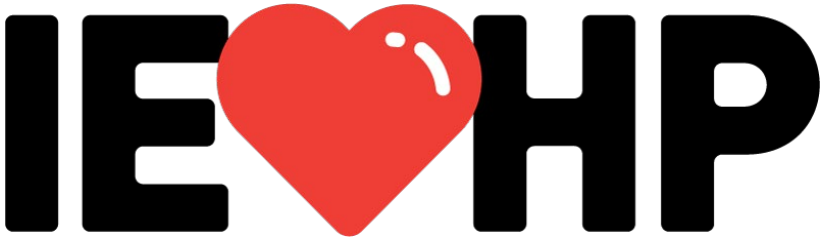


Inland Empire Health Plan

2024 Quality Improvement and Health Equity Annual Plan

March 2025

Table of Contents

Introduction

IEHP supports an active, ongoing, and comprehensive Quality Improvement & Health Equity Plan (QIHEP) with the primary goal of continuously monitoring and improving the quality of care and service, access to care, Member safety delivered to IEHP Members by providing effective, equitable, understandable, and respectful quality care and services responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. The QIHEP provides a formal process to systematically monitor and objectively evaluate, track, and trend the health plan's quality, efficiency, and effectiveness. IEHP has created a systematic, integrated approach to planning, designing, measuring, assessing, and improving the quality of care and services provided to Members. This comprehensive delivery system includes equity-focused interventions, Member safety, behavioral health, care management, culturally and linguistically appropriate services, and coordination of care, and quality improvement initiatives. In addition, IEHP's operational framework is designed to inform and deploy initiatives to advance health equity, improve quality, help eliminate health disparities, and address identified patterns of over- or under-utilization of physical and behavioral health care services. IEHP will utilize this document for oversight, monitoring, and evaluation of Quality Management (QM) and Quality Improvement (QI) activities to ensure the QIHEP is operating in accordance with standards and processes as defined in this Plan Description. These initiatives are aligned with IEHP's mission, vision, and values.

Mission, Vision, and Values

IEHP's Mission, Vision, and Values (MVV) aims to improve the quality of care, access to care, Member safety, and quality of services delivered to IEHP Members. The organization prides itself in six (6) core goals:

Mission: We heal and inspire the human spirit.
Vision: We will not rest until our communities enjoy optimal care and vibrant health.
Values: We do the right thing by:

- Placing our Members at the center of our universe.
- Unleashing our creativity and courage to improve health and well-being.
- Bringing focus and accountability to our work.

- Never wavering in our commitment to our Members, Providers, Partner, and each other.

Section 1: Quality Improvement and Health Equity Plan (QIHEP) Overview

1.1 QIHEP Purpose

The purpose of the QIHEP is provide the structure and framework necessary to monitor and evaluate the quality and appropriateness of care, quality performance measures, identify opportunities for clinical, Member safety, equity-focused initiatives, and service improvements, ensure resolution of identified problems, and measure and monitor intervention results over time to assess any needs for new improvement strategies.

1.2 QIHEP Scope

The Quality Management and Health Equity Transformation Committee (QMHETC) approves the QIHEP annually. The QIHEP review includes approval of the QIHEP Description, QIHEP Workplan, and QIHEP Annual Evaluation to ensure ongoing performance improvement. The QIHEP is designed to improve all aspects of care delivered to IEHP Members in all health care settings by:

1. Defining the Program structure;
2. Assessing and monitoring the delivery and safety of care;
3. Assessing and monitoring, population health management provided to Members, including behavioral health and care management services;
4. Supporting Practitioners and Providers to improve the safety of their practices;
5. Overseeing IEHP's QM functions through the Quality Management & Health Equity Transformation Committee;
6. Involving designated physician(s) and staff in the QMHET Program;

7. Involving a behavioral healthcare Practitioner in the behavioral health aspects of the Program;

8. Involving Long-Term Services and Supports (LTSS) Providers and Professionals with expertise in LTSS in the QMHET Program;

9. Reviewing the effectiveness of LTSS programs and services;

10. Ensuring that LTSS needs of Members are identified and addressed leveraging available assessment information;

11. Identifying opportunities for QI initiatives, including the identification of health disparities among Members;

12. Implementing and tracking QI initiatives that will have the greatest impact on Members;

13. Measuring the effectiveness of interventions and using the results for future QI activity planning;

14. Establishing specific role, structure and function of the QMHETC and other committees, including meeting frequency;

15. Reviewing resources devoted to the QMHET Program;

16. Assessing and monitoring delivery and safety of care for the IEHP population with complex health needs and Seniors and Persons with Disabilities (SPD); and

17. Assessing and monitoring processes to ensure the Member's cultural, racial, ethnic, and linguistic needs are being met.

To accomplish this, IEHP has established methods that ensure and promote access and delivery of medically necessary services in a culturally competent manner to all Members, including people with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. IEHP has defined the following objectives:

Clinician-Oriented:

- Provide training, support, technical assistance and resources to Providers and their office staff to assist them in the provision of culturally competent and linguistic services.

- Monitor the clinician credentialing and recredentialing processes for discriminatory practices, at each point of the process.

IEHP and Member-Oriented:

- Educate IEHP Team Members on cultural diversity in the Membership and raise awareness of IEHP Cultural and Linguistic policies, procedures, and resources through annual mandatory training.

- Assess the characteristics of IEHP's Membership to identify Member needs and review and updates its structure, operations, and resources accordingly.

- Evaluate areas such as social determinants of health, identification of subpopulations, needs of children/adolescents and individuals with disabilities and with serious and persistent mental illness (SPMI), Members of Limited English Proficiency (LEP), disparities in Members of different ethnicity groups, and disparities in Members with primary language other than English.

- Identify the threshold languages in the Member population of 200 or more Members and provide vital information in threshold languages and alternate formats upon request. The current threshold languages are English, Spanish, Mandarin, Cantonese, and Vietnamese.

- Use competent translators and evaluate the quality of translation.

- Review and approve externally and internally developed Member materials for readability, content, accuracy, cultural appropriateness, and non-discrimination using DHCS Readability and Suitability Checklist.

- Assess Member's experience with their utilization of language services to assist with improvements to organizational functions and healthcare encounters.

- Review Grievance and Appeals (G&A) Data by race/ethnicity and language to identify areas of opportunity for improvement.

- Support the development of new recruitment and hiring practices that promote diversity and inclusive policies including:

    - Inclusive job descriptions that use gender neutral language, indicate the job specific salary range, clarified minimum qualification requirements, all emphasizing our commitment to diversity and inclusion.

    - Require all applicants be reasonably considered for positions for which they meet all minimum qualifications.

    - Hold hiring leaders accountable to conducting fair and equitable interview and selection practices to support and sustain equal representation throughout the organization.

    - Deploy technology designed to help reduce the interference of unconscious bias in the selection and hiring process, including the use of resume redaction which removes any information identifying a candidate's gender, age, economic status, and ethnicity to ensure a more equitable initial candidate consideration.

- Conduct ongoing assessment of IEHP' Membership language profile.

- Commit to all IEHP Team Members to promote a work environment built on the premise of gender and diversity equity that encourages and enforces:

    - Respectful communication and cooperation between all Team Members.

    - Teamwork and Team Member participation permitting the representation of all groups and Team Member perspectives.

1.3 QIHEP Goals

The primary goal of the QIHEP is to continuously assess and improve the quality of care, service and safety of healthcare delivered to IEHP Members, and for IEHP to fulfill its mission by establishing a broad set of goals to ensure IEHP and its Provider Network comply with Department of Health Care Services (DHCS) and Federal regulations on Cultural and Linguistic (C&L) services. The QIHEP goals are to:

1. Implement strategies for Population Health Management (PHM) that keep Members healthy, manage Members with emerging risks, ensure patient safety and outcomes across settings, improve Member satisfaction and improve quality of care for Members with chronic conditions;

2. Implement quality programs to support PHM strategies while improving targeted health conditions;

3. Identify clinical and service-related quality and patient safety issues, and develop and implement QI plans, as needed;

4. Share the results of QI initiatives to stimulate awareness and change;

5. Empower all staff to identify QI opportunities and work collaboratively to implement changes that improve the quality of all IEHP programs;

6. Identify QI opportunities through internal and external audits, Member and Provider feedback, and the evaluation of Member grievances and appeals;

7. Monitor over-utilization and under-utilization of services to assure appropriate access to care;

8. Utilize accurate QI data to ensure program integrity; and

9. Annually review the effectiveness of the QIHEP and utilize the results to plan future initiatives and program design.

10. Enhancements in Data Collection and Stratification by Race/Ethnicity, Language, Disability, Sexual Orientation and Gender Identity.

11. Improvements in Workforce Diversity, Provider Network Adequacy & C&L Responsiveness.

12. Identification and Reduction of Health Care Disparities

Section 2: Authority and Responsibility

2.1 IEHP Governing Board

IEHP was created as a public entity as a result of a Joint Powers Agency (JPA) agreement between Riverside and San Bernardino Counties. Two (2) Members from each County Board of Supervisors sit on the Governing Board as well as three (3) public Members from each county. The Governing Board provides direction for the QIHEP, evaluates QIHEP effectiveness, and evaluates and approves the annual QIHEP.

The Governing Board's responsibilities include but are not limited to:

1. Providing oversight of health care delivered by contracted Providers and Practitioners;

2. Providing direction for the QIHEP;

3. Evaluating QIHEP effectiveness and progress;

4. Approving the overall QIHEP and its work plan;

5. Appointing an accountable entity or entities within the Plan responsible for oversight of QIHEP;

6. Reviewing written progress reports received from the Quality Management and Health Equity Transformation Committee (QMHETC) that describe actions taken, progress in meeting QIHEP objectives, and improvements made; and

7. Directing necessary modifications to QIHEP policies and procedures to ensure compliance with Quality Management/Quality Improvement and Health Equity standards set forth in the Two-Plan Contract and DHCS Comprehensive Quality Strategy (CQS).

The QMHETC reports delineating actions taken and improvements made are reported to the Board through the Chief Medical Officer (CMO) and Chief Quality Officer (CQO). The Board delegates responsibility for monitoring the quality of health care delivered to Members to the CMO, CQO, and the QMHETC with administrative processes and direction for the overall QMHETP initiated through the CMO and CQO, or Medical Director designee.

2.2 Role of the Chief Executive Officer (CEO)

Appointed by the Governing Board, the CEO has the overall responsibility for IEHP management and viability. Responsibilities include but are not limited to: IEHP direction, organization and operation; developing strategies for each Department including the QIHEP; position appointments; fiscal efficiency; public relations; governmental and community liaison; and contract approval. The CEO reports to the Governing Board and is an ex-officio member of all standing Committees. The CEO interacts with the CMO and CQO regarding ongoing QIHEP activities, progress toward goals, and identified health care problems or quality issues requiring corrective action.

2.3 Role of the Chief Medical Officer (CMO)

The Chief Medical Officer (CMO) or designee has ultimate responsibility for the quality of care and services delivered to Members, and oversight of IEHP's QIHEP. The CMO must possess a valid Physician's and Surgeon's Certificate issued by the State of California and certification by one of the American Specialty Boards. The CMO reports to the CEO and the Governing Board. As a participant of various Subcommittees, the CMO provides direction for internal and external QIHEP functions and supervision of IEHP staff.

The CMO or designee participates in quality activities as necessary; provides oversight of IEHP-credentialing and re-credentialing activities and approval of IEHP requirements for IEHP-Direct Practitioners; reviews credentialed Practitioners for potential or suspected quality of care deficiencies; provides oversight of coordination and continuity of care activities for Members;

oversight of patient safety activities; and proactively incorporates quality outcomes into operational policies and procedures.

The CMO or designee, provides direction to the QMHETC and associated Subcommittees; aids with study development; and facilitates coordination of the QIHEP in all areas to provide continued delivery of quality health care for Members. The CMO assists the Chief Network Development Officer with provider network development, contract, and product design. In addition, the CMO works with the Chief Financial Officer to ensure that financial considerations do not influence the quality of health care administered to Members.

The CMO acts as primary liaison to regulatory and oversight agencies including, but not limited to: the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid Services (CMS), and the National Committee for Quality Assurance (NCQA), with support from Health Services staff, as necessary.

2.4 Role of the Chief Quality Officer (CQO)

The Chief Quality Officer is responsible for leading quality strategy for IEHP. This includes the development of new, innovative solutions and quality measures in preventative health and improved quality of care for Members. The CQO must possess a valid Physician's and Surgeon's Certificate issued by the State of California and certification by one of the American Specialty Boards. The CQO reports to the CEO and Governing Board. The CQO works with the CEO and Chief Officers to establish goals and priorities for the quality strategy as well as communicating those goals to the Governing Board and its key stakeholders—the IEHP Provider network, regulatory and accrediting bodies. As a participant of various Subcommittees, the CQO provides direction for internal and external QIHEP functions and supervision of IEHP staff.

Along with the CMO, the CQO or designee, provides direction to the QMHETC and associated Subcommittees; aids with quality study development; and facilitates coordination of the QIHEP in all areas to provide continued delivery of quality health care for Members.

The CQO initiates and leads initiatives for continuous quality improvement and evaluating the effectiveness of interventions across the continuum of care to Members, Providers and internally.

The CQO also collaborates with state/federal regulatory agencies, accrediting bodies, and internal Government Relations, Compliance, and Legal leadership staff to ensure all quality and regulatory compliance requirements are met.

The CQO provides leadership, develops strategies, and administers programs for accreditation, monitoring, HEDIS® operations, reporting, quality scorecard reporting, and quality-related new business development.

2.5 Role of the Chief Health Equity Officer (CHEO)

The Chief Health Equity Officer (CHEO) provides leadership in the design and implementation of IEHP's strategies and programs to ensure health equity is prioritized and addressed; ensures all policies and procedures consider health inequities and are designed to promote health equity where possible, including but not limited to marketing strategy, medical and other health services policies, Member and provider outreach, Public Policy Participation Committee, quality improvement activities, including delivery system reforms, grievance and appeals, and utilization management. The CHEO is responsible for developing and implementing policies and procedures aimed at improving health equity and reducing health disparities; engaging and collaborating with Team Members, Subcontractors, Downstream Subcontractors, Network Providers, and entities including local community-based organizations, local health department, behavioral health and social services, child welfare systems and members in health equity efforts and initiatives. The CHEO is also responsible for implementing strategies designed to identify and address root causes of health inequities, which includes but is not limited to systemic racism, social drivers of health, and infrastructure barriers.

The CHEO has the authority to design and implement policies that ensure Health Equity is prioritized and addressed. The CHEO is an active member of the QMHETC to ensure engagement and collaboration with both IEHP leadership and external providers. The CHEO is responsible for supervision of all QMHETP activities. The CHEO develops targeted interventions designed to eliminate health inequities; develops quantifiable metrics that can track and evaluate the results of the targeted interventions designed to eliminate health inequities; and ensures all Contractor, Subcontractor, Downstream Subcontractor, and Network Provider staff receive mandatory diversity, equity and inclusion training annually.

2.6 Quality Management and Health Equity Transformation Committee (QMHETC)

The QMHETC reports to the Governing Board and retains oversight of the QIHEP with direction from the CMO and CQO or physician designee, in collaboration with the CHEO. The QMHETC promulgates the quality improvement process to participating groups and physicians, Providers, Subcommittees, and internal IEHP functional areas with oversight by the CMO and CQO.

1. **Role**: The QMHETC is responsible for continuously improving the quality of care for IEHP Membership.

2. **Structure**: The QMHETC is composed of Network Providers, Specialists, IPA Medical Directors, practicing Pharmacists, who are representative of network Practitioners; IEHP Medical Directors; and Public Health Department Representatives from Riverside and San Bernardino Counties. These individuals provide expertise and assistance in directing the QMHETP activities and are voting Members of QMHETC and related Subcommittees. A designated Behavioral Healthcare Practitioner is an active Member of the IEHP QMHETC to assist with behavioral healthcare-related issues.19 IEHP attendees include multi-disciplinary representation from multiple IEHP Departments including but not limited to:

    a. Quality Management;

    b. Utilization Management;

    c. Care Management;

    d. Pharmaceutical Services;

    e. Behavioral Health;

    f. Member Services;

    g. Community Health;

    h. Population Management;

    i. Health Education;

j. Grievances and Appeals;

k. Quality Informatics;

l. HealthCare Informatics;

m. Independent Living and Diversity Services;

n. Compliance; and

o. Provider Services.

3. **Function**: The QMHETC meets at least quarterly and reports findings, actions, and recommendations to the IEHP Governing Board (through the CMO) annually and reports meeting minutes to DHCS quarterly. The QMHETC seeks methods to increase the quality of health care for IEHP Members; recommend policy decisions; analyze and evaluate the results of QI and Health Equity activities; institute and direct needed actions; and ensure appropriate follow-up of identified performance deficiencies. The Committee provides oversight and direction for Subcommittees, related programs, activities, and reviews and approves Subcommittee recommendations, findings, and provides direction as applicable. QMHETC findings and recommendations are reported through the CMO to the IEHP Governing Board on an annual basis.

4. **Quorum**: Voting cannot occur unless there is a quorum of voting Members present. For decision purposes, a quorum can be composed of one (1) of the following:

    a. The Chairperson or IEHP Medical Director and two (2) appointed Physician Committee Members.

    b. A Behavioral Health Practitioner must be present for behavioral health issues.

    c. Non-physician Committee Members may not vote on medical issues.

5. **External Committee Members**: QMHETC members must be screened to ensure they are not active on either the Office of Inspector General (OIG) or General Services Administration (GSA) exclusion lists.

a. The Compliance department and QM department collaborate to ensure committee members undergo an OIG/GSA exclusion screening prior to scheduling QMHETC meetings.

b. IEHP utilizes the OIG Compliance Now (OIGCN) vendor to conduct the screening of covered entities on behalf of IEHP. In the event, any member of the QMHETC, or prospective member, is found to be excluded per OIGCN, the Compliance Department will notify the QM department so that they may take immediate action.

c. QMHETC members must be screened before being confirmed and monthly thereafter.

d. QM notifies the Compliance department of any membership changes in advance of the QMHETC meeting so that a screening can be conducted prior to the changes taking effect.

6. **Confidentiality**: All QMHETC minutes, reports, recommendations, memoranda, and documented actions are considered quality assessment working documents and are kept confidential. IEHP complies with all State and Federal regulatory requirements for confidentiality. All records are maintained in a manner that preserves their integrity to assure Member and Practitioner confidentiality is protected.

    a. All members, participating staff, and guests of the QMHETC and Subcommittees are required to sign the Committee/Subcommittee Attendance Record, including a confidentiality statement.

    b. The confidentiality agreements are maintained in the Practitioner files as appropriate.

    c. All IEHP staff members are required to sign a confidentiality agreement upon hiring. The confidentiality agreements are maintained in the employee files as appropriate.

d. All peer review records, proceedings, reports, and Member records are maintained in accordance with state, federal and regulatory requirements to ensure confidentiality.

e. IEHP maintains oversight of Provider and Practitioner confidentiality procedures.

    i. IEHP has established and distributes confidentiality standards to contracted Providers and Practitioners through the IEHP Provider Policy and Procedure Manual.

    ii. All Provider and Practitioner contracts include the provision to safeguard the confidentiality of Members' medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws.

    iii. As a condition of participation in the IEHP network, all contracted Providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of Members to their Practitioners.

    iv. IEHP monitors contracted Providers and Practitioners for compliance with IEHP's confidentiality standards during Delegation Oversight Annual Audits and Facility Site Review (FSR) and Medical Records Reviews (MRR).

7. **Enforcement/Compliance**: The QM Department is responsible for monitoring and oversight of the QMHETC's enforcement of compliance with IEHP standards and required activities. Activities can be found in sections of manuals related to the specific monitoring activity. The general process for obtaining compliance when deficiencies are noted, and Corrective Action Plans (CAPs) are requested, is delineated in internal and external policies.

8. **Data Sources and Support**: The QIHEP utilizes an extensive data system that captures information from claims and encounter data, enrollment data, UM and QM/QI activities, behavioral health data, pharmaceutical data, grievances and appeals, and Member Services, among others.

9. **Affirmation Statement**: The QIHEP assures that utilization decisions made for IEHP Members are based solely on medical necessity. IEHP does not compensate or offer financial incentives to Practitioners or individuals for denials of coverage or service or any other decisions about Member care. IEHP does not exert economic pressure on Practitioners or individuals to grant privileges that would not otherwise be granted or to practice beyond their scope of training or experience.

10. **Availability of QIHEP Information**: IEHP has developed an overview of the QMHETP and related activities. This overview is on the IEHP website at www.iehp.org and a paper copy is available to all Members and/or Practitioners upon request by calling IEHP Member Services Department. Members are notified of the availability through the Member Handbook. Practitioners are notified in the Provider Manual. The IEHP QIHEP Description and Work Plan are available to IPAs and Practitioners upon request. A summary of QM activities and progress toward meeting QM goals is available to Members, Providers, and Practitioners upon request.

11. **Conflict of Interest**: IEHP monitors IPAs for policies and procedures and signed conflict of interest statements at the time of the Delegation Oversight Annual Audit.

2.7 Quality Subcommittees

The following Subcommittees, chaired by the IEHP Chief Medical Officer, Chief Quality Officer or designee, report findings and recommendations to the QMHET Committee:

1. Quality Improvement Council (QIC)
2. Quality Improvement Subcommittee (QISC)
3. Member Experience Subcommittee (MESC)
4. Population Health Management (PHM) Subcommittee

2.7.1 Quality Improvement Council

The Quality Improvement Council (QIC) is responsible for quality improvement activities for IEHP.

1. **Role**: The QIC reviews reports and findings of studies before presenting to QMHETC and works to develop action plans to improve quality and study results. In addition, QIC directs the continuous monitoring of all aspects of Behavioral Health & Care Management (BH &CM) and Population Health Management (PHM) services provided to Members.

2. **Structure**: The QIC is composed of representation from multiple internal IEHP Departments including, but not limited to - Quality Systems, Behavioral Health & Care Management, Population Health Management, Grievance and Appeals, Utilization Management, Compliance, Community Health, Health Education, Health Equity Operations, HealthCare Informatics, Member Services, and Provider Services. The QIC is facilitated by the Vice President of Quality or designee. Network Providers, who are representative of the composition of the contracted Provider Network may participate on the Subcommittee that reports to the QMHETC.

3. **Function**: The QIC analyzes and evaluates QI activities and reports results; develops action items as needed; and ensures follow-up as appropriate. All action plans are documented on the QIC Work Plan.

4. **Frequency of Meetings**: The QIC meets monthly with ad hoc meetings conducted as needed.

2.7.2 Quality Improvement Subcommittee (QISC)

Purpose of Subcommittee

The Quality Improvement Subcommittee (QISC) establishes a culture of quality improvement within IEHP. This subcommittee provides oversight, monitoring and assessment of key organizational processes, outcomes, and reports; and makes

recommendations concerning quality improvement initiatives and activities. The cross functional makeup of the QI subcommittee supports an environment of transparency for quality improvement performance, commitment to ongoing evaluation, and wide scale spread identified successes.

Primary Goals

Through a multidisciplinary approach the QISC's primary goal in 2024 was to monitor priority quality measure performance and review assigned quality improvement studies and reports identified on the Quality management (QM) workplan or as designated by Accreditation Programs Leadership. The QISC will either, collectively explore root causes of performance opportunities and propose interventions or escalate to the Quality Improvement Council (QIC) as needed for additional recommendations. All studies, performances reports, and recommended action items are presented to the QIC on a routine basis.

2.7.3 Member Experience Subcommittee (MESC)

Purpose of Subcommittee

The Member Experience Sub-Committee (MESC) exists to establish a culture focused on continually improving the experience our IEHP Members in their journey navigating their health care. This subcommittee provides oversight, monitoring and assessment of key organizational processes, outcomes and reports; and makes recommendations concerning initiatives and activities that impact the Member experience. The cross functional makeup of the MESC subcommittee supports an environment of transparency for Member satisfaction performance, service levels, grievances, community outreach and a commitment to ongoing evaluation and wide scale spread of identified successes.

Primary Goals

The MESC's primary goal is to establish and align with IEHP's strategic commitment to optimal care and vibrant health. MESC Program performance and outcome measures include, but are not limited to:

1. Oversee the Member experience journey using data from regulatory and IEHP generated approaches to identify trends that indicate there are service concerns related to the various Member touchpoints as they interact with the IEHP, our Providers and contractors.

2. Ensure best practices, which are intended to improve the Member experience, are identified, planned, implemented, and monitored.

3. Continually improve the ability to measure the Member Experience journey and touchpoints [including community outreach] to ensure the "Voice of the Member" is measured and understood.

Member Experience initiative performance and outcomes are evaluated on an annual basis. Intervention decisions and goal revision is based on data and the subcommittee recommendations.

2.7.4 Population Health Management (PHM) Subcommittee

Purpose of Subcommittee

The Population Health Management (PHM) Subcommittee is responsible for the monitoring of IEHP's Population Health Management Program as defined in IEHP's Population Health Management (PHM) Program Description. The items included in the QM/QI and CLAS Work Plan are aligned to Population Health Management program requirements from the Department of Healthcare Services (DHCS) and the National Committee for Quality Assurance (NCQA). IEHP's approach to supporting this work is through the participation of a multidisciplinary subcommittee committed to the clinical and operational goals of the PHM program.

Population Health is a broad IEHP initiative that crosses multiple departments. Therefore, a focused, cross-departmental membership with ad hoc participation is necessary from the following departments: Behavioral Health/Care Management, Health Education, Promotion and Prevention, Pharmacy, Integrated Transitions of care, Community Supports,

Health Equity, Quality Systems Provider and member Services, Information Technology, and Medical Directors.

Primary Goals

The PHM Subcommittee's primary goal is to review and analyze PHM activities and study results that are required for both accreditation and overall regulatory compliance. The subcommittee developed action tracking items which are regularly looked over to ensure that a process to follow-up on these opportunities are set in place. The PHM subcommittee report deliverables are guided by the QMHETC workplan which is reflective of a 36-month review period covering ongoing activities throughout the year. The PHM Subcommittee assesses data to identify opportunities for intervention through processes such as data-driven risk stratification, identification of gaps, and assessment processes.

2.8 Quality Improvement Support Committees / Member Workgroups

IEHP also has Committees and/or Workgroups that are designed to provide structural input from Providers and Members. These Committees and Workgroups report directly through the QMHETC, Compliance Committee or through the CEO to the Governing Board. Any potential quality issues that arise from these Committees would be referred to the QMHETC by attending staff. The Committees and Workgroups include:

1. Community Advisory Committee (CAC)
2. Delegation Oversight Committee

2.8.1 Community Advisory Committee (CAC)

The CAC is a Member advisory committee that engages IEHP Members and community advocates within IEHP's service area. The CAC is comprised primarily of IEHP Members to maintain community engagement with stakeholders, community advocates, traditional and Safety-Net Providers and Members. The CAC provides IEHP with recommendations on the provision of equitable health and preventative care practices, educational priorities, Cultural and Linguistic Appropriate Services (CLAS), communication needs, and the

coordination of and access to services for Members. Feedback and information from the CAC will also be used to inform IEHP health equity and quality improvement efforts with meetings held quarterly.

Currently, IEHP Members including those in foster care have diverse lived experiences including some who have experienced adverse childhood experiences. CAC Member recommended the IEHP provide Trauma Informed Care training to Providers and Team Members. IEHP has confirmed a speaker and will coordinate a future Provider training on Trauma Informed Care and team will communicate the training opportunity to Providers. Additionally, CAC Members encouraged IEHP to partner with community-based organizations especially in rural areas, to share about sensitive services for foster youth. As a result, Provider Services and Community Partnerships Teams are fostering relationship with community partners to leverage more access to services and resources for Members. On the 24th of February 2025, IEHP launched its first Rural Area Support Collaborative in Needles, CA. Providers, community-based organizations, and city management participated in this collaboration.

