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2023 Quality Improvement Work Plan Evaluation

Kaiser Foundation Health Plan Southern California Region

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

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Approved by Southern California Quality Committee (SCQC) on March 22, 2024

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Overview

The overall goal of the 2023 Kaiser Permanente Southern California Quality Improvement Program Evaluation is to assess the effectiveness of the organization's Quality Improvement Program with respect to quality, accessibility, safety of clinical care, quality of service, and member experience.

This is an annual activity in which committees, departments, content experts, data analysts, and workgroups analyze and evaluate the effectiveness of the prior year's Quality Improvement Work Plan, which includes the following:

- Overall effectiveness of QI program
- QI goals and actions
- Quantitative and qualitative analysis
- Barriers and next steps

Oversight and Approval

The annual Quality Improvement Program Evaluation is reviewed and approved annually by the Southern California Quality Committee (SCQC). On an ongoing basis, the SCQC reviews analyses for all reporting areas with regional leaders.

The KP-SCAL regional senior executive quality leaders review the Quality Improvement Program Evaluation as a part of the accountabilities chartered by SCQC. Nationally, the Quality and Health Improvement Committee of the Kaiser Foundation Health Plan Board of Directors also is accountable to review and approve the KP-SCAL trilogy documents, including the 2024 Quality Program Description, 2024 Quality Improvement Work Plan, and the 2023 Quality Improvement Program Evaluation.

The KP-SCAL Quality Management Department collects and evaluates data and develops the Quality Improvement Program Evaluation as part of a centralized, integrated process. Committee members, department managers, regional content experts, data analysts, and physicians provide input for the evaluation.

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Quality Improvement Program Overall Effectiveness Summary

During 2023, KP-SCAL achieved similar levels of overall effectiveness of the QI program as in prior years. Adequate resources were dedicated to program activities resulting in the improvements discussed in detail in this document. Membership of the Southern California Quality Committee (SCQC) involved Kaiser Foundation Health Plan – Southern California leadership and the Southern California Permanente Medical Group (SCPMG). SCQC provided the necessary support, guidance, and approval of the QI program resulting in improvements throughout the Region. The resources and infrastructure, including SCQC and the SCQC sub-committees, were adequate to support a positive impact on the care and services provided to KP-SCAL members.

The overall 2023 Quality Improvement Program was highly effective and there were many positive patient care outcomes in 2023; therefore, no changes to the QI program are needed. KP-SCAL was ranked at the top in several accreditation, health plan rankings, and regional regulatory surveys.

Highlights of the quality accomplishments for clinical and service performance include:

- Medicare Quality – For 2024, Kaiser Permanente's Medicare health plans in California received an overall rating of 4 out of 5 stars, which is considered "above average" performance according to CMS. This is a reflection of Kaiser Permanente's commitment to providing high-quality care and outstanding customer service to our patients and the communities we serve.

- According to NCQA's Health Insurance Plan Ratings for 2023, Kaiser Permanente's Medicare plans are higher rated (or tied for highest) in each region or state that it serves for the 8th year in a row. The report compares more than 1,000 private, commercial, Medicare, and Medicaid health plans in key areas of patient experience, treatment, and prevention on a 0-5 scale. For the 5th consecutive ratings cycle, all Kaiser Permanente commercial plans are higher rated (or tied for highest) in each region or state that it serves. Only 7% of the nation's plans rated 4.5 stars or higher. This survey recognizes our steadfast focus on providing the best care experience and achieving the best outcomes.

- NCQA – 2023 Health Insurance Plan Rankings/Commercial Private Plan - KP Southern California with an overall Rating of 4.5.

  NCQA Overall Commercial Rating 4.5 out of 5
  - Patient Experience 2.0
  - Prevention 4.5
  - Treatment 4.0

- NCQA – 2023 Health Insurance Plan Rankings/Medicare - KP Southern California with an overall rating of 4.5.

NCQA Overall Medicare Rating 4.5 out of 5
- Patient Experience 2.5
- Prevention 5.0
- Treatment 4.5

- In 2023, Kaiser Permanente Southern California successfully achieved NCQA PCMH Recognition for 106 renewing practice sites under NCQA's Annual Reporting Program and submitted for PCMH Recognition for 1 new practice site. In the next year, leads will continue to maintain NCQA PCMH recognition for currently recognized practice sites (MOBs that offer adult primary care (family medicine and internal medicine) and/or pediatric services). Kaiser Permanente Southern California continues to have the greatest number of NCQA PCMH recognized practice sites.

  Accomplishments are noted below:
  - 106 practice sites obtained NCQA PCMH recognition (through Annual Reporting) in Q4 of 2023.
  - As of the 1st quarter of 2024, more than 90% of our KPSC membership is covered by PCMH recognized sites.
  - PCMH provides Kaiser Permanente Southern California with NCQA Health Plan automatic credit for PHM 2 and PHM 5. Supplemental documentation was also supplied to support additional Health Plan Accreditation factors.

- In 2023, Kaiser Permanente's California health plans were the only plans to receive a 5 out of 5 stars "Overall Rating" for care and experience quality from Covered California for the 2024 coverage year.

- Kaiser Permanente Medical Centers Receive 'A' Grades for Patient Safety from The Leapfrog Group –
  - Of the 15 eligible SCAL KP hospitals, 10 were given an 'A' rating for patient safety in the biannual national report card issued by The Leapfrog Group for Fall 2023.
  - Of the approximately 3,000 hospitals in the U.S that were included in the report, less than 30 percent were given an 'A' grade.

- Kaiser Permanente Hospital Named 'Top Hospitals' by Leapfrog Group –
  - In 2023, Irvine Medical Center named top teaching hospital.
  - Nationally, only approximately 6% (132) of nearly 2,100 hospitals surveyed were named "Top Hospitals".
  - Top Hospitals are defined as having better systems in place to prevent medication errors, higher quality maternity care and lower infection rates, among other qualities.

- Office of the Patient Advocate (OPA): 5 out of 5 – In 2023, for the 16th consecutive year, Kaiser Permanente Southern California (KPSC) earned a five-star rating – the highest possible – for overall quality of medical care in the annual Healthcare Quality Report Card from California's Office of the Patient Advocate. KPSC is the only health plan to

receive OPA's top rating for "quality of medical care" for 16 consecutive years. The five-star rating is based on both the quality of care we provide our members and their satisfaction with it. In addition to the top overall score, Kaiser Permanente in Southern California also earned top scores in 8 specific clinical categories.

Of note, for the 5th year in a row, KPSC received 5 stars for overall clinical effectiveness in behavioral and mental health care.

- In 2023, Kaiser Permanente was ranked #1 in the J.D. Power Pharmacy mail-order consumer satisfaction study for the second consecutive year. Kaiser Permanente was #1 in the study for 8 years of a 9-year stretch: 2009-14 and 2016-17. The study is based on responses from more than 12,000 customers who filled new prescriptions or refilled current ones within the past 12 months prior to the survey, which took place August 2022 – May 2023. The study measures satisfaction for five factors: prescription ordering process, prescription delivery, cost competitiveness, interaction with the pharmacist, and interaction with the non-pharmacist staff.

- Fourteen Kaiser Permanente Southern California hospitals rated "high performing" for Maternity Care by US News. This study rates hospitals in 4 areas: cesarean births, exclusive breast milk feeding, unexpected complications in term newborns, and vaginal births after c-section.

- Of the more than 4,500 hospitals analyzed nationwide, US News recognized all 15 Southern California hospitals as "high performing" (see KPSC hospital list below) in one or more of the 36 specialties or common procedures or conditions considered.

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Cardiac care continues to be a great source of organizational pride, as 11 of the 15 Southern California hospitals are designated "high performing" (the highest rating given) for congestive heart failure treatment. Additionally, 11 of the 15 are "high performing" for Maternity Care (Uncomplicated Pregnancy) and Kidney Failure treatment. Our work to advance colon cancer treatment is also evident, as four Southern California hospitals rank "high performing" in colon cancer surgery.

Hospital	High Performing Designations
Anaheim/Irvine	**Adult Specialties**: Gastroenterology & GI Surgery; Geriatrics; Neurology & Neurosurgery; Orthopedics
	Procedures/Conditions: Leukemia, Lymphoma & Myeloma; Colon Cancer Surgery; Heart Attack; Heart Failure; Diabetes; Kidney Failure; Stroke; Maternity Care (Uncomplicated Pregnancy); Hip Replacement; Knee Replacement; Chronic Obstructive Pulmonary Disease (COPD); Pneumonia
Baldwin Park	**Procedures/Conditions**: Heart Attack; Heart Failure; Kidney Failure; Stroke; Maternity Care (Uncomplicated Pregnancy); Pneumonia
Downey	**Adult Specialties**: Geriatrics; Pulmonology & Lung Surgery
	Procedures/Conditions: Heart Failure; Diabetes; Kidney Failure; Back Surgery (Spinal Fusion); Stroke; Maternity Care (Uncomplicated Pregnancy); Chronic Obstructive Pulmonary Disease (COPD); Pneumonia
Fontana/Ontario	**Procedures/Conditions**: Prostate Cancer Surgery; Heart Attack; Aortic Valve Surgery; Heart Bypass Surgery; Heart Failure; Diabetes; Back Surgery (Spinal Fusion); Stroke; Maternity Care (Uncomplicated Pregnancy); Chronic Obstructive Pulmonary Disease (COPD); Pneumonia
Los Angeles	**Adult Specialties**: Neurology & Neurosurgery; Pulmonology & Lung Surgery; Urology
	Procedures/Conditions: Heart Attack; Aortic Valve Surgery; Heart Bypass Surgery; Heart Failure; Diabetes; Stroke; Maternity Care (Uncomplicated Pregnancy); Pneumonia
Moreno Valley	**Procedures/Conditions**: Chronic Obstructive Pulmonary Disease (COPD); Pneumonia
Panorama City	**Procedures/Conditions**: Lung Cancer Surgery; Prostate Cancer Surgery; Maternity Care (Uncomplicated Pregnancy)
Riverside	**Procedures/Conditions**: Heart Failure; Kidney Failure; Stroke; Maternity Care (Uncomplicated Pregnancy); Hip

	Fracture; Chronic Obstructive Pulmonary Disease (COPD); Pneumonia
San Diego/ San Diego Zion	**Adult Specialties**: Orthopedics; Pulmonology & Lung Surgery
	Procedures/Conditions: Leukemia, Lymphoma & Myeloma; Colon Cancer Surgery; Lung Cancer Surgery; Heart Attack; Heart Failure; Diabetes; Kidney Failure; Stroke; Maternity Care (Uncomplicated Pregnancy); Hip Fracture; Hip Replacement; Knee Replacement; Chronic Obstructive Pulmonary Disease (COPD); Pneumonia
South Bay	**Procedures/Conditions**: Stroke; Maternity Care (Uncomplicated Pregnancy); Knee Replacement; Chronic Obstructive Pulmonary Disease (COPD); Pneumonia
West LA	**Procedures/Conditions**: Prostate Cancer Surgery; Diabetes; Stroke; Maternity Care (Uncomplicated Pregnancy); Pneumonia
Woodland Hills	**Adult Specialties**: Pulmonology & Lung Surgery
	Procedures/Conditions: Stroke; Maternity Care (Uncomplicated Pregnancy); Hip Replacement; Chronic Obstructive Pulmonary Disease (COPD); Pneumonia

In the pages to follow are the detailed quantitative and qualitative analyses of the numerous initiatives and strategies to strengthen the Quality Improvement Program and provide direction for the 2024 Quality Improvement Program Work Plan.

