categorized as "Power" are noted as organizational strengths. Opportunities noted as "Opportunities" are questions that are identified as high priority opportunities. The opportunities that are noted as "Wait" are lesser priority opportunities. The opportunities noted as "Retain" are the opportunities that are important to maintain performance. High priority opportunities for HPSJ are centered around the patient/doctor relationship and access to care.

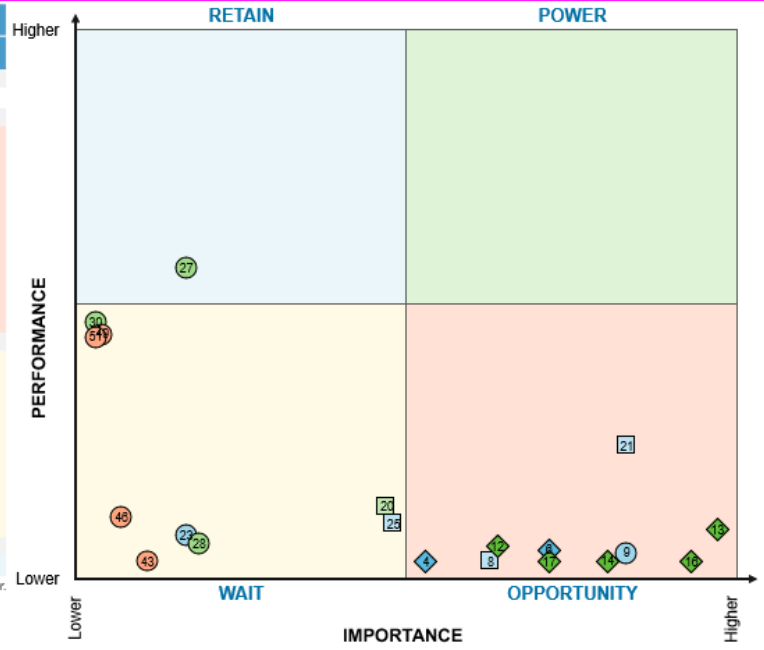
Health Plan of San Joaquin

POWER CHART: YOUR RESULTS

MEDICAID CHILD

			SURVEY MEASURE	2023 SRS	2023 %tile*	2024 SRS	2024 %tile*
			POWER				
			None				
			OPPORTUNITY				
◆	HWDC	Q13	Dr. listened carefully	91.2%	<5th	91.7%	7th
◆	HWDC	Q16	Dr. explained things to child	94.3%	52nd	87.5%	<5th
●	GNC	Q9	Getting care, tests, or treatment	81.0%	7th	80.5%	<5th
■	Rating	Q21	Rating of Personal Doctor	68.5%	<5th	74.3%	23rd
◆	HWDC	Q14	Dr. showed respect	97.8%	77th	93.5%	<5th
◆	HWDC	Q17	Dr. spent enough time	82.6%	6th	78.2%	<5th
◆	GCQ	Q6	Getting routine care	71.6%	<5th	72.3%	<5th
◆	HWDC	Q12	Dr. explained things	93.4%	32nd	88.6%	<5th
■	Rating	Q8	Rating of Health Care	62.2%	8th	56.9%	<5th
◆	GCQ	Q4	Getting urgent care	75.3%	<5th	75.0%	<5th
			WAIT				
■	Rating	Q25	Rating of Specialist +	70.0%	38th	64.4%	8th
■	CC	Q20	Coordination of Care +	82.8%	39th	78.1%	12th
●	CS	Q28	Treated with courtesy and respect	93.4%	39th	89.4%	5th
●	GNC	Q23	Getting specialist appointment	76.4%	49th	67.1%	6th
●	SQ	Q43	Easy to get referral	---	---	56.1%	---
●	SQ	Q46	Got pre-approval when needed	---	---	62.0%	---
●	SQ	Q49	Dr. respected beliefs/cultural traditions	---	---	77.5%	---
●	CS	Q30	Ease of Filling Out Forms +	93.9%	14th	95.0%	45th
●	SQ	Q51	Staff was sensitive to cultural needs	---	---	76.6%	---
			RETAIN				
●	CS	Q27	Provided information or help	83.9%	52nd	84.8%	56th

*Percentiles based on the PG Book of Business of the listed year.



Child Member Qualitative Analysis:

The HEDIS and NCQA Director, Accreditation Manager and Accreditation Coordinator conducted a qualitative analysis of the Child CAHPS results. The results of child member CAHPS show that the caregivers of child members want improved relationships with their child's personal doctor and more timely access

to care. These results and their drivers appear to be similar to those for the adult survey. Causes of dissatisfaction may be:

- Providers do not have sufficient education on communicating to members varying levels of need, including the diverse cultural and linguistic makeup of the HPSJ member population and ensuring culturally and linguistically appropriate services and resources at the time of visits.
- Providers have many competing priorities and lack the resources and time to achieve all the demands on them, creating a stressful environment that impacts providers ability to focus on the patient experience.
- Outdated data sharing methods cause delays in information exchange among providers and scheduling for members that impacts the timeliness of care.
- HPSJ does not have the details regarding provider needs to make meaningful partnerships for change and improvement.

Opportunities

- There are many opportunities to improve child member experience, most of which are contingent on provider network growth and development
- As more is learned from survey feedback, efforts are underway to engage the provider network to bring about changes and find creative ways to foster greater access and appointment availability
- The attention is on creating an environment that fosters fewer strains on doctors. The goal is to allow for more substantive visits with pediatric patients

Improvement actions

- The plan is currently actively engaged in a state sponsored collaborative study of adolescent care delivery experiences at one of the contracted FQHC groups with multiple locations. The Goal of the initiative is to improve care gap rates of vaccinations for the target population of ages 15-18. HPSJ has learned that there are special needs associated with this age group- as it is transitional between childhood and adulthood. The study has been highly informative from both the member and provider perspective. It will continue into the 2nd quarter of 2025. The findings and the remedies will be promulgated across the network and to other offices that serve this age group - where appropriate. Participation in the collaboration is intentional and deliberate, with significant time and resources invested in the collaborative.