To address racial disparities and cultural sensitivity stigma associated with mental health, DEI training topics are requested by the CAC and are looked into to be developed for monthly Inclusion, Diversity, Equity, and Access (IDEA) trainings offered at IEHP Headquarters. IDEA trainings are open to IEHP staff, Providers, and community-based organizations. Furthermore, IEHP Providers and Team Members are required to complete a Diversity Equity and Inclusion (DEI) eCourse. The course is intended to educate all in-network Providers on the cultural diversity of IEHP Members, and to raise awareness of the IEHP cultural and linguistic policies and resources. The DEI training is region-specific and includes consideration of health-related social needs that are specific to IEHP's serving counties and disparity impacts of Members including but not limited to Members with Specialty Mental Health Service and/or Substance Use Disorder needs.

IEHP has put forth efforts into increasing telehealth services and expanding provider to address the disparity of having more access to same-day appointments. IEHP has improved

visibility and accessibility of telehealth by providing a prominent search/filter capability in the Provider directory on the Member Portal. The online Provider Directory now has added functionality to filter for Providers that offer telehealth. Members also have the ability to see if Providers they are searching for offer services via telehealth.

2.8.2 Delegation Oversight Committee

The Delegation Oversight Committee is an internal committee that monitors the operational activities of contracted IPAs and other delegate's activities including Claims Audits, Pre-Service and Payment universe metrics, Financial Viability, Electronic Data Interchange (EDI) transactions, Care Management, Utilization Management, Grievances and Appeals, Quality Management, Credentialing/Re-credentialing activities, and other provider-related activities. The Delegation Oversight Committee reports directly to the QMHETC and Compliance Committee and meets monthly with ad hoc meetings conducted as needed.

Section 3: Organizational Structure and Resources

3.1 Clinical Oversight of the Quality Management/Quality Improvement Program

Under the direction of the CMO, CQO, or designee, Medical Directors are responsible for clinical oversight and management of the QM, UM, BH & CM, Health Education, PHM activities, participating in QIHEP for IEHP and its Practitioners, and overseeing credentialing functions. Medical Directors must possess a valid Physician's and Surgeon's Certificate issued by the State of California and certification by one (1) of the American Specialty Boards. Principal accountabilities include:

1. Developing and implementing medical policy for Health Services department activities and QM functions;

2. Reviewing current medical practices ensuring that protocols are implemented and medical personnel of IEHP follow rules of conduct;

3. Ensuring that assigned Members are provided health care services and medical attention at all locations;

4. Ensuring that medical care rendered by Practitioners meets applicable professional standards for acceptable medical care; and

5. Following evidence-based, Clinical Practice Guidelines (CPGs) developed by IEHP for all lines of business. The QM program adopts, disseminates, and monitors the use of preventive care and clinical practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals, considers the needs of Members, and is developed in consultation with contracted health care professionals, as standards of health care are applicable to Members and Providers.

3.2 Quality Systems (QS) Department

The Quality Systems (QS) Department operates under the direction of the Senior Director of Quality Systems. The Senior Director of Quality is responsible for the oversight of all quality studies, demographic analysis, and other research projects; and reports up to the Vice President of Quality. Areas of Accountability Include:

1. Developing research or methodologies for quality studies;

2. Producing detailed criteria and processes for research and studies to ensure accurate and reliable results;

3. Designing data collection methodologies or other tools as necessary to support research or study activities;

4. Implementing research or studies in coordination with other IEHP functional areas;

5. Ensuring appropriate collection of data or information;

6. Qualitative and quantitative analysis of research results (including barrier analysis); and

7. Implementing research studies in coordination with other IEHP functional areas to ensure accurate and reliable results for quality studies.

Staff support for the Senior Director of Quality Systems consists of clinical and/or non-clinical directors, managers, supervisors, and administrative staff.

3.3 Quality Management (QM) Department

The Quality Management Department operates under the direction of the Director of Accreditation Programs. The Director of Accreditation Programs reports up to the Senior Director of Quality Systems who reports to the Vice President of Quality. The Director of Accreditation Programs is responsible for oversight of the quality process; implementing, developing, coordinating, and monitoring for quality improvement, and maintaining the QIHEP and its related activities. Activities include the ongoing assessment of Provider and Practitioner compliance with IEHP requirements and standards, monitoring Provider trends and report submissions, and oversight of facility inspections. The Director of Quality Accreditation Programs also monitors and evaluates the effectiveness of IPA QM systems; coordinates information for the annual QIHEP and Work Plan; prepares audit results for presentation to the QMHETC, associated Subcommittees, and the Governing Board; and acts as liaison regarding medical issues for Providers, Practitioners, and Members.

Staff support for the Director of Quality Management consists of non-clinical Managers, analysts, and administrative staff.

3.4 Quality Improvement (QI) Department

The Quality Improvement Department operates under the direction of the Director of Quality Improvement who reports up to the Vice President of Quality. The Director of Quality Improvement is responsible for collaborating with internal and external stakeholders to align quality improvement initiatives with the broader organizational strategy and the overall mission of IEHP. Quality improvement activities include planning and implementing initiatives aimed at improving Member health and closing care gaps, as well as assessing the effectiveness of the initiatives to ensure measurable outcomes are achieved. The Director of Quality Improvement is

supported by the Quality Improvement and Quality Improvement Strategy teams. The Quality Improvement team is responsible for leading the development, coordination, oversight, management, and implementation of quality improvement activities; including those required by IEHP's regulatory and accrediting bodies. The Quality Improvement Strategy team is responsible for leading multidisciplinary team efforts that determine the right drivers and process changes needed to achieve organizational goals and objectives; including assessment of impact of all prioritized quality improvement activities on measure performance. The QI department is composed of composed of one clinical and one non-clinical Manager, QI Facilitators, Measure Strategists, Quality Systems Analysts, Quality Specialist Representatives, a Quality Engagement Specialist and a Special Programs Manager.

3.5 Population Health (Behavioral Health and Care Management) Department

The Population Health Management (PHM) Department currently operates under the direction of the Senior Director of Population Health, who reports to the Chief Medical Officer (CMO) and encompasses Health Education, Promotion and Prevention, and Basic Population Health Management. In addition, IEHP has an integrated care management department that includes staff experienced in medical, behavioral, psychosocial, cognitive, and functional dimensions of care. An additional integration point includes a coordinated partnership with IEHP's Pharmacy department's clinical and non-clinical staff. The Behavioral Health & Care Management department structure supports an integrated, team-based approach to ensure that Members have access to a team that extends beyond a single point of contact. Below describes the team composition which includes, but is not limited to the following:

- **Registered Nurse Care Manager:** Serves as primary care manager for the most vulnerable Members; High-Risk Members with complex medical conditions; and supports other team members (BH Care Managers, LVN Care Managers, non-clinical administrative roles) in accordance with the RN scope of practice. RN care managers support Members with primary medical conditions through education and self-management techniques, care coordination, medication management and reconciliation, linkage to community support. RN care managers are currently

overseen by clinical Supervisors (RN, LVN), Manager RN and ultimately the Clinical Director (RN).

- **Behavioral Health Care Manager (LCSW, LMFT, MSW, MFT)**: Serves as primary care manager for Members with complex behavioral health conditions and supports other team members (RN & LVN care managers, non-clinical administrative roles) in accordance with their scope of practice. BH care managers support Members with primary BH conditions through education and self-management techniques, care coordination, BH medication management, linkage to BH providers and community support. BH care managers are overseen by clinical Supervisors (RN, LVN, LCSW), Manager (RN) and ultimately the Clinical Directors (RN, (RN)

- **Licensed Vocational Nurse (LVN) Care Manager:** Serves as the primary care manager for Rising and Low-Risk Members. The LVN care manager works within the scope of the LVN license and closely with licensed care management staff (RN, LCSW) for issues outside of their scope. LVN care managers provide care coordination and support Members by reinforcing the plan of care through education and self-management techniques, care coordination, and linkage community support. LVN care managers are overseen by are overseen by clinical Supervisors (RN, LVN), Manager (RN), and ultimately the Clinical Director (RN).

- **Clinical Pharmacist**: Partners with clinical care management team to perform complex post-discharge medication reconciliation, Medication Therapy Management (MTM), physician administered drug authorization and medical benefit authorization decisioning, and other clinical pharmacy programs in addition to participating in ICT and collaborating with prescribing providers as appropriate. Clinical pharmacists are licensed, Doctor of Pharmacy (PharmD) clinical pharmacists. Clinical pharmacists are overseen by the Manager of Clinical Pharmacists, Pharmacy Directors (PharmD) and ultimately the Senior Director of Pharmacy (PharmD).

- **Pharmacy Technician:** Assists clinical pharmacist by preparing documents for post-discharge medication reconciliation, Medication Therapy Management, and other

clinical pharmacy programs such as targeted medication reviews and interdisciplinary care conference preparation. Pharmacy technicians also assist with review of physician administered drug and medical benefit requests per established criteria and can provide member, prescriber, and pharmacy communication. All pharmacy technicians are Board of Pharmacy registered pharmacy technicians and are overseen by the Managers of Medicare Operations, Manager of Medication Management Pharmacy Operations, Pharmacy Directors (PharmD) and ultimately the Senior Director of Pharmacy (PharmD).

- **Care Coordinator**: Provides administrative care coordination support for RN, BH and LVN care managers such as, but not limited to: Coordinating transportation for Members, telephonic follow-up, requests medical records, communicates with Durable Medical Equipment vendors. Care Coordinators are overseen by non-clinical supervisors, Manager (LVN) and ultimately the Clinical Director (RN).

- **IEHP County Liaisons**: IEHP County Liaisons assist with communication and coordination across systems of care, including the County Behavioral Health departments. IEHP County Liaisons are non-licensed staff who have specialized expertise in County programs and partnership. Care Management Team Members work closely with the liaisons as appropriate.

- **Dementia Care Specialist**: Provides person-centered support to individuals with dementia, their families and/or caregivers, focusing on enhancing quality of life. They assess needs, develop care plans, educate caregiver and/or family members, manage challenging behaviors, and connect families and/or caregivers with resources. With expertise in dementia care, strong communication, and advocacy skills, they play a vital role in ensuring dignity, respect, and effective care for those affected by dementia.

3.6 Health Equity (HE) Department and Health Equity (HEO) Operations Department

The Health Equity Department and the Health Equity Operations (HEO) Department operate under the direction of the Chief Health Equity Officer (CHEO) / Vice President of Health Equity. The

CHEO reports up to the Chief Medical Officer of IEHP. The CHEO is responsible for planning, organizing, directing, and coordinating the IEHP approach to health equity. The CHEO works closely with key internal and external stakeholders to design and oversee the implementation of strategies and programs to address health equity and reduce health disparities. The CHEO participates in strategy and program development across the organization and in the community to ensure that health equity is prioritized and addressed through internal health plan functions, operations, and external partnerships and initiatives. The CHEO engages and collaborates with cross-functional teams, subcontractors, contractors, network providers, community-based organizations, county departments, behavioral health, social services, child welfare systems and Members in health equity efforts and initiatives to implement strategies and identify root causes of health inequities. The CHEO, alongside IEHP's Quality team develops targeted interventions and quality improvement activities designed to eliminate health inequities.

Staff support for the Chief Health Equity Officer (CHEO) / Vice President of Health Equity consists of non-clinical Managers, analysts, and administrative staff.

Section 4: Plan Documents

4.1 Quality Management/Quality Improvement (QM/QI) and Culturally and Linguistically Appropriate Services (CLAS) Work Plan

Annually, and as necessary, the QMHETC approves the QM/QI and CLAS Work Plan that addresses clinical quality of physical, behavioral health, access and engagement of Providers continuity and coordination across settings and all levels of care, and Member experience. The QM/QI and CLAS Workplan details a 3-year (36 months) look-back period of program initiatives to achieve established goals and objectives including the specific activities, methods, projected timeframes for completion, monitoring of previously identified issues, evaluation of the QI program and Team Members responsible for each initiative. The scope of the Work Plan incorporates the needs, input, priorities of IEHP. The Work Plan is used to monitor all the different initiatives that are part of the QIHEP. These initiatives focus on improving quality of care and service, access, Member and Provider satisfaction, Member safety, and QI activities that support

PHM strategies. The QMHETC identifies priorities for implementing clinical and non-clinical Work Plan initiatives. The Work Plan includes goals and objectives, staff responsibilities, completion timeframes, monitoring corrective action plans (CAPs) and ongoing analysis of the work completed during the measurement year. The Work Plan is submitted to DHCS and CMS annually.

4.2 Annual QIHEP Evaluation

On an annual basis, IEHP evaluates the effectiveness and progress of the QMHETP including:

1. The QIHEP structure;
2. The behavioral healthcare aspects of the program;
3. How Member safety is addressed;
4. Involvement of a designated physician in the QM/QI Program;
5. Involvement of a Behavioral Healthcare Practitioner in the behavioral aspects of the program;
6. Oversight of QI functions of the organization by the QI Subcommittee;
7. An annual work plan (QM/QI and CLAS Work Plan);
8. Objectives for serving a culturally and linguistically diverse Membership; and
9. Objectives for serving Members with complex health needs.

As such, an annual summary of all completed and ongoing QIHEP activities addresses the quality and safety of clinical care and quality of service provided as outlined in the QM/QI and CLAS Work Plan. The evaluation documents evidence of improved health care or deficiencies, progress in improving safe clinical practices, status of studies initiated or completed, timelines, methodologies used, and follow-up mechanisms that are reviewed by QM staff, the CMO, CQO, or designee. The evaluation includes pertinent results from QIHEP studies, Member access to care,

IEHP standards, physician credentialing and facility review compliance, Member experience, evidence of the overall effectiveness of the program, and significant activities affecting medical and behavioral health care provided to Members.

Performance measures are trended over time and compared with established performance thresholds to determine service, safe clinical practices, and clinical care issues. The results are analyzed to assess barriers and verify and establish additional improvements. The CMO, CQO, or designee presents the results to the QMHETC for comments, consideration of performance, suggested program adjustments, and revision of procedures or guidelines as necessary.

4.3 Review and Approval of Plan Documents

On an annual basis, the Quality Improvement and Health Equity Plan and the QM/QI and CLAS Work Plan are presented to the Governing Board for review, approval, assessment of health care rendered to Members, comments, direction for activities proposed for the coming year, and approval of changes in the QIHEP. The Governing Board is responsible for the direction of the program and actively evaluates the annual plan to determine areas for improvement. Board comments, actions, and responsible parties assigned to changes are documented in minutes.

Section 5: Quality Improvement Processes

IEHP is required to align internal quality and health equity efforts with DHCS' Comprehensive Quality Strategy Report, monitors and reports quality performance DHCS-selected MCAS measures that are stratified by various demographics, and reviews and acts on items identified through DHCS' reports including but not limited to the Technical Repot, Health Disparities Report, Preventive Services Report, Focus Studies, and Encounter Data Validation Report.

IEHP aligns its QIHEP activities with the DHCS Comprehensive Quality Strategy. The planning and implementation of annual QIHEP activities follows an established process. This includes development and implementation of the Work Plan, quality improvement initiatives, and quality studies. Measurement of success encompasses an annual evaluation of the QIHEP.

IEHP aims to support the DHCS Bold Goals including, but not limited to:

1. Closing racial/ethnic disparities in well-child visits and immunizations;
2. Closing maternity care disparities;
3. Improving maternal and adolescent screening;
4. Improving follow up after emergency department visit for mental health conditions; and
5. Providing children's health preventive care services by exceeding national benchmarks.

IEHP participates in DHCS mandated statewide collaborations or additional initiatives that may improve quality and equity of care for Medi-Cal members as directed by DHCS. IEHP also attends, at a minimum, quarterly regional collaborative meetings that may be in-person.

5.1 IEHP Quality Improvement (QI) Initiatives

QI initiatives are also aligned with the IEHP Strategic Plan and Optimal Care, Vibrant Health, and Organizational Strength Vision Commitments that seeks to:

1. Provide clinical care with quality outcomes that exceed national benchmarks, along with health services that are accessible, anticipatory, and coordinated;
2. Provide health care that is equitably experienced across the Inland Empire; and
3. Leverage systems thinking that aligns IEHP's Mission, people, operations technology, and financial performance, respectively.

QI initiatives actively reinforce the Vision Commitments of the IEHP Strategic Plan, with a focus on addressing the specific needs of both IEHP's Membership and those identified by state and regulatory agencies.

QI initiatives undergo a robust process of identification, development, and implementation, ensuring a targeted approach that addresses the specific needs of the IEHP Membership. These initiatives prioritize high-volume, high-risk, or deficient areas, actively seeking improvements in care and service, access, safety, and experience. The proactive monitoring of Managed Care Accountability Set (MCAS) and other quality measures inform the identification and development

of QI initiatives, their goals and objectives, and direction of the IEHP Strategic Plan. Furthermore, a data centered approach with a focus on performance measures and customized metrics form the basis of implementation plans and actions developed to improve care and services.

5.1.1 Plan-Do-Study-Act Cycle

The "Plan-Do-Study-Act" (PDSA) Cycle is utilized to implement and test the effectiveness of changes. The model focuses on identifying improvement opportunities and changes and measuring improvements. Successful changes are adopted and applied where applicable. In general, quality improvement initiatives follow the process below:

1. Find a process to improve, usually by presenting deficient results;
2. Organize a team that understands the process and include subject matter experts (SMEs);
3. Clarify knowledge about the process;
4. Understand and define the key variables and characteristics of the process;
5. Select the process to improve;
6. Plan a roadmap for improvement and/or develop a work plan;
7. Implement changes;
8. Evaluate the effect of changes through measurement and analysis; and
9. Maintain improvements and continue to improve the process.

5.1.2 Data Collection Methodology

Performance measures developed have a specified data collection methodology and frequency. The methodology for data collection is dependent on the type of measure and available data, with data validation being a vital part of the data collection process. Quality assessment and improvement activities are linked with the delivery of health care services.

Data is collected, aggregated, and analyzed to monitor performance. When opportunities for improvement are identified, a plan for improvement is developed and implemented. Data is used to determine if the plan resulted in the desired improvement. Data collection is ongoing until the improvement is considered stable. At that time, the need for ongoing monitoring is reevaluated. Data may also indicate the need to abandon an action and reassess options for other action items necessary to drive performance improvement.

5.1.3 Measurement Process

Quality measures are used to regularly monitor and evaluate the effectiveness of quality improvement initiatives, and compliance with internal and external requirements. IEHP reviews and evaluates, on not less than a quarterly basis, the information available to the plan regarding accessibility and availability. IEHP measures performance against community, national or internal baselines and benchmarks when available, and applicable, which are derived from peer-reviewed literature, national standards, regulatory guidelines, established clinical practice guidelines, and internal trend reviews.

5.1.4 Evaluation Process

IEHP uses several techniques and tools to evaluate effectiveness of QI studies and initiatives. These include conducting a robust quantitative and qualitative analysis. A quantitative analysis includes comparison to benchmarks and goals, trend analysis, and tests of statistical significance. The Quality Department Analytics team selects the appropriate tools to complete the quantitative analysis. The QM Department works closely with the Quality Department Analytics Department and other key stakeholders to complete a robust qualitative analysis. A qualitative analysis includes barrier analysis and attribution analysis. IEHP performs this analysis in a focus group-like setting using all the key stakeholders.

5.1.5 Communication and Feedback

Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, joint operation meetings, mailings, and announcements.

1. Providers are educated regarding quality improvement initiatives through on-site quality visits, Provider newsletters, specific mailings, and the IEHP website.

2. Specific performance feedback regarding actions or data is communicated to Providers. General and measure-specific performance feedback is shared via special mailings, Provider newsletters, IEHP's Provider Portal, and the IEHP website.

3. Feedback to Providers may include, but is not limited to, the following:

    a. Listings of Members who need specific services or interventions;

    b. Clinical Practice Guideline recommended interventions;

    c. Healthcare Effectiveness Data Information Sets (HEDIS®) and Consumer Assessment of Healthcare Providers (CAHPS®) results;

    d. Recognition for performance or contributions; and

    e. Discussions regarding the results of medical chart audits, grievances, appeals, referral patterns, utilization patterns, and compliance with contractual requirements.

5.1.6 Improvement Process

Performance indicators are also used to identify quality issues. When identified, IEHP QM staff investigates cases and determines the appropriate remediation activities including Corrective Action Plans (CAPs). Providers or Practitioners that are significantly out of compliance with QM requirements must submit a CAP. If a Provider or Practitioner does

not submit CAP or continues to be non-compliant with the CAP process (including CAP timelines), the Provider is frozen to auto-assignment until such time as the corrections are verified and the CAP is closed. The CAP process must be completed within 90 calendar days from the date of the audit and CAP notification.

5.2 Quality Improvement Initiatives – Quality of Care

IEHP monitors several externally and internally developed clinical quality measures and tracks the quality of care provided by IEHP. To evaluate these measures IEHP collects data from a number of different sources that include, but are not limited to, the following:

1. HEDIS® submission for Medi-Cal and IEHP DualChoice (HMO D-SNP);
2. State/Federal required Performance Improvement Projects and Quality Activities; and
3. Claims and encounter data from contracted Providers (e.g., Primary Care Providers, Specialists, labs, hospitals, IPAs, Vendors, etc.).

Measuring and reporting on these measures helps IEHP to guarantee that its Members are getting care that is safe, effective, and timely. The clinical quality measures discussed below are used to evaluate multiple aspects of Member care including:

1. Performance with healthcare outcomes and clinical processes;
2. Adherence to clinical and preventive health guidelines;
3. Effectiveness of chronic conditions, Population Health and Behavioral Health Care Management programs; and
4. Member experience with the care they received.

5.2.1 HEDIS® Measures

HEDIS® is a group of standardized performance measures designed to ensure that information is available to compare the performance of managed health care plans. IEHP has initiatives in place that focuses on a broad range of HEDIS® measures that cover the

entire Membership, including, priority measures that relate to children, adolescents, and Members with chronic conditions.

To generate the rates for different measures, the IEHP Quality Informatics team loads data in an NCQA certified HEDIS® software. Technical specifications from the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans were utilized for measure reporting. HEDIS® Measurement Year (MY) 2023 includes measures across 16 domains:

A. Effectiveness of Care

    1. Prevention and Screening
    2. Respiratory Conditions
    3. Cardiovascular Conditions
    4. Diabetes
    5. Musculoskeletal Conditions
    6. Behavioral Health
    7. Care Coordination
    8. Overuse/Appropriateness
    9. Measures Collected Through the Medicare Health Outcomes Survey
    10. Measures Collected Through CAHPS® Health Plan Survey
    11. Access/Availability of Care
    12. Experience of Care

B. Utilization and Risk Adjusted Utilization

    13. Utilization

14. Risk Adjusted Utilization

15. Health Plan Descriptive Information

C. Measures Reported Using Electronic Clinical Data Systems

16. Measures Reported Using Electronic Clinical Data Systems

Data collection methods for HEDIS® measures include administrative, hybrid, survey, and electronic clinical data systems data (ECDS). Administrative information is collected through claim and encounter data. Hybrid measure information is captured using administrative data supplemented with medical record review of a sample population. Hybrid specifications allow for a drawing of a random sample using an NCQA-approved proportional systematic sampling method. A medical record review is conducted for these hybrid measures. Survey data is captured from Member surveys and ECDS data is obtained from electronic data exchange systems with contracted partners for data, such as electronic health records (EHRs) and clinical registries. Rates are reported separately for Medi-Cal and Medicare lines of business.

HEDIS® Timeline

HEDIS® data is collected throughout the year. In March 2024, technical specifications were finalized for the 2023 measurement year with the Volume 2 Technical Update and Value Set Directory. From January to May 2024, administrative data from claims/encounters continued to be captured and medical records were retrieved from Providers and reviewed for hybrid measures. IEHP reported HEDIS® MY 2023 results to NCQA in June 2024.

Barriers and Quality Improvement Activities

IEHP develops several Member and Provider engagement programs to improve HEDIS® rates. Interventions include a combination of incentives, outreach and education, Provider-level reports and gaps in care reports, and other activities deemed critical to improve performance. These interventions are tracked and monitored in the QM/QI and CLAS Work Plan and are presented at the QI Subcommittee. In addition, IEHP's performance on HEDIS® measures is reported and discussed annually at the QI Subcommittee, who

provides guidance on prioritizing measures for the subsequent year(s). IEHP's goal is to continually develop and implement interventions that are aimed at improving HEDIS® rates and quality of care for its Members.

General barriers to meeting HEDIS® MY2023 measurement goals are included in Figure 1 below:

Figure 1: General Barriers to HEDIS® Quality Improvement

Barrier	Analysis
Data Optimization	IEHP has identified an opportunity to improve data capture of services rendered prior to infant enrollment into the health plan. Current "mom" and "baby" Member ID linkage does not completely capture early infant care visit data. A review of immunization and well care visit data demonstrates gaps during the early months which may contribute to exhibiting lower compliance among early childhood measures. IEHP hosts numerous community events and outreaches throughout the year to offer preventative services to members. For these events, IEHP has identified an opportunity to improve data capture for all medical services provided that will result in gap closure. IEHP continues enhance data optimization opportunities by leveraging health information exchange, medical management systems, and electronic medical records.
Provider Barriers	Most HEDIS® information can be obtained through claims or encounters data. Common reason for not receiving Member visit information is missing or incorrect encounter data captured through numerous medical record documentation systems among IEHP Providers. Outdated Electronic Medical Record (EMR) and Electronic Health Record (EHR) systems used by providers were insufficient in tracking and alerting on open quality care gaps. Furthermore, these systems lacked the automated coding functionalities—such as CPT, CPTII, and LOINC—necessary to close care gaps upon claim submission.

	Other documentation barriers are related to chart collection capacity and strain from Provider offices for HEDIS® abstraction. Incomplete or incorrect data and process changes that result in changes to received data, inconsistent behavioral health claims submission from County partners, and processes not capturing all possible data. Beyond data, many Providers struggled with understanding essential information needed for quality measure performance, including anchor dates, measurement periods, population criteria, and numerator/denominator requirements. A significant amount of Provider offices are unable to perform certain preventive tests on-site during wellness visits, necessitating Members schedule at least one additional visit to a laboratory or specialized clinic. Consequently, many Members did not complete these follow-up visits, resulting in unresolved gaps in their care.
Member Barriers	Limited primary and specialist appointment availability across the county made it difficult for members to receive care at times that better aligned with school or work schedules. This resulted in limited opportunities to provide preventative services and close care gaps. When providers get an opportunity to see their patients, there is limited time in the appointment to cover all missing preventative services that could have been spread out through multiple visits and members may decline the preventive care services. Members continue to struggle with the understanding of key information surrounding preventative services, benefits, and incentives. Regarding preventative services, this often results in many members only choosing to visit their primary provider when they have an urgent medical need instead of taking a proactive approach to their health. Significant examples are missing immunizations, skipping yearly wellness visits, and abandoning prescribed medications. When it comes to benefits, IEHP offers complimentary transportation to and from appointments, but many members remain unaware of that benefit. The lack of transportation has been identified as a significant deterrent in appointment completion. IEHP also offers member incentives upon preventative service completion (immunizations, mammograms, yearly visits etc.) however, many members may be unaware.

Quality improvement activities are planned and/or are in place for 2023-2024 to improve HEDIS® performance. Organization wide IEHP activities and initiatives are organized by HEDIS® category and HEDIS® domain in *Figure 2*.