Internal Reporting

Clinical Quality Key Measures 2022 Announcement

Maintaining high performance in most of the clinical measures continues to be imperative. Our results are published in several venues for publicly reported clinical quality metrics (e.g., NCQA Commercial Ratings, Medicare 5-Star, CMS, CA Office of the Patient Advocate, Covered CA, and the Integrated Healthcare Association AMP (Align Measure Perform). Each of these organizations may use different cut points for categorizing, or rating, our clinical quality, which makes it challenging to manage and monitor performance for these publicly reported measures.

The methodology for calculating the Ambulatory Quality Composite (AQC) Score allows us to consider a spectrum of measures that are publicly reported by NCQA, CMS, and the Office of the Patient Advocate (now known as the Center for Data Insights and Innovation), including measures that are being monitored and measures with targeted improvement efforts. Individual measure targets for the AQC may be set to the highest benchmark across different rating systems to maintain our strong clinical quality performance; targets may also be set at a level that will move KP SCAL's performance to a higher star rating than current performance. The most appropriate annual target for the composite measures is determined by a CSG Planning committee. The AQC Score allows each Area to focus and prioritize based on their performance on specific measures relative to the gap to the measures' targets. In fact, the Ambulatory Quality Composite Score is designed such that no single specialty or group of physicians can improve all, or even most, components of the composite. Performing well on the composite requires a team effort involving the entire medical center. We have chosen to continue including the inter-area interdependence goal: the proportion of Areas that are meeting the AQC target. Our goal is to have all 13 service areas meeting the target by the end of the incentive cycle as everyone benefits when all are successful.

The 2023 Clinical Quality of Care Key Measures now includes a section for behavioral health, and the focus for this year is on the continuation phase of the Antidepressant Medication Management measure. While we recognize that depression care can include a variety of effective modalities, our performance results on this measure of medication adherence for depression pharmacotherapy are below the external benchmarks. Ensuring higher adherence rates in the continuation phase would demonstrate that our members have enough supply of antidepressant medications to run a six-month course of pharmacotherapy.

Protecting our members from avoidable illnesses with vaccination continues to be a priority from prior years, and our focus in the 2023 Clinical Quality of Care Key measures will be on the childhood Combo7 vaccination rates among African American infants and toddlers. This measure highlights the importance of early childhood vaccination for our more vulnerable populations of young children and specifically addresses known inequities. Pediatricians and other healthcare professionals who treat children will need to reinforce the message to the parents or caregivers that childhood vaccinations are important to keeping our children healthy.

Management of our members who suffer from diabetes and other cardiovascular conditions continues to be an area of focus, and we again commit to addressing inequities. Our goal will be to provide equitable care (instead of just 'equal' care) for our members with diabetes who are

part of the Hispanic/Latino population, even as we address challenges with glycemic control in the overall population in the new "Staying Healthy" section. We will also be monitoring Statins adherence in this new section.

The 2023 Clinical Quality Key Measures are posted on the CSG Sharepoint site in the "Current Monthly Reports" subfolder of the CSG Reports Library, and each of the Quality Key Measures has an incentive attached to it.

The complete list of the 2023 Clinical Quality Key Measures is in the table below:

2023 Clinical Quality Key Measures	Target
Ambulatory Quality Composite Score (Area-specific)	100.0
Proportion of Areas meeting AQC Target	13/13
Behavioral Health *(new)*	
Antidepressant Medication Management – Continuation Phase (18+) *(new)*	63.0%*
Equitable Care	
HbA1c < 8.0% - Hispanic/Latino Population (18-<65 y/o)	57.0%*
Childhood Vaccinations: Combo 7 – AA/Black population *(new)*	70.0%*
Staying Healthy *(new)*	
Proportion of Days Covered by Medications: Statins (Ages 18-85) *(new)*	85.0%*
HbA1c Control (<8%) in Members with Diabetes (Total Ages 18-75) *(new)*	67.0%*

**** The targets displayed for these measures reflect the incentive targets for 2023, and they differ from the targets used in the Ambulatory Quality Composite z-score calculations.***

Clinical Strategic Goals 2023 Results

The CSG reports include both publicly reported measures and internal measures relating to areas of important clinical concern. We aspire to be the best at getting better, and continuous improvement across the range of clinical quality measures is one way to demonstrate it, including when those measures are used for internal monitoring of progress on clinical initiatives. These CSG reports inform us about whether we are attaining high quality clinical care for our members, maintaining our position as a national role model for an integrated health care system.

The rates for most measures have been updated with data for the rolling measurement period ending October 31, 2023, unless otherwise noted.

2023 Clinical Quality Key Measures

Clinical Strategic Goals

Results through October 31, 2023	Time Period		AV	BP	DO	KC	LA	OC	PC	RI	SBC	SD	SBY	WLA	WH	REG	TGT
1. CSG Ambulatory Quality Composite																	
Ambulatory Quality Composite Score (Area-specific)	2023 M10	Score	97.1	126.8	106.1	87.7	111.9	124.3	108.0	103.5	87.6	121.7	104.5	110.1	112.4	106.9	100.0
1.a.2. Quality Improvement from Baseline	2023 M10	Increase from 2022 M12	3.8	12.2	4.8	7.5	4.6	6.6	2.5	12.1	12.9	6.3	6.5	4.3	11.4	7.9	10.0
Proportion of Areas meeting AQC Target	2023 M10	Score	77% (10/13 areas)														100% (13/13)
2. Behavioral Health																	
Antidepressant Medication Management – Continuation Phase (18+)	2023 M10	Rate (%)	56.9	59.8	57.2	59.1	62.1	60.9	62.3	60.2	58.9	64.5	60.6	60.2	61.8	60.8	63.0
		Δ from 2022 YE	1.5	0.7	0.4	3.7	-0.2	-0.1	-0.4	4.0	1.1	0.8	-0.1	1.4	-0.6	0.8	
		Denominator	2,025	3,184	4,475	1,645	5,147	8,486	4,451	6,379	9,027	9,654	3,214	3,490	4,611	65,792	
3. Equitable Care																	
HbA1c < 8% (Ages 18-64) - Hispanic/Latino Population	2023 M10	Rate (%)	56.1	55.2	58.3	58.2	54.9	60.3	62.3	60.2	53.9	63.1	59.2	58.2	61.2	58.2	57.0
		Δ from 2022 YE	3.7	2.9	2.8	6.5	3.2	4.6	4.8	5.4	4.8	2.9	3.5	3.1	4.8	3.9	
		Denominator	3,548	10,263	15,894	3,394	8,954	11,419	7,238	12,108	17,290	9,907	5,631	4,347	4,452	114,452	
Childhood Vaccinations: Combo 7 – AA/Black population	2023 M10	Rate (%)	56.7	70.0	63.6	65.8	71.9	69.5	69.4	70.3	60.4	74.3	67.0	69.2	61.6	66.3	70.0
		Δ from 2022 YE	1.0	-2.2	4.8	-1.9	-0.3	-6.4	-5.2	3.8	3.0	3.0	-0.7	-0.1	3.9	1.2	
		Denominator	187	30	198	38	114	95	72	320	482	191	400	438	73	2,638	
4. Staying Healthy																	
Proportion of Days Covered by Medications: Statins (Ages 18-85)	2023 M10	Rate (%)	82.0	83.7	77.7	83.0	81.6	84.1	81.6	82.4	81.8	85.6	81.9	80.7	86.1	82.8	85.0
		Δ from 2022 YE	-0.9	-0.1	-2.3	-1.7	-1.5	-0.6	-1.6	-1.2	-1.1	-0.3	-1.3	-1.2	-0.2	-1.0	
		Denominator	18,622	49,746	54,747	17,699	47,646	91,105	43,088	70,469	84,954	99,913	42,917	32,265	50,116	703,352	
HbA1c Control (<8%) in Members with Diabetes (Total Ages 18-75)	2023 M10	Rate (%)	64.7	65.9	67.1	67.8	65.5	71.4	71.0	68.9	63.9	73.5	69.1	68.5	71.0	68.5	67.0
		Δ from 2022 YE	3.0	1.5	2.0	5.2	2.3	3.1	3.9	4.2	3.7	2.6	2.6	2.1	3.5	3.0	
		Denominator	11,083	24,934	33,388	9,444	24,339	40,124	20,522	36,113	46,786	39,339	21,651	17,123	17,249	342,135	

1) These are the annual incentive targets which differ from the targets used in Ambulatory Quality Composite z-score calculations

Met Target

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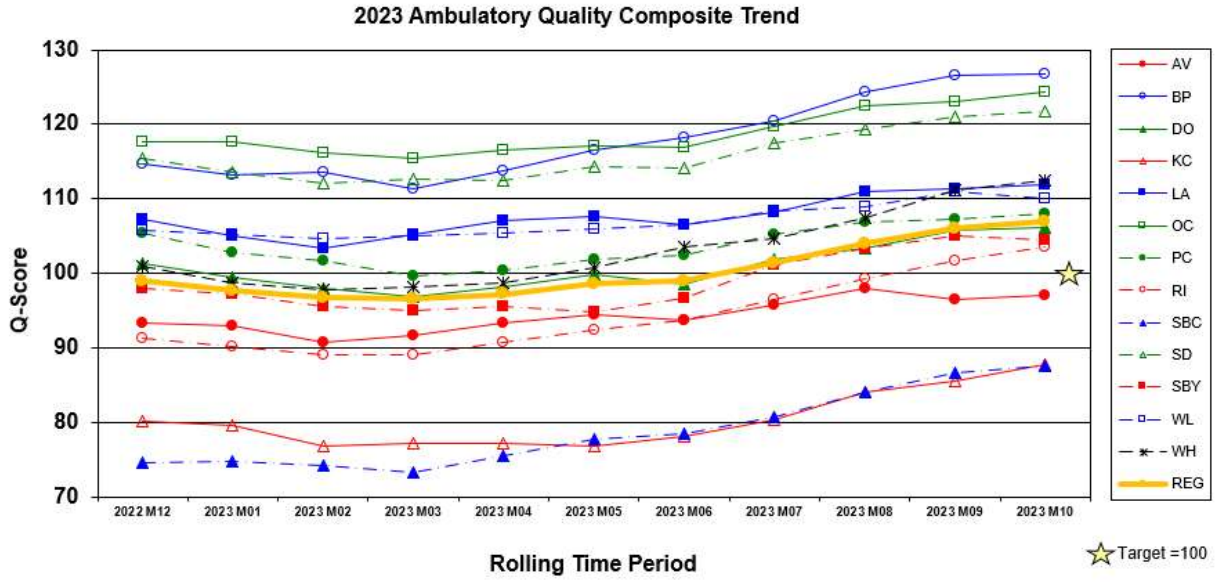
Measure Analysis – 2023 Results

1. Ambulatory Quality Composite

The 2023 Ambulatory Quality Composite (AQC) regional scores increased overall as compared to the prior year's report measured at the same time, with exceptions in some Areas. The regional AQC score is above target. The Clinical Quality Key measures includes an inter-area interdependence goal to have all thirteen service areas meeting the annual AQC target, as everyone benefits when all are successful. We achieved 77% (10/13) of Areas with scores above 100 points by this reporting period. The largest YTD gains on the AQC scores have been achieved by Baldwin Park, Orange County, and San Diego.