Intervention	Barrier Addressed	Timeframe	Responsible
Employee and Provider Education on Health Equity	Providers do not have sufficient education on communicating with members with varying level of need, including the diverse cultural and linguistic makeup of the HPSJ member population.	2024	HEDIS & NCQA Department, C&L Manager
Health Equity Accreditation	The workforce at a plan for marginalized and disenfranchised individuals should reflect the faces of the individuals served	2024/2025	NCQA Accreditation Team.
Network expansion	Providers have many competing priorities and lack the resources and time,	2024/2025	Provider Services
Leverage grants to implement practice improvements to create operational efficiencies.	Providers have many competing priorities and lack the resources and time to achieve all the demands on them, creating a stressful environment that impacts providers ability to focus on the patient experience.	2024	Health Equity Department, HEDIS & Accreditation Director
Priority: Development of Interdepartmental Task Forces for Improvement of Member Experience	The member experience collaboration has been launched and will have held 6 meetings as of October 1, 2024. The attendance and interest is growing with each of the key departments bringing forth and describing their roles and the ways that what they do effect the member. The meeting has been	2024	HEDIS & Accreditation Director, with Support of CMO

Intervention	Barrier Addressed	Timeframe	Responsible
	successful in that the contributors are re-imagining their impact on the experience of the member, as they report on what they do. As the staff experiences the collaboration there is a different level of ownership, synergy and connectivity with the departments who present each week. Information is shifting to action as of October. It is not expected that rates will suddenly be better, it is expected that the shift in thinking, interacting and reflecting will form a collective and a momentum.		
Priority: CG CAHPS Survey Launch	HPSJ does not have real time detail regarding member/provider interactions to make meaningful partnerships for change and improvement.	2024	HEDIS & Accreditation Director/ Team, with Support of CMO

Overall Member Experience with Non-Behavioral Health

Qualitative Analysis:

When considering both CAHPS and grievances and appeals data together, themes surrounding service and access can be identified. CAHPS data showed that members want improved relationships with their primary providers and easier access to routine and urgent care. Grievance data, while meeting all thresholds for performance, provides further detail into member dissatisfaction with access including telephone access, issues with cancelled or rescheduled appointments outside timely access standards, issues with transportation and interpreter services issues.

Analysis of Prior Year Activities:

Health Plan has not been successful in implementing actions that will ultimately improve member experience. Customer Service has continued to focus on improving customer service staffing and training. Given more frequent trainigns and focusing on employee retention, the intended end result was to lessen the amount of time members waited for their calls to be received and the call time hold might be reduces. These things did not happen. Health Plan continues to provide valuable health plan information in the form of a member focused newsletter describing the avenues members can use to get care tests and treatment from HPSJ. Customer service rating improved in both the Adult and Child surveys and was a top performing measure in the Child Survey in RY2024. The investment in the Customer Service team is driving the favorable response of the member. Additional training in innovative and engaging customer service concepts is required for all employees identified from member facing departments.

Although Health Plan had after visit surveys on the Roadmap for FY 2024, they are going to be implemented in FY2025. These surveys will provide insights into the experience close to the time of the visits. In time surveying will assist Health Plan in identifying best practices and opportunities at the provider office level. Provider education that was developed continues with emphasis on the messaging that Timely access is regulatory not optional. access to care as well as HPSJ standards for access for different appointment types (i.e., within 10 days for routine care). The impact is unclear. The Plan will continue to do provider education and may see a greater impact upon repetition as providers become more familiar with the expectations and standards.

Plan for Opportunities for Improvement:

No opportunities for improvement were identified for grievances and appeals as all goals were met.
HPSJ has identified the following activities that focus on improvement in the areas of greatest opportunity for both adult and child surveys:

- Develop and implement a Member Experience Task Force to focus on the member's experience using multidisciplinary teamwork and collaboration.
- Deploy resources through the Task Force that will be focused on improving member experience one provider office at a time.

Adequacy of Resources:

With Health Equity accreditation in mind the health plan hired an Accreditation Manager as of August of 2023. The goal is to provide greater attention and focus on member experience, member initiatives and business practices that support

the delivery of quality and timely care to the member population. Additionally, Health Plan will dedicate one HEDIS/NCQA Coordinator to support member experience surveys and the Member Experience Task Force.

Customer Service

HPSJ & MVHP monitors access to its customer service department on a quarterly basis. HPSJ & MVHP has established the following standards and goals to evaluate access to Customer Service by telephone. The key findings for FY 2023 - 2024 are provided in the graphs below.

Methodology

HPSJ & MVHP collected data on average speed to answer and abandonment rates from their call center system. Data regarding the service level, average speed to answer and abandonment rate are obtained through our Automated Call Distribution (ACD), ShoreTel. ShoreTel contains raw statistical data while compiling reporting real time and historically tracking and trending against the department service goals. In addition, member inquiries are tracked through call logs and reviewed on an hourly, daily, weekly, and monthly basis to ensure member inquiries are resolved expediently and in real time. The timeframe for this analysis is based on the calendar year, which is outlined for the respective business lines along with the graphs presented below.

Contact Center Service KPI/Goals:

- Service Level goal is 80% of call volume answered within 30 seconds
- Abandonment rate of 5% or less
- Average Speed to Answer is 30 seconds or less

Program Performance:

CUSTOMER SERVICE QUALITY METRIC RESULTS				
Metric	**Goal**	**FY 2023-2024**	**FY 2022-2023**	**FY 2021-2022**
Service Level	80%			
Abandonment Rate	≤ 5%	17.74%	8.5%	
Average Speed of Answer	30 sec.	225	91	
Handle Time		09:37	08:04	

Green = goal met; Red = goal not met

Quantitative Analysis

- Average customer service calls per month are 25,316. The month with the highest call volume was April.

- Performance goals were not met for any of the customer service telephone access measures
- When compared to the previous fiscal year the following trends were observed:
  - Call volume increased by 20.73%
  - Handle time in the previous year was 08:04 compared to 09:37 in the current year.
  - Abandonment rate of 8.50% in the previous year compared to 17.74% in the current year.
  - Average speed to answer of 01:31 in the previous year compared to 03:45 in the current year.

Qualitative Analysis

- The Director of Customer Service and manager of Customer Service participated in the analysis of call center metrics.
- Contact center performance was inconsistent due to contributing factors including issues maintaining appropriate staffing levels because of increased customer service representative (CSR) turnover and subsequent recruiting efforts.
- In addition, the department experienced an increase in employee leaves which impacted performance due to reduced staffing.

Measurement of Intervention Effectiveness

Activities put in place throughout the fiscal year were not effective in assisting the plan in reaching call service metric goals. The volume of calls far exceeded the capacity to handle the calls. Additional training and hiring of new customer service staff were ongoing and periodic assessments of live call handling helped the department to maintain call quality standards.

Opportunities

Health plan will use the Member Experience Task Force to help identify whether there are ways to automate some of the activities that are now handled manually and over the phone by customer service staff in an attempt to reduce the number of calls coming in to the plan where the solution does not require personal interaction.

Improvement Actions

- Bring an aggregate and stratified list of call types to the Member Experience Task Force for evaluation and discussion.
- Identify at least one high volume activity that is now handled by a live voice that can be automated.

Quality Assurance

Methodology:

Customer service representative calls are sound and screen capture recorded and quality audits are conducted on a random basis 1-2 times per week depending on tenure. The purpose of quality audits is to measure the accuracy of the information provided and determining financial responsibility. The audit tool includes indicators for measuring performance for each of the following categories:

- Opening-Greeting
- Call Discovery
- Transactional Requirements I
- Transactional Requirements II
- Closing
- Soft Skills

Quality audits measure a variety of components, including HIPAA factors, accuracy of information provided and ensure all expression of dissatisfaction are gathered, and appeal options are provided.

A sample quality assurance form has been included for reference, *QA Response Detail_Sample*.