Figure 2: MY 2023 IEHP Quality Improvement Activities by Type

Intervention Name		IPA/Provider Incentives	IPA/ Provider Initiative	Member Incentives	Member Initiative	Reporting / Data Enhancements
1	**Academic Detailing**		x		x	
2	**Baby N Me App**			x	x	
3	**Care Gap Alerts**				x	
4	**Community Resource Centers Classes**				x	
5	**Comprehensive Medication Management (CMM)**				x	
6	**Global Quality Pay For Performance (GQP4P) - PCP**	x				x
7	**Global Quality Pay For Performance (GQP4P) - IPA**	x				x
8	**HEDIS Care Gap Texting Campaign**				x	
9	**Improved data sharing and development of San Bernardino & Riverside counties BH Dashboard by HCI**					x
10	**Medicare Annual Visit Incentive**	x				
11	**Medicare P4P - IEHP Direct**	x				
12	**Member Incentive Program**			x		

13	**OB Pay for Performance Program (OB P4P)**	x				
14	**PCP and IPA Trainings**		x			
15	**Preventive Care Outreach**				x	
16	**Provider Quality Resource Guide**		x			
17	**Quarterly PCP Report Card**		x			
18	**Standing Orders Program**		x			
19	**Well Child Visit Prospective Chart Review**					x
20	**Value Based Payments**	x				
21	**Vision Provider Member Outreach Program**		x	x	x	
22	**Quality Achievement Program**		x		x	x
23	**Root Cause Analysis**		x			x
24	**Regional Quality Model**		x			
26	**Provider Learning Modules**		x			
27	**DHCS SWOT Analysis**		x		x	x
28	**Shared Vision Partnership: Riverside University Health System**		x		x	

Intervention Name	Description
Academic Detailing	An educational and evidence-based outreach program for Providers and Pharmacies. Pharmacy Academic Detailing team conducts phone and one-on-one outreach with physicians, nurse practitioners, physician assistants, and pharmacy staff.

Baby N Me App	A free Member app that provides expectant mothers with clinically approved information and access to exclusive content based on their due date.
Care Gap Alerts	Member-specific gap in care alerts in IEHP's call center systems indicate what preventive care services are due. Alerts prompt Team Members to remind Members of needed services when they call the health plan.
Community Resource Centers Education Classes	Various classes are available to Members free of cost. Health education topics include childhood immunizations, diabetes, asthma, breast cancer screening, and cervical cancer screening.
Comprehensive Medication Management (CMM)	A whole-person approach where a pharmacist under a Collaborative Practice Agreement (CPA) has the autonomy to add, remove or change medications without prior physician approval. The program focuses on the following: Patient medications, Patient condition, clinical assessment, Medical History, Labs
Global Quality Pay For Performance (GQP4P) - PCP	Rewards PCPs for high performance and year-over-year improvement in key quality performance measures across Clinical Quality, Access, Behavioral Health Integration and Patient Experience domains. Supporting Provider rosters are available in the Provider Portal.
Global Quality Pay For Performance (GQP4P) - IPA	Rewards IPAs for high performance and year-over-year improvement in key quality performance measures across Clinical Quality, Access, Behavioral Health Integration and Patient Experience domains.
HEDIS® Care Gap Texting Campaign	Text message reminders are sent to Members to complete their needed preventive health services.
San Bernardino & Riverside counties BH Dashboard and Data Sharing Improvements	To improve inconsistent utilization data volume shared from county partners. The dashboard illustrates fallout reasons by total volume and month and aid in collaborative data sharing improvement discussions with county partners.
Medicare Annual Visit Incentive	Annual visit for Medicare Members ensures that all IEHP DualChoice Members have timely annual visits, with an emphasis on evaluating chronic illness.
Medicare P4P - IEHP Direct	This program aims to improve the quality of care for IEHP Direct DualChoice Members through incentive payment for completion of the following services: Blood Pressure Control; Colorectal Cancer Screening; Flu Vaccine; HbA1c Control; Post Discharge Follow-Up.
Member Incentive Program	Members are incentivized to receive a gift card of their choice when completing a needed preventive care service, lab, or immunization.

OB Pay for Performance Program (OB P4P)	Provides an opportunity for OB/GYN Providers to earn financial reward for improving the quality of maternity care for IEHP's pregnant and postpartum Members.
PCP and IPA Trainings	IEHP hosted targeted trainings for PCPs and IPAs. Topics include measure education, review of best practices, and coding/medical record documentation standards.
Preventive Care Outreach	Outbound calls to Members with gaps in care to educate Members on preventive care services that are due and facilitate setting up PCP appointments.
Provider Quality Resource Guide	Designed for IEHP Providers and their staff, a single source containing appropriate information and resources for quality improvement efforts. Each topic section in the guide contains measure overviews and the following information: Measure overview; Tips for measure improvement; IEHP Resources for Providers and Members.
Quarterly PCP Report Card	Analysis of individual PCP Performance compared to peer Specialty Performance and established Health Plan goals; results are based on all assigned Members meeting measure criteria.
Standing Orders Program	Standing orders facilitate PCP orders and follow-up of routine labs and screenings for breast cancer screening (mammograms), diabetic lab tests, and colorectal cancer screening (home test kits)
Well Child Visit Prospective Chart Review	Medical record review of Members meeting HEDIS technical specification criteria for identification of a qualifying well child visit documentation.
Value Based Payments	Proposition 56 VBP Program provided direct payments incentivizing Providers to meet measures aimed at delivering key quality healthcare services. Targeted areas were behavioral health integration, chronic disease management, prenatal/post-partum care and early childhood prevention. This program ended as of DOS 6/30/22 with payments running through June 2023.
Vision Provider Member Outreach Program	IEHP matches Diabetic Members needing an eye exam with Vision Providers in their neighborhoods. The office staff at the Vision Provider offices outreach to Members schedule timely eye exam appointments.
Root Cause Analysis	Studies conducted on specific quality measures to identify root barriers and provide findings and recommendations for improvement.

Regional Quality Model	Dedicated IEHP team members visit Provider offices with improvement opportunities. Current state performance is reviewed along with potential countermeasures. Provider feedback is collected on quality and process support. Recommendations and resources are shared in the form of training and education in the following areas: billing, coding, outreach, scheduling, measure education, and reiterating the importance of a yearly visit. To support outreach sustainment, a team member in the clinic is trained before working with a new provider.
Provider Learning Modules	Provider Learning Modules are available on the IEHP website. These learning modules are designed to support Providers and their office staff in becoming familiar with preventive screening recommendations, available tools/resources, and clinical best practices. Each module includes the following components: measure overview, keys to success, tools for practice improvement, tips for outreach and communication and additional IEHP resources.
DHCS SWOT Analysis	IEHP conducted an organization-wide Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis on all measures that fell below the DHCS minimum performance level for MY2022. This analysis provided insights and became the launching pad for new interventions and mitigation strategies for MY2023.
Shared Vision Partnership: Riverside University Health System	Partnership with the county of Riverside Health System to set and achieve bold synergistic outcomes for Access and Quality that neither organization could accomplish independently.

5.2.2 Performance Review of Managed Care Accountability Set (MCAS)

MCAS is founded on the CMS Child and Adult Core Set Measures, which includes NCQA HEDIS® measures. For the year, there are 39 measures spanning the behavioral health, children's health, chronic disease management, reproductive health, and cancer prevention domains. Managed Care Plans (MCPs), such as IEHP, are mandated by DHCS to submit annual reports on their performance of MCAS measures. DHCS sets a Minimum Performance Level (MPL) for specific MCAS measures, aligning with NCQA's national Medicaid 50th percentile.

IEHP regards MCAS measures a priority. IEHP's MCAS measure performance guide the development of its Strategic Plan, QI activities, and department initiatives. IEHP seeks to

not only meet and exceed the MCAS MPL established by DHCS but achieve the MCAS High Performance Level (HPL) set at the 90th percentile for qualified measures.

IEHP proactively oversees its performance of MCAS measures and their corresponding MPL to evaluate and enhance clinical quality of care. The evaluation yields insights into Member and Provider behavior, guiding the development of QI activities and direction of the IEHP Strategic Plan that are both pertinent and responsive. These QI activities may be incorporated into IEHP's Strategic Plan or department initiatives with the ultimate objective to meet or exceed the MCAS HPL.

Based on prior year performance, IEHP continues to find opportunities to improve these MCAS measures including, but not limited to: Childhood Immunization Status: Combination 10 (CIS-10), Immunizations for Adolescents: Combination 2 (IMA-2), Lead Screening in Children (LSC), Well-Child Visits in the First 30 Months of Life – 15 to 30 Months (W30-2), Child and Adolescent Well-Care Visits (WCV) and Cervical Cancer Screening (CCS). Detailed plans on activities to meet or exceed the MPL for these measures can be found on the MY 2022 | CY 2024 Comprehensive Quality Strategy.

5.2.3 Performance Improvement Projects (PIPs) [DHCS and CMS] and Quality Activities

IEHP implements quality improvement activities as required by regulatory agencies (DHCS, CMS) and in accordance with requirements in the Capitated Financial Alignment Model.

1. **Performance Improvement Projects (PIPs)** – A thorough analysis of a targeted problem is completed. A baseline and key indicators are established and then interventions are implemented. Interventions are designed to enhance quality and outcomes that benefit IEHP Members. DHCS Medi-Cal Managed Care Division contracts with Health Services Advisory Group (HSAG), and external quality review organization (EQRO) to conduct validation of these projects.

2. **NCQA Quality Activities** – These are quality improvement activities conducted to meet NCQA accreditation standards.

The Quality Improvement Department, under the direction of the Director of Quality Improvement, is responsible for monitoring these programs and implementing interventions to make improvements. For 2025, IEHP is focusing on the following studies:

Study Name	Reporting Agency	Type of Study
IEHP All-Cause Readmissions	NCQA	Quality Activity
2023–26 Clinical PIP - Improve Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure rates for Black/African American Populations	DHCS	PIP
2023–26 Non-Clinical PIP – Improve the percentage of Provider notifications for Members with SUD/SMH diagnoses following or within 7 days of emergency department (ED) visit	DHCS	PIP
2024 Comprehensive Quality Strategy – Well Care Visits in First 30 months of life (W30-2), Childhood Immunizations Combination 10 (CIS) Immunizations for Adolescents Combination 2 (IMA), Lead Screening in Children (LSC), Child and Adolescent Well Care Visits (WCV) and Cervical Cancer Screening (CCS)	DHCS	SWOT

Item	Deliverable
Outcomes/findings from Performance improvement Projects (PIPs), consumer	➢ **Institute for Healthcare Improvement (IHI)** **IEHP and San Bernardino Department of Behavioral Health**

satisfaction surveys and collaborative initiatives	Outcomes: Currently unavailable as the collaborative is still ongoing. **Goal:** To increase FUA/FUM rates by 5% by June 2025. ➢ **Child Health Equity Collaborative** Outcomes: Currently unavailable as the collaborative is still ongoing. **Goal:** To increase WCV rates in the Arlanza and Eastside (Riverside, CA) clinics by 3% and 7%, respectively. **Data Stratification**: Race, ethnicity, age, zip code **Key Learning**: SDoH data is a significant factor in identifying health equity opportunities, IEHP continues to consider enhancement mechanisms to collect this information and incorporate into quality improvement initiatives. **WCV Change Ideas:** ➢ Double education efforts for parents (importance of visits, incentives, benefits, letters of consent) ➢ In-clinic materials/advertising for parents and target population (pamphlets, books, stickers) ➢ Customized outreach and education materials for (target population) adolescents ➢ Provision of completion incentive for both the parent and the adolescent ➢ Provide appointment scheduling for entire family once parent is in-clinic ➢ Extend clinic hours, open on Saturdays

	➢ **PIPs** **Clinical PIP**: *Improving Well-Child Visit (W30) Measure Rates for the Black Population* The California 2020 Health Disparities Report identified disparities for a majority of the indicator rates in the Black population within the Children's Health domain. Most rates for the Black population were below 70 percent (%) in comparison to the highest performing group within the Children's Health domain. To help address the findings from the Health Disparities Report, one of DHCS' statewide goals is to reduce the disparity among the Black population for the Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure. As required by the state, IEHP will be focusing on addressing the identified disparity within the Black child population and improving the Well-Child Visit (W30-6) measure rate for Black children 0-15 months. **Plan-Specific Data**: In MY2023, IEHP's overall W30-6 rate was 59.95%. IEHP reported rates to DHCS stratified by race/ethnicity and found the rate for Members identified as Black was 47.31%, one of the lowest reported rates. This confirms the opportunity to address the disparity for this population. **Quality Improvement**: The Quality Improvement Team utilized a key driver diagram to determine the focus areas and possible interventions. Barriers included Member Education, Provider Engagement, Member Transportation, and Communication Strategy. Interventions included Educational Materials, Provider Surveys, Transportation Accommodations, and External Partnership. The focus of the intervention was to perform phone outreach to Black pregnant women and refer them to the resources provided by Black

	Infant Health (BIH). The team who completed this outreach was comprised of Community Health Workers (CHW) at IEHP. **Outcomes**: As this is a three-year PIP, the data and final outcomes are not yet available. The data from year one is as follows – **Goal**: By identifying engagement strategies for the Black population, IEHP hopes to close the disparity gap and provide care to the identified population of children 0-15 months of age. Through improving the completion of well child visits timely and access to care, Members will receive age-appropriate screenings, vaccinations, and other preventive care services to improve their well-being and health through regular visits with their PCP and provide the opportunity to address any health concerns. **Baseline Rate**: 185/391 (47.31%) **Goal Rate**: Not set **Members Outreached**: 90 **Members Pregnant During Outreach**: 62 **Members Engaged with BIH**: 20 **Members Contacted After Delivery**: 28 **Members Who Reported a Child Initial Visit**: 5 **Intervention**: *Community-Based Organization Partnership with Black Infant Health Program* 1. **Barriers Addressed**: Member education, support and resources are not culturally specific to the Black population. 2. This intervention specifically engages Members who identify as Black and are pregnant. The Members who are outreached to are referred to a community-based program tailored for Black pregnant Members and their babies. Additionally, IEHP CHWs will be

	outreaching to Black pregnant Members to provide education on well child visits and provide any additional needed resources identified for this population. 3. **Intervention Effectiveness Measure**: *Community Health Worker Outreach* a. Numerator: Unique Members identified through the monthly intervention list and were successfully contacted by a CHW. b. Denominator: Unique Members identified through the monthly intervention list who are pregnant or had delivered and identify as Black. Throughout the intervention period (06/01/2024 - 08/31/2024), the CHW team received a total of 1,128 unique Members for outreach through the monthly intervention lists. Out of these Members, a total of 90 Members were successfully contacted by the CHW team. From the 90 total Members contacted, 31.11% (n=28) were reached after delivery of which eight (8) indicated that their pregnancy did not result in a live birth. The remaining 62 Members had an initial contact with a CHW during their pregnancy. CHWs documented expected delivery date of Members pregnancy so they may plan a follow up call post-delivery. The aim of CHW outreach is to engage with Members twice; first during pregnancy to refer Members to BIH and conduct the second outreach after delivery to provide scheduling assistance with well child visits. The table above indicates that at this time, only a small portion of Members who were pregnant during initial contact have delivered to-date (n = 15). The CHW team plans on conducting

follow-up calls for these Members in the coming weeks to connect on any Member barriers to care and assist with scheduling follow up appointments as needed.

From the 20 Members who reported a live birth during initial outreach:

- five (5) Members reported an initial visit date for their child
- two (2) Members requested CHW assistance with scheduling an appointment

The remaining 13 Members stated that they would schedule an appointment on their own or indicated not needing assistance with scheduling a well child visit.

4. **Intervention Effectiveness Measure**: *Black Infant Health Engagement*
    a. Numerator: Unique Members who reported being engaged with Black Infant Health (BIH)
    b. Denominator: Unique Members identified through the monthly intervention list, were successfully contacted by a CHW and reported being pregnant at the time of initial outreach.

    From the 62 Members who reported being pregnant at the time of CHW outreach, 32.26% (n=20) confirmed engagement with BIH. The additional 42 Members who were not engaged with BIH at the time of the initial successful outreach were referred to the program. IEHP plans to collect BIH program engagement confirmation from Members during follow-up calls to compare whether engagement in this program yields higher rates of

	completion of early well child visit appointments and vaccinations due by 2 months such as Hep B, Rotavirus, DTap, Hib, PCV and IPV. The process improvement opportunities identified include: • Enhancing tools used to conduct outreach and collect outreach data to further refine standardization across regional CHW teams supporting intervention efforts, • Enhancing existing internal BIH referral job aids, • Enhancing Team Member training on BIH program benefits and intervention documentation, and • Create additional opportunities for BIH and IEHP to share insights that strengthen this process. The member education opportunities identified include: • Enhance Member messaging on available resources that support engaging with needed care, including BIH, doula services benefit, transportation, etc. While reporting was available to identify pregnant Members, expected delivery dates were not readily available to assist with planning timing of outreach efforts. This resulted in some initial outreach attempts being conducted after delivery rather than before as intended – out of the 90 Members with an initial contact, 31.11% (n=28) Members either did not have a viable pregnancy or they were reached after they had already given birth and were removed from the subsequent intervention effectiveness measure denominator. IEHP plans on enhancing reporting criteria used to generate Member lists to highlight pregnant

	Members for initial contact as well as improve notification to CHWs that a follow-up outreach is due. **Barriers**: 1. Expected delivery dates not available a. <u>Resolution</u>: Upon initial outreach, every Member was asked for their expected delivery date and then called after that date for BIH enrollment confirmation. 2. Outdated contact information a. <u>Resolution</u>: CHWs conducted outreach to Pharmacies and Provider offices to attempt retrieval of alternative Member phone numbers. The outreach team was able to successfully connect with a total of 90 Members. During these calls, IEHP gained valuable insights into Member barriers to care such as needing assistance with newborn enrollment soon after delivery. While still early in the implementation of the planned intervention as indicated by the limited number of Members who have delivered after initial contact, IEHP has received confirmation of five deliveries based on claims data. IEHP anticipates that as the intervention progresses and Members deliver, additional information will become available to further assess the intervention impact on completion of early well child visits and vaccinations. ➢ **Non-Clinical PIP**: *Improve Provider Notifications for Members with Substance Use Disorder (SUD) and Specialty Mental Health (SMH) Diagnoses after Emergency Department (ED) Visits*

	The selected topic for the non-clinical PIP is to improve the percentage of provider notifications for Members with Substance Use Disorder (SUD) and Specialty Mental Health (SMH) diagnoses following or within 7 days of emergency department (ED) visit. IEHP elected to focus on this topic after identifying that there is currently no standard process to identify Members with these diagnoses and in turn, notify Providers of needed follow up in a timely manner. **Plan-Specific Data**: As there is no process currently in place at IEHP that notifies Providers that their assigned Members have an ED visit with an SUD or SMH diagnoses, the current Provider notification rate is zero. IEHP plans on collecting baseline and remeasurement data at least monthly to monitor indicator outcomes, including total denominator, numerator, and percentage. IEHP informatics teams will build reporting to identify the total IEHP Members with SUD and SMH diagnoses, ED Visit dates, assigned provider information and whether the Provider received notification of the Member's ED event within seven (7) days. The Quality Improvement team will utilize the reporting to monitor indicator performance month-over-month. **Quality Improvement**: The Quality Improvement Manager, Quality Improvement Facilitator, and Quality Systems Analyst collaborated to develop the intervention. The Quality Performance Informatics Manager and Healthcare Data Analyst assisted with developing reporting on the success of the fax notifications to Providers. The Provider Relations Managers were informed of unsuccessful faxes sent to Providers and conducted outreach to the Providers to update contact information and notify them of their patients with recent ED visits for a diagnosis of SUD/SMH. **Outcomes:** As this is a three-year PIP, the data and final outcomes are not yet available. The data from year one is as follows –

	Goal: To improve the percentage of provider notifications for Members with Substance Use Disorder (SUD) and Specialty Mental Health (SMH) diagnoses following or within 7 days of emergency department (ED) visit. **Baseline Rate**: No process, zero. **Goal Rate**: 100% **Unsuccessful Fax Rate** : 9.19% **PRM Successful Contact Rate**: 18.52% **7-Day Visit Rate**: 31.62% **Intervention**: *Quality Improvement and Provider Services Partnership to Improve Provider Notifications* 1. **Barriers Addressed**: a. Timely notifications to Providers b. Updated PCP assignment information c. Obtaining SUD/SMH discharge information 2. This intervention applies across all applicable Emergency Department (ED) events supporting Member engagement with Provider follow up. 3. **Intervention Effectiveness Measure**: *Unsuccessful Fax Rate* a. Numerator: Total number of unsuccessful faxes sent to Providers within 7 days of the Member's ED visit with a principal diagnosis of substance use disorder or specialty mental health. b. Denominator: Total number of fax notifications sent to Providers within 7 days of the Member's ED visit with a principal diagnosis of substance use disorder or specialty mental health. The plan had no timely notification to Providers regarding their Patients' ED discharge for FUA/FUM diagnosis during

	the baseline period. IEHP implemented a Phase #1 process utilizing fax notifications. The fax notification system was implemented 5/01/24 notifying Providers 1 day after their Patient's had a discharge from the ED with a FUA/FUM diagnosis. As of September 5, 2024 this process resulted in a 90.81% success fax notification rate (n = 800). In order to address the unsuccessful notifications (n = 81), the Quality Improvement (QI) Team collaborated with the Provider Experience Team (Provider Relations Managers). The Provider Relations Managers (PRM) outreached to Providers regarding their Patients' ED discharge for a FUA/FUM diagnosis, requested a 7-day follow-up visit, and obtained updated contact information for future notifications. During the Phase #1 Provider notification process, IEHP used the RightFax system to notify Providers of their Patients' ED visit. The RightFax system experienced a system upgrade which caused unforeseen technical delays preventing faxes from being released for a period of 5/22/2024 to 06/12/2024. During this time period, Provider notification faxes and reporting functions were not available. Therefore, these counts are not included in the measure indicator. Once the system upgrade was completed, notifications resumed. This was an unexpected delay in the plan's effort to improve Provider notifications. After the RightFax system was upgraded, we saw an improvement in the indicator, from 10.75% (n = 20) for the rate of unsuccessful faxes to 8.78% (n = 61) after the issue was resolved. 4. **Intervention Effectiveness Measure**: *Updated Provider Information*

	a. Numerator: Total number of Providers with successful contact by the Provider Experience Team (Provider Relations Managers) of their Members ED visit within 7 days. Success is measured by providing the Provider the fax notification and updating the contact information for future notifications. b. Denominator: Total number of unsuccessful faxes sent to Providers within 7 days of the Member's ED visit with a principal diagnosis of substance use disorder or specialty mental health. Out of the Providers who had an unsuccessful initial fax notification (n=81), 18.52% (n=15) had successful contact by a Provider Relations Managers (PRM) to notify of the Member's ED visit and request appropriate follow up within seven (7) days of the Member's event. While the remaining 66 Providers were notified of their Member's ED event, IEHP could not confirm notification occurred within seven (7) days of the Member's event. To ensure accurate contact information for future notifications to these Providers, fax numbers were updated as needed. The PRM Team notified IEHP's Provider Network Department to update Provider's contact information and reflect accurately throughout IEHP systems. There were no faxes or reporting generated during the RightFax system upgrade, therefore, the potential missed faxes are not included in the denominator. QI also identified a need to improve the tracking of follow-up outcomes for Provider outreach efforts. 5. **Intervention Effectiveness Measure**: *HEDIS® Measure Impact – FUA & FUM*

	a. Numerator: Total number of ED visits that resulted in a follow-up visit within 7-days of being discharged from the ED per FUA and FUM HEDIS® numerator criteria. b. Denominator: Total number of ED visits among Members with a primary diagnosis of SUD or SMH captured in the FUA FUM MY 2024 HEDIS® denominator and Provider received intervention fax notification. During the intervention period, the FUA 7-day follow up rate for Members who were included in an unsuccessful fax was 42.11% (n=8), while those included in a successful fax was 38.02% (n=46). The intervention 7-day follow-up rate for Members who had an ED visit, at 38.57%, is higher than the measurement year 2023 final rate for FUA 7-day of 25.05%, indicating positive signal of the notification's effect. During the intervention period, the FUM 7-day follow up rate for Members who were included in an unsuccessful fax was 22.22% (n=2), while those included in a successful fax was 24.39% (n=30). The intervention 7-day follow-up rate for Members who had an ED visit, at 24.24%, is lower than the measurement year 2023 final rate for FUM 7-day of 48.37%. Since 01/01/24, there have been 9,062 ED visits not included in the intervention due to being seen outside of a contracted hospital or having a visit prior to the intervention launch. As next steps, QI will be assessing additional members beyond those in the HEDIS denominator to continue evaluating the intervention effectiveness for IEHP Members moving forward.

	6. **Lessons Learned**: Establishing and maintaining clear communication channels between Quality Improvement and Provider Experience Teams helped streamline the outreach process and facilitates quicker updates. When analyzing the HEDIS measure impact on FUA and FUM, additional opportunities were identified to perform root cause analysis to enhance the effectiveness of the Provider notification. There were 9,062 ED visits with no Provider notification since 01/01/2024 which require further analysis on how IEHP can enhance processes to capture and notify Providers of these ED visits. 7. **Challenges**: a. RightFax system functionality limitations did not capture if notifications were retrieved by the Providers. The RightFax system only confirmed that the fax was delivered successfully. b. From 5/22/2024 to 06/12/2024, the RightFax system was upgraded which resulted in an unforeseen pause of faxed being sent to Providers and no reporting was generated. c. Standard work was not establish at the start of the intervention, so expectations were unclear from the Provider Relations Manager Team regarding the Provider notification timeframe. d. There was no formal tracking for successful Provider notification by the Provider notification by the Provider Relations Managers in place at time of intervention launch. e. It was difficult to identify the correct Provider using the original fax template, especially when there were multiple Providers at one site, which delayed Provider outreach. 8. **Resolutions**:

	a. QI is in the process of implementing Phase #2, an enhancement in the Provider Portal to provide daily and continuous ED rosters with notification alert that the Provider accessed the information. b. The IT Department was notified of the RightFax failure and corrected the issue within three weeks. The RightFax system has not had any issues as to date and the Provider notifications has resumed. c. The QI Team established specific responsibilities for the PRM Team. The PRM Team notifies the Providers of their Patients ED visit with SUD/SMH diagnoses, request a follow-up appointment within 7 days, and obtains an updated fax number. d. The QI Team is collaborating with the IT department to develop a Provider Portal roster to allow for timely notifications of patient ED visits. e. The QPI Team was able to modify the original fax template to specify the Provider and correct office location. The updated template began use on 6/13/2024 upon the notification resuming from the RightFax upgrade issue. 9. **Successes**: Providers receive timely notifications of their Patients' ED visits, allowing them to follow-up within 7 days of the discharge, and ensure continuous care. The updated Provider contact information ensures that future communications will be delivered accurately and with less delays. Additionally, there was increased communication and collaboration between QI and PRM teams.

5.2.4 Continuity and Coordination of Care Studies

Continuity and coordination of care are key determinants for overall health outcomes. Comprehensive coordination of care improves Member safety, avoids duplicate

assessments, procedures or testing, and results in better treatment outcomes. IEHP evaluates continuity and coordination of care on an annual basis through multiple studies. The purpose of these studies is to assess the effectiveness of the exchange of information between:

1. Medical care Providers working in different care settings; and
2. Medical and behavioral healthcare Providers.

The results of these studies are presented and discussed by the PHM Subcommittee and QMHETC. Based on these findings, the committee Members recommend opportunities for improvement that are implemented by the responsible department.