Period	AV	BP	DO	KC	LA	OC	PC	RI	SBC	SD	SBY	WL	WH	REG
2022 M12	93.3	114.6	101.3	80.2	107.3	117.7	105.5	91.4	74.7	115.4	98.0	105.8	101.0	99.0
2023 M01	93.0	113.3	99.5	79.7	105.0	117.6	102.9	90.2	74.8	113.6	97.2	105.3	98.7	97.7
2023 M02	90.8	113.5	98.0	76.9	103.4	116.2	101.7	89.0	74.3	112.1	95.5	104.6	97.8	96.7
2023 M03	91.7	111.4	96.9	77.3	105.3	115.5	99.7	89.1	73.4	112.6	95.1	105.1	98.2	96.6
2023 M04	93.4	113.7	98.1	77.2	107.1	116.6	100.4	90.8	75.6	112.5	95.5	105.4	98.7	97.2
2023 M05	94.4	116.5	99.8	76.9	107.7	117.1	101.9	92.5	77.7	114.4	94.9	105.9	100.7	98.6
2023 M06	93.8	118.2	98.5	78.1	106.5	116.9	102.5	93.7	78.6	114.2	96.7	106.6	103.6	99.0
2023 M07	95.8	120.5	101.8	80.4	108.2	119.7	105.3	96.6	80.8	117.4	101.2	108.4	104.6	101.4
2023 M08	97.9	124.3	103.3	84.0	111.0	122.5	106.9	99.2	84.0	119.3	103.4	109.0	107.5	104.0
2023 M09	96.5	126.5	105.8	85.5	111.3	123.1	107.3	101.7	86.6	121.0	105.0	110.9	111.1	106.0
2023 M10	97.1	126.8	106.1	87.7	111.9	124.3	108.0	103.5	87.6	121.7	104.5	110.1	112.4	106.9
Change	*0.6*	*0.3*	*0.3*	*2.2*	*0.6*	*1.2*	*0.7*	*1.8*	*1.0*	*0.7*	*-0.5*	*-0.8*	*1.3*	*0.9*
Since YE	*3.8*	*12.2*	*4.8*	*7.5*	*4.6*	*6.6*	*2.5*	*12.1*	*12.9*	*6.3*	*6.5*	*4.3*	*11.4*	*7.9*

2. Antidepressant Medication Management – Continuation Phase

The care teams in Riverside and Kern County achieved the highest gains in performance over the course of the year, and one Area, San Diego, met the target with a 64.5% rate. This measure is important in demonstrating our behavioral health care quality for new courses of pharmacotherapy to treat depression in our members.

3. Diabetic Hemoglobin A1c Control

The Hemoglobin A1c control rates (A1c <8%) typically show seasonal variation; the rates are now trending higher and are higher than at this point last year. This metric remains a key area of focus for our quality work. The physicians, providers and care teams in San Diego are still leading the Region in helping our Latinx members achieve good A1c control. Performance in nine Areas out of thirteen (69%) are currently meeting the target.

4. Childhood Vaccinations: Combo 7

This is a measure for the current cohort of two-year old children and the completion of vaccine series. Our focus for equitable care is to improve the performance rates among children identified as Black. The three Areas with the largest improvement this year for this subgroup

include Downey, Riverside, San Bernardino County, and San Diego. As of the current report, there are now four Areas out of thirteen (31%) meeting the target. Some Areas with small denominators did see decreases in their rates.

5. Proportion of Days Covered by Medications: Statins

Increasing adherence rates in our members being treated with Statins medications has been a challenge. There are currently two Areas out of thirteen (15%) are currently above target: Woodland Hills and San Diego.

6. Flu Vaccination Rates 2022-23 Season

This report continues to reflect the historical vaccination rates for the prior flu season (ending 6/30/2023) for annual incentive purposes. Current flu rates indicate the importance of helping our members get protected though vaccination.

Proactive Care Successful Opportunities – 2023 Results

Each department has opportunities to help our members get the preventive screening and monitoring they need. The attached reports reflect the results from the Proactive Office Encounter Successful Opportunity Reports (SOR), which exclude Allied Health encounters. Telephone Appointment Visits, Video Visits, and Retail Health encounters are included in the report for these initiatives. These reports show the number of encounter opportunities available and the percentage successful with the care gap closed.

Calculation of the SOR Composite Score will be based upon the number of opportunities, instead of an average of the rates. Measures with a greater number of opportunities will have more of an impact on the SOR Composite Score than measures that have a smaller number of opportunities. For Successful Opportunities we look to see if the care gap was closed within 30 days of an appointment OR within 7 days prior to the appointment. Therefore, any department that sees that patient within the 37-day window will receive credit if the care gap is closed.

POE Composite Score – Successful Opportunities Report
October 2022 – September 2023

SOR Composite Measure	Regional Visit Total	Regional % SOR
Diabetes Hgb A1c Testing	1,229,189	76.76%
Blood Pressure	4,540,082	71.62%
Colorectal Cancer Screening	2,552,304	32.04%
HPV	1,561,538	17.78%
ACE-I/ARB Low Medication Adherence	1,651,456	57.00%
DM Orals Low Medication Adherence	748,316	69.32%
Statin Low Medication Adherence	2,495,526	54.45%
Breast Cancer Screening	2,658,921	39.80%

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SOR Composite Measure	Regional Visit Total	Regional % SOR
Cervical Cancer Screening	2,689,371	31.51%
Retinal Screening	1,832,337	37.61%
SOR Composite Score	21,959,040	48.75%

SOR Target Goals (per measure)

SOR Composite Measure	Unsatisfactory	Needs Improvement	Successful	Excellent	Exceptional
Diabetes Hgb A1c Testing	< 72.0%	72.0%	73.0%	77.0%	78.0%
Blood Pressure	< 65.0%	65.0%	69.0%	76.0%	79.0%
Colorectal Cancer Screening	< 27.0%	27.0%	29.0%	36.0%	40.0%
HPV	< 15.0%	15.0%	17.0%	20.0%	21.0%
ACE-I/ARB Low Medication Adherence	< 46.0%	46.0%	49.0%	56.0%	60.0%
DM Orals Low Medication Adherence	< 58.0%	58.0%	62.0%	70.0%	72.0%
Statin Low Medication Adherence	< 43.0%	43.0%	46.0%	55.0%	58.0%
Breast Cancer Screening	< 27.0%	27.0%	29.0%	40.0%	43.0%
Cervical Cancer Screening	< 27.0%	27.0%	31.0%	37.0%	40.0%
Retinal Screening	< 35.0%	35.0%	36.0%	41.0%	44.0%
SOR Composite Score	< 44.0%	44.0%	46.0%	50.0%	53.0%

As a region, all initiatives have successfully met or exceeded the target goal. Baldwin Park Medical Center leads in overall performance with 4 measures meeting the exceptional target, 1 measure meeting the excellent target, and 5 measures meeting the successful target, followed by West LA Medical Center with 4 measures meeting the exceptional target, 2 measures meeting the excellent target, and 3 measure meeting the successful target.

The tables below summarize the SOR by medical center.

	A1c		Blood Pressure Needed		Colorectal		HPV		Low ADH ACEARB		Low ADH DM	
Medical Center	Visit. Total	% SOR	Visit. Total	% SOR	Visit. Total	% SOR	Visit. Total	% SOR	Visit. Tota	% SOR	Visit. Tota	% SOR
Antelope Valley	39467	75.13%	126655	77.01%	81275	28.94%	57603	18.04%	54612	48.05%	23048	59.10%
Baldwin Park	89374	78.11%	254475	74.31%	136798	40.07%	82139	21.02%	103100	54.27%	49320	66.12%
Downey	112014	76.76%	353119	71.12%	196526	30.22%	119153	18.90%	157687	59.29%	79082	72.89%
Kern County	35678	74.67%	102452	77.03%	68530	27.74%	42368	17.48%	45993	52.12%	26259	65.40%
Los Angeles	84379	77.56%	314626	74.14%	158659	34.13%	95888	19.55%	115138	62.81%	52389	74.53%
Orange County	140845	79.71%	600851	73.62%	319876	35.37%	195264	18.09%	183861	51.05%	78891	64.59%
Panorama City	72091	76.18%	261481	74.48%	153493	29.55%	84244	17.45%	100038	54.70%	45483	65.50%
Riverside	122768	75.91%	418149	70.46%	256537	31.39%	188528	15.24%	170211	65.80%	76993	76.26%
San Bernardino County	180420	75.21%	644956	68.83%	368347	31.36%	267839	15.15%	246602	56.85%	101385	70.07%
San Diego	141388	77.83%	677126	65.81%	374323	31.24%	190565	19.28%	190437	55.29%	92695	68.11%
South Bay	84266	76.05%	312459	69.35%	165134	30.85%	80344	21.38%	111696	60.74%	46393	70.33%
West Los Angeles	59562	74.26%	195764	78.29%	110464	32.91%	64657	20.38%	83181	61.86%	39894	74.77%
Woodland Hills	66937	76.98%	277969	75.67%	162342	29.68%	92946	16.05%	88900	49.54%	36484	61.76%
REGION	1229189	76.76%	4540082	71.62%	2552304	32.04%	1561538	17.78%	1651456	57.00%	748316	69.32%

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

	Low ADH Statin		Mammogram		Cervical Cancer		Retinal Screening		Composite	
Medical Center	Visit. Tota	% SOR	Visit. Total	% SOR	Visit. Total	% SOR	Visit. Total	% SOR	Visit. Total	% SOR
Antelope Valley	76985	44.57%	84282	37.42%	86211	27.83%	52021	40.87%	682159	45.75%
Baldwin Park	162083	51.87%	150335	45.83%	148500	38.79%	122080	40.87%	1298204	52.38%
Downey	259019	56.44%	205036	36.62%	217807	28.70%	168344	39.91%	1867787	49.32%
Kern County	63883	50.04%	61556	43.97%	76968	24.30%	55678	35.57%	579365	46.72%
Los Angeles	182316	60.74%	167238	40.95%	185812	34.85%	132393	36.25%	1488838	52.05%
Orange County	291356	48.24%	330103	47.30%	322413	35.32%	192106	43.31%	2655566	50.52%
Panorama City	167927	52.65%	157067	38.48%	160369	29.42%	109339	34.87%	1311532	47.91%
Riverside	236889	64.48%	295769	31.32%	273038	31.24%	185038	38.59%	2223920	48.11%
San Bernardino County	323286	54.15%	378188	38.05%	391192	28.84%	273366	35.72%	3175581	46.49%
San Diego	292327	52.69%	369772	38.57%	348411	30.63%	214098	36.58%	2891142	47.02%
South Bay	167749	57.80%	158559	36.67%	180166	32.89%	128540	35.01%	1435306	49.38%
West Los Angeles	124485	61.20%	127473	46.18%	145013	31.54%	95038	35.07%	1045531	51.88%
Woodland Hills	147221	45.95%	173543	42.83%	153471	31.93%	104296	34.40%	1304109	47.42%
REGION	2495526	54.45%	2658921	39.80%	2689371	31.51%	1832337	37.61%	21959040	48.75%