QA Response Detail

Opening		Yes	No	N/A	Critical
Greeting					
Contingent on what ACD and language line call arrives (2 points)					
Expressed willingness to assist (1 point)					
Identification of caller					
A) Request caller's name; B) Request caller's phone number (2 points)					
HIPAA Validation Information					
Three (3) of the five (5) following criteria must be confirmed by all callers (15 points)					
1. Caller validation box used					
2. Member Name					
3. Member ID Number					
4. Member date of birth					
5. Member's PCP name					
6. Member's address					
Comments					
Total	**20**				

Discovery		Yes	No	N/A	Critical
Problem or Inquiry Recognition					
Listen, acknowledge, clarify problem/inquiry (3 points)					
Use of effective probing skills: e.g. Claim, DOS, billed amount, authorization (3 points)					
Captures information first time offered (2 points)					
Demonstrates active listening (2 points)					
Comments					
Total	8				
Transactional Requirements I		**Yes**	**No**	**N/A**	**Critical**
Transaction Accuracy					
Accurate information provided (15 points)					
Correct process followed (10 points)					
Comments					
Total	25				
Transactional Requirements II		**Yes**	**No**	**N/A**	**Critical**
Problem Resolution					
All concerns/questions addressed (5 points)					
If caller expressed dissatisfaction- was grievance documented and routed to the Quality Team for review? (5 points)					
Effective use of resources: AEVS, DRE, ProCare, Emdeon, First Health, Etc. (1 point)					
Properly notate the call (5 points)					
Provider Linkage					
Recycling of PLog					
Correct usage of SBAR format (3 points)					
Assign appropriate Issue Category and Sub Category (1 point)					
Comments					
Total	19				
Closing		**Yes**	**No**	**N/A**	**Critical**
Closing the call					
Closing script (3 points)					
Call reference log offered (2 points)					
Comments					
Total	5				

Soft Skills		Yes	No	N/A	Critical
Telephone Etiquette / Soft Skills					
Addressed caller by name at least once during conversation (1 point)					
Respond "You're welcome" when caller expresses thanks (1 point)					
Use "Please" when asking for information & "Thank You" when given (1 point)					
Soft Skills (Cont.)					
Ask caller permission to place on hold (1 point)					
Appropriate Use of Hold Time - hold not to exceed 60 seconds (2 points)					
Took ownership of the call (2 points)					
Positive vocal tone/quality (2 points)					
Professional Language - no slang (1 point)					
Demonstrated empathy, if applicable (2 points)					
Do not interrupt or talk over caller (2 points)					
Maintains confidence throughout the call (2 points)					
Post call survey (3 points)					
Comments					
Total	**20**				
Overall Comments					
Overall Score					

CUSTOMER SERVICE QUALITY ASSURANCE AUDIT RESULTS			
Performance Goal	**FY 2023-2024**	**FY 2022-2023**	**FY 2021-2022**
90% Overall Audit Score	89.28%	91%	92%

Green = goal met; Red = goal not met

Quantitative Analysis

- During the fiscal year 2023-2024, a total of 3,561 calls were audited for quality, resulting in an average score of 89.28%, which is just 0.72 percentage points below and thus does not meet the 90% performance goal.

Qualitative Analysis

- The root causes for why the results did not meet the performance goal were that there was higher than expected call volume, more than expected staff turnover and more opportunities for newer staff to develop their skills over time.
- Activities in place to train staff are effective. However, there were far more calls and more new staff. In time the staff will develop their skills and positively impact call quality metrics.

Opportunities

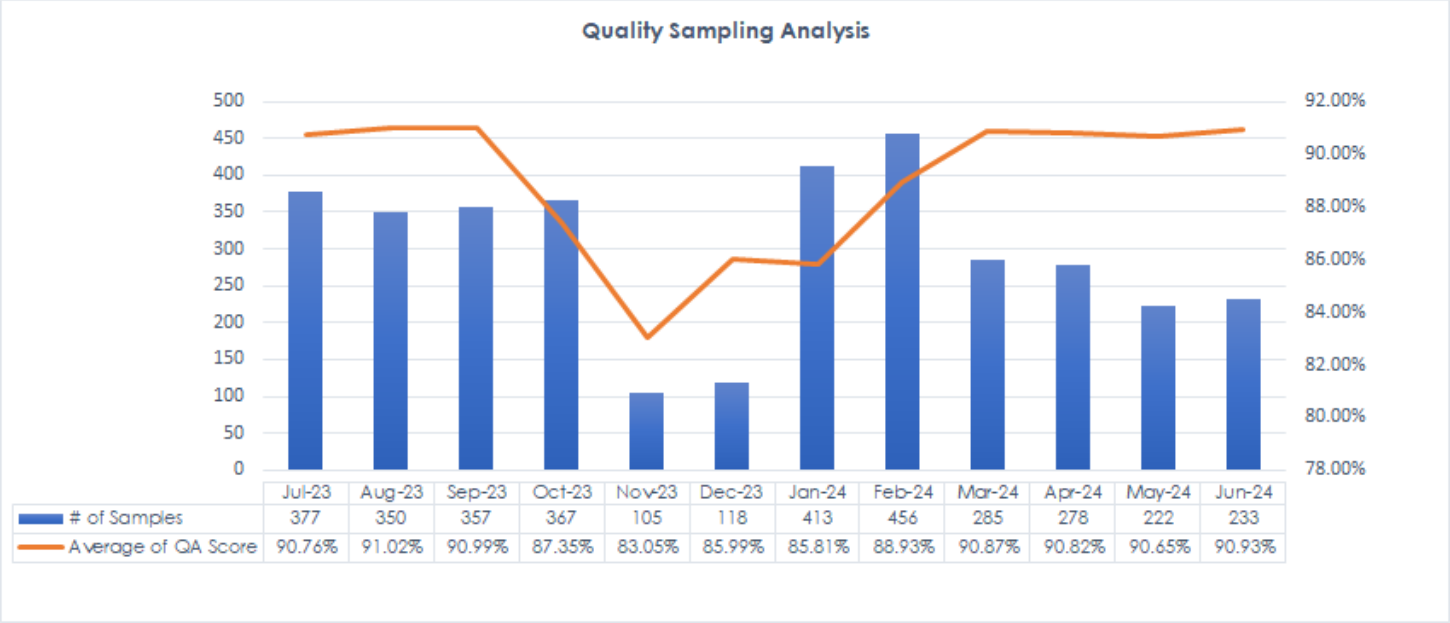
- Identify whether there are ways to deliver more efficient staff training.

Improvement Actions

- Any errors identified via quality audits, are coached via coaching sessions within 1 – 2 business days and any corrective actions necessary are completed.