5.2.5 Improving Quality for Members with Complex Needs

IEHP has multiple programs, at no cost to the Member, that focus on improving quality of care and services provided to Members with complex medical needs (i.e., chronic conditions, severe mental illness, long-term services and support) and Seniors and Persons with Disabilities (SPD), including physical and developmental, as well as quality of behavioral health services focused on recovery, resiliency, and rehabilitation. These programs include, but are not limited to, the following:

Complex Care Management (CCM) Program

The CCM program was established for Members with chronic and/or complex conditions. The goal of the CCM program is to optimize Member wellness, improve clinical outcomes, and promote self-management and appropriate resource management across the care continuum, through efficient care coordination, education, referrals to health care resource, and advocacy. IEHP assesses the performance of the CCM program annually using established measures and quantifiable standards. These reports are presented to the PHM Subcommittee and QMHETC for discussion and input. Based on the committee recommendations, the Care Management Department collaborates with other Departments within the organization to implement improvement activities.

Transition of Care (TOC) Program

IEHP has developed a system to coordinate the delivery of care across all healthcare settings, Providers, and services to ensure all hospitalized Members are evaluated for discharge needs to provide continuity and coordination of care. Multiple studies have shown that the poor transition between care settings have resulted an increase in mortality and morbidity. Transitioning care without assistance for Members with complex needs (e.g., SPD Members that very often have three (3) or more chronic conditions) can be complicated by several other health and social risk factors. IEHP's TOC program has been designed to provide solutions to these challenges. Through the TOC program, IEHP makes concerted efforts to coordinate care when Members move from one setting to another. This coordination ensures quality of care and minimizes risk to Member safety. IEHP also works with the Member or their caregiver to ensure they have the necessary medications/supplies to prevent readmissions or complications. The goals of the TOC program include the following:

1. Avoiding of hospital readmissions post discharge
2. Improvements in health outcomes post discharge from inpatient facilities; and
3. Improving Member and caregiver experience with care received.

Facility Site Review (FSR)/Medical Record Review (MRR) and Physical Accessibility Review Survey (PARS)

IEHP requires all Primary Care Physician (PCP) sites to undergo an initial Facility Site Review (FSR) and Medical Record Review (MRR) Survey performed by a Certified Site Reviewer (CSR) prior to the PCP site participating in the IEHP network. The purpose of the FSR/MRR is to ensure a PCP site's capacity to support the safe and effective provision of primary care services.

In addition to the FSR/MRR, IEHP also conducts a Physical Accessibility Review Surveys (PARS) prior to the PCP site participating in the IEHP network. The purpose of the PARS is to assess the physical accessibility, physical appearance, safety, adequacy of room space, availability of appointments, and adequacy of record keeping, and any other issue that

could impede quality of care. PARS also ensures Provider sites that are seeing Members with disabilities do not have any physical access limitations as when visiting a Provider site.

The FSR/MRR and PARS are conducted every three (3) years. Sites will be monitored every six (6) months until all deficiencies are resolved. The Quality Management Department is responsible for oversight of PARS and FSR/MRR activities. In partnership with IEHP key stakeholders, the QM Department is also responsible for providing training should physical access issues or deficiencies be identified. The QMHETC reviews an annual assessment of PARS activities to ensure compliance.

5.2.6 Other Clinical Measures and Studies

Initial Health Assessment Monitoring

IEHP also monitors the rate of Initial Health Assessments (IHA) performed on new Members. The timeliness criteria for an IHA is within one hundred twenty 120 calendar days of enrollment for Members. This rate is presented to QI Council for review and analysis. IEHP has a number of Member and Provider outreach programs to improve the IHA rate.

Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines

To make health care safer, higher quality, more accessible, equitable and affordable, IEHP has adopted evidence-based clinical practice guidelines for prevention and chronic condition management. In addition, IEHP considers recommendations for Adult and Pediatric Preventive Services per DHCS contractual requirements which include criteria for the following:

1. FSR/MRR Documentation;
2. Select United States Preventive Services Task Force (USPSTF) recommendations;
3. The American College of Obstetricians and Gynecologists (ACOG);
4. American Diabetes Association (ADA);

5. Bright Futures from American Academy of Pediatrics (AAP); and
6. IEHP/Advisory Committee on Immunization Practices (ACIP) Immunizations Schedule.

Over-Utilization and Under-Utilization

1. IEHP monitors over-utilization and under-utilization of services at least annually. The QM and UM departments work collaboratively to capture utilization trends or patterns. The results are compared with nationally recognized thresholds. Under-utilization of services can result due to a number of reasons that include but are not limited to the following:
    a. Access to health care services based on geographic regions;
    b. Demographic factors also impact over-utilization and under-utilization of services/care:
        i. Race, ethnicity, and language preference (RELP);
        ii. Knowledge and perceptions regarding health care which are largely driven by cultural beliefs; and
        iii. Income and socioeconomic status.
2. IEHP also reviews trends of ER utilization, pain medications prescriptions, and potential areas of over-utilization on an annual basis. The purpose of the analysis is to:
    a. Identify the dominant utilization patterns within the population.
    b. Identify groups of high and low utilizers and understand their general characteristics.

Section 6: Member and Provider Experience

6.1 CAHPS® Survey Report

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.1H Survey is a standardized Member experience assessment. The CAHPS® Health Plan Survey is a tool for collecting information on enrollees' experiences with health plans and their services. It supports

consumers in assessing the performance of health plans and health plans can also use the survey results to identify their strengths and weaknesses and target areas for improvement. The CAHPS® survey is a vital tool for IEHP to assess Member-centered results of the care delivered, identify areas for improvement, and develop improvement initiatives. The survey asks Members to report on the aspects of their experiences around healthcare domains such as access to care, how well their doctors communicate, customer service, and coordination of care.

The goal of the Medicaid CAHPS Survey is to meet the NCQA 90th percentile national benchmarks. Measure goals and benchmarks presented in this study are obtained from the 2024 NCQA Health Plan Ratings published in August 2024 for Health Plan Rating (HPR) measures and from 2023 NCQA Quality Compass National Benchmarks published in September 2023 for non-Health Plan Rating measures.

Press Ganey conducted the Member experience survey from February 2024 through May 2024. For the CAHPS® Adult section of this report, a random sample of 1,836 cases was drawn from IEHP Members 18 years of age or older as of December 31, 2023, who were continuously enrolled with IEHP for the last six months as of December 31, 2023. Out of the 1,836 cases, 21 were ineligible and removed from the denominator. A total of 205 completed surveys were valid with 130 completed by mail, 45 completed by phone, and 30 completed by internet for a total response rate of 11.3%.

For the CAHPS® Child section of this report, a random sample of 2,244 cases were drawn from IEHP Members 17 years of age or younger as of December 31, 2023, who were continuously enrolled with IEHP for the at least five of the last six months of 2023. Out of the 2,244 cases, 15 were ineligible and removed from the denominator. A total of 176 completed surveys were valid with 49 completed by mail, 83 completed by phone, and 44 completed by internet. This yielded a response rate of 7.9%.

Press Ganey, an NCQA Certified Survey Vendor, was selected by Inland Empire Health Plan to conduct its MY 2023 Medicaid CAHPS® Survey. A comprehensive report of results and analyses was submitted to IEHP.

The survey was collected using a mixed methodology approach (mail, telephone, and internet). The telephone surveys were conducted with Members who did not respond to the mail or internet survey. The mail, telephone, and internet surveys were available in both English and Spanish. Comprehensive quantitative analysis of the survey responses was compiled by Press Ganey and presented to IEHP in a final report.

The Adult and Child Medicaid Members were surveyed separately; therefore, results in this report are presented separately for Adult and Child populations. In addition, an analysis of race/ethnicity and Member experience by IPA is also included.

This study includes the measurement years 2021 to 2023 scores for IEHP for composites measures, overall ratings, and the single-item measures when available. Summary rates for all areas are taken from the Press Ganey final report. Measures with less than 100 responses are not reported to NCQA. Changes from MY 2022 to MY 2023 were assessed using a z-test of proportions. A p-value of <0.05 is set as the standard of statistical significance.

The results of these analyses are presented to IEHP's Member Experience Subcommittee annually for review, comment, and approval.

NCQA Reported Health Plan Ratings Results

The following results were reported to NCQA for IEHP's Health Plan Ratings:

CAHPS Question	MY 2021	MY 2022	MY 2023
Overall Ratings			
Rating of Specialist	N/A	N/A	70.0%
Rating of Health Plan	66.67%	67.04%	71.4%
Rating of Health Care	57.04%	55.14%	60.6%
Rating of Personal Doctor	60.71%	63.28%	69.5%
Composite Summary			
Customer Service	N/A	N/A	92.3%
Getting Needed Care	78.29%	N/A	81.7%
Getting Care Quickly	N/A	N/A	75.2%
Coordination of Care (measure)	N/A	N/A	N/A

HEDIS Measures			
Advised to Quit Smoking	N/A	N/A	N/A

N/A: Question did not meet the minimum required response needed (n≥100) to calculate a rate.

Adult Survey Results

The survey used a 0 – 10 rating for assessing overall experience with *Health Plans, Providers, Specialists*, and *Health Care*. The following overall ratings, reflective of Member ratings of 9 or 10, are reported as achievement scores. In addition, NCQA determines the CAHPS® portion of the score by comparing the plan's results to a national benchmark and to national thresholds.

Table 1: Overall Ratings – Adult

Rating Question	MY 2021 Percentile	MY 2022 Percentile	MY 2023 Percentile	MY 2023 Health Plan Rating
Rating of Personal Doctor	10th	<10th	33.33rd	**3**
Rating of Specialist	N/A (Sample Size <100)		50th	**N/A** (Not a HPR measure)
Rating of Health Care	33.33rd	33.33rd	66.67th	**4**
Rating of Health Plan	66.67th	66.67th	90th	**5**

For composite performance categories, each composite consists of performance-related questions. Achievement is defined as responses of "Usually" or "Always" to the question. Note that the *Coordination of Care (other measure)* is a single question and not a composite. IEHP's percentiles are noted in Table 2 below.

Table 2: Composite Results – Adult

Composite	MY 2021 Percentile	MY 2022 Percentile	MY 2023 Percentile	MY 2023 Health Plan Rating
Getting Needed Care	10th	**N/A** (Sample Size <100)	33rd	**3**
Getting Care Quickly	N/A	**N/A**	10th	**2**

		(Sample Size <100)		
Other Measure-Coordination of Care	N/A	25th	N/A (Sample Size <100)	**N/A** (Not a HPR measure)
Customer Service	25th	90th	66.67th	
How Well Doctors Communicate	<10th	25th	<10th	

Child Survey Results

Table 3: Overall Ratings – Child

Rating Question	MY 2021 Percentile	MY 2022 Percentile	MY 2023 Percentile	MY 2023 Health Plan Rating
Rating of Personal Doctor	10th	<10th	**<10th**	**1**
Rating of Specialist	90th	50th	**N/A** (Sample Size <100)	**N/A** (Not an HPR measure)
Rating of Health Care	<10th	10th	**<10th**	**1**
Rating of Health Plan	66.67th	66.67th	**90th**	**5**

For composite performance categories, each composite consists of performance-related questions. Achievement is defined as responses of "Usually" or "Always" to the question. Graph 8 displays the rates for the composite measures from MY 2021 through MY 2023. All child composite measures increased in performance in MY 2023 as compared to MY 2022, except for *Getting Care Quickly* and *Coordination of Care*; these composite rates were not reported due to the sample size being less than 100. *How Well Doctors Communicate* is the only composite category with a sample size over 100, but it is not a health plan rating measure and, therefore, also not reported. The graphs below reflect "best available" data to provide results and trending information to the health plan, regardless of sample size restrictions. A z-test of proportions revealed that the rate change in *Customer Service* and *Getting Needed Care* are statistically significant ($p<0.05$) in comparison to

MY 2021; the difference in rates for all other composite measures are not statistically significant ($p>0.05$).

Table 4: Composite Results – Child

Composite	MY 2021 Percentile	MY 2022 Percentile	MY 2023 Percentile	MY 2023 Health Plan Rating
Getting Needed Care	10th	**N/A** (Sample Size <100)	**N/A** (Sample Size <100)	**N/A** (Sample Size <100)
Getting Care Quickly	<10th			
Coordination of Care	<10th	75th		**N/A** (Not an HPR measure)
Customer Service	25th	90th		
How Well Doctors Communicate	<10th	<10th	<10th	

IPA Results

IPA results for Overall Ratings are displayed in the table below in descending order by "IPA Average Rate". The highest overall ratings (above 80%) are bolded. Lasalle Medical Associates has the highest rates across all Overall Ratings.

Table 5: IPA Results

IPA Name	Rating of Health Care	Rating of Personal Doctor	Rating of Specialist	Rating of Health Plan	*IPA Average Rate*
LaSalle Medical Associates	**87.5%**	77.8%	**100%**	**100%**	***84.40%***
IEHP Direct	58.2%	70.4%	68.6%	69.9%	*68.00%*
IFMG	66.7%	75.0%	68.8%	73.9%	*65.20%*
Other Medical Group	56.3%	52.9%	68.4%	70.4%	*43.00%*

The IPA results for the Composites are displayed in the table below in descending order by "IPA Average Rate". The rates above 80% are bolded. When compared to the other IPAs, LaSalle Medical Associates was among the highest rating IPAs for each Composite, followed by Other Medical Groups and IFMG. All Composites display an average summary rate above 85% across all IPAs except *Getting Care Quickly* (71.73%). The *Customer Service* and *How Well Doctors Communicate* Composites averaged above 90% across all IPAs.

Table 6: Composite Results – IPA

IPA Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Coordination of Care (measure)	*IPA Average Rate*
LaSalle Medical Associates	**100%**	73.2%	**93.8%**	**100%**	75.0%	***88.40%***
Other Medical Group	73.3%	66.7%	**94.2%**	**95.0%**	**100%**	***85.84%***
IFMG	**90.4%**	70.0%	**90.0%**	**85.7%**	**90.0%**	***85.22%***
IEHP Direct	**80.1%**	77.0%	**89.6%**	**92.5%**	79.6%	***83.76%***

Study Period Past Interventions

The following are interventions implemented during the study period which may have contributed to the study measure results:

INTERVENTION	ACTIVITY	COMPLETED?	OUTCOME	STATUS
PREDICTIVE MODELING	• By October 2024, design a predictive modeling system framework to identify focus populations for CAHPS-related improvement initiatives. Design	**YES**	Predictive Modeling tool was drafted by the Data Science team. Insights of Member Attributes were shared among Leadership. Findings are being used to draft Root Cause Analysis and future interventions.	**Completed; Date: 10/23/2023**

INTERVENTION	ACTIVITY	COMPLETED?	OUTCOME	STATUS
	a predictive modeling system framework to identify focus populations for CAHPS-related improvement initiatives.			
APPOINTMENT SCHEUDLING ASSISTANCE	• By October 2024, Members will be provided assistance with appointment scheduling during outreach call campaigns, as needed.	**YES**	Member appointment scheduling assistance has been integrated as a standard process to those who accept for all Member outreach campaigns.	**Adopt as Standard Work**
TRANSPOR-TATION SERVICES OFFERED	• By October 2024, eligible Members will be offered the transportation benefit during outreach call campaigns, as appropriate.	**YES**	Offering of transportation services to those in need have been integrated as a standard process for all Member outreach campaigns.	**Adopt as Standard Work**
CAHPS STRATEGY WORKGROUP	• Identify at least one immediate action initiative to positively impact Member experience by February 2024. • Identify at least one long term action initiative for implementation by December 2024 that will positively impact the workgroup areas of focus	**YES**	The Call Center Consistency Committee implemented several "just do it's" to the standard work of organizational call centers relating to Rating of Personal Doctor, Getting Care Quickly and Getting Needed Care. Examples include, but are not limited to: Educating Members on the "PCP Change" process – *where to go, what to do, who can help if needed,* Increasing the Digital Access Rate (DAR) by increasing Member Portal registration through	**Adopt as Standard Work**

INTERVENTION	ACTIVITY	COMPLETED?	OUTCOME	STATUS
			education of services that can be accessed "now", Assistance in appointment scheduling and locating doctor assignment (helpful to those auto-assigned), and Developing "hold" messaging to include information on where to get care (PCP, NAL, MD Live, Urgent Care, ED, etc.) and how they can find it.	

Causal/Barrier Analysis

The following barriers were identified:

STUDY MEASURE NOT MET	CAUSAL/BARRIER ANALYSIS	OPPORTUNITY
Getting Needed Care	• Limited Provider capacity within the IEHP network. • Scheduling timely appointments with Providers can be challenging.	• Expand access to care via home and alternate locations. • Assist in the scheduling of Member appointments.
Getting Care Quickly	• Limited Provider capacity within the IEHP network. • Members may not be familiar with the various urgent service access points available to them. • Telemedicine is hard to access and not visible to Members. Many Members are unaware this service is available to them. • Compliance rates for PCP appointment standards have decreased in recent years.	• Expand access to care via home and alternate locations. • Simplify access to telemedicine. • Improve PCP appointment availability for urgent and non-urgent appointments
Rating of Personal Doctor	• Provider offices often experience high staff turnover which can result in office staff who may not be familiar with best practices for communicating with patients	• Improve the Member-Provider relationship through soft skills coaching and education of best practices to improve the Member Experience.
Rating of Health Plan	• Some Member grievances are directly related to the health plan and the services our internal departments provide.	• Improve Member experience with the health plan by reducing common grievances.
Coordination of Care Measure	• Care is often fragmented or siloed. • Providers within the network have been slow to transition to electronic systems which provide a greater visibility of the Members	

	overall care with specialists, primary care, and other ancillary services.

Planned Future Interventions

The following are interventions impacting study Quality Measures that are planned for the following study period:

STUDY INTERVENTION #1			
INTERVENTION NAME		**INTERVENTION DESCRIPTION**	
Mobile Units and Other Sites of Care		Contracting with mobile agencies to improve Member Access to Care.	
STUDY MEASURE(S) IMPACTED		**OPPORTUNITY**	
Access: Getting Needed Care & Getting Care Quickly		Expand access to care via home and alternate locations.	
RESPONSIBLE DEPARTMENT	**START DATE**	**DUE DATE**	**STATUS**
Provider Experience	**April 2024**	**October 2025**	**New; Start Date: April 2024**
SMART GOAL(S)			
• **By October 2025,** IEHP will contract with six (6) mobile agencies who can deliver Member care in-home or in an assigned location, making access to care easier for the Member.			

STUDY INTERVENTION #2			
INTERVENTION NAME		**INTERVENTION DESCRIPTION**	
Access to Telemedicine		Improve **Member** access to telemedicine by making it visible and easier to access while increasing the number of access points.	
STUDY MEASURE(S) IMPACTED		**OPPORTUNITY**	
Getting Care Quickly		**Simplify access to telemedicine**.	
RESPONSIBLE DEPARTMENT	**START DATE**	**DUE DATE**	**STATUS**
Innovation	**April 2024**	**October 2025**	**New; Start Date: April 2024**
SMART GOAL(S)			
• **By October 2025**, IEHP will improve its telemedicine access points, making access to urgent services easier for the Member.			

STUDY INTERVENTION #3			
INTERVENTION NAME		**INTERVENTION DESCRIPTION**	
Low Performing Providers Project		In partnership with the Provider Relations team, IEHP's Regional Quality team will target the bottom ten (10) performing Providers in area of Rating of Personal Doctor, coaching office staff on best practices to improve the Member experience.	
STUDY MEASURE(S) IMPACTED		**OPPORTUNITY**	
Rating of Personal Doctor		**Improve the Member-Provider relationship through soft skills coaching and education of best practices to improve the Member Experience.**	
RESPONSIBLE DEPARTMENT	**START DATE**	**DUE DATE**	**STATUS**
Quality Improvement	**August 2024**	**July 2025**	**New; Start Date: August 2024**
SMART GOAL(S)			
• By July 2025, the ten (10) Provider offices identified will no longer appear as a bottom performer for the Rating of Personal Doctor Measure. • By October 2025, a minimum of 20 Provider offices will have engaged in the Low Performing Providers Project.			

STUDY INTERVENTION #4			
INTERVENTION NAME		**INTERVENTION DESCRIPTION**	
Shared Vision Partnership (SVP) Expansion		Expand Shared Vision Partnership to include Arrowhead Regional Medical Center (ARMC), allowing the IEHP Member Service team to schedule preventive care appointments for ARMC Members in need.	
STUDY MEASURE(S) IMPACTED		**OPPORTUNITY**	
Getting Needed Care		Assist in the scheduling of Member appointments.	
RESPONSIBLE DEPARTMENT	**START DATE**	**DUE DATE**	**STATUS**
Member Services	**August 2024**	**October 2025**	**New; Start Date: August 2024**
SMART GOAL(S)			
• By October 2025, IEHP will partner with ARMC, allowing IEHP Member Service Team Members to schedule Provider appointments for IEHP-ARMC Members in need.			

STUDY INTERVENTION #5			
INTERVENTION NAME		**INTERVENTION DESCRIPTION**	
Problem Solvers Task Force (PSTF) – Appointment Availability		Assemble a workgroup of subject matter experts (SMEs) to identify challenges tied to PCP access and appointment availability, implementing solutions to improve the overall performance rate.	
STUDY MEASURE(S) IMPACTED		**OPPORTUNITY**	
Getting Care Quickly		Improve PCP appointment availability for urgent and non-urgent appointments	
RESPONSIBLE DEPARTMENT	**START DATE**	**DUE DATE**	**STATUS**
Provider Experience & Quality	**July 2024**	**October 2025**	**New; Start Date: July 2024**
SMART GOAL(S)			
• By October 2025, IEHP will have implemented solutions from the PSTF – Appointment Availability SME team, improving PCP access times and appointment availability for our Members.			

STUDY INTERVENTION #6			
INTERVENTION NAME		**INTERVENTION DESCRIPTION**	
Actionable Grievances – "Great Force (GRTF)" Expansion		Tracking and trending of internal grievances to influence organizational change through established partnerships and collaboration with Plan departments resulting in an improved Member experience and reduced Member grievances.	
STUDY MEASURE(S) IMPACTED		**OPPORTUNITY**	
Rating of Health Plan		Improve Member experience with the health plan by reducing common grievances.	
RESPONSIBLE DEPARTMENT	**START DATE**	**DUE DATE**	**STATUS**
Grievance & Appeals	**September 2024**	**October 2025**	**New; Start Date: September 2024**
SMART GOAL(S)			
• By October 2025, IEHP will have an 8% reduction of all Member grievances.			

STUDY INTERVENTION #7			
INTERVENTION NAME		**INTERVENTION DESCRIPTION**	
CAHPS Strategy Workgroup ***(Member Experience Strategy – 5.4)***		**Organizational strategy to improve CAHPS measure performance in the areas of *Getting Needed Care, Getting Care Quickly, Rating of Personal Doctor, Care Coordination, and Rating of Health Plan.***	
STUDY MEASURE(S) IMPACTED		**OPPORTUNITY**	
Getting Needed Care, Getting Care Quickly, Rating of Personal Doctor, Care Coordination, and Rating of Health Plan		**Organizational CAHPS improvement strategy.**	
RESPONSIBLE DEPARTMENT	**START DATE**	**DUE DATE**	**STATUS**
Member Experience	**May 2024**	**October 2025**	**New; Start Date: May 2024**
SMART GOAL(S)			
• **By 12/31/2024, at least one (1) immediate action will be implemented to positively impact the Member experience.** • **By October 2025, at least three (3) initiatives will be implemented to positively impact the Member experience.**			

Overall, the results for the CAHPS® 2024 (MY 2023) survey for the Adult population reveal stable performance. There was a statistically significant increase in health plan rating of Rating of Health Plan to 5. Rating of Health Care increased from a health plan rating of 3 to 4 while Rating of Personal Doctor increased from a health plan rating of 2 to 3. The Getting Needed Care (Rating of 3) and Getting Care Quickly (Rating of 2) measures met sample size requirements for MY2023 and were reported for Health Plan Ratings.

The Child Survey results reveal that the MY 2023 percentiles had mixed results compared to MY 2022. Rating of Health Plan increased from a health plan rating of 4 to 5. Rating of Personal Doctor and Rating of Health Care both remain at a health plan rating of 1. Rating of Specialist did not meet sample size requirements and a health plan rating was not reported because this is not a health plan rating measure. How Well Doctors Communicate has remained at the <10th percentile for the past 3 years. Getting Needed Care, Getting Care Quickly, Coordination of Care and Customer Service composites did not meet sample size requirements in MY 2023.

Analyses of both Adult and Child survey results reveal opportunities for improvement in many of the measures. Rating of Personal Doctor and Rating of Health Care have been at the <10th

percentile for the child population for the past 3 years. Getting Care Quickly adult measure met sample size requirements for the first time in 3 years but rated at the 10th percentile for MY 2023. An assessment of the IPA scores revealed LaSalle Medical Group is the highest performing IPA.

Section 7: Population Health Management (PHM)

7.1 PHM Population Assessment Study

Annually, IEHP assesses the characteristics of the membership to identify Member needs and to review and update its Population Health Management (PHM) structure, strategy, and resources. IEHP assesses areas such as social determinants of health, identification of subpopulations, needs of children/adolescents and individuals with disabilities and with serious and persistent mental illness (SPMI). Furthermore, health disparities among different populations are identified. The needs of Members of different ethnic groups and of those with limited English proficiency (LEP) are also included in this analysis.

Data was extracted from IEHP's claims and encounters systems, IEHP's Medical Management System (MedHOK), HEDIS® data and ACG data. All Members who were currently active at the time of the study (January 2024) were included in this analysis. The following individuals participated in this analysis: Vice President of Quality, Sr Director of Quality, Senior Director of Population Health, Healthcare Informatics Director, Clinical Informatics Manager. The results of these analyses are presented to IEHP's Population Health Management Subcommittee annually for review, comment, and approval.

1. Assesses the characteristics and needs, including social determinants of health, of its member population using the following analysis:
    a. Seniors and Persons with Disabilities (SPD) breakdown by line of business
    b. Ethnicity
    c. Language

d. Age

e. Homeless

f. Transportation Needs

g. Top Diagnosis

    i. Overall Chronic conditions

    ii. Social Determinants of Health Top Diagnoses (All Plan Letter 21-009 'Collecting SDOH Data')

h. HEDIS Disparities

    i. Disparity analysis for Members using key quality of care measures in Disease Management, Behavioral Health, and Women's Health. (using HEDIS measures) Disparity analysis includes age, gender, ethnicity, language, homelessness indicator and region for measurement year 2022.

2. Identifies and assesses the needs of relevant member subpopulations using the following analysis:

    a. Frail and Elderly

    b. Chronic Condition Count (ACG)

    c. Direct vs. Delegated Membership Distribution

    d. IPA Membership

    e. Risk Categorization (High Risk, Rising Risk, Low Risk)

3. Assesses the needs of child and adolescent members using the following analysis:

    a. Children with Special Needs

    b. Age ranges of children enrolled in the BHT Program

c. Childhood Depression Stats

d. Top Diagnoses – Child/Adolescents (ages 2 – 19)

4. Assesses the needs of members with disabilities and serious and persistent mental illness (SPMI):

    a. Top Diagnoses – SPD

    b. Top BH Diagnoses

    c. Top BH Medication Filled by County

5. Assesses the needs of members of racial and ethnic groups:

    a. Disparity analysis for Members using key quality of care measures in Disease Management, Behavioral Health, and Women's Health (using HEDIS® measures).

    b. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Medicaid Disparity analysis for Members of different ethnicities (White, Black, Hispanic, Asian, Native Hawaiian, American Indian) was assessed using the following key measures: Overall Rating of Health Plan, Overall Rating of Health Care, Getting Needed Care, Getting Care Quickly, Rating of Personal Doctor, Rating of Specialist, Customer Service, How Well Doctors Communicate, and Coordination of Care. The annual survey results are conducted by a third-party vendor.

    c. The Medicare CAHPS® annual survey was not fielded for MY 2022 due to the sunsetting of IEHP's CalMediConnect product on 12/31/2022. As of 1/1/2023, IEHP launched Medicare benefit coverage under the Duals Special Needs Plan (D-SNP) contract. The next Medicare CAHPS® survey will be fielded in 2024 to assess MY 2023 performance. The study will be presented at the Member Experience Subcommittee in 2024.