KPSC HEDIS MY 2022 Effectiveness of Care (EOC) / Use of Services Results
Commercial Population (1523)

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COMMERCIAL Measures HEDIS Measurement Year 2022	METHOD	^ MY 2022 Rating Wt.	HEDIS MY2022 NUM	HEDIS MY2022 DEN	HEDIS MY2022 RATE	MY2022 Percentile Rank	Change from Prior Yr	Percentile Change (Scale Diff) from Prior Yr*	HEDIS MY2021 RATE	HEDIS MY2021 DEN	MY2021 Percentile Rank	HEDIS MY2020 RATE	HEDIS 2020 RATE	HEDIS 2019 RATE
Effectiveness of Care: Prevention and Screening														
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents **(WCC)**														
BMI Percentile														
3-11 Years	A		203,880	208,368	97.85%	95th	0.13%		97.72%	198,861	95th	96.07%	98.87%	98.97%
12-17 years	A		139,268	141,755	98.25%	95th	0.28%		97.97%	139,109	95th	97.17%	99.21%	99.22%
TOTAL (Ages 3-17)	A	1	343,148	350,123	98.01%	95th	0.19%		97.82%	337,970	95th	96.51%	99.01%	99.07%
Counseling for Nutrition														
3-11 Years	A		190,501	208,368	91.43%	95th	-1.58%		93.01%	198,861	95th	91.91%	95.15%	95.37%
12-17 years	A		126,143	141,755	88.99%	95th	-0.97%		89.96%	139,109	95th	91.45%	93.45%	93.64%
TOTAL (Ages 3-17)	A		316,644	350,123	90.44%	95th	-1.31%		91.75%	337,970	95th	91.73%	94.47%	94.68%
Counseling for Physical Activity														
3-11 Years	A		192,898	208,368	92.58%	95th	-1.36%		93.94%	198,861	95th	92.81%	96.00%	96.23%
12-17 years	A		129,931	141,755	91.66%	95th	-1.01%		92.67%	139,109	95th	93.30%	95.54%	95.83%
TOTAL (Ages 3-17)	A		322,829	350,123	92.20%	95th	-1.22%		93.42%	337,970	95th	93.01%	95.82%	96.07%
Childhood Immunization Status **(CIS)**														
DTaP	A		24,281	28,060	86.53%	50th	-0.64%		87.17%	29,927	50th	87.61%	89.35%	89.27%
IPV	A		26,021	28,060	92.73%	50th	-0.93%	-1	93.66%	29,927	66.67th	93.37%	93.72%	93.83%
MMR	A		25,829	28,060	92.05%	50th	0.07%		91.98%	29,927	50th	93.23%	93.72%	92.96%
HiB	A		25,950	28,060	92.48%	50th	-1.02%	-1	93.50%	29,927	66.67th	93.45%	93.75%	93.88%
Hepatitis B	A		26,308	28,060	93.76%	75th	-0.80%		94.56%	29,927	75th	94.09%	94.29%	94.41%
VZV	A		25,835	28,060	92.07%	50th	-0.09%		92.16%	29,927	50th	92.95%	93.37%	93.20%
Pneumococcal Conjugate	A		24,271	28,060	86.50%	50th	-0.65%		87.15%	29,927	50th	87.68%	88.29%	88.68%
Hepatitis A	A		25,775	28,060	91.86%	66.67th	-0.04%	-1	91.90%	29,927	75th	92.77%	93.44%	93.44%
Rotavirus	A		24,658	28,060	87.88%	66.67th	-1.78%	-1	89.66%	29,927	75th	88.91%	88.19%	88.18%
Influenza	A		19,009	28,060	67.74%	50th	-6.01%		73.75%	29,927	50th	76.50%	73.82%	70.86%
Combination #3	A		23,255	28,060	82.88%	66.67th	-0.65%	-1	83.53%	29,927	75th	83.73%	85.20%	85.15%
Combination #7	A		22,421	28,060	79.90%	75th	-0.84%		80.74%	29,927	75th	80.71%	81.39%	81.23%
Combination #10	A	3	17,397	28,060	62.00%	66.67th	-4.88%		66.88%	29,927	66.67th	68.62%	66.77%	64.28%
Immunizations for Adolescents **(IMA)**														
Meningococcal	A		31,563	36,465	86.56%	50th	0.32%		86.24%	38,708	50th	87.88%	87.99%	88.15%
Tdap	A		34,247	36,465	93.92%	75th	1.64%		92.28%	38,708	75th	93.27%	93.81%	93.64%
HPV	A		18,459	36,465	50.62%	90th	0.36%		50.26%	38,708	90th	54.13%	54.01%	53.56%
Combination 1 (meningococcal + Tdap)	A		31,434	36,465	86.20%	50th	0.52%		85.68%	38,708	50th	87.05%	87.01%	87.22%
Combination 2 (Meningococcal, Tdap, HPV)	A	3	18,250	36,465	50.05%	90th	0.64%	-1	49.41%	38,708	95th	53.01%	52.74%	52.28%
Breast Cancer Screening **(BCS)**	A	1	246,212	301,454	81.67%	90th	4.40%	1	77.27%	299,896	75th	77.66%	84.98%	84.65%
Cervical Cancer Screening **(CCS)**	A	1	575,806	725,682	79.35%	75th	-1.02%	-1	80.37%	716,422	90th	78.13%	87.00%	86.06%
Colorectal Cancer Screening **(COL)**									Ages 51-75 years			Ages 51-75 years		
Ages 46-49	A		75,504	169,341	44.59%	95th								
Ages 50-75	A		528,763	705,972	74.90%	95th	-0.75%	1	75.65%	665,828	90th	73.31%	76.44%	77.37%
TOTAL (Ages 46-75)	A	1	604,267	875,313	69.03%	90th								
Chlamydia Screening in Women **(CHL)**														
Ages 16-20	A		16,613	32,658	50.87%	75th	-1.77%		52.64%	34,155	75th	49.79%	62.44%	62.24%
Ages 21-24	A		34,645	49,884	69.45%	95th	-2.33%		71.78%	52,766	95th	65.49%	79.46%	79.41%
TOTAL (Ages 16-24)	A	1	51,258	82,542	62.10%	90th	-2.16%		64.26%	86,921	90th	59.31%	72.54%	72.49%
Effectiveness of Care: Respiratory Conditions														
Appropriate Testing for Pharyngitis **(CWP)**														
Ages 3-17	A		3,478	4,353	79.90%	33.33rd	30.29%	4	49.61%	2,961	0th	85.68%	92.18%	94.54%
Ages 18-64	A		12,004	23,297	51.53%	10th	25.62%	2	25.91%	22,066	0th	54.69%	63.04%	
Ages 65+	A		107	264	40.53%	33.33rd	21.89%	3	18.64%	279	5th	31.13%	44.82%	
TOTAL (Ages 3+)	A	1	15,589	27,914	55.85%	10th	27.25%	2	28.60%	25,306	0th	61.66%	70.66%	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD **(SPR)**	A		1,267	3,105	40.81%	75th	2.45%	1	38.36%	2,706	66.67th	57.22%	75.17%	76.31%
Pharmacotherapy Management of COPD Exacerbation **(PCE)**														
Systemic Corticosteroid	A	1	455	538	84.57%	75th	1.13%		83.44%	483	75th	84.25%	84.09%	87.60%
Bronchodilator	A	1	515	538	95.72%	95th	0.90%		94.82%	483	95th	91.96%	94.31%	96.34%
Asthma Medication Ratio **(AMR)**														
Ages 5-11	A		1,841	1,978	93.07%	66.67th	-2.03%	-1	95.10%	2,081	75th	96.21%	94.10%	93.22%
Ages 12-18	A		1,430	1,562	91.55%	75th	-1.38%	-2	92.93%	1,669	95th	93.19%	92.37%	90.22%
Ages 19-50	A		10,189	11,797	86.37%	75th	-1.57%	-1	87.94%	12,757	90th	87.38%	87.26%	85.19%
Ages 51-64	A		8,760	9,683	90.47%	75th	-1.76%	-1	92.23%	10,401	90th	92.13%	92.66%	92.68%
TOTAL (Ages 5-64)	A	1	22,220	25,020	88.81%	75th	-1.65%	-2	90.46%	26,908	95th	90.56%	90.57%	89.45%
Effectiveness of Care: Cardiovascular														
Controlling High Blood Pressure **(CBP)** Age 18-85	A	3	96,156	130,472	73.70%	75th	0.44%	-1	73.26%	119,788	90th	66.69%	79.41%	80.22%
Persistence of Beta Blocker Treatment after a Heart Attack (Ages 18+) **(PBH)**	A		1,452	1,756	82.69%	25th	1.35%	1	81.34%	1,490	10th	81.76%	86.23%	89.19%
Statin Therapy for Patients With Cardiovascular Disease (**SPC**)														
Ages 21-75 (Male) Received Statin	A		5,316	5,934	89.59%	75th	-0.13%		89.72%	5,994	75th	89.19%	89.67%	87.64%