To attain and/or exceed the 90% quality average for FY 2024 - 2025 the following actions will be completed:

- Calibration Sessions – Leadership team will meet once a month to ensure usage



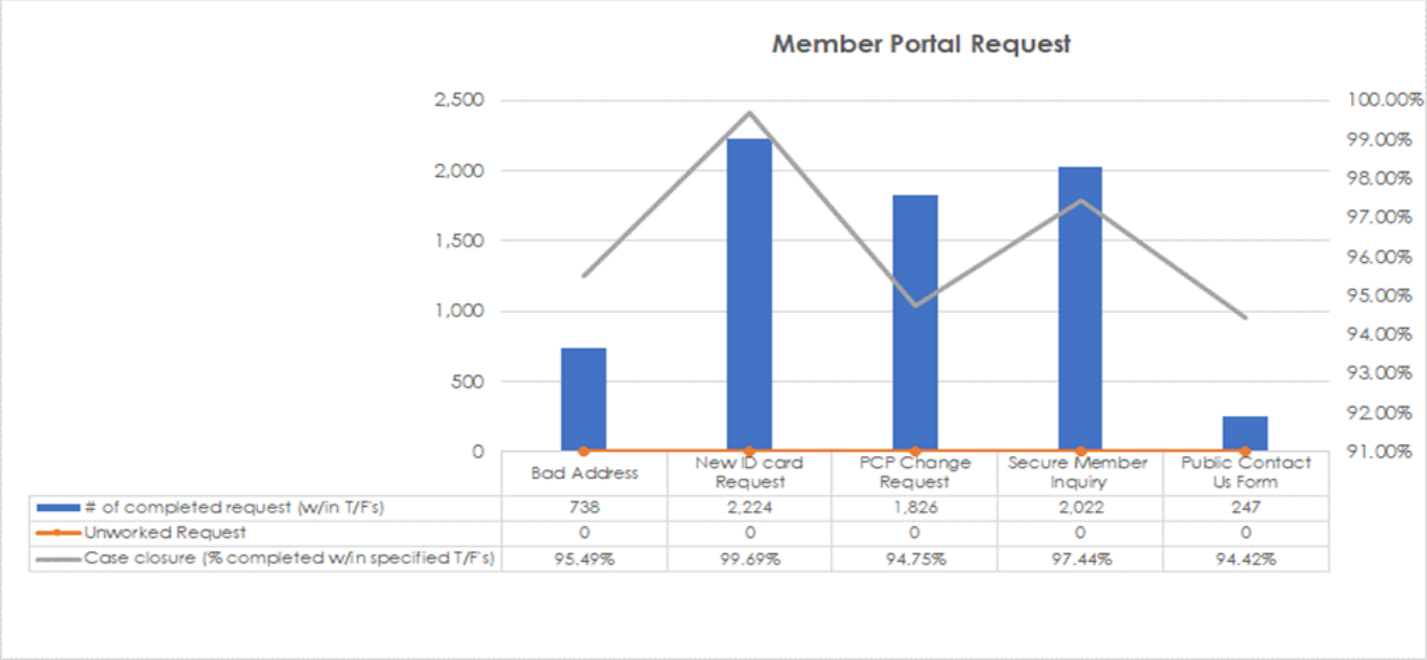
	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
# of Samples	377	350	357	367	105	118	413	456	285	278	222	233
Average of QA Score	90.76%	91.02%	90.99%	87.35%	83.05%	85.99%	85.81%	88.93%	90.87%	90.82%	90.65%	90.93%

of the
QA Response Detail Form is calibrated. Calls will be reviewed and scored to ensure each category is being measured to ensure accuracy of the inquiry.

- Customer service representatives will also be included in select sessions to ensure they too understand quality assurance measures.
- Ongoing review of Standard Operating Procedures (SOP's) to ensure the documented processes fall with in Health Plan of San Joaquin & Mountain Valley Health Plan guidelines. Any changes to the SOPS will be documented through SharePoint and shared with impacted staff immediately.

- Quality trends or common errors identified will be shared via weekly communication to the impacted staff to ensure processes are followed correctly and the information provided is accurate.

Member Portal Requests



	Bad Address	New ID card Request	PCP Change Request	Secure Member Inquiry	Public Contact Us Form
# of completed request (w/in T/Fs)	738	2,224	1,826	2,022	247
Unworked Request	0	0	0	0	0
Case closure (% completed w/in specified T/Fs)	95.49%	99.69%	94.75%	97.44%	94.42%

Analysis

Customer service maintained a completion average of 96.36% for FY 2023 – 2024. 7,286 total requests were received and 7,057 were completed within one business day.

Customer service is dedicated to achieving a minimum average of 95% for the fiscal year 2024-2025. A weekly report on Member Portal Requests will be generated and reviewed to ensure that completion standards are consistently met.

Planned Changes for Next Year

1. Enlist the support of the Member Experience Task Force to provide multidisciplinary support for improving call volume metrics.
2. Migrate the customer service team to a new call management platform.

Resources allocated to customer service were not adequate to maintain the appropriate level of call quality. Service level goals were not met. Additional resources will be evaluated for feasibility in FY2025.

Provider Network Adequacy

Provider Availability Analysis

Introduction

Health Plan of San Joaquin/Mountain Valley Health Plan (Health Plan) monitors its provider network capacity and availability on an annual basis. Health Plan's monitoring efforts are meant to ensure adequate primary care, specialty care and behavioral health providers are available for members. Health Plan's oversight is measured against established standards for both the number and geographic distribution of network providers. Providers are educated on the regulatory access and availability standards to ensure members receive care timely. This evaluation provides an overview and analysis of Health Plan's provider network availability for fiscal year 2023 - 2024.

Program Goals

- To ensure that Health Plan's provider network is sufficient to meet timely access to primary, specialty, and behavioral health services for our members.
- To monitor providers for timely access availability within the regulatory standards as set forth by the Department of Managed Healthcare (DMHC) and the Department of Health Care Services (DHCS).
- To monitor for after business hours access to care, for the provision of 24 hours per day, 7 days per week, of triage or screening services by telephone in a timely manner.
- To monitor provider satisfaction levels by using information obtained from the provider satisfaction survey to measure how well Health Plan is meeting our provider's expectations and needs.
- To conduct root cause analyses and identify opportunities for quality improvement and take action as necessary.

Program Objectives

- Evaluate the appropriateness of network availability standards quarterly.
- Identify high volume specialists.
- Measure availability of practitioner network in HPSJ's geographic area.
- Evaluate HPSJ's performance against the standards.
- Identify opportunities for improving practitioner availability.
- Develop interventions, as appropriate, for identified opportunities for improvement.

Methodology

Calculating Member to Provider Ratio:

Provider Appointment Availability Methodology

- Providers are surveyed according to sample size and methodology provided by the Department of Managed Health Care (DMHC). The survey is focused on appointment availability, thus the survey name, Provider Appointment Availability Survey (PAAS)
- In order to meet the ratio goals below, we make every effort to contract with providers in the area
- Health Plan currently participates in a community reinvestment program which includes a provider recruitment grant to increase the providers in the community
- Primary Care Provider (PCP): Member Ratio = Total Membership / Total number of PCPs for the specific type (general medicine and family practice, internal medicine, and pediatrics).
    - Note that the current Department of Health Care Services (DHCS) Standard for PCP to Member Ratio is 1:2,000
    - A PCP can exceed 2,000 members if they have mid-levels in accordance with the following ratios: 1:1,000
- Specialty Care Provider (SCP): Member Ratio = Total Membership / Total number of SCP Physicians (Ratio 1:10,000)
    - Note: The Specialist to Member Ratio is defined by HPSJ
- Based on current membership data, Geo Access software calculates the ratio of PCPs and SCPs to members
        - The capacity ratios are run at a minimum, annually

Calculating Member to Provider Drive Time or Distance:

- PCP and SCP Drive Time or Distance: Quest, Geo Access software, is utilized to calculate time and distance.
- Using zip codes and membership data, Quest determines the percentage of members with desired access.