6. Assesses the needs of Members with limited English proficiency (LEP):

a. Hanna Interpreting Service, a third-party vendor is utilized by IEHP Members when requesting face to face interpreters during the Member's medical appointments.
b. Pacific Interpreters, a third-party vendor, submitted data to IEHP for calendar year 2023.
c. Disparity Analysis by language (including Spanish, Vietnamese, Mandarin, and Cantonese) for Members using key quality of care measures in Disease Management, Behavioral Health, and Women's Health.
d. CAHPS® Member experience survey results are assessed by Primary member language, English and Spanish. Key measures assessed include: Overall Rating of Health Plan, Overall Rating of Health Care, Getting Needed Care, Getting Care Quickly, Rating of Personal Doctor, Rating of Specialist, Customer Service, How Well Doctors Communicate, and Coordination of Care. The annual survey results are conducted by a third-party vendor.

Member Population

Table 1 reports Members with an SPD Aid code. These SPD Members require a higher level of care management as they are identified as high-risk and compose of 4.5% of IEHP's total Member population.

Table 1: SPD Breakdown – By Line of Business

Category*	SPD	Non-SPD	All
D-SNP	0	36,604	36,604
MMD	0	124,284	124,284
D-SNP and MMD	0	0	0
Non-DSNP/Non-MMD	82,096	1,586,572	1,668,668
Total	**82,096**	**1,747,460**	**1,829,556**

The majority (56.1%) of the IEHP membership identifies as being Hispanic. Caucasians make up the second highest proportion of the Member population at 16.7%.

Not reported ethnicity makes up 12.4% of the population and 8.5% of the population identified as Black. Asian or Pacific Islanders make up 4.6%, Other Race or Ethnicity 1.5%. Lastly, American Indian or Alaskan Native make up 0.2% of the IEHP Member population.

Table 2: Ethnicity Breakdown

Ethnicity	Member Count	% of Membership
Hispanic	1,026,011	56.1%
Caucasian	305,156	16.7%
Not Reported	226,095	12.4%
Black	156,287	8.5%
Asian or Pacific Islander	83,601	4.6%
Other Race or Ethnicity	28,302	1.5%
American Indian or Alaskan Native	4,104	0.2%
Total Membership	**1,829,556**	**100.0%**

Table 3 displays the language breakdown for the IEHP Membership. Only the top languages are displayed. The data consists of active Members who reported speaking the language (as primary or secondary). The majority of the population reported English and Spanish as their preferred language.

Table 3: Top Spoken Languages

Language	Member Count	% of Membership
English	1,441,686	78.8%
Spanish	373,126	20.4%
Vietnamese	5,275	0.29%
Chinese (Chinese, Mandarin, Yue)	9,264	0.51%
Other	125	0.007%
Arabic	62	0.003%
Korean	18	0.001%
Total	1,829,556	100%

A large proportion of IEHP's Membership are children between the ages of 2-12 (22.4%). Those aged 13-19 and 20-29 make up 15% and 17% of the Membership in each group. Members aged

30-39 make up 13% of the population, 40-49 years old 8.5%, 50-59 years old 8.7%, 60-69 years old 7.5%, and those over 69, 4.5% of the Member population.

Table 4: Age Breakdown

Age Range	Count	% of Membership
Children: <2	51,093	2.8%
Children: 2-12	410,634	22.4%
Adolescence: 13-19	277,058	15.1%
20-29	312,633	17.1%
30-39	244,930	13.4%
40-49	155,406	8.5%
50-59	158,285	8.7%
60-69	136,755	7.5%
Over 69	82,762	4.5%
Total	**1,829,556**	**100.0%**

The results in Table 5 show that 6.7% of the population (122,398 Members) were identified as being potentially homeless. For all members, the most recent claims or encounters by date of service within the past 4 months were used. The Member was identified as homeless if:

1. The claim had a homeless diagnosis code (e.g., Dx Codes: Z59.0, Z59.1, Z59.2, Z59.3, Z59.4, Z59.5, Z59.6, Z59.7 Z59.8, Z58.9). The list of codes is maintained by the Healthcare Analytics team.

2. The member has an address matching a Homeless Address.

3. The member has a street address containing a Homeless Keyword (e.g. Homeless, no address).

Table 5: Potentially Homeless Counts

Category	Homeless	Non- Homeless	Total	% of Members
D-SNP	434	36,170	36,604	2.0%
MMD	3,975	120,309	124,284	6.8%

Non-DSNP/Non-MMD	117,989	1,550,679	1,668,668	91.2%
Total	122,398	1,707,158	1,829,556	**100%**

Table 6 below reveals that 42,300 unique Members accessed IEHP's transportation benefit during Jan-Dec 2023. Transportation modes are defined as non-emergency medical transportation (NEMT), non-medical transportation (NMT) and/or bus. Members are able to call into the IEHP Member Services department to connect with the Transportation team and schedule transportation services when needed.

Table 6: Transportation Needs

LOB	Member Count
D-SNP	5,877
Medi-Cal	36,423
Medi-Cal - SPD (1)	8,015
Medi-Cal - MMD (2)	7,883
Total	42,300

(1) LOB on Last Eligible Month = Medi-Cal and Member was SPD and not MMD
(2) LOB on Last Eligible Month = Medi-Cal and Member was MMD and not SPD

Table 7 below lists the top diagnosis codes for both lines of business for the general population. Hypertension is the top diagnosis for both line of business. Back pain, hyperlipidemia, vitamin D deficiency, and gastro-esophageal reflux disease are also diagnoses that appear in both lines of business.

Table 7: Top Diagnoses in the General Population – Medi-Cal

	Medi-Cal Member Top 10 Diagnoses	Member Count
1	Essential hypertension	202,037
2	Hyperlipidemia	148,480
3	Obesity	111,159
4	Vitamin D deficiency	110,276
5	Other long term drug therapy	110,105
6	Type 2 diabetes mellitus without complications	103,955
7	Anxiety disorder	87,629
8	Low Back Pain	86,635
9	Gastro-esophageal reflux disease without esophagitis	84,832

10	Chronic Pain	66,111
	D-SNP Member Top 10 Diagnoses	**Member Count**
1	Essential hypertension	24,603
2	Hyperlipidemia	18,278
3	Type 2 diabetes mellitus without complications	13,470
4	Other long term drug therapy	9,612
5	Vitamin D deficiency	8,603
6	Gastro-esophageal reflux disease without esophagitis	8,341
7	Mixed hyperlipidemia	7,904
8	Presbyopia	7,742
9	Type 2 diabetes mellitus with other specified complication	7,584
10	Low Back Pain	7,307

An analysis of the top 20 SDOH was assessed for all IEHP Members. Low income, homelessness, and food insecurity diagnoses codes have the highest member counts.

Table 8: Top 20 SDOH Diagnoses (All Members)

	Diagnosis Name	Member Count
1	Low Income	42,352
2	Homelessness	13,411
3	Food Insecurity	12,109
4	Acculturation	9,231
5	Unemployment	9,072
6	Problems Related to Unwanted Pregnancy	8,178
7	Problem Related to Social Environment	8,042
8	Problem Related to Unspecified Psychosocial Circumstances	7,746
9	Other Stressful Life Events Affecting Family and Household	7,376
10	Other Specified Problems Related to Psychosocial Circumstances	6,554
11	Problems related to housing	5,041
12	Problem Related to Housing and Economic Circumstances	4,139
13	Disappearance And Death of Family Member	2,954
14	Problems Related to Living Alone	2,928
15	Child In Welfare Custody	2,861
16	Underachievement In School	2,767
17	Other Specified Problems Related to Primary Support Group	2,711
18	Disruption Of Family by Separation and Divorce	2,462
19	Problems In Relationship with Spouse Or Partner	2,435
20	Other Problems Related To Education And Literacy	2,150

Member Subpopulations

Table 9 shows that 8.3% of Members have a frailty flag. The frailty flag indicator was taken from IEHP's Johns Hopkins' ACG tool. Members with the frailty flag had an incidence of at least one of the following during 2023: malnutrition, dementia, severe vision impairment, decubitus ulcer, major problems of urine retention or control, loss of weight, absence of fecal control, social support needs, difficulty in walking, or falling (some Members may be listed as frail or not frail at different points throughout the year).

Table 9: Frail and Elderly

Frailty Flag	Member Count	Percent
No	1,677,771	91.7%
Yes	150,910	**8.3%**
Total	**1,828,681**	100%

The Johns Hopkins' ACG Tool was used to run the total Medi-Cal and D-SNP population data and are indicated in accordance with chronic condition counts. The counts include all active Members with ACG data for profile date 12/01/2023.

1. A chronic condition is defined as disease which are: 1) likely to last longer than 12 months with or without medical treatment, and (2) likely to have a negative impact on health or functional status.

2. Expanded Diagnosis Clusters (EDCs) are used to identify chronic conditions within the ACG System.

3. 3.7% of the overall population was identified as being within the Complex category and having 10+ Chronic Condition Counts (depicted in table 10 below). The Extended Chronic Condition category measured at 4.1%.

4. Most of the Member population (82.7%) has a chronic condition count of 0 or 1-3 for "Low" and "Basic" respectively.

Table 10: Chronic Condition Count

Chronic Condition Category	Number of Chronic Conditions	Number of Members	Percent of Members
Low	0	840,064	51.8%
Basic	1-3	501,051	30.9%
Intermediate	4-6	152,964	9.4%
Extended	7-9	66,607	4.1%
Complex	10+	60,480	3.7%
Total		1,621,166	100.0%

Table 11 shows that 44.5% of the IEHP Membership is assigned to a delegated Independent Physician Association (IPA). Many Members' Care Management Services and Care Coordination services are delegated to an IPA and IEHP has developed Delegation Oversight (DO) processes to ensure that regulatory requirements and IEHP Guidelines/Standards are met. The IEHP DO staff monitors and supports various delegated activities through case reviews and delegation oversight audits.

Table 11: Direct Total versus Delegated Total

Line of business	Direct Membership	Delegated Membership
Medi-Cal	877,572	714,354
D-SNP	24,543	9,720
Total	**902,115 (55.5%)**	**724,074 (44.5%)**

Table 12 displays the Membership breakdowns between IPAs for each LOB. For the Medi-Cal and D-SNP LOB, the largest percentage of Membership is currently assigned to IEHP Direct (55.5%), followed by Optum Care-Inland Faculty Medical Group (12.9 %). Only IEHP Direct and Dignity Health Medical Network services both lines of business.

Table 12: Breakdown of IPA Membership

IPA Name	Medi-Cal	D-SNP	Total Members	% of Members
IEHP Direct	877,572	24,543	902,115	55.5%
Optum Care Network - Inland Faculty MG	210,186	0	210,186	12.9%

Kaiser - Fontana & Riverside	158,797	1	158,798	9.8%
IEHP Health Plan	86,480	0	86,480	5.3%
Alpha Care Medical Group	81,224	0	81,224	5.0%
LaSalle Medical Associates	74,879	0	74,879	4.6%
Physicians Health Network	67,896	0	67,896	4.2%
Horizon Valley Medical Group	22,644	0	22,644	1.4%
Dignity Health Medical Network	11,487	452	11,939	0.7%
Heritage Medical	0	2,529	2,529	0.2%
Primecare Medical Network	0	3,692	3,692	0.2%
Epic Health Plan	0	1,839	1,839	0.1%
CPN - Horizon Valley Medical Group	0	543	543	0.0%
Riverside Medical Clinic	0	497	497	0.0%

IEHP's population health risk stratification algorithm uses all available data sources and a variety of risk models to identify Members who are at higher risk of poor health outcomes. The objective of the risk stratification is to segment IEHP members into a system that provides data-driven support for the allocation of population-based disease management resources.

The stratification algorithm utilizes the following sources to stratify Members into low, rising, and high categories: IEHP utilization data, ACG coordination risk scores, ACG diagnosis- based markers social determinant of health tools (i.e. Healthy Places Index, Social Vulnerability Index, Area of Deprivation Index), Supplemental data (i.e. Health Information Form, IHSS, MSSP, IRC, CCS, and BHT)

The current risk categorization for 1,636,559 Members is summarized in the table below. Currently, 10% of the IEHP membership is categorized as High risk utilizing this PHM risk stratification methodology.

Table 13: PHM Risk Stratification of Members

Risk Categorization	Count of Members
High	163,184
Rising	331,659
Low	1,141,716
Total Members	1,636,559

Active membership with a risk categorization as of 11/06/2023

Children and Adolescent Population

The California Children Services (CCS) Program and IEHP's Behavioral Health Treatment (BHT) Program provide services for children with special needs. Table 14 shows that 9,403 Members are enrolled in BHT and 31,354 Members are enrolled in CCS. CCS is a carve-out benefit that provides and pays for diagnostic, treatment, and rehabilitation services to children under the age of 21. A small population (1,268 Members) receive both BHT and CCS. IEHP Plan Based Integrated Care Team works together to coordinate Members care between both BHT and CCS.

Table 14: Children with Special Needs

Program	Total Members
Behavioral Health Treatment (BHT)	9,403
California Children Services (CCS)	31,354
Both	1,268
Total	42,025

Members enrolled in the BHT Program are eligible to receive treatment, functional behavior assessment, speech therapy, occupational therapy, and/or physical therapy. The table 15 below illustrates most children are between the ages of 6 and 12 years old. Furthermore, about 83% of members enrolled in IEHP's BHT Program are children 12 years old and younger.

Table 15: Children Utilizing BHT Services by Age

Age range	Total Members
<5 years	3,993
6-12	4,866
13-17	1,370
18-21	442
Total Members	10,671

Table 16 indicates the total count of children under 21 with a diagnosis of depression and/or suicidal ideation. The "NAL" column is a count of Members who reported depression self- harm when calling the Nurse Advice line (NAL). The NAL dispositions criteria reported 24 child

Members with a disposition of depression and/or suicide. The NAL is available 24/7 and nurses can offer medical advice over the phone or guide Members to get the care they need.

Table 16: Childhood Depression

Line of Business	Total Members	NAL*
Medi-Cal	34,917	33
Medi-Cal SPD	1,767	2
Medi-Cal MMD	13	
Total	**36,697**	**35**

**Using Nurse Advice Line (NAL) dispositions criteria*

Table 17 lists top diagnoses in children ages 2-19. The most common diagnoses for children are disorders of refraction, vasomotor/allergic rhinitis, and overweight/obesity. Asthma and anxiety are also listed in the top 10.

Table 17: Top Diagnoses in Children Aged 2 – 19

	Top Diagnoses list for Members under 19 years	Member Count
1	Disorders of refraction and accommodation	95,927
2	Vasomotor and allergic rhinitis	54,978
3	Overweight and obesity	51,164
4	Asthma	44,562
5	Symptoms and signs involving the circulatory and respiratory system	41,184
6	Unspecified soft tissue disorders	34,570
7	Joint disorder	33,129
8	Specific developmental disorders of speech and language	25,904
9	Anxiety disorders	24,985
10	Functional intestinal disorders	22,182

Members with Disabilities and SPMI

Table 18 displays the top diagnoses for the SPD population. The most common conditions among this population are hypertension, lipidemia and diabetes. Table 18 shows SPD Members who are also covered under Medicare (MMD Members).

Table 18: Top Diagnoses – SPD Members

	SPD Members Top Diagnoses	Member Count
1	Essential hypertension	43,934
2	Disorders of lipoprotein metabolism and other lipidemia	38,891
3	BMI/Overweight/Obesity	34,677
4	Type 2 diabetes mellitus	29,269
5	Long term (current) drug therapy	25,168
6	Unspecified soft tissue disorders	20,504
7	Dorsalgia	19,814
8	Other joint disorder	19,690
9	Gastro-esophageal reflux disease	16,626
10	Chronic kidney disease (CKD)	15,282

IEHP members who meet Title 9 "specialty mental health criteria" receive their Behavioral Health services from the county Mental Health plan and not the Medi-Cal managed care plan. These members meet the criteria for the NCQA "SPMI Population" and since IEHP is not financially responsible for this group of members' care, data is limited and therefore excluded from the Medi-Cal data presented.

For the Medi-Cal members that IEHP does serve, depressive disorder, anxiety, and nicotine dependance accounts for the top 3 diagnoses for both lines of business. This was also the noted trend in 2022. Alcohol related disorders also fall within the top 10 diagnoses. Due to the nature of mental health and substance use, both have a propensity to go hand in hand making secondary diagnoses equally as significant as the primary.

Table 19: Behavioral Health Top Diagnoses by LOB

	BH Top 10 Diagnoses – Medi-Cal Members	Member Count
1	Major depressive disorder	151,009
2	Other anxiety disorders	138,582
3	Nicotine dependence	66,435
4	Severe stress/adjustment disorders	51,046
5	Attention-deficit hyperactivity disorders	30,462
6	Disorders of speech and language	28,098
7	Pervasive developmental disorders	26,411
8	Alcohol related disorders	25,810
9	Cannabis related disorders	23,596
10	Bipolar disorder	22,286

	BH Top 10 Diagnoses – Medicare Members	Member Count
1	Major depressive disorder	12,658
2	Anxiety disorders	7,169
3	Nicotine dependence	5,245
4	Opioid related disorders	2,823
9	Schizophrenia	2,717
5	Bipolar disorder	2,332
6	Alcohol related disorders	2,018
7	Severe stress/adjustment disorders	1,904
8	Unspecified dementia	1,769
10	Sleep Disorders	1,252

Table 20 illustrates the unique Member fills for each medication type in the categories of Anti-Alcoholic Preparations, Psychoactive Drugs, and Opioid Analgesics.

1. The count of fills is based on 87,000 unique IEHP Members. The largest volume of medications are in the Opioid Drug Class.

The proportion of unique Members with a county medication fill is larger for the SPD population (23.8%) than in the Non-SPD population (3.9%).

Table 20: Count of Top Fills of BH Medications

Medication Type	Medi-Cal Non- SPD	SPD	Total
Total Unique Members	67,475	19,525	87,000
○ Anti-Alcoholic Preparations	1,255	97	1,352
○ Psychoactive Drugs	29,568	13,631	43,199
○ Opioid Analgesics	42,410	7,940	50,350
Total Membership	1,747,460	82,096	1,829,556
Proportion of unique Members with a county fill	3.9%	23.8%	

Members of Racial and Ethnic Groups

An assessment of health disparities using HEDIS® measures was assessed using HEDIS® 2020 2021, and 2022 data. Table 21 below describes disparities identified among the Hispanic, White,

Black, American Indian or Alaskan Native, and Asian and Pacific Islander ethnicities. The conditions where disparities were noted were in the Child Preventative measures, Women's Health, Disease Management, Behavioral Health measures, and Cancer Screening measures.

Table 21: Assessment of Needs of Members by Racial or Ethnic Groups – Medi-Cal

Race/Ethnic Group	**HEDIS® 2020-2022 Measure Disparities for Medi-Cal Members** 3-year trends are summarized (i.e. Members with the disparity identified during measurement years 2020, 2021, 2022)
Hispanic	• **Diabetes A1C Control of less <8** was identified as a disparity for the Hispanic group. The compliance rate of 49.64% is lower than the total IEHP population compliance rate of 51.37%. (Lower rate signifies poorer health). • **Diabetes Control of greater than >9** (measurement of poor health) was identified as a disparity for the Hispanic group. The rate of 40.67% is higher than the total IEHP Population rate of 39.59%. (Higher rate signifies poorer health).
White	• **Immunizations for adolescents** was identified as a disparity for the White race/ethnic group. The compliance rate of 23.38% is lower than the total IEHP population compliance rate of 34.41%. • **Breast Cancer screening** was identified as a disparity for the White race/ethnic group. The compliance rate of 47.92%. is lower than the total IEHP population compliance rate of 58.73%. • **Cervical Cancer Screening** was identified as a disparity for the White race/ethnic group. The compliance rate of 47.96% is lower than the total IEHP population compliance rate of 55.18% • **Chlamydia screening** was identified as a disparity for the White race/ethnic group. The compliance rate of 59.35% is lower than the total IEHP population compliance rate of 64.88%. • **Prenatal Care** was identified as a disparity for the White race/ethnic group. The compliance rate of 81.27% is lower than the total IEHP population compliance rate of 82.57%.

	• **Post-Partum Care** was identified as a disparity for the White race/ethnic group. The compliance rate of 71.13% is lower than the total IEHP population rate of 74.21%. • **Well child Visits** was identified as a disparity for the White race/ethnic group. The compliance rate of 38.48% is lower than the total IEHP population compliance rate of 46.78%. • **Colorectal Screening** was identified as a disparity for the White race/ethnic group. The compliance rate of 36.49% is lower than the total IEHP population rate of 40.36% • **Kidney Health Evaluation for patients with Diabetes** was identified as a HEDIS® disparity for the White race/ethnic group. The compliance rate of 40.74% is lower than the total IEHP population rate of 45.47%. • **Prenatal Immunization Status** was identified as a HEDIS® disparity for the White race/ethnic group. The compliance rate of 10.67% is lower than the total IEHP population rate of 14.48%. • **Risk of continued opioid use** was identified as a HEDIS® disparity for the White race/ethnic group. The rate of 9.80% is higher than the total IEHP population rate of 6.76% (higher rate signifies higher risk) • **Lead screening** was identified as a HEDIS® disparity for the White race/ethnic group. The compliance rate of 43.75% is lower than the total IEHP population rate of 50.26%.
Black	• Childhood immunization-10 was identified as a disparity for the Black race/ethnic group. The rate of 9.89% is lower than the total IEHP population compliance rate of 22.94%. • Well child visits was identified as a disparity for the Black race/ethnic group. The rate of 39.55% is lower than the total IEHP population compliance rate of 46.78%. • Well Child visits in the first 30 months was identified as a disparity for the Black race/ethnic group. The rate of 49.47% is lower than the total IEHP population compliance rate of 62.93%. • Well Child visits in the first 15 months was identified as a disparity for the

	Black race/ethnic group. The rate of 40.05% is lower than the total IEHP population compliance rate of 55.79% • Immunizations for adolescents was identified as a disparity for the Black race/ethnic group. The compliance rate of 21.73% is lower than the total IEHP compliance rate of 34.41%. • Prenatal Care was identified as a disparity for the Black race/ethnic group. The compliance rate of 78.41% is lower than the total IEHP population compliance rate of 82.57%. • Post-Partum Care was identified as a disparity for the Black race/ethnic group. The compliance rate of 64.25% is lower than the total IEHP population compliance rate of 74.21%. • Controlling Blood Pressure was identified as a disparity for the Black race/ethnic group. The compliance rate of 45.55% is lower than the total IEHP population rate of 50.97%. • Antidepressant Medication management was identified as a HEDIS® disparity for the Black race/ethnic group. The compliance rate of 56.86% is lower than the total IEHP population rate of 63.39%. • Lead screening was identified as a HEDIS® disparity for the Black race/ethnic group. The compliance rate of 39.49% is lower than the total IEHP population rate of 50.26%. • Kidney Health Evaluation for patients with Diabetes was identified as a HEDIS® disparity for the Black race/ethnic group. The compliance rate of 38.94% is lower than the total IEHP population rate of 45.47%. • Prenatal Immunization Status was identified as a HEDIS® disparity for the Black race/ethnic group. The compliance rate of 9.44% is lower than the total IEHP population rate of 14.48%. • Risk of continued opioid use was identified as a HEDIS® disparity for the Black race/ethnic group. The rate of 8.88% is higher than the total IEHP population rate of 6.76% (higher rate signifies higher risk)

American Indian or Alaskan Native	• Well Child Visits was identified as a disparity for the American Indian or Alaskan Native ethnic group. The compliance rate of 32.80% is lower than the total IEHP population compliance rate of 46.78%. • Cervical Cancer Screening was identified as a disparity for the American Indian or Alaskan Native ethnic group. The compliance rate of 42.95% is lower than the total IEHP population compliance rate of 55.18%. • Diabetes A1C Control of less <8 was identified as a disparity for the American Indian or Alaskan Native. The compliance rate of 32.85% is lower than the total IEHP population compliance rate of 51.37%. • WCC- Physical Activity, Nutrition, BMI was identified as a disparity for the American Indian or Alaskan Native ethnic group. The compliance rate of 53.66% is lower than the total IEHP population compliance rate of 72.81%. • Diabetes Control of greater than >9 (measurement of poor health) was identified as a disparity for the American Indian or Alaskan Native ethnic group. The rate of 60.65% is higher than the total IEHP Population rate of 39.59%. (Higher rate means poorer health).
Asian or Pacific Islander	• Cervical Cancer Screening was identified as a disparity for the Asian or Pacific Islander ethnic group. The compliance rate of 52.76% is lower than the total IEHP population compliance rate of 55.18%. • Chlamydia Screening was identified as a disparity for the Asian or Pacific Islander ethnic group. The compliance rate of 60.23% is lower than the total IEHP population compliance rate of 64.88%.

Members with Limited English Proficiency (LEP)

IEHP ensures that services (clinical and non-clinical) are provided in a culturally competent manner and are accessible to all IEHP Members. All Network Providers must offer services to Members with limited English proficiency in the Member's primary language. Both Providers and Members may call IEHP Member Services department and request a face-to-face interpreter prior to a medical appointment.

In 2023, IEHP received a total of 32,178 face-to-face interpreter requests. This is an increase from the 25,152 face-to-face interpreter requests received in 2022. Members may request interpreter services prior to routine medical appointments or emergency medical appointments. The top requested languages in 2023 were Spanish, American Sign Language (ASL), Arabic, and Mandarin. Spanish and ASL interpreter requests make up 83% of total requests.

Table 22: Face-to-Face Interpreter Requests (Top Languages)

Language	2023 total requests	% of total requests
Spanish	22810	70.9%
ASL	4006	12.4%
Arabic	2323	7.2%
Mandarin	1473	4.6%
Vietnamese	583	1.8%
Yue Chinese (Cantonese)	125	0.4%
Other	858	2.7%
Total	**32,178**	**100%**

In addition to medical appointment interpreters, IEHP offers telephonic interpreter services within the Member Services call center based on the linguistic needs of Members. IEHP contracts with a third-party interpreter language line to offer interpreter services for over 200 languages. During normal business hours, the Member Services Representative (MSR) facilitates access which involves a three-way conversation between the MSR, the non-English speaking Member/caller and the contracted interpreter Agent.

In 2023, a total of 60,372 telephone interpreter requests were received by IEHP staff. This is an increase from the 59,171 requests in 2022.

The top requested languages were Spanish, Mandarin, Arabic, and Vietnamese. Spanish interpreter requests make up the largest volume of requests at 76.9%. Cantonese is an IEHP threshold language but not a top requested language. There were only 376 requests for Cantonese interpretation in 2023.

Table 23: Telephone Language Interpreter Requests (Top 4 Languages)

Top languages	2023 Total Calls	% of total requests

Spanish	46,436	76.9%
Mandarin/Chinese	4,272	7.1%
Arabic	2,609	4.3%
Vietnamese	2,274	3.8%
Other	4,781	7.9%
Total	**60,372**	**100%**

HEDIS® disparities identified for MY 2021 (using HEDIS® 2022 results) are depicted in the tables below. Chinese, Vietnamese, Mandarin and Cantonese are new threshold languages included in this report. Disparities identified for the new threshold languages were only identified during MY 2021, versus English and Spanish which identified disparities in both MY 2020 and MY 2021. The majority of HEDIS® disparities was identified with English speaking Members, followed by Vietnamese speaking Members. There were no disparities identified for the Spanish speaking population using the selected HEDIS® measures.