KPSC HEDIS MY 2022 Effectiveness of Care (EOC) / Use of Services Results
Commercial Population (1523)
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COMMERCIAL Measures HEDIS Measurement Year 2022	METHOD	^ MY 2022 Rating Wt.	HEDIS MY2022 NUM	HEDIS MY2022 DEN	HEDIS MY2022 RATE	MY2022 Percentile Rank	Change from Prior Yr	Percentile Change (Scale Diff) from Prior Yr*	HEDIS MY2021 RATE	HEDIS MY2021 DEN	MY2021 Percentile Rank	HEDIS MY2020 RATE	HEDIS 2020 RATE	HEDIS 2019 RATE
Ages 21-75 (Male) Statin Adherence 80%	A		4,107	5,316	77.26%	25th	-1.54%	-1	78.80%	5,378	33.33rd	78.32%	77.36%	75.79%
Ages 40-75 (Female) Received Statin	A		1,308	1,546	84.61%	90th	-2.14%	-1	86.75%	1,555	95th	83.02%	84.16%	77.89%
Ages 40-75 (Female) Statin Adherence 80%	A		977	1,308	74.69%	25th	1.15%		73.54%	1,349	25th	74.49%	71.61%	70.46%
TOTAL (Ages 21-75 M&F): Received Statin	A	1	6,624	7,480	88.56%	90th	-0.55%		89.11%	7,549	90th	87.85%	88.54%	85.43%
TOTAL (Ages 21-75 M&F): Statin Adherence 80%	A	1	5,084	6,624	76.75%	25th	-1.00%	-1	77.75%	6,727	33.33rd	77.54%	76.24%	74.69%
Cardiac Rehabilitation (**CRE**)														
Ages 18-64 Initiation: two or more sessions	A		10	2,973	0.34%	0th	0.06%		0.28%	3,215	0th			
Ages 18-64 Engagement 1: 12 or more sessions	A		40	2,973	1.35%	0th	0.63%		0.72%	3,215	0th			
Ages 18-64 Engagement 2: 24 or more sessions	A		43	2,973	1.45%	0th	0.58%	-1	0.87%	3,215	5th			
Ages 18-64 Achievement: 36 or more sessions	A		28	2,973	0.94%	10th	0.22%		0.72%	3,215	10th			
Ages 65+ Initiation: two or more sessions	A		5	547	0.91%	5th	0.59%	1	0.32%	631	0th			
Ages 65+ Engagement 1: 12 or more sessions	A		12	547	2.19%	0th	0.76%		1.43%	631	0th			
Ages 65+ Engagement 2: 24 or more sessions	A		10	547	1.83%	5th	0.25%	1	1.58%	631	0th			
Ages 65+ Achievement: 36 or more sessions	A		5	547	0.91%	10th	-0.20%		1.11%	631	10th			
TOTAL (Ages 18+) Initiation: two or more sessions	A		15	3,520	0.43%	0th	0.14%		0.29%	3,846	0th			
TOTAL (Ages 18+) Engagement 1: 12 or more sessions	A		52	3,520	1.48%	0th	0.65%		0.83%	3,846	0th			
TOTAL (Ages 18+) Engagement 2: 24 or more sessions	A		53	3,520	1.51%	0th	0.52%		0.99%	3,846	0th			
TOTAL (Ages 18+) Achievement: 36 or more sessions	A		33	3,520	0.94%	5th	0.16%	-1	0.78%	3,846	10th			
Effectiveness of Care: Diabetes														
Hemoglobin A1c Control for Patients With Diabetes (**HBD**)														
Adequate HbA1c control <8%	A	**3**	105,494	177,700	59.37%	33.33rd	-0.76%	-1	60.13%	171,845	50th	60.10%	64.22%	64.96%
Poor HbA1c control >9% *Lower Rate is favorable*	A		49,790	177,700	28.02%	33.33rd	0.73%	-2	27.29%	171,845	66.67th	28.52%	23.91%	23.52%
HbA1c testing	A								92.23%	171,845	66.67th	88.63%	93.32%	93.41%
Blood Pressure Control for Patients With Diabetes (**BPD**)	A	**3**	130,287	177,700	73.32%	75th	1.24%		72.08%	171,845	75th	66.25%	80.96%	81.58%
Eye Exam for Patients With Diabetes (**EED**)	A	1	132,675	177,700	74.66%	95th	5.49%		69.17%	171,845	95th	67.24%	79.59%	81.98%
Kidney Health Evaluation for Patients With Diabetes (**KED**)														
Ages 18-64	A		119,889	155,756	76.97%	95th	1.11%		75.86%	149,164	95th	72.23%		
Ages 65-74	A		15,536	18,581	83.61%	95th	1.37%		82.24%	17,349	95th	78.09%		
Ages 75-85	A		2,476	2,987	82.89%	95th	0.33%		82.56%	2,804	95th	77.47%		
TOTAL (Ages 18-85)	A	1	137,901	177,324	77.77%	95th	1.15%		76.62%	169,317	95th	72.96%		
Statin Therapy for Patients with Diabetes (**SPD**)														
Received Statin Therapy	A	1	98,590	136,227	72.37%	95th	-1.58%		73.95%	130,852	95th	73.94%	74.08%	71.81%
Statin Adherence 80%	A	1	69,366	98,590	70.36%	25th	-0.71%		71.07%	96,762	25th	70.36%	67.60%	65.85%
Effectiveness of Care: Behavioral Health														
Antidepressant Medication Management **(AMM)**														
Effective acute phase (12-week) treatment	A		31,292	37,493	83.46%	90th	0.18%		83.28%	36,293	90th	81.31%	78.44%	75.97%
Effective continuation (6-month) treatment	A	1	21,444	37,493	57.19%	25th	0.39%		56.80%	36,293	25th	53.32%	51.69%	50.29%
Follow-Up Care for Children Prescribed ADHD Medication **(ADD)**														
Initiation Phase	A		2,630	3,672	71.62%	95th	2.34%		69.28%	4,072	95th	66.63%	59.68%	56.88%
Continuation and Maintenance Phase	A	1	809	1,093	74.02%	95th	5.14%		68.88%	1,041	95th	68.97%	65.94%	61.01%
Follow-Up After Hospitalization for Mental Illness **(FUH)**														
6-17 years: 30-day follow-up	A		1,735	1,828	94.91%	95th	-0.93%		95.84%	2,045	95th	93.22%	90.27%	89.00%
6-17 years: 7-day follow-up	A		1,594	1,828	87.20%	95th	-0.53%		87.73%	2,045	95th	82.73%	80.87%	80.10%
18-64 years: 30-day follow-up	A		3,349	3,758	89.12%	95th	0.37%		88.75%	4,010	95th	84.24%	83.02%	81.47%
18-64 years: 7-day follow-up	A		3,067	3,758	81.61%	95th	3.85%		77.76%	4,010	95th	71.88%	74.46%	72.53%
65+ years: 30-day follow-up	A		47	63	74.60%	90th	-6.76%		81.36%	59	90th	80.65%	80.72%	78.79%
65+ years: 7-day follow-up	A		44	63	69.84%	95th	-1.35%		71.19%	59	95th	66.13%	65.06%	60.61%
TOTAL (Ages 6+): 30-day follow-up	A		5,131	5,649	90.83%	95th	-0.22%		91.05%	6,114	95th	86.96%	85.23%	83.71%
TOTAL (Ages 6+): 7-day follow-up	A	1	4,705	5,649	83.29%	95th	2.26%		81.03%	6,114	95th	75.16%	76.33%	74.69%
Follow-Up After ED Visit for Mental Illness **(FUM)**														
6-17 years: 30-day follow-up	A		521	604	86.26%	75th	-2.50%	-1	88.76%	596	90th	82.83%	75.09%	76.80%
6-17 years: 7-day follow-up	A		459	604	75.99%	90th	-3.71%		79.70%	596	90th	70.82%	61.94%	60.37%
18-64 years: 30-day follow-up	A		1,405	1,799	78.10%	90th	1.14%		76.96%	1,866	90th	72.50%	61.56%	62.75%
18-64 years: 7-day follow-up	A		1,170	1,799	65.04%	90th	0.52%	-1	64.52%	1,866	95th	59.23%	47.80%	48.90%
65+ years: 30-day follow-up	A		33	43	76.74%	95th	-7.70%		84.44%	45	95th	70.59%	30.56%	45.45%
65+ years: 7-day follow-up	A		29	43	67.44%	95th	-3.67%		71.11%	45	95th	55.88%	16.67%	31.82%
TOTAL (Ages 6+): 30-day follow-up	A		1,959	2,446	80.09%	90th	0.19%		79.90%	2,507	90th	74.68%	64.29%	65.96%
TOTAL (Ages 6+): 7-day follow-up	A	1	1,658	2,446	67.78%	90th	-0.47%		68.25%	2,507	90th	61.65%	50.67%	51.48%
Follow-Up After High-Intensity Care for Substance Use Disorder **(FUI)**														
13-17 years: 30-day follow-up	A		73	87	83.91%	95th	3.66%		80.25%	81		82.69%	58.93%	
13-17 years: 7-day follow-up	A		48	87	55.17%	95th	-6.56%		61.73%	81		59.62%	30.36%	
18-64 years: 30-day follow-up	A		2,569	3,166	81.14%	95th	1.61%		79.53%	3,087	95th	85.63%	68.34%	
18-64 years: 7-day follow-up	A		2,056	3,166	64.94%	95th	0.67%		64.27%	3,087	95th	65.80%	36.67%	
65+ years: 30-day follow-up	A		37	55	67.27%	75th	-16.40%		83.67%	49		81.40%	55.00%	
65+ years: 7-day follow-up	A		27	55	49.09%	75th	-6.01%		55.10%	49		58.14%	40.00%	
TOTAL (Ages 13+): 30-day follow-up	A		2,679	3,308	80.99%	95th	1.38%		79.61%	3,217	95th	85.50%	67.89%	
TOTAL (Ages 13+): 7-day follow-up	A	1	2,131	3,308	64.42%	95th	0.35%		64.07%	3,217	95th	65.55%	36.58%	