Identifying High Volume Specialists

- The high-volume specialty types are identified based on the number of claims submitted. Based on this definition, the high-volume specialists for this period are as follows:
    - Cardiologists
    - General Surgeons
    - Gastroenterologists
    - Ophthalmologists
    - OB-GYN

- The CORE specialty types per the DHCS are listed below:

CORE SPECIALISTS	
Cardiology/Interventional Cardiology	Nephrology
Dermatology	Neurology
Endocrinology	Oncology
ENT/Otolaryngology	Ophthalmology
Gastroenterology	Orthopedic Surgery
General Surgery	Physical Medicine & Rehabilitation
Hematology	Psychiatry
HIV/AIDS Specialists/Infectious Diseases	Pulmonology

Provider Appointment Availability Standard (PAAS)

- The PAAS is conducted annually from October-December to the following provider types:
    - Primary Care Providers
    - Specialists
    - Behavioral Health Providers
    - Ancillary (Physical Therapy, Radiology)
- The Knox-Keene Act requires that health plans maintain networks sufficient to meet urgent care and non-urgent appointment availability standards, which include specific appointment wait time standards set forth in section 1367.03(a)(5) and Rule1300.67.2.2(c)(5) (time-elapsed standards) under which enrollees are able to obtain an appointment.
- The PAAS Methodology is designed to measure the network providers' ability to deliver timely appointments to enrollees. Using the PAAS Methodology, Health Plan's vendor contacts all applicable network providers to request the next available appointment. The providers' responses to these survey questions are measured against the appointment time-elapsed standards.

Language Accessibility Standard

- The data is pulled by utilizing Quest Analytics software by the Corporate Analytics Department.
- Using zip codes and membership data, Quest Analytics software determines the percentage of members with threshold languages that are within 10 miles of providers that have the threshold language(s) available.

Language Access for Primary Care Providers – 2023 Results

Language	# of Members	# of Providers	Member to Provider Ratio	Goal	% of Accessibility
English	97,902	511	191:1	95%	100%

Language	# of Members	# of Providers	Member to Provider Ratio	Goal	% of Accessibility
Spanish	113,341	425	266:1	95%	100%
Cambodian	2,455	40	61:1	95%	99.8%
Hmong	1,070	21	50:1	95%	99.6%
Vietnamese	2,248	37	60:1	95%	98%
Punjabi	3,133	121	25:1	95%	99.7%
Chinese	834	38	21:1	95%	98.4%
No language selected	250,151	511	489.5:1	95%	100%

Green text = goal met; Red text = goal not met

Quantitative Analysis:

- Health Plan has met the accessibility goal for all 7 languages tracked
- The results improved from FY22-23 with all 7 languages tracked exceeding the goals.
- The results reflect that members have adequate access to providers who speak the most prevalent languages within the Health Plan population

Qualitative Analysis:

- All performance goals were met, and therefore qualitative analysis is not indicated. Interpreter services are available to all members regardless of language

Evaluation of Intervention Effectiveness:

- No interventions were implemented in the previous FY, as results have met the performance goals for the last two years. Therefore, there are no interventions to evaluate.

Opportunities:

- All performance goals were met for the current and previous FY, no opportunities for improvement were identified.

Improvement actions:

- Not applicable.

DHCS Performance Standards

Performance standards are based on state requirements, external benchmarks, industry standards, and national and regional comparative data. Performance standards are shown below.

PROVIDER TYPE	Capacity	TIME & DISTANCE
PCP	1:2,000	10 Miles or 30 Minutes
Primary Care – OB/GYN	1:2,000	10 Miles or 30 Minutes
SCP*	1:10,000	30 Miles or 60 Minutes
Specialty Care – OB/GYN		30 Miles or 60 Minutes
Hospitals		15 Miles or 30 Minutes
Mental Health (Non-Psychiatry) Outpatient Services		30 Miles or 60 Minutes
Substance Use Disorder Outpatient Services		30 Miles or 60 Minutes
Substance Use Disorder Opioid Treatment Programs		30 Miles or 60 Minutes
Pharmacy		10 Miles or 30 Minutes
Pediatric Dental**		10 Miles or 30 Minutes

**Note: The Specialist to Member Ratio is defined by the Health Plan*

***Health Plan does not manage Dental benefits and therefore does not have any Dental providers*

NCQA Network Availability Performance Standards

These performance standards are based on the requirements of the National Committee for Quality Assurance (NCQA). NCQA requires geographic distribution standards for high-volume and high-impact specialty types. In addition, performance standards for member-to-provider ratios for specialists and behavioral health are only required for high-volume providers.

HIGH VOLUME SPECIALISTS (SPCS)		
Provider Type	**Capacity**	**Time & Distance**
Cardiologists	1:10,000	95% within 30 Miles or 60 Minutes
Gastroenterologists		
General Surgeons		
Obstetrics and Gynecology		
Ophthalmologists		

HIGH VOLUME BEHAVIORAL HEALTH PROVIDERS (BHPS)		
Provider Type	**Capacity**	**Time & Distance**
Behavior Analysts	1:10,000	95% within 30 Miles or 60 Minutes
Marriage & Family Therapists		
Licensed Clinical Social Workers		
Licensed Professional Clinical Counselor		
Psychologists		
Psychiatrists		

High Impact Providers

High impact specialty types are based on high morbidity and mortality for HPSJ members.

HIGH IMPACT PROVIDERS	
Provider Type	**Time & Distance Goal**
Oncology	95% within 30 Miles or 60 Minutes
HIV/AIDS Specialists/Infectious Diseases	
Orthopedic Surgery	
Neurosurgery	

2023 PROGRAM GOALS AND PERFORMANCE EVALUATION

The provider availability results are presented in the table below based on Geo access data.

PCP ACCESSIBILITY ANALYSIS SPECIFICATIONS	
Provider Type	PCP 511unique Providers at 879 unique locations
Provider Type	SCP: OB-GYN 138 unique OBGYN Providers at 268 locations
Member Group	383,899 Members 206,074 Female Members (OBGYN)
Access Standard	1 Provider in 10 Miles OR 30 minutes
All Members	100% with Access to PCP 0% without Access to PCP 99.9% Female Members with Access to OBGYN 0.1% without Access to OBGYN

High Volume Specialists (SCPs) – San Joaquin/Stanislaus				
Goals:	**Capacity:** 1:10,000 providers to members **Time & Distance:** 95% w/in 30 Miles or 60 Minutes			
	2023 Results		**2022 Results**	
Provider Type	**Capacity**	**Time and Distance**	**Capacity**	**Time and Distance**
Cardiologists	1:4,277	100%	Met	Met
Gastroenterologists	1:10,753	100%	Met	Met

High Volume Specialists (SCPs) – San Joaquin/Stanislaus				
Goals:	**Capacity:** 1:10,000 providers to members **Time & Distance:** 95% w/in 30 Miles or 60 Minutes			
General Surgeons	1:2,788	100%	Met	Met
Obstetrics/Gynecology	1:1,860	100%	Met	Met
Ophthalmologists	1:6,843	100%	Met	Met