Table 24: Assessment of Needs of Members by Primary Language – Medi-Cal

Language	**HEDIS 2022 Measure Disparities for Medi-Cal Members** 2-year trends are summarized (i.e., members with the disparity identified during measurement years 2021 and 2022)
English	• **Immunizations of adolescents** was identified as a disparity for the English-speaking group. The compliance rate of 30.92% is lower than the IEHP population compliance rate of 34.41% • **Well Child Assessment for BMI** was identified as a disparity for the English-speaking group. The compliance rate of 70.57% is lower than the IEHP population compliance rate of 72.81%. • **Developmental Screening in the First Three Years of life** was identified as a disparity for the English-speaking group. The compliance rate of 39.69% is lower than the IEHP population compliance rate of 40.69%. • **Hemoglobin A1C control for Patients with Diabetes A1C<8** was identified as a disparity for the English-speaking group. The compliance rate of 50.14% is lower than the IEHP population compliance rate of 51.37%.

	• **Lead Screening** was identified as a disparity for the English-speaking group. The compliance rate of 48.14 is lower than the IEHP population compliance rate of 50.26%.
Spanish	• **Appropriate Testing for Pharyngitis** was identified as a disparity for the Spanish-speaking group. The compliance rate of 14.43% is lower than the IEHP population compliance rate of 18.34%.
Vietnamese	• **Well Child Assessment for BMI*** was identified as a disparity for the Vietnamese-speaking group. The compliance rate of 55.05% is lower than the IEHP population compliance rate of 72.81%. • **Well Child Assessment for Nutrition*** was identified as a disparity for the Vietnamese -speaking group. The compliance rate of 52.26% is lower than the IEHP population compliance rate of 70.76%. • **Well Child Assessment for Physical Exercise*** was identified as a disparity for the Vietnamese -speaking group. The compliance rate of 51.22% is lower than the IEHP population compliance rate of 69.40%. • **Child and Adolescent Well Care Visits** was identified as a disparity for the Vietnamese -speaking group. The compliance rate of 39.75% is lower than the IEHP population compliance rate of 46.78%.
Mandarin	• **Kidney Health Evaluation for patients with Diabetes*** was identified as a disparity for the Mandarin -speaking group. The compliance rate of 32.18% is lower than the IEHP population compliance rate of 45.47%.

**Include disparity data for 3 years: 2020, 2021, 2022*

An assessment of language disparities using the same HEDIS® measures as the table above, reveals disparities were identified with the English-speaking Members (Breast Cancer Screening and Colonoscopy measures), and Spanish speaking Members (Statin Adherence). No Disparities were found with Vietnamese, Chinese, Mandarin, or Cantonese speaking languages.

Needs Assessment

Population	Summary of Key Findings

General Population	• The largest ethnicity is the Hispanic Group which makes up 56.1% of the membership. • Children under 19 make up 40% of the population, while adults ages 20-49 make up 39% of the population. • English and Spanish are the primary languages. • 6.7% of the population was identified as homeless. • The top diagnoses in the general population are Hypertension, Hyperlipidemia, type 2 diabetes.
Sub Populations	• About half of the IEHP Membership is delegated to an IPA • 8.3% of the population was identified as frail. • Most of the Member population (82.7%) has a chronic condition count of 0 or 1-3, while 7.8% of the Members have 7+ chronic conditions.
Children and Adolescents	• 42,025 children were identified as special needs. • The top diagnoses for children ages 2-19 are Disorders of refraction allergic rhinitis, and obesity. • Asthma in children is a top chronic condition.
SPD Members	• 4.5% of the Membership are Members and persons with disabilities. • The top diagnoses of SPD Members are hypertension, lipidemia, obesity, and diabetes.
Members with SPMI	• For BH related top diagnoses, anxiety, depression, and nicotine disorder are the most common. • 23.8% of SPD Members fill prescriptions for Anti-Alcoholic, Psychoactive, or Opioid medications through the county. • Alcohol related disorders is a top diagnosis for both lines of business

Ethnic Groups	• 56.1% of the total IEHP population is Hispanic • For Pediatric Preventative Care, Black Ethnicity disparity across all measures was identified. • For Cancer Prevention, the White race/ethnic group had a disparity in Breast Cancer, Cervical Cancer and Colorectal cancer screening for 3 consecutive years. • Hemoglobin A1C control was identified as a disparity for the Hispanic and American Indian/Alaskan Native Ethnicity • Risk of Opioid use was identified as a disparity for the White and Black Ethnicity Group • Controlling Blood Pressure and Antidepressant medication management was identified as a disparity for Black Ethnicity. • For Member Experience, Members of White ethnicity reported low Member experience rates in 'Rating of Health Plan', 'Rating of Personal Doctor', and 'Rating of Specialist' as well as 'Getting Care Quickly' Composite.
Members with LEP	• Of the Members that call into IEHP requiring translator services, 76.9% are Spanish speaking. • For face-to-face interpreter requests during doctor visits, 70.9% require a Spanish translator. Followed by 12.4% requiring American Sign Language. • Well Child Assessments and Well Child visits was identified as a disparity for Vietnamese speaking Members for 3 consecutive years. • Kidney Health Evaluation for patients with Diabetes was identified as a disparity for the Mandarin speaking Members. • Members who speak 'English' reported lower rates in CAHPS® questions than Members whose primary language is Spanish.

Activities and Resources

The results of the Population assessment were used to review and update activities, resources, and community resources.

1. **Hypertension** is the most common diagnosis for the general population and for the SPD population.

    - Activity: Controlling Blood Pressure measure is included in the Global Quality P4P PCP and IPA Programs which provide a financial incentive to PCPs and IPAs for improved measure performance.

    - Activity: IEHP's Enhanced Care Management (ECM) team to engage high risk and complex care Members to participate in self-monitoring blood pressure to achieve improved blood pressure control in support of the 'Controlling Blood Pressure' (CBP) HEDIS® measure.

    - Activity: Blood Pressure control of 140/90 is a Value Based Payment metric to incentivize quality performance in ECM providers.

    - Activity: Targeted fax outreach by IEHP's Pharmacy department to Providers with Members eligible for and noncompliant with HEDIS® CBP. The MTM program outreaches to Members (Medicare LOB) for medication optimization for those with Diabetes/Hypertension.

    - Activity: Targeted telephonic outreach by IEHP's pharmacy department to Members newly diagnosed with hypertension to provide medication education.

2. **Special Needs Children**: About 42,000 children are identified as special needs and about 2.3% of the total IEHP Member population is under the age of 2 years old.

    - Activity: Development Screening in Children is a measure included in the Global Quality P4P PCP and IPA Programs which provide a financial incentive to PCPs and IPAs for improved measure performance.

    - Activity: Developmental Screening education during Provider office visits is part of the Regional Quality Community Model (RQCM). Offices are provided with Quality Coding resources and education on the developmental screening billing code, 96100.

- Activity: Key Pediatric Preventative Care Measures will consist of targeted efforts utilizing a community-based approach to support care coordination in WIC Program offices leveraging new CHW-led care coordination and support resources.

3. **Members with Diabetes** is a top condition for the general population and the SPD population. Activities to support diabetes care include:

    - Activity: Targeted outreach (fax) to Providers with Members eligible for and noncompliant with HEDIS® CDC. The MTM program outreaches to Members (Medicare LOB) for medication optimization for those with Diabetes/Hypertension.

    - Activity: TMR program outreaches to Members for medication education for those who are newly diagnosed and with history of Diabetes/Hypertension.

    - Activity: The Global Quality P4P Program provides financial incentives to PCPs and IPAs for improving measure performance on Diabetes related measures.

4. **Depression** was identified as a top diagnosis for the SPMI population. Activities to support Depression screening include:

    - Activity: Screening for Clinical Depression is a measure included in the Global Quality P4P PCP and IPA Programs which provide a financial incentive to PCPs and IPAs for improved measure performance.

    - Activity: Screen Members for depression with PHQ-9 within first 90 days of enrollment and improve follow-up screening with Members identified for moderate/severe risk.

    - Activity: Depression Screening with PHQ9 is a Value Based Payment metric to incentivize quality performance in ECM providers.

    - Activity: The Community BH department identify at risk Members via depression screening (PHQ-2) and either refer to the ‘in-house’ clinician or to a Provider referral, when appropriate.

5. **Asthma** is a top diagnosis in children and adolescents.

    - Activity: The Community Supports Asthma Remediation Program addresses environmental triggers in the Members home.

    - Activity: The Asthma Medication Ratio (AMR) HEDIS® Measure is a measure on the PCP and IPA Global Quality P4P Program.

    - Activity: Pharmacy Fax Blast targeted to providers not meeting AMR measure.

    - Activity: Pharmacy Call Campaign targeted to Members not meeting AMR measure.

    - Activity: Health Equity Operations department aim to increase referrals to asthma program and asthma classes as identified in the community.

6. **Depression** diagnosis ranks as the #1 diagnosis related to Behavioral Health. It is also found in the child population.

    - Resource: Health Education Department to disseminate education materials to Providers with focus on preventive education; including depression screening.

7. **Diabetes** is a top diagnosis in the general population and SPD population.

    - Resource: Diabetes Self-Management Workshops is a 6 week class for people with type 2 diabetes and their relatives that need information on diabetes self-management.

    - Resource: The Health Education and Marketing departments develop educational brochures and booklets to help stay healthy with Diabetes. Material is available on the website and available in different languages when requested.

8. **Members with LEP** that call into IEHP requiring translator services are Spanish speaking 76.9% of the time. For face-to-face interpreter requests during doctor visits, 70.9% require a Spanish translator.

- Resource: The Health Equity Operations department will lead activities such as language assessments for Member Service Representatives, develop and support Member educational materials in English, Spanish, Vietnamese, Mandarin, and Cantonese.

- Resource: Educate new Network Providers in Cultural & Linguistics training. The CLAS program description was updated and approved by the PHM Subcommittee in 2023 to align with regulatory requirements.

Addressing Health Care Disparities

Well Child visits in the first 15 months was identified as a disparity for the Black ethnic group. The rate of 40.05% is lower than the total IEHP population compliance rate of 55.79%. Well Child visits in the first 30 months was identified as a disparity for the Black ethnic group. The rate of 49.47% is lower than the total IEHP population compliance rate of 62.93%. Improving Well Child Visits within the first 30 months of life in Black infants will be implemented to improve compliance rates.

- IEHP will be assigning a CHW to our community services team that will aid in providing additional support to Members who are referred to Black Infant Health. In addition, our community services team will offer a referral option for fathers of the children in Black Infant Health to Project Fatherhood, an initiative that engages fathers in the care and upbringing of their children.

Community Resources for Integration into Programs

1. **Asthma** is also a leading chronic condition in children**.**

- Community Resource: IEHP Health Navigators provide individual asthma education to Members as needed.

- Community Resource: IEHP Community Health Team connect Members to the "Breathe IE" community asthma program.

- Community Resource: Health Education classes on Asthma are available to Members. Informational Member brochures on Controlling asthma are available on the IEHP Website.

2. **Depression** was identified as a top diagnosis for the SPMI population.

    - Community Resource: The Community BH department identify at risk Members via depression screening (PHQ-2) and either refer to the 'in-house' clinician or to a Provider referral, when appropriate.

3. **Homelessness** was identified in approximately 122,398 of Members. Homelessness was identified as the #2 ranking SDOH, after 'low income'.

    - Community Resource: The Community supports Program assists with Housing Navigation Services, Housing Sustaining Services, and Housing Deposits.

4. **Chronic diseases** such as Hypertension, Hyperlipemia, Diabetes, and Obesity are the most common chronic conditions of the IEHP population:

    - Community Resources: Heath Educators host health coaching sessions on the Healthy Heart Topic. Healthy Heart classes include Blood pressure control and Cholesterol control.

    - Community Resource: Community Health Workers (CHW) Heart Disease Curriculum for Targeted populations. 1.) 'Healthy Heart, Healthy Family' for the Filipino Community 2.) 'Your Heart, Your Life' for the Hispanic Community 3.) 'With Every Heartbeat is Life' for the African American Community 4.) 'Your Choice for Change' for the American Indian Community.

    - Community Resource: The Community Supports Benefit assists Members with Medically Supportive Food, Meals, and Medically Tailored Meals. To support better health outcomes among members with Chronic conditions.

Conclusion

Based on medical claims and behavioral health claims data, the top diagnoses in the general population are Hypertension, hyperlipidemia and obesity. For the SPD population, the most common diagnoses are hypertension, hyperlipidemia, and type 2 diabetes. For children and adolescents, the top diagnoses are disorders of refraction, allergic rhinitis obesity and asthma (chronic condition). For BH Members, the top diagnoses are anxiety and depression. The SDOH top diagnoses are Low income, homelessness, and food insecurity.

When assessing language, English and Spanish are the primary languages, followed by Vietnamese and Chinese. Members with limited English proficiency had a primary language of Spanish. Of the Members that call into IEHP requiring translator services, 76.9% are Spanish speaking and of the Members that require face-to-face interpreter requests during doctor visits, 70.9% require a Spanish translator.

An assessment of needs of Members that do not speak English as their primary language also revealed disparities in preventative care measures. For the Vietnamese speaking group, disparities were identified in the well-child visits and adolescent well care visits for 2 consecutive years.

An analysis across all ethnic groups revealed for pediatric preventative care, Black Ethnicity disparity across the Well child visits measures and immunization measures. Prenatal and Post-Partum care was also identified as a disparity for the Black ethnic group. For Chronic disease, Controlling Blood Pressure and Antidepressant Medication management was identified as a disparity.

For women's health, White race/ethnic group had a disparity in the following: Prenatal and Postpartum Care, Breast Cancer Screening, Cervical Cancer Screening, and Colorectal Cancer Screening.

The findings in the annual population assessment report are used to review and update activities, resources and community resources to better support and meet the needs of the Member population. The activities and resources will address the needs of Members with chronic conditions such as diabetes, hypertension, depression, and asthma.

Activities to address health care disparities will be focused on Improving Well Child Visits within the first 30 months of life in Black infants. The Black ethnicity was identified as a disparate group

for well child visits during the first 30 months of life. The Community Health Workers will aid in providing additional support to Members who are referred to Black Infant Health.

Lastly, IEHP's 3 Community Wellness Centers (CWC) are available to Members in the Riverside and San Bernardino County Communities. CWC offer free exercise classes and health workshops. The CWC also consists of multilingual Team Members to assists with Members with limited English proficiency. In addition to fitness and Wellness support, the CWC also assist with Benefits assistance and Plan enrollment.

7.2 PHM Effectiveness Study

The organization measures the effectiveness of its Population Health Management (PHM) Strategy. Annually, IEHP outlines its PHM Strategy for meeting the care needs of its Members and designs a cohesive plan of action to address Members' needs. This study assesses the impact of the PHM Strategy using clinical, utilization and Member experience measures and identifying opportunities for improvement in accordance with NCQA Standard PHM 6 Elements A and B.

This study assesses the following programs: Enhanced Care Management Program (ECM), My Path, IEHP's Housing Benefit with Community Supports, and the Complex Case Management (CCM) Program.

The Enhanced Care Management (ECM) Program began in January 2022. The populations of focus that it serves are homeless, adults who are high utilizers or have serious mental illness/substance use disorder, and Members leaving incarceration. The ECM Program is a clinical service delivery model that focuses on providing individualized, whole-person care by a trained, integrated care team that works in close connection with the Member's Primary Care Provider (PCP). This integrated care team provides an intensive set of services to Members who require coordination of care at the highest levels. The ECM Program's overarching goals are to improve care coordination, integrate services, facilitate community resources, address social determinants of Health (SDOH), improve health outcomes, and decrease inappropriate utilization and duplication of services.

My Path is a palliative care approach for IEHP Members with advanced diseases. These members have a life expectancy of 2 years or less and are most likely to use the emergency room to best

manage their symptoms and disease. The My Path Program is a patient and family-centered approach that addresses the physical, emotional, social, and spiritual needs of our Members and caregivers. My Path's goal is to optimize the quality of life by anticipating, preventing and treating suffering.

Members experiencing housing insecurity may benefit from being referred to one or more of the housing-related services provided under CalAIM Community Supports. These services can substitute for and potentially decrease utilization of a range of covered Medi-Cal benefits, such as hospital care, nursing facility care, and emergency department (ED) use. If the Member meets criteria for Community Supports, the assigned Community Supports Provider(s) will assist the Member with potential housing options and other supportive services. IEHP offers a robust and comprehensive menu of 14 pre-approved Community Supports to comprehensively address the needs of the Members, which includes those with the most complex challenges affecting health such as homelessness, unstable and unsafe housing, food insecurity and/or other social needs. The effectiveness of the four (4) community supports services related to Housing will be measured in this study.

Complex Case Management (CCM) provides coordination of care and services to Members who have experienced a critical event or diagnosis that requires the extensive use of resources. The purpose of the CCM Program is to improve the quality of life for the Member and ensure that Members obtain optimal health through appropriate settings, time frames, and provider utilization. The program is designed based on the principles of case management as defined by the Case Management Society of America. Clinical practice guidelines are used to develop goals and interventions for conditions that are identified as program triggers and common comorbidities.

Data sources used include Enrollment, Claims, Encounters, HEDIS® QSI Software, Pharmacy Claims, Care Management Systems Data.

Administrative data was extracted from all data sources listed above. Once all data was compiled, an analysis was reviewed and approved by the following individuals: Vice President of Quality, Senior Director of Quality Systems, Senior Director of Medical Management, Care Management Medical Director, Director of Integrated Care, BH/CM Manager, BH/CM Support Services

Manager. The results of these analyses are presented to IEHP's Population Health Management (PHM) Subcommittee annually for review, comment, and approval.

The ECM Program is a clinical service delivery model that focuses on providing whole person care to high risk Members. This study examines five (5) measures to determine the effectiveness of program goals for blood pressure control, depression documentation, depression response, transition of care, and member experience. This program addresses the following areas of focus: Managing Members with Multiple Chronic Illnesses and Managing Members with Rising Risk. Each measure is described on the table below:

Measures	Methodology
1. **Blood Pressure Control** (% of ECM enrolled Members who have a diagnosis of hypertension or who have documented elevated blood pressure in Care Director by the first day of the measurement period whose blood pressure (BP) was controlled (<140/90 mm Hg) by the end of the measurement period)	○ Source: Care Director System Data ○ Measurement Period: 03/01/23-12/31/23 ○ Numerator: Members who have at least one Physical Health Measures assessment with a status = complete with a contact date in the measurement period where the Systolic (SBP) field is less than 140 but greater than 40 AND the Diastolic (DBP) field is less than 90 but greater than 40. ○ Denominator: Members (18 years and older) continuously enrolled during the entire measurement period **and** Where the SBP *and* DBP field values are within the valid ranges a) SBP: > 40 and < 300 (greater than 40 and less than 300) b) DBP: > 40 and < 150 (greater than 40 and less than 150), **and** meet at least one of the following criteria: a) Members who have a diagnosis of hypertension within the last two years **or** b) Members who have at least two Physical Health Measures assessments with a status = complete, where the SBP was greater than or equal to 140 **or** DBP was greater than or equal to 90 prior to the start

	of the measurement period. Goal: 50%
2. **Depression Documentation** (% of ECM enrolled Members who have a PHQ-9 documented within 90 days of enrollment)	○ Source: Care Director System Data ○ Measurement Period: 03/01/23-12/31/23 ○ Numerator: Members with a PHQ-9 assessment with a status = complete with a contact date within 90 days of their enrollment date. ○ Denominator: Members (12 years and older) continuously enrolled during the entire measurement period **and** Who achieved 90 days of enrollment during the measurement period. ○ Goal: 80%
3. Depression Response (% of ECM enrolled Members who, in response to a previously elevated PHQ-9, have a subsequent meaningful reduction in PHQ-9 documented during the measurement period)	○ Source: Care Director System Data ○ Measurement Period: 03/01/23-12/31/23 ○ Numerator: Members in the denominator who have at least one PHQ-9 assessment with a status = complete and a contact date in the measurement period and Who's lowest PHQ-9 score within the measurement period is less than 10, or Who's lowest PHQ-9 score within the measurement period equals a 50% or greater reduction compared to the last PHQ-9 prior to the start to the measurement period. ○ Denominator: Members (12 years and older) continuously enrolled during the entire measurement period and Who's last PHQ-9 prior to the start of measurement period was greater than 9. ○ Goal: 35%

4. Transition of Care (TOC) (% of Members with a TOC – Post- discharge Assessment completed within 14 days of inpatient discharge)	○ Source: Care Director System Data ○ Measurement Period: 03/01/23-12/31/23 ○ Numerator: Members who have a TOC-Post-discharge Assessment with a status = complete and a contact date equal to or less than 14 days after the Inpatient discharge date. ○ Denominator: Members continuously enrolled during the entire measurement period and Who have an Inpatient discharge date within the last 14 calendar days of the previous measurement period and prior to the last 14 calendar days of the current measurement period. ○ Goal: 50%
5. ECM Member Experience	○ Source: The ECM Member experience survey was fielded in December 2023. ○ The compliance rate is calculated using the sum of respondents who selected '4' and '5'. ○ The survey consisted of the following 5 questions: • On a scale of 1-5, please rate the following: ECM Program, ECM Staff, Usefulness of information provided by the ECM Team. • I am likely to follow the recommendations made by my ECM Case Manager to meet the care plan goals we developed together. (Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree) • Being in the ECM Program helped me achieve my personal health goals. (Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree) ○ Goal: 80% (internally set)

The Community Supports Housing Services support Members in need of Housing assistance. This study examines four (4) Community Supports services related to improving housing status for Members. This Program addresses the following area of focus: Managing members with Multiple Chronic Illnesses. The measures for each Housing Service is described in the table below.

Community Supports Housing Services

Measures	Methodology
• Emergency Department (ED) Visits • Hospital Admits	Includes Members who utilized the following services: 1. Housing Deposits Program. 2. Housing Tenancy and Sustaining Services 3. Housing Transition/Navigation Services 4. Short-Term Post Hospitalization Housing o Source: IEHP Paid Claims o Rates are calculated in PTMPY (per thousand Members per year). o Measurement Period: 01/01/23-12/31/23 o Goal: Reduction in rate compared to the prior year

The Palliative Care Program supports Members with advanced disease. This study examines the My Path Programs' Utilization metrics as well as clinical outcome metrics. This program addresses the following area of focus: Managing members with Multiple Chronic Illnesses.

The measures are described in the table below:

My Path Program

Measure	Methodology

• Emergency Department (ED) Visits • Inpatient Acute Bed Days • Total Member Cost	○ Rates are calculated in PTMPY (per thousand Members per year). ○ Analysis among My Path Members Pre-enrollment and Post-Enrollment ○ Cost includes Medical and Pharmacy ○ Measurement Period: January- December 2022 ○ Goal: Reduction in 'Post-enrollment' rate
PCP Visits	○ Rates are calculated in PTMPY (per thousand Members per year). ○ Analysis among My Path Members Pre-enrollment and Post-enrollment ○ Measurement Period: January-December 2022 ○ Goal: Higher rate in the 'Post-enrollment' Rate
Advance Care Planning	○ Evidence of advanced care planning (a discussion or documentation about preferences for resuscitation, life-sustaining treatment and end of life care) during the measurement year. ○ HEDIS® ACP Measure specifications. ○ Administrative Data only (Claims and Encounters) ○ Measurement Period: January -December 2022 ○ Goal: 90%
Medication Review	○ My Path Members with evidence of a medication review by a prescribing physician or a clinical pharmacist using the HEDIS® COA Sub measure specifications (Continuous enrollment, age requirement, and hospice removed for this analysis) ○ Administrative Data only (Claims and Encounters) ○ Measurement Period: January -December 2022 ○ Goal: 80%

Functional Status Assessment	○ My Path Members with at least one functional status assessment using the HEDIS® COA Sub measure specifications (Continuous enrollment, age requirement, and hospice removed for this analysis) ○ Administrative Data only (Claims and Encounters) ○ Measurement Period: January -December 2022 ○ Goal: 80%
Pain Assessment	○ Members with at least one pain assessment using the HEDIS® COA Sub measure specifications (Continuous enrollment, age requirement, and hospice removed for this analysis) ○ Administrative Data only (Claims and Encounters) ○ Measurement Period: January -December 2022 ○ Goal: 90%

The CCM Program supports Members who have experienced a critical event or diagnosis that requires the extensive use of resources. This program addresses the area of focus: Managing Members with Multiple Chronic Illnesses. The CCM Program measures assessed in this study are described below.

Complex Case Management (CCM) Program

Measure	Methodology
• Hospital Readmissions • Emergency Department (ED) Visits	○ Rates are calculated using Member Months ○ Members who were enrolled in CCM for more than 60 days in both 2022 and 2023 and with 22-24 months of continuous CCM Program enrollment and who had a Hospital readmission or ED visit. ○ Goal: Decrease by 10% in the 'post-enrollment' rate

PCP Visits	○ Rates are calculated using Member Months ○ Members who were enrolled in CCM for more than 60 days in both 2022 and 2023 and with 22-24 months of continuous CCM Program enrollment and who had a PCP visit. ○ Goal: Increase by 10% in the 'post-enrollment rate'

CCM Member Experience	○ Source: The CCM Member experience survey was fielded in November-December 2023.
	○ The compliance rate is calculated using the sum of respondents who selected '4' and '5'.
	○ CCM enrollment must include an open / active complex care plan with an HRA completed (coded as HRAv4 or HRAv4_1 in our electronic medical records).
	○ The compliance rate is calculated using the sum of respondents who selected '4' and '5'.
	○ The survey consisted of the following 5 questions:
	  ○ On a scale of 1-5, please rate the following: CCM Program, CCM Staff, Usefulness of information provided by the CCM Team.
	  ○ I am likely to follow the recommendations made by my Complex Case Manager to meet the care plan goals we developed together. (Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree)
	  ○ Being in the CCM Program helped me achieve my personal health goals. (Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree)
	○ Goal: 80% (internally set)

Enhanced Care Management Program

To achieve success for the blood pressure measure, 80% of enrolled Members must have a blood pressure documented in Care Director. Analysis is conducted to determine if blood pressure is controlled at the performance level. The program achieved a documentation rate of 63% and therefore, met the goal of a minimum performance level of 50%.

For the Transition of Care measure, the goal is for 50% of enrolled Members to be connected to the TOC Team within 14 days of their hospital discharge. The program achieved a transition of care rate of 635%, which met the goal.

For the Depression documentation measure, the goal is for 80% of patients to have a PHQ-9 completed within 90 days of enrollment. The rate of 74% did not meet the goal.

For the Depression response documentation measure, 35% of ECM enrolled Members who, in response to a previously elevated PHQ-9, have a subsequent meaningful reduction in PHQ- 9 documented during the measurement period. The Depression response goal is set at 35%, therefore the 35% performance level met the goal.

The table below illustrates all measure results for 2023. Only the Depression Documentation measure did not meet the set goal.

Table 1: ECM Program Metrics

Measure	2022 Rate	2023 rate	Goal	Goal Met?
Blood Pressure Control	68%	63%↓	50%	Yes
Transition of Care	67%	65%↓	50%	Yes
Depression Documentation	68%	74%↑	80%	No
Depression Response	37%	35%↓	35%	Yes

In January 2024, IEHP's Member services team utilized a call campaign to conduct the Enhanced Care Management (ECM) Member Experience Survey. A total of 282 Members completed the survey. Members who participated were asked to rate the ECM Program, ECM Program Team

Members, and information provided by the ECM team on a scale from 1-5 (where 1 is the worst and 5 is the best). Our results are as follows:

- 93.6% of participants rated the program a 4 or 5
- 95.4% of participants rated ECM staff with a 4 or 5
- 92.2% of participants rated the usefulness of the information provided by the ECM team as a 4 or 5.

Below are the results for the ECM Member experience survey. Members were asked to rate the ECM program, the ECM Team, and the usefulness of the info on a scale of 1-5.