KPSC HEDIS MY 2022 Effectiveness of Care (EOC) / Use of Services Results
Commercial Population (1523)
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COMMERCIAL Measures HEDIS Measurement Year 2022	METHOD	^ MY 2022 Rating Wt.	HEDIS MY2022 NUM	HEDIS MY2022 DEN	HEDIS MY2022 RATE	MY2022 Percentile Rank	Change from Prior Yr	Percentile Change (Scale Diff) from Prior Yr*	HEDIS MY2021 RATE	HEDIS MY2021 DEN	MY2021 Percentile Rank	HEDIS MY2020 RATE	HEDIS 2020 RATE	HEDIS 2019 RATE
Follow-Up After ED Visit for Substance Use **(FUA)**														
13-17 years: 30-day follow-up	A		87	226	38.50%	50th	3.68%	-4	34.82%	112	95th	34.25%	15.84%	11.41%
13-17 years: 7-day follow-up	A		50	226	22.12%	33.33rd	-1.99%	-5	24.11%	112	95th	22.60%	11.76%	9.24%
18+ years: 30-day follow-up	A		1,365	3,503	38.97%	75th	2.42%	-2	36.55%	3,119	95th	38.38%	26.29%	23.98%
18+ years: 7-day follow-up	A		992	3,503	28.32%	75th	3.70%	-2	24.62%	3,119	95th	27.28%	19.86%	18.34%
TOTAL (Ages 13+): 30-day follow-up	A		1,452	3,729	38.94%	75th	2.45%	-2	36.49%	3,231	95th	38.17%	25.60%	23.31%
TOTAL (Ages 13+): 7-day follow-up	A	1	1,042	3,729	27.94%	75th	3.33%	-2	24.61%	3,231	95th	27.04%	19.33%	17.86%
Pharmacotherapy for Opioid Use Disorder **(POD)**														
16-64 years	A		235	1,154	20.36%	10th	1.02%		19.34%	1,210	10th	12.17%	10.03%	
65+ years (NA)	A		10	42	23.81%		-4.76%		28.57%	28		23.53%	23.08%	
TOTAL (Ages 16+)	A	1	245	1,196	20.48%	10th	0.93%		19.55%	1,238	10th	12.43%	10.27%	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia **(SAA)**	A	1	1,073	1,571	68.30%	50th	-2.87%		71.17%	1,651	50th	67.76%	53.63%	
Metabolic Monitoring for Children and Adolescents on Antipsychotics **(APM)**														
Ages 1-11 Blood Glucose	A		161	226	71.24%	95th	8.99%	1	62.25%	204	90th	63.20%	62.63%	
Ages 1-11 Cholesterol	A		144	226	63.72%	95th	5.88%		57.84%	204	95th	59.31%	57.65%	
Ages 1-11 Blood Glucose and Cholesterol	A		143	226	63.27%	95th	6.41%		56.86%	204	95th	58.87%	55.52%	56.72%
Ages 12-17 Blood Glucose	A		993	1,175	84.51%	95th	0.54%		83.97%	1,148	95th	78.44%	78.83%	
Ages 12-17 Cholesterol	A		839	1,175	71.40%	95th	2.93%		68.47%	1,148	95th	64.16%	64.46%	
Ages 12-17 Blood Glucose and Cholesterol	A		828	1,175	70.47%	95th	2.53%		67.94%	1,148	95th	63.38%	62.84%	56.93%
TOTAL (Ages 1-17) Blood Glucose	A		1,154	1,401	82.37%	95th	1.67%		80.70%	1,352	95th	75.90%	75.70%	
TOTAL (Ages 1-17) Cholesterol	A		983	1,401	70.16%	95th	3.30%		66.86%	1,352	95th	63.35%	63.14%	
TOTAL (Ages 1-17) Blood Glucose and Cholesterol	A	1	971	1,401	69.31%	95th	3.04%		66.27%	1,352	95th	62.63%	61.43%	56.89%
Effectiveness of Care: Overuse/Appropriateness														
Non-Recommended CCS in Adolescent Females **(NCS)** *Lower Rate is favorable*	A		55	98,218	0.06%	75th	-0.01%	-1	0.07%	98,187	90th	0.06%	0.11%	0.15%
Appropriate Treatment for Upper Respiratory Infection **(URI)** *Inverted Rate*														
3 mos-17 years	A(I)		2,122	103,198	97.94%	95th	-0.76%		98.70%	30,650	95th	98.07%	97.96%	
18-64 years	A(I)		6,930	74,603	90.71%	90th	-2.68%	1	93.39%	35,518	75th	93.48%	92.68%	
65+ years	A(I)		251	2,117	88.14%	90th	-0.96%	1	89.10%	862	75th	92.08%	91.26%	
TOTAL (Ages 3 mos+)	A(I)	1	9,303	179,918	94.83%	95th	-0.93%	1	95.76%	67,030	90th	95.24%	94.95%	99.03%
Avoidance of Antibiotic Treatment with Acute Bronchitis **(AAB)** *Inverted Rate*														
3 mos-17 years	A(I)		408	3,667	88.87%	90th	1.04%	-1	87.83%	526	95th	88.37%	86.52%	
18-64 years	A(I)		1,476	4,416	66.58%	95th	3.33%		63.25%	2,901	95th	79.75%	79.49%	
65+ years	A(I)		68	168	59.52%	95th	10.77%	2	48.75%	80	75th	72.53%	69.62%	
TOTAL (Ages 3 mos+)	A(I)	1	1,952	8,251	76.34%	95th	9.73%		66.61%	3,507	95th	83.76%	82.92%	80.96%
Use of Imaging Studies for Low Back Pain **(LBP)** *Inverted Rate*														
18-64 years	A(I)		12,291	115,660	89.37%	95th								
65-75 years	A(I)		718	5,553	87.07%	95th								
TOTAL (Ages 18-75)	A(I)	1	13,009	121,213	89.27%	95th	1.94%		87.33%	77,473	95th	89.16%	87.59%	87.87%
Use of Opioids at High Dosage **(HDO)** *Lower Rate is favorable*	A	1	288	29,218	0.99%	90th	-0.09%	-1	1.08%	30,396	95th	1.27%	1.57%	1.57%
Use of Opioids From Multiple Providers **(UOP)** *Lower Rate is favorable*														
Multiple Prescribers	A		7,845	32,464	24.17%	0th	2.96%		21.21%	35,635	0th	18.70%	21.06%	21.91%
Multiple Pharmacies	A		891	32,464	2.74%	5th	0.26%	-1	2.48%	35,635	10th	3.09%	2.73%	3.95%
Multiple Prescribers and Multiple Pharmacies	A	1	558	32,464	1.72%	5th	0.25%	-1	1.47%	35,635	10th	1.62%	1.69%	2.75%
Risk of Continued Opioid Use **(COU)** *Lower Rate is favorable*														
Ages 18-64: ≥15 Days Covered	A		5,878	160,656	3.66%	50th	-0.37%		4.03%	167,522	50th	4.93%	5.30%	6.77%
Ages 18-64: ≥31 Days Covered	A		1,791	160,656	1.11%	75th	-0.08%		1.19%	167,522	75th	1.41%	1.45%	1.66%
Ages 65+: ≥15 Days Covered	A		625	8,035	7.78%	50th	-1.43%	1	9.21%	8,979	33.33rd	10.53%	12.23%	14.87%
Ages 65+: ≥31 Days Covered	A		185	8,035	2.30%	75th	-0.55%	2	2.85%	8,979	50th	3.20%	3.45%	3.90%
TOTAL (Ages 18+): ≥15 Days Covered	A		6,503	168,691	3.85%	50th	-0.45%		4.30%	176,501	50th	5.19%	5.62%	7.12%
TOTAL (Ages 18+): ≥31 Days Covered	A	1	1,976	168,691	1.17%	75th	-0.11%		1.28%	176,501	75th	1.50%	1.54%	1.76%
Access/Availability of Care														
Initiation and Engagement of Substance Abuse Disorder **(IET)**														
13-17 Years														
Alcohol: Initiation of SUD	A		134	227	59.03%	90th	15.00%	3	44.03%	134	50th	57.71%	53.01%	51.94%
Engagement of SUD	A		88	227	38.77%	95th	12.65%	1	26.12%	134	90th	33.60%	30.12%	32.16%
Opioid: Initiation of SUD	A		35	41	85.37%		3.89%		81.48%	27		83.33%	69.57%	83.33%
Engagement of SUD	A		27	41	65.85%		14.00%		51.85%	27		59.52%	52.17%	56.67%
Other: Initiation of SUD	A		609	1,026	59.36%	75th	9.54%	2	49.82%	548	50th	59.84%	55.24%	55.31%
Engagement of SUD	A		400	1,026	38.99%	95th	6.33%		32.66%	548	95th	38.01%	34.73%	35.94%
TOTAL: Initiation of SUD	A		778	1,294	60.12%	90th	12.05%	2	48.07%	649	66.67th	58.53%	53.59%	52.92%
Engagement of SUD	A		515	1,294	39.80%	95th	8.83%		30.97%	649	95th	37.36%	33.35%	34.13%
18-64 Years									18+ Years			18+ Years		
Alcohol: Initiation of SUD	A		6,531	12,727	51.32%	95th	3.13%		48.19%	13,610	95th	54.10%	48.23%	42.54%

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Engagement of SUD	A		3,249	12,727	25.53%	95th	-1.94%		27.47%	13,610	95th	30.15%	25.80%	21.59%
Opioid: Initiation of SUD	A		653	1,071	60.97%	90th	2.17%	-1	58.80%	1,512	95th	63.00%	60.77%	51.46%
Engagement of SUD	A		366	1,071	34.17%	75th	-3.20%	-2	37.37%	1,512	95th	41.82%	37.45%	29.56%
Other: Initiation of SUD	A		3,929	8,244	47.66%	95th	4.90%	1	42.76%	9,449	90th	50.88%	47.24%	44.48%
Engagement of SUD	A		2,080	8,244	25.23%	95th	1.34%		23.89%	9,449	95th	29.04%	25.40%	23.63%
TOTAL: Initiation of SUD	A		11,113	22,042	50.42%	95th	4.78%		45.64%	22,604	95th	52.30%	47.22%	39.26%
Engagement of SUD	A		5,695	22,042	25.84%	95th	0.01%		25.83%	22,604	95th	29.51%	25.23%	21.88%
65+ Years														
Alcohol: Initiation of SUD	A		277	517	53.58%	95th								
Engagement of SUD	A		67	517	12.96%	95th								
Opioid: Initiation of SUD	A		41	70	58.57%	95th								
Engagement of SUD	A		11	70	15.71%	95th								
Other: Initiation of SUD	A		67	115	58.26%	95th								
Engagement of SUD	A		20	115	17.39%	95th								
TOTAL: Initiation of SUD	A		385	702	54.84%	95th								
Engagement of SUD	A		98	702	13.96%	95th								
TOTAL (Ages 13+)														
Alcohol: Initiation of SUD	A		6,942	13,471	51.53%	95th	3.39%		48.14%	13,744	95th	54.17%	48.34%	42.71%
Engagement of SUD	A		3,404	13,471	25.27%	95th	-2.18%		27.45%	13,744	95th	30.22%	25.90%	21.78%
Opioid: Initiation of SUD	A		729	1,182	61.68%	95th	2.49%		59.19%	1,539	95th	63.50%	60.88%	51.88%
Engagement of SUD	A		404	1,182	34.18%	90th	-3.44%	-1	37.62%	1,539	95th	42.25%	37.63%	29.91%
Other: Initiation of SUD	A		4,605	9,385	49.07%	95th	5.93%	1	43.14%	9,997	90th	51.87%	48.20%	45.54%
Engagement of SUD	A		2,500	9,385	26.64%	95th	2.27%		24.37%	9,997	95th	30.03%	26.52%	24.83%
TOTAL: Initiation of SUD	A		12,276	24,038	51.07%	95th	5.36%		45.71%	23,253	95th	52.65%	47.62%	39.94%
Engagement of SUD	A	1	6,308	24,038	26.24%	95th	0.26%		25.98%	23,253	95th	29.96%	25.73%	22.49%
Prenatal and Postpartum Care **(PPC)**														
Timeliness of Prenatal Care	A	1	32,725	34,993	93.52%	75th	3.56%		89.96%	35,732	75th	94.99%	94.46%	94.40%
Postpartum Care	A	1	32,447	34,993	92.72%	75th	-0.09%		92.81%	35,732	75th	90.59%	92.98%	90.02%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics **(APP)**														
1-11 years	A		40	65	61.54%	75th	16.33%	4	45.21%	73	25th	46.00%	37.74%	33.91%
12-17 years	A		347	497	69.82%	66.67th	13.40%	4	56.42%	436	10th	44.66%	50.00%	47.99%
TOTAL (Ages 1-17)	A	1	387	562	68.86%	75th	14.05%	5	54.81%	509	10th	44.89%	47.67%	45.55%
Utilization														
Well-Child Visits in the First 30 Months of Life **(W30)**														
First 15 Months	A		22,674	26,653	85.07%	50th	3.55%	1	81.52%	27,958	33.33rd	83.05%		
15 Months-30 Months	A		21,079	28,010	75.26%	0th	8.84%		66.42%	29,293	0th	73.70%		
Child and Adolescent Well-Care Visits **(WCV)**														
3-11 years	A		173,936	294,166	59.13%	10th	0.68%		58.45%	301,503	10th	43.19%		
12-17 years	A		113,542	233,707	48.58%	10th	-0.71%		49.29%	237,405	10th	35.86%		
18-21 years	A		34,421	161,148	21.36%	5th	2.42%	1	18.94%	163,379	0th	11.95%		
TOTAL (Ages 3-21)	A		321,899	689,021	46.72%	10th	0.55%		46.17%	702,287	10th	33.46%		
ECDS - Measures Collected Using Electronic Clinical Data Systems														
Depression Screening and Follow-Up for Adolescents and Adults **(DSF-E)**														
Depression Screening 12-17	E		88348	219885	40.18%		9.45%		30.73%	224,669		30.03%		33.79%
Depression Screening 18-64	E		201420	1956011	10.30%		0.67%		9.63%	1,972,104		7.83%		8.76%
Depression Screening 65+	E		3324	74140	4.48%		-0.88%		5.36%	70,689		3.88%		4.80%
TOTAL: Depression Screening	E		293092	2250036	13.03%		1.45%		11.58%	2,267,462		9.91%		11.13%
Follow-Up on Positive Screen 12-17	E		8956	9236	96.97%		-0.48%		97.45%	8,691		98.27%		95.46%
Follow-Up on Positive Screen 18-64	E		74739	84059	88.91%		-1.54%		90.45%	81,071		92.56%		83.40%
Follow-Up on Positive Screen 65+	E		930	1010	92.08%		4.10%		87.98%	982		89.49%		80.22%
TOTAL: Follow-Up on Positive Screen	E		84625	94305	89.74%		-1.35%		91.09%	90,744		93.11%		84.46%
Utilization of PHQ9 to Monitor Depression Symptoms for Adolescents and Adults **(DMS-E)**														
01/01/2022 to 04/30/2022 (period 1)														
12-17 years	E		1,049	6,802	15.42%		-6.23%		21.65%	7,126		18.11%		39.35%
18-44 years	E		31,988	41,506	77.07%		7.13%		69.94%	38,843		69.62%		71.91%
45-64 years	E		14,664	21,038	69.70%		12.55%		57.15%	21,115		59.44%		60.75%
65+ years	E		924	1,615	57.21%		11.12%		46.09%	1,779		51.35%		51.09%
TOTAL: Utilization of the PHQ-9	E		48,625	70,961	68.52%		8.12%		60.40%	68,863		60.65%		63.60%
05/01/2022 to 08/31/2022 (period 2)														
12-17 years	E		1,228	6,654	18.46%		-1.38%		19.84%	8,858		27.91%		42.72%
18-44 years	E		33,597	43,328	77.54%		12.42%		65.12%	52,980		57.60%		77.07%
45-64 years	E		15,336	21,461	71.46%		16.95%		54.51%	29,537		45.77%		66.80%
65+ years	E		1,041	1,631	63.83%		22.01%		41.82%	2,616		38.03%		57.72%
TOTAL: Utilization of the PHQ-9	E		51,202	73,074	70.07%		13.20%		56.87%	93,991		50.37%		69.25%
09/01/2022 to 12/31/2022 (period 3)														
12-17 years	E		1,304	6,546	19.92%		1.58%		18.34%	10,247		29.96%		33.30%
18-44 years	E		31,872	42,691	74.66%		14.65%		60.01%	62,817		62.76%		76.84%
45-64 years	E		14,789	20,824	71.02%		21.78%		49.24%	35,474		50.52%		67.91%
65+ years	E		988	1,533	64.45%		27.39%		37.06%	3,025		41.57%		59.24%
TOTAL: Utilization of the PHQ-9	E		48,953	71,594	68.38%		16.25%		52.13%	111,563		54.76%		68.51%