Green text = goal met; Red text = goal not met

High Volume Specialists (SCPs) – Alpine/El Dorado				
Goals:	**Capacity:** 1:10,000 providers to members **Time & Distance:** 95% w/in 45 Miles or 75 Minutes			
	2023 Results		**2022 Results**	
Provider Type	**Capacity**	**Time and Distance**	**Capacity**	**Time and Distance**
Cardiologists	1:525	100%	Met	N/A
Gastroenterologists	1:1,139	100%	Met	N/A
General Surgeons	1:262	100%	Met	N/A
Obstetrics/Gynecology	1:236	100%	Met	N/A
Ophthalmologists	1:402	49%	Met	N/A

High Volume Behavioral Health Providers (BHPs) – San Joaquin/Stanislaus				
Goals	**Capacity:** 1:10,000 providers to members **Time & Distance:** 95% w/in 30 Miles or 60 Minutes			
	2023 Results		**2022 Results**	
Provider Type	**Capacity**	**Time and Distance**	**Capacity**	**Time and Distance**
Marriage & Family Therapists	1:207	100%	Met	Met
Licensed Clinical Social Workers	1:271	100%	Met	Met
Licensed Professional Clinical Counselor	1:726	100%	Met	Met
Psychologists	1:1,470	100%	Met	Met
Psychiatrists	1:2,253	100%	Met	Met

Green text = goal met; Red text = goal not met

High Volume Behavioral Health Providers (BHPs) – El Dorado/Alpine County		
Goals:	**Capacity:** 1:10,000 providers to members **Time & Distance:** 95% w/in 45 Miles or 75 Minutes	
	2023 Results	**2022 Results**

Provider Type	Capacity	Time and Distance	Capacity	Time and Distance
Marriage & Family Therapists	1:1,139	N/A	N/A	N/A
Licensed Clinical Social Workers	1:683	N/A	N/A	N/A
Licensed Professional Clinical Counselor	1:3,418	N/A	N/A	N/A
Psychologists	1:1,139	N/A	N/A	N/A
Psychiatrists	1:3,418	N/A	N/A	N/A

High Impact Providers – San Joaquin/Stanislaus				
Goals:	**Capacity:** 1:10,000 providers to members **Time & Distance:** 95% w/in 30 Miles or 60 Minutes			
	2023 Results		**2022 Results**	
Provider Type	**Capacity**	**Time & Distance**	**Capacity**	**Time & Distance**
Oncology	100%	100%	Met	Met
HIV/AIDS Specialists/Infectious Diseases	100%	100%	Met	Met
Orthopedic Surgery	100%	100%	Met	Met
Neurosurgery	100%	100%	Met	Met

Green text = goal met; Red text = goal not met

High Impact Providers – El Dorado/Alpine		
Time and Distance Goal:	95% w/in 45 Miles or 75 Minutes	
Provider Type	**2023 Results**	**2022 Results**
Oncology	100%	N/A
HIV/AIDS Specialists/Infectious Diseases	79.6%	N/A
Orthopedic Surgery	100%	N/A
Neurosurgery	48.2%	N/A

Quantitative Analysis

- HPSJ met the member ratios and geographic standards established for Primary Care Physicians, which is consistent with FY2022 performance
- HPSJ met the geographic standards established for all high-volume specialist providers
- Member ratio results for Gastroenterology were 1:10,753, which is slightly above and therefore does not meet the 1:10,000 performance standard. Results in 2022 met the performance goal, so 2023 results reflect a decline in performance.
- Geographic standards were not met for the high volume specialty of Ophthalmologists and high impact specialties of HIV/AIDS Specialists/ Infectious Diseases and Neurosurgery in El Dorado and Alpine counties. Results in 2022 met the performance goal, so 2023 results reflect a decline in performance.
- HPSJ met the member ratios and geographic standards established for all high-volume behavior health providers, which is consistent with 2022 performance.
- The General Surgery provider type capacity ratio in San Joaquin and Stanislaus has improved over FY22-23, which is consistent with 2022 performance.
- High Volume Behavioral Health access for San Joaquin and Stanislaus Counties has dramatically improved over FY22-23.

Qualitative Analysis

- There are a small number of members who live in rural areas and outside of the expected time and distance range. For those members, Health plan offers telehealth.
- The challenge of meeting the geo access standards for certain specialties is not unique to the Health Plan or California plans in general as many members live in the outer reaches/remote areas of the state.
- The Health Plan has contracted with available specialty providers in all areas within our defined service area

Measurement of Intervention Effectiveness

- Health Plan's contracting team has worked diligently to expand the provider network by conducting rigorous outreach to new providers in the area.
- Health Plan re-contracted with a large multi-specialty group in Stanislaus and San Joaquin counties.

- A provider recruitment grant was initiated to increase access to primary care, hard to recruit specialties, other specialties, and non-physician mental/behavioral health services in an outpatient setting for Health Plan members.
- Health Plan has expanded into Alpine and El Dorado Counties which increases the network of providers.
- All of these improvement actions have been instrumental in enabling Health Plan to meet the majority of its member ratio and geographic availability standards. Continued efforts are needed to ensure that members can access needed services and that performance standards for Gastroenterology, HIV/AIDS Specialists/Infectious Diseases are met.

Improvement Actions:

- HPSJ received regulatory approval for alternative access to the nearest providers outside of time and distance standards due to rural or bordering county zip codes
- HPSJ continues to monitor the availability of practitioners in remote areas and initiates recruitment efforts
- Health plan will evaluate the possibility of providing access to members through in-home care by mid-level practitioners.

2023 Provider Appointment & Availability Survey (PAAS) Evaluation

PCP – Provider Appointment Availability Survey (PAAS) Results

MEASURE	GOAL	RATE	2022
Urgent Care Appointments within 48 hours.	80%	62%	74%
Routine Care Appointments within 10 business days		78%	76%
Summary Rate		70%	75%

Green text = goal met; Red text = goal not met

SCP – Provider Appointment Availability Survey (PAAS) Results

MEASURE	GOAL	2023	2022
Urgent Care Appointments within 96 hours.	80%	70%	64%
Routine Care Appointments within 15 business days		64%	76%
Summary Rate		67%	70%

Non-Physician Mental Health Care Providers – Provider Appointment Availability Survey (PAAS) Results

MEASURE	GOAL	2023	2022
Urgent Care Appointments within 96 hours.	80%	88%	41%
Routine Care Appointments within 10 business days		87%	75%
Summary Rate		88%	58%

Psychiatrists – Provider Appointment Availability Survey (PAAS) Results

MEASURE	GOAL	2023	2022
Urgent Care Appointments within 96 hours.	80%	75%	45%
Routine Care Appointments within 15 business days		100%	54%
Summary Rate		88%	50%

Ancillary – Provider Appointment Availability Survey (PAAS) Results

MEASURE	GOAL	2023	2022
Routine Care Appointments within 15 business days	80%	72%	82%
Summary Rate		72%	82%

All Provider Types – Provider Appointment Availability Survey (PAAS) Results

MEASURE	GOAL	2023	2022
Urgent Care Appointments hours	80%	72%	57%
Routine Care Appointments	80%	79%	74%

Quantitative Analysis:

- PCP and SCP appointment availability standards were not met for any of the appointment measure types. Results were 2-18 percentage points below the 80% performance standard and reflect a decline in performance from 2022 with the exception of routine care appointment availability for PCPs and urgent care appointment availability for SCPs, which improved 2 and 6 percentage points, respectively, from 2022.
- Results for Non-Physician Mental Health Care Providers met the performance goals and reflect an improvement of 47 percentage points

for urgent care appointment availability and 12 percentage points for routine care from 2022.