Table 2: ECM Member Experience Survey Results

Rating	ECM Program		IEHP ECM Team		Usefulness of Info	
	2022	2023	2022	2023	2022	2023
1	2.7%	1.4%	3.4%	1.4%	3.1%	1.1%
2	1.5%	0.7%	1.5%	1.1%	2.7%	2.5%
3	4.2%	4.3%	6.1%	2.1%	7.3%	3.9%
4	14.5%	13.1%	14.1%	12.1%	9.5%	11.0%
5	77.1%	80.5%	74.8%	83.3%	77.5%	81.2%
Combined 4+5	91.6%	93.6%↑	88.9%	95.4%↑	87.0%	92.2%↑
Goal 80% Met?	Yes	Yes	Yes	Yes	Yes	Yes

Community Supports Housing Services

IEHP Members experiencing complex challenges affecting their health such as chronic homelessness can be referred to and assessed by the IEHP Care Teams. If the Member meets criteria for Community Supports and is approved for Housing services, IEHP's tenancy partner will work closely with the county to try and secure a housing voucher (i.e. housing deposit) for the Member. The Member will also be assigned to a Community Supports Housing Tenancy and Sustaining provider to assist in finding the optimal housing solution for them. Ongoing support is

provided until the Member is self-sufficient. Additional details regarding each category housing support are provided below.

The total member count of those that utilized the housing benefits are listed below by housing category. For housing deposits, the goal is to in increase the number of members utilizing housing deposits by 15% when compared to the prior year. The results in Table 3 below reveal that the goal was met. No goals were set for the other three categories. The 2022 and 2023 data, however, are important to note as they help program implementors understand baseline counts and monitor Member reach. Future studies may examine the housing services more closely to show trends, identify areas of greatest Member need, and inform future programming.

Table 3: Community Supports Housing Services – Unique Member Counts

Housing Category	2022 Unique Member Count	2023 Unique Member Count	Increase by 15%
Housing Deposits	117	535	Yes
Housing Transition/Navigation Services	2,504	7,131	
Housing Tenancy and Sustaining Services	575	566	
Short-Term Post-Hospitalization Housing	48	196	

Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board. Utilization data for Members that accessed the Housing Deposit benefit are listed below. The results show that the ED visit rates and the Hospital admission rates both had positive results during the 2023 measurement. These utilization rates demonstrated a slight decrease compared to the prior year.

Table 4: Housing Deposits Utilization

Measure	2022 (117 Members)	2023 (535 Members)	Goal	Goal Met?

ED visits count	245	1,098	Reduction in ED visit rate	Yes
ED visit rate	2,164.95	2,155.05↓		
Hospital admission count	62	157	Reduction in hospital admits /inpatient stays	Yes
Hospital admission rate	547.86	308.15↓		

*Note: Rate is PTMPY (per thousand Members per year) [count / Member months * 12,000]*

Housing Transition Navigation Services assist Members with obtaining housing by developing an individualized housing support plan, searching for housing, presenting options, and assisting in securing housing. The results show that the ED visit and the hospital admission rates for Members who utilized this service demonstrated a slight decrease when compared to the prior year.

Table 5: Housing Transition / Navigation Services Utilization

Measure	2022 (2,504 Members)	2023 (7,131 Members)	Goal	Goal Met?
ED visits count	6,915	15,947	Reduction in ED visit rate	Yes
ED visit rate	2,939.74	2,402.29↓		
Hospital admission count	1,784	3,487	Reduction in hospital admits/ inpatient stays	Yes
Hospital admission rate	758.42	525.42↓		

Note: Rate is PTMPY (per thousand Members per year)

The goal of the **Housing Tenancy and Sustaining Services** is to maintain safe and stable tenancy once housing is secured; it includes elements such as education for tenant responsibilities, assistance with landlords/neighbor disputes, and early intervention and linkage to community resources to reduce risk of eviction. The results show that the ED visit rates, and the Hospital admission rates both had positive results during the 2023 measurement. These utilization rates demonstrated a slight decrease when compared to the prior year.

Table 6: Housing Tenancy and Sustaining Services Utilization

Measure	2022 (575 members)	2023 (566 Unique Members)	Goal	Goal Met?
ED visits count	1,589	1,120		Yes

ED visit rate	2,946.69	2,078.89↓	Reduction in ED visit rate	
Hospital admission count	459	319	Reduction in hospital admits/ inpatient stays	Yes
Hospital admission rate	851.18	592.11↓		

Note: Rate is PTMPY (per thousand Members per year)

Short-Term Post-Hospitalization Housing provides a place to stay for high medical- or behavioral-health utilization members who do not have a home to continue their recovery immediately after exiting an inpatient hospital. There were 196 unique members in 2023 that accessed this benefit. The results show that the 2023 ED visits and Hospital Admit rate decreased in 2023.

Table 7: Short-Term Post-Hospitalization Housing Utilization

Measure	2022 (48 Members)	2023 (196 Members)	Goal	Goal Met?
ED visits count	198	603	Reduction in ED visit rate	Yes
ED visit rate	4,432.84	3,272.73↓		
Hospital admission count	54	193	Reduction in hospital admits /inpatient stays	Yes
Hospital admission rate	1,208.96	1,047.49↓		

Note: Rate is PTMPY (per thousand Members per year)

My Path Program

The table below illustrates utilization and cost (6) months pre-enrollment and (6) months post enrollment into the My Path Program for 3 years. When assessing CY 2022 data, the results show that all goals were met. The ED visits, Inpatient Visits, and total Member Cost were lower post enrollment compared to pre-enrollment into the My Path Program. This trend is observed annually for the past 3 measurement periods as noted below.

Table 8: My Path Member Utilization

Timeframe	Metric	6 months pre-enrollment rate (PTMPY)	6 months post-enrollment rate (PTMPY)	Goal=reduction in post-enrollment rate
Jan.-Dec. 2022 605 unique Members	ED Visits	6,381	4,930↓	Goal Met
	Inpatient Acute Bed Days	23,790	15,273↓	Goal Met
	Total Member Cost	$120,105,984	$111,487,531↓	Goal Met
Jan.-Dec. 2021 749 unique Members	ED Visits	6,522	4,818↓	Goal Met
	Inpatient Acute Bed Days	24,086	16,522↓	Goal Met
	Total Member Cost	$129,827,993	$118,627,343↓	Goal Met
Jan.-Dec. 2020 861 unique Members	ED Visits	4,742	3,660 ↓	Goal Met
	Inpatient Acute Bed Days	17,128	11,616 ↓	Goal Met
	Total Member Cost	$111,825,814	$104,104,500 ↓	Goal Met

Note: Rate is PTMPY (per thousand Members per year)

The PCP visit rate shows an increase in visits post-enrollment compared to pre-enrollment into the My Path Program for the 2022 measurement period. The goal is to observe an increase in PCP visits post enrollment; therefore, the goal was met.

Table 9: My Path Program – PCP Visits

Timeframe	Metric	6 months pre-enrollment rate (PTMPY)	6 months post-enrollment rate (PTMPY)	Goal=higher rate in post-enrollment rate
Jan.-Dec. 2022 605 Unique Members	PCP Visits	25,721	32,284↑	Goal Met
Jan.-Dec. 2021 749 Unique Members	PCP Visits	13,565	12,772↓	Goal Not Met
Jan.-Dec. 2020 861 unique Members	PCP Visits	8,168	9,696↑	Goal Met

Note: Rate is PTMPY (per thousand Members per year)

The table below shows the Care for Older Adults (COA) compliance rates for Members with an enrollment date into the My Path Program between January 2022 and December 2022.

Functional Status Assessment, Medication Review, and Pain assessment are calculated by using the COA HEDIS Submeasure (continuous enrollment, age requirement, and hospice removed for this analysis).

The Advanced Care Planning rate uses the ACP HEDIS® measure, therefore, the denominator is different.

Rates are compared to prior years. Although, all measures increased from the prior year, the goals were not met.

Table 10: My Path Care for Older Adults Measures

Date range	Measure	Num.	Den.	Rate	Goal-	Goal Met?
Jan-Dec 2022	Advanced Care Planning (ACP HEDIS® Measure)	45	69	65.2%↑	90%	No
	Functional Status Assessment (COA HEDIS® Sub measure)	103	381	27.0%↑	80%	No
	Medication Review (COA HEDIS® Sub measure)	114	381	29.9%↑	80%	No
	Pain Assessment (COA HEDIS® Sub measure)	120	381	31.5%↑	90%	No
Jan.-Dec. 2021	Advanced Care Planning (ACP HEDIS® Measure)	31	54	57.4%	90%	No
	Functional Status Assessment (COA HEDIS® Sub measure)	72	389	18.5%	80%	No
	Medication Review (COA HEDIS® Sub measure)	99	389	25.5%	80%	No
	Pain Assessment (COA HEDIS® Sub measure)	84	389	21.6%	90%	No
Jan.-Dec. 2020	Advanced Care Planning	174	461	37.7%	90%	No
	Functional Status Assessment	118	461	25.6%	80%	No
	Medication Review	118	461	25.6%	80%	No
	Pain Assessment	123	461	26.7%	90%	No

CCM Program Results

The CCM Program effectiveness was examined by comparing Member readmission rates, ED Visits, and PCPs visit rates for Members during pre-CCM enrollment versus post-CCM enrollment. Members who were enrolled in CCM for more than 60 days during 2022 and 2023 (for 22-24 continuous months) were included in the analysis (n=743). The readmission rate per thousand members increased during the post enrollment period and did not meet the goal.

Table 11: CCM Readmission Rates

Measure	2022 (pre CCM enrollment)	2023 (post CCM enrollment)	Goal	Goal Met?
Total Admissions	719	566	Decrease by 10%	No
Admissions/1,000	967.70	380.89		
Total Readmissions	225	235		
Readmission Rate*	302.83	316.29↑		

**Readmissions/1000*

CCM Emergency Department (ED) visits were examined and are shown in Table 12. A Member ER visit was excluded if the visit resulted in the Member being admitted. The results reveal that the rate of ED visits increased during the post enrollment period and did not meet the goal.

Table 12: CCM Member ED Visits

Measure	2022 (pre CCM enrollment)	2023 (post CCM enrollment)	Goal	Goal Met?
Total ED Visits	1,586	1590	Decrease by 10%	No
Member Months	8,916	8,916		
ED Visit Rate*	2,134.59	2,139.97↑		

**ED visits/1000*

The table below shows the total number of CCM Members who had a PCP visit in 2022 and 2023. The PCP visit counts are for distinct Members. The PCP visits rate remained stable during the post CCM enrollment period, with only a slight improvement. The 10% improvement goal was not achieved.

Table 13: CCM PCP Visits

Measure	2022 (pre CCM enrollment)	2023 (post CCM enrollment)	Goal	Goal Met?

PCP Visits	721	716	Increase by 10%	No
Member Months	8,916	8,916		
PCP Visits rate*	970.39	963.66↓		

**PCP visits/1000*

Each year, IEHP conducts a Complex Case Management Member Experience Survey to assess Member satisfaction with both the CCM Program and CCM Team Members. The 2023 Member Experience Survey was conducted between November and December 2023.

A total of 198 Members completed the survey. Respondents were asked to rate the CCM Program, CCM Team Members, and information provided by the CCM team on a scale from 1-5 (where 1 is worst and 5 best). Our results are as follows:

- 87.4% of participants rated the program a 4 or 5
- 92.9% of participants rated CCM staff with a 4 or 5
- 87.4% of participants rated the usefulness of the information provided by the CCM team as a 4 or 5.

Table 14: On a Scale of 1 – 5, Please Rate the Following

Rating	CCM Program		CCM Staff		Usefulness of Info	
	2022	2023	2022	2023	2022	2023
1	1.8%	4.0%	1.8%	3.0%	1.8%	4.0%
2	0.0%	2.0%	0.0%	0.5%	1.8%	1.5%
3	7.1%	6.6%	1.8%	3.5%	7.1%	7.1%
4	11.5%	14.1%	11.5%	14.6%	13.3%	14.6%
5	79.6%	73.2%	85.0%	78.3%	76.1%	72.7%
Combined 4+5	91.2%	87.4%↓	96.5%	92.9%↓	89.4%	87.4%↓
Goal 80% Met?	Yes		Yes		Yes	

Study Period Past Interventions

The following are interventions implemented during the study period.

Intervention	SMART Goals	Goal Met?	Outcome	Status
Review and validate depression documentation and screening PIR data each month, by chart audits, team huddles, dashboards, and issuance of corrective action plans.	• Audit 2 charts per team/per month for depression documentation and screening. • By 06/01/23, create a dashboard to use within the ECM Teams. Dashboard will be used to track monthly chart audits, discuss findings, and corrective actions. • Remeasure the depression documentation measure by 12/31/23 to check if rate is at least 80% in ECM enrolled Members	No	The practice coaches continue to audit 2 charts per team/month. The findings are documented and shared with the care teams. The ECM dashboard is currently being used for monitoring and data sharing. Practice coaches continue to discuss findings and apply corrective action as needed.	Improvement of measure by 6% was observed but goal was not met.
IEHP's Health services team to work with Palliative Providers to document and ensure My Path Members are seen by their PCP (in person or via Telehealth)	Every 2 months (from March to December 2023), request Palliative care Providers to document when the Members (who were presented at the Interdisciplinary Conference) were last evaluated by their PCP either in person or via telehealth.	Partially Met	Documentation related to the completion of this goal was discontinued due to potential Provider burden. In order to reach the desired outcome, Providers were reminded of the goal during 3 meetings and during ICC presentations. The goal of increasing PCP visits was met without adding extra paperwork burden.	Modified
Collaborate with the palliative care providers to come up with an effective data capture strategy that they will implement.	• In the next 8 weeks, schedule meetings with all the adult home-based palliative care groups to discuss data capture of HEDIS measures. • From that meeting, have the providers take lead with developing at least one S.M.A.R.T. goal on how to improve data capture of HEDIS measures for 2023. • Review the S.M.A.R.T. goal (for progress) with the providers at least 2 times between March 2023 and December 2023.	Partially Met	Initial meetings were held in March and April 2023 Destiny: Monday March 13, 2023; Care Connect Tuesday March 14, 2023; Palliative Partners Monday April 17, 2023; Charter Thursday March 16, 2023. From these meetings, it became clear that while some options include direct access to the electronic medical records to capture the codes for care for older adult's measures, IEHP is only using claims related codes. The limitation with using claims codes is that these providers are paid a member rate requiring a different code to be submitted. The COA codes are not payable. The goal for all groups was to submit COA measures codes with all the claims encounters. Palliative Partners and Charter stated they were already	Increases in these measures were observed, however the goals were not met.

			submitting codes. There were 2 further discussions about these measures with these groups in August 2023 (9th, 15th, and 30th), and in November and December 2023 during the audit cycle.	
BHCM Integrated Regional Leadership to work to increase PCP visits for Members enrolled in CCM, by following the current standard process to proactively identify PCP visits and educate Members in scheduling yearly PCP visits	• BH CM Team Members to proactively identify PCP visits and educate Members in scheduling yearly PCP visits. • The Care team will make an attempt to schedule PCP visits for 100% of the Members enrolled in Complex Care Management (CCM).	Partially Met	The BHCM integrated team effectively devised a process to identify members lacking PCP visits, contacting the Members and then providing education and assistance to schedule yearly PCP visits. The efforts were documented in the care plan. Although the goal was not fully achieved, there was an observable increase in PCP visits based on the data.	

Barrier Analysis

STUDY MEASURE NOT MET	CAUSAL/BARRIER ANALYSIS	OPPORTUNITY
Depression Documentation in ECM enrolled Members	ECM Care Teams are missing the 90-day mark of documentation upon Member enrollment. The documentation takes place on the 3rd month, and not necessarily within 90 days. Therefore, the credit for measurement is missed. Health care organizations in general had challenges in maintaining their staffing level. Staffing levels were at 75% capacity. Unable to Contact Enrolled Members - Change in contact information, no-	Implement standard work that will prioritize and ensure that depression screening is captured in a timely manner. *(See detailed future planned intervention for description)*

	shows to scheduled appointments to complete initial assessments and client's not answering phone calls and/or texts after enrollment.	
Care for Older Adults Measures for My Path Members	Connecting with the people who provide the source data to determine details of how the data is obtained	Explore other ways of data capture that does not include use of non-payable claim codes. *(See detailed future planned intervention for description)*
Readmission Rates in CCM enrolled Members ED Visit Rates in CCM enrolled Members	Lack of communication between the transitions of care team (responsible for discharge planning) and the complex case manager assigned to the member's case. Without effective communication channels in place, the complex case manager may be unaware of key details regarding the member's discharge plan, including post-discharge needs and follow-up appointments. Members may lack clarity on when to seek care from their PCP versus when to go to the emergency room. Members may be unaware of alternative services such as urgent care facilities and nurse advice lines	Implement a process to include the CCM Program case managers in the transition of care process of their assigned Members**.** *(See detailed future planned intervention for description)*

PCP visit rate in CCM enrolled Members	Improved oversight by the CCM Team is needed to ensure that all Members requiring PCP visits are appropriately identified and contacted.	Member Follow up to ensure Members are aware of completing their PCP visits. *(See detailed future planned intervention for description)*

Planned Future Interventions

STUDY INTERVENTION #1			
INTERVENTION NAME		**INTERVENTION DESCRIPTION**	
ECM Provider Support for Depression Screening Documentation		**Depression Screening documentation and follow up will be included as standard of care for follow up.** • Reinforce the 'Clinical Measures Report' for better tracking of newly enrolled members and timing of depression screening. • L&D Trainers and Practice Coaches to collaborate on strategies to engage with ECM Care teams. Continue to meet monthly (Care Team-Practice Coach meetings) and annually (ECM Collaborative Conference & ECM End of Year Leadership Meeting).	
STUDY MEASURE IMPACTED		**OPPORTUNITY**	
Depression Documentation in ECM enrolled Members		Implement standard work that will prioritize and ensure that depression screening is captured in a timely manner.	
RESPONSIBLE DEPARTMENT	**START DATE**	**DUE DATE**	**STATUS**
ECM	1/01/2024	12/31/2024	New
S.M.A.R.T. GOALS			

Reinforce the utilization of the 'Clinical Measures Report' for better tracking of newly enrolled members and timing for 90- day mark for depression documentation.

- Starting 3/1/2024, the ECM Analyst downloads, color codes, and breakdown by HCO the Clinical Measures Report (CMR) and distributes to the Practice Coaches via email. The Practice Coaches use the CMR to coach and set goals with each care team. The CMR report includes the following information: a list of enrolled members, # days enrolled, First PHQ-9 score, Last PHQ-9 score and Date of last PHQ-9. The care team will have the ability to filter out members who are missing depression documentation via PHQ-9 score columns and last PHQ-9 date. The report will help the care teams identify and track upcoming patients that require a depression screening to avoid untimely and missing documentation. The ECM Practice Coaches will oversee compliance of monthly depression documentation via the PIR report. The goal is to meet 80% depression documentation by 12/31/2024.

Provide ongoing strategic support, coaching and education for our ECM Providers through their assigned IEHP Practice Coach**.**

- The Practice Coaches will continue to meet once a month with each ECM Care Team to go over PIR report and review the teams' scores on each quality measure which includes the depression documentation measure. Additionally, they will discuss trends, barriers, interventions and share best practices.
- The Practice Coaches will collaborate with the L&D team to build learning materials, webinars and other training documents that will support the ECM Care Teams.

STUDY INTERVENTION #2			
INTERVENTION NAME		**INTERVENTION DESCRIPTION**	
STUDY MEASURE IMPACTED		**OPPORTUNITY**	
Care for Older Adults Measures for My Path Members		Improve data capture of the Care for Older Adults measures	
RESPONSIBLE DEPARTMENT	**START DATE**	**DUE DATE**	**STATUS**
Care Management			
S.M.A.R.T. GOALS			

1. Meet with the director of Technology Solutions Delivery by May 10, 2024, to understand their process for obtaining the source data for Care for Older Adults measures.
2. Schedule follow up meetings by June 10, 2024 with all the adult home-based palliative care groups to share recent results for data capture and reinforce the need for their billing departments to submit these codes.

STUDY INTERVENTION #3	
INTERVENTION NAME	**INTERVENTION DESCRIPTION**
Implementation of a transitional care services process for CCM Enrolled Members	The complex care team will implement a transition of care services process for Members enrolled in complex case management. Complex case managers will be responsible for: • Following members from admission, discharge and follow up on discharge needs for up to 30 days post-discharge. • Member education on appropriate use of healthcare services, including when to seek care from their PCP versus when to go to the ED. • Member education on managing chronic conditions, recognizing early signs of worsening health, and accessing alternative care options, such as urgent care centers or telehealth services. • Ensure Members receive comprehensive support during the transition back to home or community-based care. (e.g. medication reconciliation, post-discharge follow-up calls, and coordination with benefits and community resources based on their needs)
STUDY MEASURE IMPACTED	**OPPORTUNITY**
• Readmission Rates in CCM enrolled Members	Implement a process to include the CCM Program

• ED Visit Rates in CCM enrolled Members	case managers in the transition of care process of their assigned Members.

RESPONSIBLE DEPARTMENT	START DATE	DUE DATE	STATUS
BHCM	04/01/24	04/11/25	New

S.M.A.R.T. GOALS

- By April 1, 2024, the Complex Care Management team will successfully implement a transitions of care process for members enrolled in complex case management. Utilizing interventions aimed at reducing emergency department visits by 10% and hospital admissions by 10% for the year 2024, we will track progress monthly and adjust strategies as needed to ensure goals are achieved.
- By August 2024, the Complex Care Management team will develop/designing a user-friendly dashboard or report template that provide real-time insights into the ED visit and readmission rates for CCM members, allowing for easy identification of trends and areas needing improvement.

STUDY INTERVENTION #4	
INTERVENTION NAME	**INTERVENTION DESCRIPTION**
PCP Visit Integration into Standard work for Case Managers	Work with the Quality team to implement a robust reporting system to accurately track and identify members who are overdue for their annual PCP visits. This will enable the CCM Team to target specific Members and proactively intervene to ensure compliance and adherence to recommended healthcare guidelines. • The CCM Staff will prioritize the promotion of regular PCP visits for preventive care and chronic disease management among all members enrolled in CCM Program. • Incorporate specific goals and interventions in the care plan to address the needs of members who have missed PCP visits.
STUDY MEASURE IMPACTED	**OPPORTUNITY**

PCP Rates in CCM enrolled Members		Member Follow up to ensure Members are aware of completing their PCP visits.	
RESPONSIBLE DEPARTMENT	**START DATE**	**DUE DATE**	**STATUS**
BHCM	05/2024	12/2024	

S.M.A.R.T. GOALS

- By July 2024, the Complex Care Management team will update the current standard work/job aids. In addition, the Complex Care Management team will conduct retraining sessions to ensure all team members are proficient in utilizing the updated standard work/job aid and effectively promoting regular PCP visits for preventative care.
- By August 2024, the Complex Case Management team will develop a user-friendly report that provides real-time insights into primary care physician (PCP) visits for members enrolled in complex case management. This report will enable the identification of members who have not seen their PCP, allowing the team to target these members directly for follow-up and intervention.

Conclusion

ECM Program

The ECM Member Experience results showed a significant improvement from the previous year, the IEHP care teams were effective in providing intensive coordination of health care for our highest risk population with a program rating of 93.6%, 95.4% of respondents think that ECM Care Teams showed strong relationships with their Members and 92.2% found that program was helpful and useful in improving their health needs.

For the metrics assessed in this study (Blood Pressure Control, Transition of Care, Depression Documentation, Depression Response, all met the set goal except for depression documentation. There was 8% improvement of the measure which yielded 74% compliance but still did not meet the 80% goal.

Some of the barriers identified for not meeting goal were the ECM Care Teams missing the 90-day mark of documentation upon Member enrollment. The documentation takes place on the 3rd month, and not necessarily within 90 days. Therefore, the credit for measurement is missed. Health

care organizations in general had challenges in maintaining their staffing level. Staffing levels were at 75% capacity. Lastly, care teams experience difficulty contacting members when there is a change in contact information, no-shows to scheduled appointments to complete initial assessments and client's not answering phone calls and/or texts after enrollment.

To address this, ECM will implement standard work to ensure that depression screening documentation and follow up is captured in a timely manner. ECM will reinforce the utilization of the Clinical Measures Report for better tracking of newly enrolled members and timing of depression screening and documentation. Trainers and practice coaches will continue to collaborate and explore best practices and strategies to engage ECM Care teams to improve depression screening and documentation.

Community Supports Housing Program

The Community Supports services help to address Members' health related social needs to help them live healthier longer lives and avoid higher, costlier levels of care. There are 14 community supports services offered to Members to in areas of food insecurity, respite services, sobering centers and other community-based services. The measures assessed in this study looked at emergency department visits and hospital admission utilization in Members who utilized any of the 4 housing services during 2022 and 2023. The 4 housing categories include: Housing Deposits, Housing Tenancy and Sustaining services, Housing Transition/Navigation services, and Short-Term post-hospitalization housing.

The data revealed that both ED visit rates and hospital admission rates decreased during the 2023 measurement period when compared to the 2022 measurement year. These positive findings indicate the Community Supports housing services is effective in ensuring Members have fewer ED visits and fewer hospital admissions while being supported with housing services. These programs prove to be valuable in Members facing health challenges in addition to homelessness or unstable/unsafe housing. Members will continue to be informed of these services through IEHP Team Members, Providers, the Member portal, Community Supports brochures, hospitals, and community-based organizations.

My Path Program

Utilization and cost data six months pre-enrollment and six months post-enrollment into the My Path Program for 3 years shows that ED visits, Inpatient Visits, and total Member Cost were lower post enrollment compared to pre-enrollment into the My Path Program. This trend is observed annually for the past 3 measurement periods from January to December of 2022, January to December of 2021 and January to December of 2020.

For the Care of Older Adults (COA) measures: Advanced Care Planning, Functional Status Assessment, Medication Review and Pain Assessment, goals were once again not met, although there was a marked increase in the rates for example from 21.6% for pain assessment in 2021 to 31.5% in 2022. The SMART goal for this data issue included meeting with the palliative care groups and obtaining their insights into what the issue could be. Initial meetings were held in March and April 2023 and from these meetings, the fact that this is a data capture issue and not a quality-of-care issue was reinforced. IEHP is only using claims related codes to capture the data around COA measures.

The limitation with using claims codes is that these providers are paid a member rate requiring a different code to be submitted. The COA codes are not payable. Furthermore, if the Providers were not providing the services in the COA measures, the reduction in utilization would not occur. We will continue to work on ways to improve data capture for the COA measures so that the values reflect the work that we know is being done; when we audit individual charts these COA measures have been documented in >90% of the audited charts.

Overall, these results show that participation in My Path is beneficial to our members by decreasing ED visits and Inpatient Visits, while increasing engagement with their PCPs.

CCM Program

The effectiveness of the Complex Case Management (CCM) program was evaluated by analyzing readmission rates, emergency department (ED) visits, primary care physician (PCP) visits, and Member satisfaction scores. The data spanned over the years 2022 and 2023, focusing on members enrolled in the CCM program for at least 90 days to allow ample time for care plan development and member education.

CCM Readmission Rate: The goal of reducing the CCM member readmission rate was not met;

the readmission rate increased from 302.83 to 316.29. To address this, a transition of care process will be implemented in the coming year, aiming to decrease inpatient hospitalizations and readmissions by providing a single point of contact throughout the members' transitions of care.

ED Visits: CCM Member ED visits also increased from 2,134.59 to 2,139.97. Despite this, the CCM program's intensive case management services will continue, and efforts will be made to educate members about appropriate healthcare service utilization to reduce unnecessary ED visits.