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Total														
12-17 years	E		3,581	20,002	17.90%		-1.84%		19.74%	26,231		25.61%		38.29%
18-44 years	E		97,457	127,525	76.42%		12.17%		64.25%	154,640		63.30%		75.32%
45-64 years	E		44,789	63,323	70.73%		17.74%		52.99%	86,126		52.15%		65.05%
65+ years	E		2,953	4,779	61.79%		20.89%		40.90%	7,420		44.08%		55.69%
TOTAL: Utilization of the PHQ-9	E		148,780	215,629	69.00%		13.17%		55.83%	274,417		55.32%		67.12%
Depression Remission or Response for Adolescents and Adults **(DRR-E)**														
Follow-Up														
Ages 12-17	E		439	1,505	29.17%		1.95%		27.22%	1,778		18.65%		41.38%
Ages 18-44	E		14,545	28,811	50.48%		5.20%		45.28%	19,299		38.72%		43.58%
Ages 45-64	E		6,565	12,732	51.56%		7.21%		44.35%	8,050		40.61%		47.57%
Ages 65+	E		378	720	52.50%		10.17%		42.33%	463		42.83%		46.24%
Total (Ages 12+)	E		21,927	43,768	50.10%		6.21%		43.89%	29,590		38.90%		45.03%
Remission														
Ages 12-17	E		63	1,505	4.19%		-1.43%		5.62%	1,778		3.77%		7.49%
Ages 18-44	E		2,672	28,811	9.27%		-1.05%		10.32%	19,299		9.81%		10.66%
Ages 45-64	E		1,377	12,732	10.82%		0.52%		10.30%	8,050		9.58%		11.30%
Ages 65+	E		84	720	11.67%		1.52%		10.15%	463		10.86%		13.39%
Total (Ages 12+)	E		4,196	43,768	9.59%		-0.44%		10.03%	29,590		9.59%		10.78%
Response														
Ages 12-17	E		137	1,505	9.10%		-0.74%		9.84%	1,778		6.94%		16.85%
Ages 18-44	E		5,520	28,811	19.16%		0.02%		19.14%	19,299		18.68%		20.40%
Ages 45-64	E		2,597	12,732	20.40%		2.39%		18.01%	8,050		18.04%		21.73%
Ages 65+	E		146	720	20.28%		1.92%		18.36%	463		19.34%		21.47%
Total (Ages 12+)	E		8,400	43,768	19.19%		0.93%		18.26%	29,590		18.16%		20.72%
Adult Immunization Status (**AIS-E**)														
Influenza vaccine (ages 19-65)	E		803,175	2,048,692	39.20%	95th								
Td or Tdap vaccine (ages 19-65)	E		1,489,851	2,048,692	72.72%	95th								
Zoster (ages 50-65)	E		171,568	639,032	26.85%	75th								
Prenatal Immunization Status (**PRS-E**)														
Influenza vaccine	E		20,510	32,772	62.58%	95th	-8.28%		70.86%	33,512	95th	80.03%		62.73%
Td or Tdap vaccine	E		28,139	32,772	85.86%	90th	-1.95%	-1	87.81%	33,512	95th	90.50%		87.84%
Combination	E	1	19,747	32,772	60.26%	95th	-7.77%		68.03%	33,512	95th	77.26%		53.45%
Prenatal Depression Screening and Follow-Up (**PND-E**)														
Depression Screening	E		31,921	32,772	97.40%	95th								
Follow Up on Positive Screening	E		3,024	4,481	67.48%	90th								
Postpartum Depression Screening and Follow-Up (**PDS-E**)														
Depression Screening	E		34,200	35,900	95.26%	95th								
Follow Up on Positive Screening	E		5,403	6,742	80.14%	95th								

Notes: ^ MY 2022 Star Rating Weight: Bold **3** indicates maximum weight value of 3, others are 1 in the overall score calculation.
Risk-Adjusted Utilization not included in this report are: AHU, PCR, EDU. FVA (Prevention) is not in this report. They all have weight value of 1.
(NA) indicates the denominator was < 30 and a rate is not reported.

indicates measure lookback period overlaps with COVID-19 pandemic during 2020-2022.

*The percentile change from prior year presents the difference in percentile performance based on the national benchmark scaling. National Benchmark scaling: 0th, 5th, 10th, 25th, 33.33rd, 50th, 66.67th, 75th, 90th, 95th.