- Urgent care appointment availability for Psychiatrists was 75%, which is 5 percentage points below and thus did not meet the 80% performance goal. However, these results reflect a 30percentage point improvement from 2022. Routine care results met the performance goal and reflect a 46 percentage point improvement from 2022.
- Routine care appointment availability for ancillary providers was 72%, which is 8 percentage points below and thus did not meet the 80% performance goal.

Qualitative Analysis:

PCPs have struggled to meet performance goals due to a shortage of providers in California, particularly in the Central Valley. This shortage has impacted timely access for member appointments offered due to the inability to keep up with the demand for appointments.

Appointment availability for some specialists is very difficult to meet. Specialty physicians are not readily available in the San Joaquin Valley. Many areas are rural even though there are urban centers within the county. The loss of one specialist, particularly for neurology and oncology, has a very detrimental impact on appointment availability.

Behavioral Health is improving with the exception of urgent care appointments with psychiatry. The plan is contracted with all practitioners who are agreeable to participating in the network. Despite that, psychiatry appointments continue to be a challenge.

HPSJ continues to collect and conduct detailed analyses of the data with the intent to further understand the reasons why appointment availability goals are not being met.

Measurement of Intervention Effectiveness:

Noncompliant letters were sent to individual PCP, SCP, and BH practitioners who did not meet performance goals. In addition, support and coaching are provided to these practitioners to get a better understanding of the challenges that they are facing and to offer support where possible. Improvements were noted with BH appointment availability, which demonstrates the effectiveness of our interventions with these providers, however; results for PCPs and SCPs had slight improvements in one or more appointment types and demonstrates that continual efforts are slowly improving performance.

Opportunities:

- Continued practitioner support and coaching
- Escalation process for continued noncompliance

Improvement Actions:

- Continue to conduct 1:1 coaching and support with practitioners
- Measure appointment availability twice a year to monitor performance
- Update noncompliance letter template to include specific actions (e.g., CAP) that will be taken when repeat noncompliance is identified
- Continue to send noncompliance letters and increase frequency to twice a year, as needed, to address noncompliance
- Improve accuracy of the provider network data by ensuring that providers review/validate and update their information (e.g., phone number, address, etc.) at least twice annually. This includes contact information and willingness to accept Medi-Cal.
- Continue to monitor availability of new PCP, SCP, and BH practitioners and extend contracts as applicable

After Hours Accessibility Analysis 2023-2024

The After-Hours Accessibility Survey is designed to identify non-compliance with after-hours emergency instructions and access to providers by HPSJ members. The initial survey outreach was conducted to 398 providers (PCPs & Behavior Health Specialists).

After-Hours Emergency Instructions Analysis

Period	# Providers Surveyed	# Compliant Providers	Rate of Compliance
2021	256	194	75.7%
2022	520	395	76%
2023	398	276	69.3%

Quantitative Analysis:

- Of the 398 providers surveyed, 276 were found to be compliant with appropriate emergency instructions associated with their after-hours messaging. The 2023 survey results indicate that 69.3% of providers were compliant with their after-hours accessibility messaging Trend analysis indicates a decrease in the number of providers surveyed in 2022, while compliance decreased in 2023 due to the lower number of providers surveyed.

Qualitative Analysis:

The reasons that PCPs have not been able to meet after hour access performance goals are not clear.

HPSJ continues to collect and conduct detailed analyses of the data with the intent to further understand the reasons why appointment availability goals are not being met.

Measurement of Intervention Effectiveness:

Noncompliant letters were sent to individual PCP practitioners who did not meet performance goals. However, results did not meet the performance goal which demonstrates that this intervention has not been successful and continued efforts are needed to improve performance.

Opportunities:

- Continued practitioner support and coaching
- Escalation process for continued noncompliance

Improvement Actions:

- Measure appointment availability twice a year to monitor performance
- Provide 1:1 coaching and support to improve performance
- Update noncompliance letter template to include specific actions (e.g., CAP) that will be taken when repeat noncompliance is identified
- Continue to send noncompliance letters and increase frequency to twice a year, as needed, to address noncompliance
- Improve accuracy of the provider network data by ensuring that providers review/validate and update their information (e.g., phone number, address, etc.) at least twice annually. This includes contact information and willingness to accept Medi-Cal.
- Continue to monitor availability of new PCP practitioners and extend contracts as applicable

Provider Experience

Provider Satisfaction Survey

The Provider Satisfaction Survey targeted Primary Care Providers, Specialists and Behavioral Health providers to measure their satisfaction with Health Plan for reporting period 2024. Information obtained from this survey allows Health Plan to measure how well providers are meeting expectations and needs.

The 2023 Provider Satisfaction Survey was designed by a vendor, SPH Analytics, to support the following NCQA Standards:

- **NCQA Standard QI 3** (Continuity and Coordination of Medical Care) This standard looks for managed care organizations to gather information, at least annually, to assess and identify opportunities to improve coordination of medical care across its delivery system. This includes conducting quantitative analysis of data and feedback.
- **NCQA Standard QI 4** (Continuity and Coordination Between Medical Care and Behavioral Health Care). To enhance the value of the survey to organizations providing behavioral health care services, there was an optional supplemental survey module (3 questions), which was implemented to address a similar standard to QI 3. This standard looks for the organization to demonstrate evidence of collaboration between medical care delivery system and its behavioral healthcare network.

Composites

The following composites were included in the Health Plan survey:

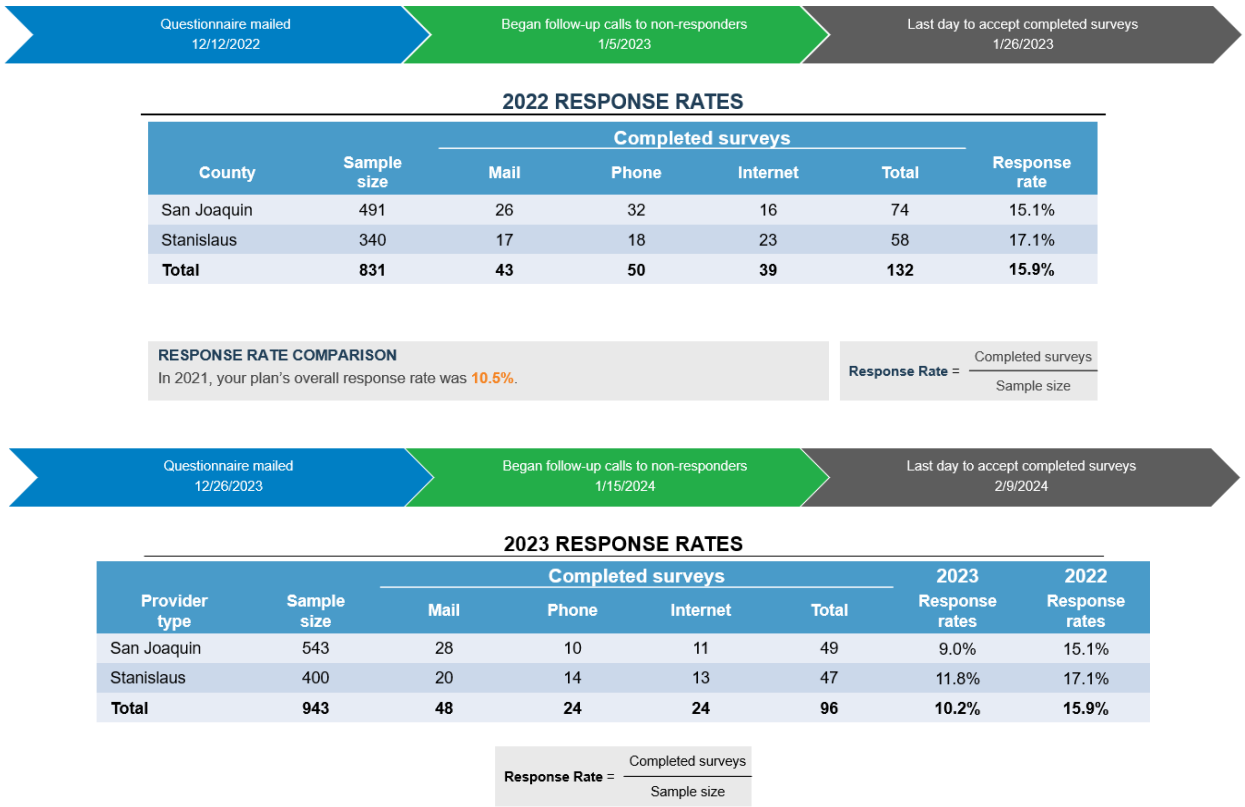
- ✓ Overall Satisfaction
- ✓ All Other Plans (Comparative Rating)
- ✓ Finance Issues
- ✓ Utilization and Quality Management
- ✓ Network/Coordination of Care
- ✓ Health Plan Call Center Service Staff
- ✓ Provider Relations

Benchmark

All core measures are compared to the previous year, 2022 vendor's Medicaid Book of Business (2022 PG Medicaid), 104 health plans with a total of 19,251respondents.

Methodology

The Provider Satisfaction survey was administered via mail, telephone, and internet. Qualified respondents were providers contracted with Health Plan. A synopsis of the data collection methodology is outlined below:



The total surveys completed from a sample size of 943, 96 surveys were completed (48 mail, 24 phone, and 24 internet) yielding a response rate of 10.2%, a 5.7% decrease from previous year (2022).

Provider Satisfaction Survey Results				
Survey Questions	**Measurement**	**Performance Goal**	**2023**	**2022**
Would Recommend/Net Promoter	% Yes responses	N/A	90.6%	94.5%
All Other Plans (Comparative Rating)	% Well or Somewhat above average	N/A	49.5%	64.4%
Overall Satisfaction		N/A	79.2%	87.8%
Financial Issues		N/A	46.5%	46.2%

Provider Satisfaction Survey Results				
Survey Questions	**Measurement**	**Performance Goal**	**2023**	**2022**
Utilization and Quality Management			47.1%	54.8%
Network/Care Coordination			23.9%	41.9%
Health Plan Call Center Service Staff			49.1%	51.4%
Provider Relations			43.6%	44.1%

Quantitative Analysis:

- Net Satisfaction Score: 68.8%
- Net Loyalty Score: 71.8%
- Overall satisfaction score: 79.2%

- (add item for overall) were willing to recommend the plan to

Qualitative Analysis:

- Low response rate: We continue to have lower response rates as there was a 5.7% decrease in response rates.

Key Drivers of the Overall Rating of Health Plan of San Joaquin that promote and leverage strengths (Top 4) include:

1. Timeliness of obtaining pre-certification/referrals/authorization information
2. HPSJ's facilitation/support of appropriate clinical care for patients
3. Procedures for obtaining pre-certification/referral/authorization information
4. Access to Case/Care Managers from this health plan

Improvement Actions:

Health Plan will review methods of communicating authorization and referral information to the network through provider orientation and timely notification when processes change at the plan.

Resource Adequacy

Resources are adequate to ensure that regulatory requirements are met and to ensure that timely monitoring of appointment availability non-compliance can be monitored and actions taken.

Plans for the Upcoming Year

- Health Plan will be implementing a tracker to collect additional language accessibility quality metrics that can be tracked and trended over time, in which benchmarks could be established.
- Conduct additional analysis for decline in "Would Recommend" (Net Promoter Score) and Network/Care Coordination results to identify opportunities to improve these results
- Implement the following activities to ensure identified deficiencies are corrected moving forward.
    - Sending notifications to non-compliant providers
    - Providing education as necessary
    - Hired a Program Manager that will oversee the Timely Access monitoring for providers by doing the following:
        - Reviewing the PAAS results and Identifying areas of improvement by providers
        - Engage in training opportunities for the providers
        - Tracking and trending of Grievance data related to access issues
- Provider Networks continue to address these issues by keeping up with the regulatory guidance updating processes as necessary and sharing the information with providers to ensure that they are up to date with regulatory requirements as it relates to Timely Access Standards. Additionally, Provider Networks continues to train the staff on any regulatory updates and/or changes.

Conclusion

During Fiscal Year 2024, Health Plan focused on provider and community reinvestment and partnerships, education and investing in staffing and training. Resources were dedicated to expanding health equity, health plan accreditation and population health. Health Plan was focused on delivering high quality care and ensuring robust quality improvement implementation organization wide.

A holistic review of the quality and equity program activities and achievements demonstrated a robust quality and equity program with sufficient leadership, structure resources and provider involvement to accomplish program objectives. Opportunities exist to improve member experience, call metrics and access to care. Despite the opportunities, there were many gains in quality and

performance scores and Health Plan forged many new partnerships through investments made in the community. Health Plan has enjoyed expansion into additional service areas and will continue to monitor progress towards achievement goals in the additional service areas to ensure that quality goals can be met organization wide. Activities that are identified with opportunities are carried forward to the fiscal year 2024-2025 Quality and Equity Work Plan.

2023-2024 Quality Improvement Health Equity Transformation Program Description Reviewed and Approved:

DocuSigned by:
Lakshmi Dhanvanthari
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3/3/2025

QIHEC Co-Chair, Lakshmi Dhanvanthari, MD, Chief Medical Officer, Health Plan of San Joaquin/Mountain Valley Health Plan — Date

Signed by:
Robert Ruiz
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3/21/2025

QIHEC Co-Chair, Robert Ruiz, Executive Director of Quality & Health Equity (Chief Health Equity Officer) — Date

Signed by:
Genevieve Valentine
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3/21/2025

SJ Health Commission, Genevieve Valentine, Chair — Date