PCP Visits: While PCP visit rates showed improvement, the goal of a 10% increase was not achieved. Pre-enrollment PCP visit rates in 2022 were 970.39, decreasing to 963.66 in 2023. To further enhance PCP visit rates, targeted interventions will continue to be implemented, emphasizing annual physical exams. Routine reporting will be emphasized to track progress and ensure adherence to this goal.

Member Experience: Member satisfaction with the CCM program was generally positive, with overall program satisfaction at 87.4%, CCM staff satisfaction at 92.9%, and usefulness of information satisfaction at 87.4%, all exceeding the 80% goal. However, satisfaction with following recommendations made by complex case managers showed a slight decrease from last year, dropping to 88.9% from 95.5%. Efforts will be made to address this decrease and maintain high levels of member satisfaction.

In conclusion, while certain goals were not fully met, the qualitative analysis highlights areas for improvement and underscores the importance of ongoing efforts to enhance the effectiveness of the CCM program in meeting the needs of enrolled Members.

Section 8: Delegation Oversight

8.1 Auditing and Monitoring Activities

IEHP performs a series of activities to monitor IPAs and other Delegates:

1. An annual Delegation Oversight Audit is conducted using a designated audit tool that is based on the NCQA, DMHC and DHCS standards. Delegation Oversight Audits are performed by IEHP Health Services, Provider Services and Compliance Staff using the most current NCQA, DHCS, CMS and IEHP standards;

2. Joint Operations Meetings (JOM) – These meetings are called by IEHP as a means of discussing performance measures and findings as needed. The JOM includes representation from the delegate and IEHP Departments as applicable;

3. Review of grievances and other quality information;

4. Specified audits:

    a. Focused Approved and Denied Referral Audits;

    b. Focused Case Management Audits;

    c. Utilization data review (Denial/Approval Rates, timely Member notification, overturn rate; and

    d. Provider Satisfaction Surveys.

5. IPAs are required to submit the following information to the IEHP Provider Services Department:

    a. Utilization Management (UM) Trend Report – Monthly report of utilization data;

    b. Referral Universe and Letters – Monthly report of all approvals, denials and modifications of requested services;

    c. Care Management (CM) Log – Monthly report of CM activities;

    d. Second Opinion Tracking Log – Monthly report to track Member requested second opinions;

    e. Credentialing Activity – Periodic report of any changes to the network at the Delegate level (e.g., terminated PCPs, specialists);

f. Annual QM and UM Program Descriptions;

g. Annual QMHETP and UM Work Plans;

h. Semi-annual reports of quality improvement activities;

i. Semi-annual reports of credentialing/re-credentialing;

j. Quarterly reports of utilization management activities; and

k. Annual QM and UM Program Evaluations.61

6. IPAs and Health Plans with trends of deficient scoring must submit a CAP to remedy any deficiencies. If an IPA is unable to meet performance requirements, IEHP may implement further remediation action including but not limited to:

    a. Conduct a focused re-audit;

    b. Immediately freeze the IPA to new Member enrollment, as applicable;

    c. Send a 30-day contract termination notice with specific cure requirements;

    d. Rescind delegated status of IPA or Provider, as applicable;

    e. Terminate the IEHP contract with the IPA or Provider; or

    f. Not renew the contract.

7. **Assessment and Monitoring**: To ensure that IPA or Providers have the capacity and capability to perform required functions, IEHP has a rigorous pre-contractual and post-contractual assessment and monitoring system. IEHP also provides clinical and Member experience data to Delegates upon request so they can initiate improvement activities.

8. **Pre-Delegation Evaluation**: All Providers desiring to contract with IEHP must complete a comprehensive pre-contractual document and on-site review.

9. **Reporting**: IEHP's Delegation Oversight Committee (DOC) monitors and evaluates the operational activities of contracted Delegates to ensure adherence to contractual obligations, regulatory requirements and policy performance. Elements of delegation are monitored on monthly, quarterly and annual basis for trending and assessment of ongoing compliance. The reporting includes review of monthly assessment packets, encounter adequacy reports and Provider Services highlights. All oversight audits performed on delegates are reported to the DOC. CAP activities are implemented as deficiencies are identified. Findings and summaries of DOC activities are reported to the Compliance Committee.

8.2 Delegation Oversight Study

The Delegation Oversight Study provides an annual assessment of the Annual Delegation Oversight Audit (DOA) which evaluates the Delegate's abilities to carry out their delegated responsibilities in the areas of Quality Management (QM), Utilization Management (UM), Care Management (CM), Credentialing (CR), Compliance and Fraud, Waste and Abuse (FWA), HIPAA Privacy, and HIPAA Security. Oversight of Medi-Cal Delegates is conducted through regular extensive evaluations including monthly reporting and file audits, quarterly, semi- annual and annual reporting, and the annual DOA. The study period was July 2022 through June 2023.

In 2023, the goal of the study was to evaluate the Medi-Cal Delegates' overall performance from July 2022 through June 2023 for delegated responsibilities as compared to the 2021-2022 DOA performance results. The 2022-2023 DOA goals were to ensure that Delegates' performance demonstrated improvement in providing Member Care that is aligned with regulatory and IEHP requirements and guidelines. Monthly oversight monitoring activities allow IEHP to identify any challenges the Delegates may encounter throughout the year. This frequent monitoring ensures timely mitigation through a corrective action plan process that supports sustained resolution. The desktop audit and system validation audits allow IEHP to conduct more comprehensive file and policy documentation review and allows for interviewing of delegate staff involved in the delegated activity.

A year-to-year comparison of the 2022-2023 Delegation Oversight Audit Results and the 2021-2022 Delegation Oversight Audit (Table 1) demonstrated an overall increase in scores in the areas

of Denial File Audit, and Credentialing File Review. In the Credentialing Policy and Procedure Audit, policies did not meet compliance for sections CR 1 Credentialing Policies, and CR 5 Ongoing Monitoring and Interventions. Additionally, enhancements were made to the audit tools for 2022-2023, which included additional attributes to be tested and an updated scoring methodology. As a result of the 2022-2023 DOAs conducted, IEHP's Delegation Oversight Committee will continue to further develop the Delegation Oversight Program to stringently monitor each of the areas within the Delegation Oversight audit tool and provide on-going training as we see necessary and/or as requested by our Delegated IPA partners.

Section 9: Equity-Focused Interventions

IEHP has compiled a Culturally and Linguistically Appropriate Services (CLAS) Program Description to integrate the National CLAS Standards within IEHP's operational framework to ensure the delivery of care and programs is safe, effective, patient centered, equitable, culturally, and linguistically appropriate manner for our diverse population as well as to inform and deploy initiatives to advance health equity, improve quality, and help eliminate health disparities.

Through this work, IEHP has identified patterns of underutilization of clinical services among a subset of our membership when stratified by race/ethnicity. Some of these measures include (by disparate population) and the intervention to address the clinical disparity:

- Glycemic Status >9% = Hispanic
    - High touch pilot targeting Hispanic diabetic members that meet criteria for receiving Medically Tailored Meals (MTM). Members will be paired with a community health worker and Spanish-speaking Registered Dietician over the course of 3 months.
- Controlling High Blood Pressure = Black/African American
    - Equity-focused clinical measure integrated into the 2025 pay for performance program

- Child and Well Care Visits = White/American Indian
    - Focused outreach by community health workers and other member facing departments to targeted population to ensure completion of visit
- Immunization for Adolescents – Combo 2 = Black/African American
    - Equity-focused clinical measure integrated into the 2025 pay for performance program
    - Participation in DHCS' Equity Practice Transformation (EPT) with targeted pediatric offices
- Colorectal Cancer Screening = all populations
    - Program under development
- Breast Cancer Screening = White/Hispanic
    - Mobile Mammography units dispatched to IEHP's Community Wellness Centers to facilitate access by targeted populations
- Prenatal/Postpartum Care = Black/African American
    - Enhanced Care Management (ECM) Birth Equity Population of Focus targeting pregnant and postpartum members with disparities
    - Doula Benefit
    - Targeted outreach by trained community health workers

In addition, through a partnership with one of our largest contracted provider groups (Riverside University Health Systems – RUHS), we have identified nearly 40,000 members that have not engaged with their PCP since initial enrollment. Of these members, 55% identify as Hispanic/Latino. A cross-functional workgroup has been established to develop a targeted outreach campaign to close this gap.

The National Committee of Quality Assurance (NCQA) has selected IEHP as one of their pilot sites to participate in the "Putting Health Equity into Practice" project using our children's measures data to assess:

1. Which health equity scoring methods are valid and meaningful for health care organizations, and;

2. How useful these approaches are in tracking and monitoring inequitable performance outcomes as a mechanism for accountability in advancing health equity.

Through this exercise, we expect to leverage findings to identify new ways of identifying patterns of underutilization by populations and regions.

Although no equity-focused interventions to address patterns of over utilization of services have been conducted to date, we are in the process of conducting overutilization analysis of several services (including transportation) and will then filter those findings to assess if there are populations that are identified for targeted interventions.

Section 10: Global P4P Performance – IPA

10.1 Program Assessment

The purpose of this study is to assess the effectiveness of Inland Empire Health Plan's (IEHP's) Global Quality (GQ) Pay-for-Performance (P4P) Program for Independent Physician Associations (IPAs) with Medi-Cal Membership. The GQ P4P Program for IPAs is designed to reward IPAs high performance and year-over-year improvement in key quality performance measures. IEHP contracted IPAs are an important support to IEHP Providers in the care for IEHP Members.

The GQ P4P Program measures performance from January – December of the program year and provides a monthly PMPM (per Member per Month) quality payment based on their previous year's GQ P4P performance. The quality measures included in the GQ P4P program are categorized in five domains: Access; Clinical Quality; Behavioral Health Integration; Patient

Experience and Encounter Data. Most measures included in the Clinical Quality Domain primarily use standard Healthcare Effectiveness Data and Information Set (HEDIS) process and outcomes measures that are based on the specifications published by the National Committee for Quality Assurance (NCQA). Non-HEDIS measures that are included in the program come from the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Quality Program and the Pharmacy Quality Alliance (PQA). The GQ P4P Program measures IPA performance during the calendar year of January through December of the measurement year.

To be eligible for the Program, IPAs must: have at least 5,000 Medi-Cal Members assigned to them as of January of the program year; have at least 30 Members in the denominator as of December of the program year for each quality measure to qualify for scoring; submit a GQ P4P Quality Work Plan to IEHP by the first quarter of the program year in order to be eligible to participate in the program; and meet minimum Encounter Data Gates in order to qualify for incentive payments. An additional eligibility requirement for the 2022 GQ P4P Program was for IPAs to designate a Quality Team of 2-4 staff dedicated to quality improvement work for the IPA.

This assessment explores GQ P4P performance for IPAs for program years 2019 through 2022.

Data sources used include Encounters, Claims, EDW and HEDIS QSI Software.
Administrative data was extracted from all data sources listed above. Once all data was compiled, an analysis was reviewed and approved by the following individuals: Vice President of Quality, Senior Director of Quality Systems, Provider Quality Incentives Manager, Quality Performance Informatics Manager. The results of these analyses are presented to IEHP's Quality Improvement (QISC) Subcommittee for review, comment, and approval.

Study Measures

The following are study measures used to assess effectiveness of study interventions:

STUDY MEASURE #1	IPA - Provider Participation Rate
STUDY MEASURE DESCRIPTION	The percent of IEHP Medi-Cal Primary Care Physicians (PCPs) participation in the Global Quality P4P Program (for PCPs) by each IPA.

NUMERATOR DESCRIPTION	The count of unique IEHP Medi-Cal Primary Care Physicians who received a Global Quality P4P Quality Score for the 2019-2022 performance year by each IPA.
DENOMINATOR DESCRIPTION	The count of unique IEHP Medi-Cal Primary Care Physicians (PCPs) in the IEHP network in the 2019-2022 calendar year by each IPA.
GOAL	75%

STUDY MEASURE #2	IPA Financial Incentive
STUDY MEASURE DESCRIPTION	The percent of total financial payout earned by IPAs.
NUMERATOR DESCRIPTION	The total amount earned by participating Independent Physician Associations (IPAs) in the Global Quality P4P Program for the 2019 – 2022 performance year.
DENOMINATOR DESCRIPTION	The Global Quality P4P Program (for IPAs) annual budget for the 2019 – 2022 performance year.
GOAL	75%

STUDY MEASURE #3	Overall Performance - IPA Quality Score
STUDY MEASURE DESCRIPTION	The average quality score for participating IPAs in the Global Quality P4P Program for the 2019 – 2022 performance years.
GOAL	1.0 quality score

Results

Table 1 below shows the rate of Primary Care Physicians (PCPs) that were eligible to participate in the Global Quality P4P Program per IPA for program years 2019 - 2022. For PCPs to qualify for the program, each PCP must:

- Have at least 200 assigned Medi-Cal Members as of January of the program year.

- Have at least 30 Members in the denominator as of December of the program year for each quality measure to qualify for scoring.

- Have at least three quality measures that meet minimum denominator requirements in order for a global quality score to be calculated.

- Be connected to CAIR2 (must enter immunizations into the registry and use to look up prior immunizations given to assigned patients) by July 1 of the program year (program years 2021 and 2022 only).

Arrowhead Regional Medical Center (ARMC), Riverside University Health Systems (RUHS) and Integrated Health Partners (IHP) are contracted partners with IEHP Direct that, for the purposes of the GQ P4P Program, are treated as pseudo-IPAs. To determine the PCPs assigned to IHP, a filter was used to only include PCPs contracted with IEHP Direct that have the tax identification number (TIN) of 474334653. The PCPs assigned to ARMC and RUHS were verified by the IPA at the end of each program year to ensure accurate reporting details. The verified lists of PCPs were only available for program years 2020 – 2022.

Physicians Health Network and LaSalle Medical Association were the only two IPAs to meet the 75% participation rate goal for all four years. The following four IPAs did not meet the goal set at 75% for every included program year: IEHP Direct, IHP, Optum Care Network – IFMG, and RUHS.

Table 1: IPA – Provider Participation Rate – Goal 75%

	2019		2020		2021		2022	
IPA Name	**Den/Num Rate**	**Goal Met?**	**Den/Num Rate**	**Goal Met?**	**Den/Num Rate**	**Goal Met?**	**Den/Num Rate**	**Goal Met?**
Alpha Care Medical Group	244/168 69%	No	224/163 73%	No	218/168 77%	Yes	204/138 68%	No
ARMC*			33/29 88%	Yes	44/39 89%	Yes	47/9 19%	No
Dignity Health Medical Network	9/4 44%	No	9/7 78%	Yes	7/4 57%	No	7/6 86%	Yes

Horizon Valley Medical Group	20/14 70%	No	24/17 71%	No	25/22 88%	Yes	27/23 85%	Yes
IEHP Direct	856/509 59%	No	798/463 58%	No	841/488 58%	No	871/465 53%	No
Integrated Health Partners	15/4 27%	No	15/4 27%	No	23/4 17%	No	26/7 27%	No
LaSalle Medical Associates	108/83 77%	Yes	93/79 85%	Yes	86/73 85%	Yes	79/64 81%	Yes
Optum Care Network - IFMG	164/116 71%	No	173/121 70%	No	189/138 73%	No	185/131 71%	No
Physicians Health Network	38/29 76%	Yes	44/35 80%	Yes	48/43 90%	Yes	53/50 94%	Yes
RUHS*			26/17 65%	No	19/13 68%	No	21/15 71%	No

**At the time of this study, verified list of PCP data unavailable for the 2019 performance year*

Payment to IPAs for their final GQ P4P performance rate is paid via a monthly Per Member Per Month (PMPM) Quality Payment. The IPA's assigned Membership for the current payment month is multiplied by the final PMPM amount earned from the previous year's program and is paid as a monthly additional incentive payment. The table below shows the annual budget for the 2019 – 2022 GQ P4P performance years, and the amount paid to IPAs via the PMPM Quality Payment. In all four years, the goal of paying at least 75% of the budgeted amount was not achieved, with the lowest payment rate occurring in 2019. The 2022 total estimated payment was calculated by using the estimated Total Member Year Membership, multiplied by 2022 final GQ P4P PMPM amounts.

Table 2: IPA Financial Incentive – Goal 75%

Program Year	Denominator	Numerator	Rate	Goal Met?
2019	$20,000,000.00	$5,254,172.02	26.27%	No
2020	$20,000,000.00	$7,949,221.43	39.75%	No
2021	$20,000,000.00	$10,886,207.63	54.43%	No
2022*	$45,000,000.00	$19,411,870.20	43.14%	No

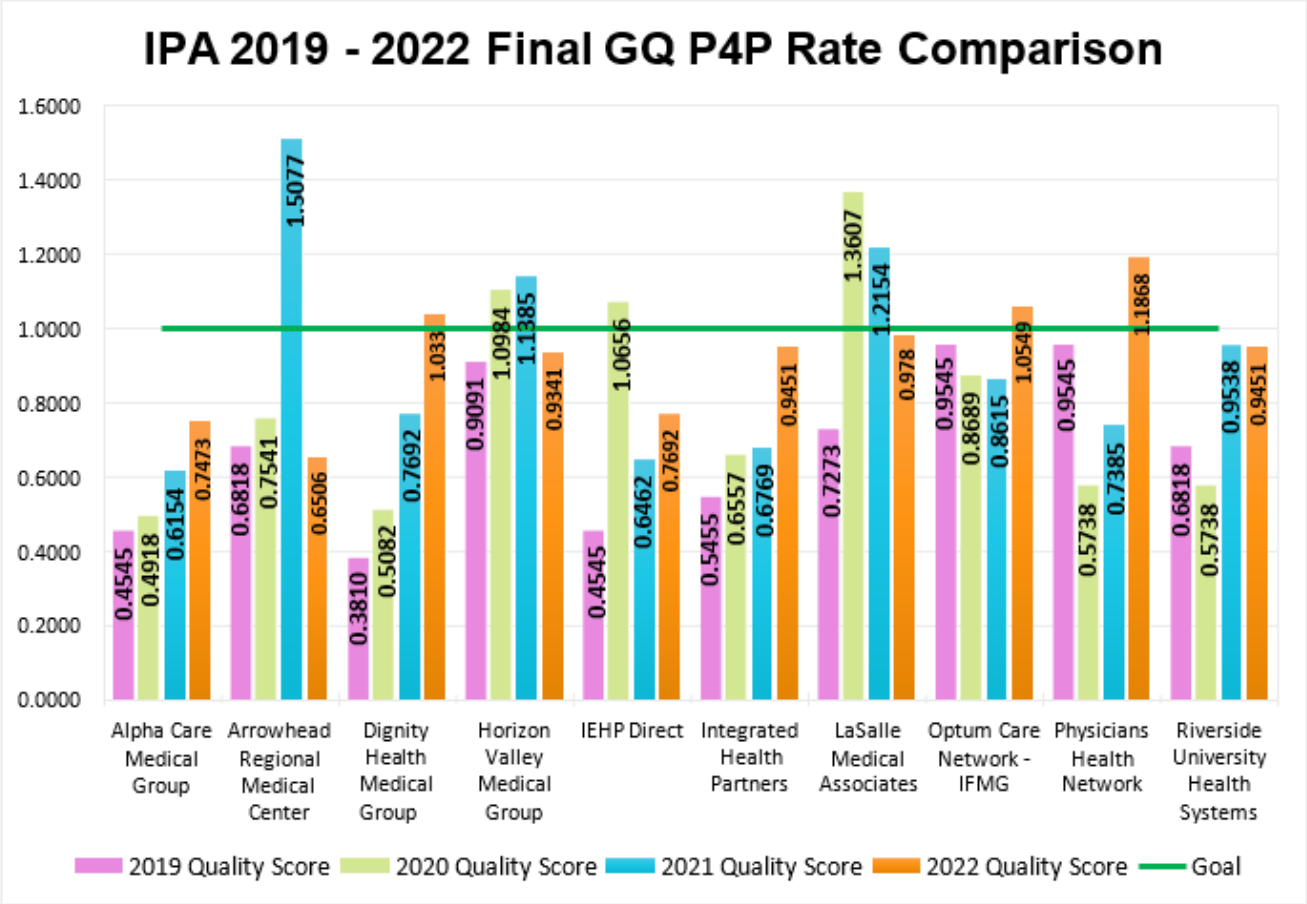
**estimated total payment*

The final quality score for all IPAs for the GQ P4P Program years 2019 – 2022 is shown in *Table 3* below. The only performance year to not meet the goal of 1.0 for all IPAs was in 2019. 2020 – 2022 has three IPAs meet the goal each year, with Horizon Valley and LaSalle Medical Association being the only two IPAs to meet the goal in both 2020 and 2021. The following IPAs did not meet the goal of a 1.0 quality score for all four years: Alpha Care Medical Group, Integrated Health Partners and RUHS. Alpha Care Medical Group, Integrated Health Partners and Dignity Health Medical Network, however, are the only three IPAs to show a consistent improvement in their quality score year over year, as reflected in *Graph 1* below.

Table 3: Overall Performance – IPA Quality Score – Goal 1.0

	2019		2020		2021		2022	
IPA Name	**Quality Score**	**Goal Met?**	**Quality Score**	**Goal Met?**	**Quality Score**	**Goal Met?**	**Quality Score**	**Goal Met?**
Alpha Care Medical Group	0.4545	No	0.4918	No	0.6154	No	0.7473	No
ARMC	0.6818	No	0.7541	No	1.5077	Yes	0.6506	No
Dignity Health Medical Network	0.3810	No	0.5082	No	0.7692	No	1.0330	Yes
Horizon Valley Medical Group	0.9091	No	1.0984	Yes	1.1385	Yes	0.9341	No
IEHP Direct	0.4545	No	1.0656	Yes	0.6462	No	0.7692	No
Integrated Health Partners	0.5455	No	0.6557	No	0.6769	No	0.9451	No
LaSalle Medical Associates	0.7273	No	1.3607	Yes	1.2154	Yes	0.9780	No
Optum Care Network - IFMG	0.9545	No	0.8689	No	0.8615	No	1.0549	Yes
Physicians Health Network	0.9545	No	0.5738	No	0.7385	No	1.1868	Yes
RUHS	0.6818	No	0.5738	No	0.9538	No	0.9451	No

Graph 1: IPA 2019 – 2022 Final GQ P4P Rate Comparison



Causal / Barrier Analysis

STUDY MEASURE NOT MET	CAUSAL/BARRIER ANALYSIS	OPPORTUNITY
Study Measure #1 IPA - Provider Participation Rate	• Meeting the assigned Membership count of 200 Members by January of the program year does not allow for Providers who gain Membership throughout the program year to participate.	• Updating the PCP requirements to be more flexible may allow for more PCPs to be eligible to participate in the program.

Study Measure #3 Overall Performance - IPA Quality Score	• Lack of Provider knowledge with GQ P4P coding specifications. • Disconnect between PCPs and IPAs with data submissions.	• Hold best practice meetings to learn from top performing Providers on their best practice tactics. • Host biller/coder P4P workshop to assist in P4P data submissions and data capture.

Planned Future Interventions

STUDY INTERVENTION #1			
INTERVENTION NAME		**INTERVENTION DESCRIPTION**	
Update GQ P4P - PCP Program Participation Requirements		GQ P4P – PCP Program Participation requirements were updated in the 2023 GQ P4P Program to requiring 200 assigned Medi-Cal Members as of July 2023 instead of January 2023, and requiring only 20 Members in the denominator for each measure to qualify instead of 30.	
STUDY MEASURE(S) IMPACTED		**OPPORTUNITY**	
Study Measure #1: IPA - Provider Participation Rate		Increase the rate of PCPs who are eligible to participate in the GQ P4P Program.	
RESPONSIBLE DEPARTMENT	**START DATE**	**DUE DATE**	**STATUS**
Quality Systems Administration	**January 2023**	**December 2023**	In Progress
SMART GOAL(S)			
• By December 2023, there will be a 10% improvement in the rate of Providers who are eligible to participate in the 2023 GQ P4P Program.			

STUDY INTERVENTION #2			
INTERVENTION NAME		**INTERVENTION DESCRIPTION**	
Best Practice Meetings for IPAs and PCPs		Once the 2022 and 2023 GQ P4P quality scores are finalized, invite the top performing PCPs and IPAs to speak at the Best Practice Meetings to share their insights and tactics to encourage other PCPs and IPAs on how to improve their quality scores.	
STUDY MEASURE(S) IMPACTED		**OPPORTUNITY**	
Study Measure #3: Overall Performance - IPA Quality Score		Increase the overall quality scores for PCPs, which will in turn increase the overall rates for IPAs.	
RESPONSIBLE DEPARTMENT	**START DATE**	**DUE DATE**	**STATUS**
Quality Systems Administration	**January 2023**	**August 2024**	In Progress
SMART GOAL(S)			
• By December 2023, the 2023 Best Practice Meetings for the 2022 GQ P4P Program will result in 10% improvement to the overall quality score of both PCPs and IPAs. • By December 2024, the 2024 Best Practice Meetings for the 2023 GQ P4P Program will result in a 10% improvement to the overall quality score of both PCPs and IPAs.			

STUDY INTERVENTION #3	
INTERVENTION NAME	**INTERVENTION DESCRIPTION**
Host Biller/Coder P4P Workshop	Host Biller/Coder P4P Workshop that will include training and learning opportunities for Provider office billers. Workshop to include: best practice bill guidance, GQ P4P measure specific coding recommendations and more.
STUDY MEASURE(S) IMPACTED	**OPPORTUNITY**

Study Measure #3: Overall Performance - IPA Quality Score	Increase data accuracy, through proper billing and coding, that will assist in measure compliance by capturing the rendered services provided by IEHP Providers participating in the Global Quality P4P Program.

RESPONSIBLE DEPARTMENT	START DATE	DUE DATE	STATUS
Quality Systems Administration	**January 2023**	**February 2024**	In Progress

SMART GOAL(S)

- By February 2024, 5% of IEHP 2024 GQ P4P participating Providers having at least one (1) Provider office biller attend the Biller/Coding P4P Workshop.

Conclusion

The Global Quality (GQ) P4P Program for IPAs is now on its eighth year of the program, providing financial incentives to IPAs for high performance and year-over-year improvement for specified quality measures that impact IEHP's Medi-Cal population. The aim of the program is to create behavioral changes for the PCPs and IPAs, that would improve the quality of care for IEHP Members and in turn positively impact the HEDIS® measure rates. The IPA - Provider Participation Rate results show that majority of each year the percentage of the IEHP PCP network participating in the GQ P4P fell short of the 75% goal. The 2021 GQ P4P Program year had the overall highest percentage of IPAs able to meet the goal, with five out of the ten IPAs meeting the 75% goal.

The results from *Table 2* show that each year the goal of paying 75% of the budgeted GQ P4P Program amount were not met, with justification being shown in the low performing, overall quality scores from *Table 3*. In 2019, there were no IPAs who met the goal of having a 1.0 or higher quality score. In 2020 – 2022, each year only three IPAs out of the ten total were able to meet or surpass the goal.

The results for this assessment signify additional resources are needed to help encourage the IPAs to increase their quality performance scores. In the 2022 and 2023 GQ P4P Program years, two penalty measures were introduced into the program: PCP Encounter Data Rate and Provider Grievance Response Rate. The purpose of the IEHP PCP Encounter Data Rate penalty measure is to ensure IEHP receives adequate PCP encounter data from IEHP- Contracted Medi-Cal Providers. Encounter data is important to performance scoring and is essential to the success of the GQ P4P Program. A limitation to the GQ P4P Program, however, was the Provider eligibility requirements not allowing for more PCPs to participate in the program given the guidelines in 2019 – 2022. The 2023 GQ P4P Program updated those guidelines and will be monitored to see if it results in a significant impact in more PCPs being eligible to participate in the program. In addition to monitoring the current measures, future assessment will also analyze the specific measures included in the GQ P4P Program to assess where additional efforts may be needed to increase quality scores, that can assist in increasing IEHP's HEDIS® rates.