KPSC HEDIS MY 2022 Effectiveness of Care (EOC) / Use of Services Results
Medicare Risk Population (10626)
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MEDICARE RISK Measures HEDIS Measurement Year 2022	METHOD	MY 2022 Rating Wt.	HEDIS MY2022 NUM	HEDIS MY2022 DEN	HEDIS MY2022 RATE	MY2022 Percentile Rank	Change from Prior Yr	Percentile Change (Scale Diff) from Prior Yr*	HEDIS MY2021 RATE	HEDIS MY2021 DEN	MY2021 Percentile Rank	HEDIS MY2020 RATE	HEDIS 2020 RATE	HEDIS 2019 RATE
Effectiveness of Care: Prevention and Screening														
Breast Cancer Screening **(BCS)**														
Non-LIS/DE, Nondisability	A		118,445	136,123	87.01%		4.35%		82.66%	136,771		82.90%	89.09%	88.77%
LIS/DE	A		13,639	15,893	85.82%		5.69%		80.13%	12,930		82.00%	91.48%	91.08%
Disability	A		11,041	13,174	83.81%		5.79%		78.02%	13,877		79.86%	86.32%	86.09%
LIS/DE and Disability	A		7,494	9,161	81.80%		5.41%		76.39%	7,967		80.04%	86.80%	86.45%
Other	A		238	286	83.22%		2.55%		80.67%	300		79.76%	87.94%	88.44%
Unknown (NA)	A		36	45	80.00%					-		83.33%	80.58%	83.10%
TOTAL	A	1	150,893	174,682	86.38%	95th	4.58%		81.80%	171,845	95th	82.44%	88.79%	88.48%
Colorectal Cancer Screening **(COL)**			Ages 46-75 years						Ages 51-75 years			Ages 51-75 years		*(Hybrid)*
Non-LIS/DE, Nondisability	A		249,183	279,862	89.04%		0.53%		88.51%	278,407		86.47%	87.36%	90.09%
LIS/DE	A		24,958	28,570	87.36%		0.40%		86.96%	27,589		84.63%	90.04%	83.33%
Disability	A		25,869	30,003	86.22%		0.02%		86.20%	30,366		84.15%	86.02%	85.45%
LIS/DE and Disability	A		15,354	18,651	82.32%		-1.97%		84.29%	16,714		82.65%	86.40%	100.00%
Other	A		703	811	86.68%		-0.98%		87.66%	762		86.78%	88.69%	0.00%
Unknown	A		68	81	83.95%		2.32%		81.63%	283		84.47%	80.30%	100.00%
TOTAL	A	1	316,135	357,978	88.31%	95th	0.33%		87.98%	508,207	95th	85.96%	87.24%	89.29%
Effectiveness of Care: Respiratory Conditions														
Appropriate Testing for Pharyngitis **(CWP)**														
Ages 3-17	A		-	-										
Ages 18-64	A		46	167	27.54%	10th								
Ages 65+	A		515	1,446	35.62%	33.33rd								
TOTAL (Ages 3+)	A	1	561	1,613	34.78%	25th								
Use of Spirometry Testing in the Assessment and Diagnosis of COPD **(SPR)**	A		2,218	5,546	39.99%	95th	2.85%	1	37.14%	6,188	90th	59.43%	78.02%	78.04%
Pharmacotherapy Management of COPD Exacerbation **(PCE)**														
Systemic Corticosteroid	A	1	1,983	2,311	85.81%	90th	2.86%	1	82.95%	2,200	75th	84.23%	87.63%	88.04%
Bronchodilator	A	1	2,248	2,311	97.27%	95th	-0.32%		97.59%	2,200	95th	97.46%	97.62%	98.08%
Effectiveness of Care: Cardiovascular														
Controlling High Blood Pressure Age 18-85 **(CBP)**	A	3	185,069	220,888	83.78%	90th	1.33%		82.45%	202,788	90th	79.02%	87.60%	87.27%
Persistence of Beta Blocker Treatment after a Heart Attack **(PBH)**	A		960	1,075	89.30%	33.33rd	2.65%	1	86.65%	996	25th	89.43%	92.61%	94.69%
Statin Therapy for Patients With Cardiovascular Disease (**SPC**)														
Ages 21-75 (Male) Received Statin	A		13,423	14,764	90.92%	90th	0.65%	1	90.27%	14,364	75th	90.37%	90.23%	89.48%
Ages 21-75 (Male) Statin Adherence 80%	A		11,836	13,423	88.18%	50th	-0.55%	-1	88.73%	12,967	66.67th	88.16%	87.18%	85.38%
Ages 40-75 (Female) Received Statin	A		6,170	7,155	86.23%	75th	0.06%		86.17%	6,978	75th	85.80%	85.80%	85.77%
Ages 40-75 (Female) Statin Adherence 80%	A		5,375	6,170	87.12%	50th	-0.71%	-2	87.83%	6,013	75th	87.26%	85.04%	82.14%
TOTAL (Ages 21-75 M&F): Received Statin	A	1	19,593	21,919	89.39%	75th	0.46%		88.93%	21,342	75th	88.89%	88.85%	88.35%
TOTAL (Ages 21-75 M&F): Statin Adherence 80%	A	1	17,211	19,593	87.84%	66.67th	-0.60%	-1	88.44%	18,980	75th	87.88%	86.54%	84.42%
Cardiac Rehabilitation (**CRE**)														
Ages 18-64 Initiation: two or more sessions	A		2	356	0.56%	10th	0.56%	-1	0.00%	440	25th			
Ages 18-64 Engagement 1: 12 or more sessions	A		5	356	1.40%	10th	1.17%	-1	0.23%	440	25th			
Ages 18-64 Engagement 2: 24 or more sessions	A		4	356	1.12%	10th	0.67%	-1	0.45%	440	25th			
Ages 18-64 Achievement: 36 or more sessions	A		3	356	0.84%	33.33rd	0.39%		0.45%	440	33.33rd			
Ages 65+ Initiation: two or more sessions	A		20	3,773	0.53%	10th	0.23%		0.30%	4,614	10th			
Ages 65+ Engagement 1: 12 or more sessions	A		87	3,773	2.31%	10th	0.97%		1.34%	4,614	10th			
Ages 65+ Engagement 2: 24 or more sessions	A		111	3,773	2.94%	10th	1.51%		1.43%	4,614	10th			
Ages 65+ Achievement: 36 or more sessions	A		90	3,773	2.39%	33.33rd	1.18%	1	1.21%	4,614	25th			
TOTAL (Ages 18+) Initiation: two or more sessions	A		22	4,129	0.53%	10th	0.25%		0.28%	5,054	10th			
TOTAL (Ages 18+) Engagement 1: 12 or more sessions	A		92	4,129	2.23%	10th	0.98%		1.25%	5,054	10th			
TOTAL (Ages 18+) Engagement 2: 24 or more sessions	A		115	4,129	2.79%	10th	1.44%		1.35%	5,054	10th			
TOTAL (Ages 18+) Achievement: 36 or more sessions	A		93	4,129	2.25%	33.33rd	1.10%		1.15%	5,054	33.33rd			
Effectiveness of Care: Diabetes														
Hemoglobin A1c Control for Patients With Diabetes (**HBD**)														
HbA1c adequate control <8%	A	3	84,528	109,049	77.51%	75th	0.47%		77.04%	105,154	75th	77.52%	80.33%	80.31%
HbA1c poorly controlled >9% *Lower Rate is favorable*	A		12,431	109,049	11.40%	75th	-0.48%	-1	11.88%	105,154	90th	12.97%	9.87%	9.89%
Blood Pressure Control for Patients With Diabetes (**BPD**)	A	3	90,538	109,049	83.03%	90th	2.08%		80.95%	105,154	90th	78.27%	87.13%	86.95%
Eye Exam for Patients With Diabetes (**EED**)														
Non-LIS/DE, Nondisability	A		63,656	74,172	85.82%		4.09%		81.73%	72,066		78.51%	88.44%	90.58%
LIS/DE	A		10,980	12,787	85.87%		4.85%		81.02%	11,702		78.07%	90.35%	91.33%
Disability	A		9,547	11,764	81.15%		5.26%		75.89%	11,917		73.31%	84.23%	85.76%
LIS/DE and Disability	A		7,500	9,407	79.73%		3.23%		76.50%	8,688		73.65%	86.14%	87.40%
Other	A		491	662	74.17%		4.40%		69.77%	645		67.61%	78.06%	75.50%
Unknown	A		211	238	88.66%				0.00%	136		87.10%	89.29%	88.81%
Total	A	1	92,385	109,030	84.73%	90th	4.36%	1	80.37%	105,154	75th	77.41%	87.67%	89.61%
Kidney Health Evaluation for Patients With Diabetes (**KED**)														
Ages 18-64	A		6,667	8,091	82.40%	95th	1.84%		80.56%	8,054	95th	78.22%		
Ages 65-74	A		76,920	87,843	87.57%	95th	3.08%		84.49%	85,014	95th	82.20%		
Ages 75-85	A		48,204	55,678	86.58%	95th	2.66%		83.92%	51,961	95th	80.77%		

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TOTAL (Ages 18-85)	A	1	131,791	151,612	86.93%	95th	2.86%		84.07%	145,029	95th	81.47%		
Statin Therapy for Patients with Diabetes (**SPD**)														
Received Statin Therapy	A	1	73,473	84,768	86.68%	90th	-0.13%	-1	86.81%	82,574	95th	86.87%	86.79%	85.38%
Statin Adherence 80%	A	1	62,886	73,473	85.59%	50th	0.16%		85.43%	71,681	50th	85.41%	83.20%	81.13%
Effectiveness of Care: Musculoskeletal														
Osteoporosis Management in Women Who Had a Fracture (**OMW**)	A	1	2,383	2,846	83.73%	95th	6.07%		77.66%	2,507	95th	79.58%	87.04%	89.95%
Osteoporosis Screening in Older Women (**OSW**)	A	1	113,356	142,811	79.37%	95th	0.47%		78.90%	141,654	95th			
Effectiveness of Care: Behavioral Health														
Antidepressant Medication Management (**AMM**)														
Effective acute phase (12-week) treatment	A		14,269	15,932	89.56%	95th	0.84%	1	88.72%	14,387	90th	87.85%	86.19%	84.21%
Effective continuation (6-month) treatment	A	1	10,744	15,932	67.44%	50th	1.71%	1	65.73%	14,387	33.33rd	63.95%	62.14%	60.09%
Follow-Up After Hospitalization for Mental Illness (**FUH**)														
6-17 years: 30-day follow-up (NA)	A		-	-						-				
6-17 years: 7-day follow-up (NA)	A		-	-						-				
18-64 years: 30-day follow-up	A		382	487	78.44%	95th	-1.67%		80.11%	528	95th	73.69%	74.88%	70.32%
18-64 years: 7-day follow-up	A		324	487	66.53%	95th	0.43%		66.10%	528	95th	59.89%	58.87%	57.31%
65+ years: 30-day follow-up	A		451	523	86.23%	95th	-0.77%		87.00%	523	95th	80.66%	76.27%	80.82%
65+ years: 7-day follow-up	A		381	523	72.85%	95th	-2.87%		75.72%	523	95th	64.61%	65.42%	67.97%
TOTAL (Ages 6+): 30-day follow-up	A		833	1,010	82.48%	95th	-1.06%		83.54%	1,051	95th	77.01%	75.55%	74.94%
TOTAL (Ages 6+): 7-day follow-up	A	1	705	1,010	69.80%	95th	-1.08%		70.88%	1,051	95th	62.13%	62.02%	62.00%
Follow-Up After ED Visit for Mental Illness (**FUM**)														
6-17 years: 30-day follow-up (NA)	A		-	-						-				
6-17 years: 7-day follow-up (NA)	A		-	-						-				
18-64 years: 30-day follow-up	A		143	196	72.96%	90th	-5.53%	-1	78.49%	186	95th	76.34%	65.33%	61.43%
18-64 years: 7-day follow-up	A		107	196	54.59%	75th	-7.78%	-1	62.37%	186	90th	62.90%	49.75%	45.71%
65+ years: 30-day follow-up	A		293	368	79.62%	95th	-1.33%		80.95%	399	95th	74.29%	53.31%	53.94%
65+ years: 7-day follow-up	A		247	368	67.12%	95th	3.96%		63.16%	399	95th	54.23%	38.95%	41.64%
TOTAL (Ages 6+): 30-day follow-up	A		436	564	77.30%	95th	-2.87%		80.17%	585	95th	75.05%	57.58%	56.93%
TOTAL (Ages 6+): 7-day follow-up	A	1	354	564	62.77%	95th	-0.14%		62.91%	585	95th	57.43%	42.78%	43.26%
Follow-Up After High-Intensity Care for Substance Use Disorder (**FUI**)														
13-17 years: 30-day follow-up (NA)	A		-	-						-				
13-17 years: 7-day follow-up (NA)	A		-	-						-				
18-64 years: 30-day follow-up	A		168	212	79.25%	95th	3.17%		76.08%	209	95th			
18-64 years: 7-day follow-up	A		130	212	61.32%	95th	6.30%		55.02%	209	95th			
65+ years: 30-day follow-up	A		280	381	73.49%	95th	0.89%		72.60%	354	95th			
65+ years: 7-day follow-up	A		214	381	56.17%	95th	3.63%		52.54%	354	95th			
TOTAL (Ages 6+): 30-day follow-up	A		448	593	75.55%	95th	1.66%		73.89%	563	95th			
TOTAL (Ages 6+): 7-day follow-up	A	1	344	593	58.01%	95th	4.55%		53.46%	563	95th			
Follow-Up After ED Visit for Substance Use (**FUA**)														
13-17 years: 30-day follow-up (NA)	A		-	-						-				
13-17 years: 7-day follow-up (NA)	A		-	-						-				
18+ years: 30-day follow-up	A		232	607	38.22%	50th	2.58%	-4	35.64%	550	95th	44.18%	23.64%	23.40%
18+ years: 7-day follow-up	A		174	607	28.67%	66.67th	7.22%	-2	21.45%	550	90th	30.32%	16.73%	18.89%
TOTAL (Ages 13+): 30-day follow-up	A		232	607	38.22%	50th	2.58%	-4	35.64%	550	95th	44.18%	23.64%	23.40%
TOTAL (Ages 13+): 7-day follow-up	A	1	174	607	28.67%	66.67th	7.22%	-2	21.45%	550	90th	30.32%	16.73%	18.89%
Pharmacotherapy for Opioid Use Disorder (**POD**)														
16-64 years	A		35	90	38.89%	50th	5.14%	2	33.75%	80	25th			
65+ years	A		65	191	34.03%	33.33rd	-3.56%		37.59%	141	33.33rd			
TOTAL (Ages 18+)	A	1	100	281	35.59%	50th	-0.61%	1	36.20%	221	33.33rd			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (**SAA**)	A	1	1,701	2,155	78.93%	50th	0.07%		78.86%	2,152	50th	77.29%	65.79%	
Effectiveness of Care: Medication Management and Care Coordination														
Transitions of Care (**TRC**)													*Rotated from*	
Notification of Inpatient Admission													*HEDIS2019*	
18-64 years	H		26	30	86.67%	95th	-6.43%		93.10%	29	95th	90.00%	60.00%	60.00%
65+ years	H	1	353	381	92.65%	95th	1.29%		91.36%	382	95th	95.54%	78.69%	78.69%
TOTAL (Ages 18+)	H		379	411	92.21%	95th	0.73%		91.48%	411	95th	95.13%	76.64%	76.64%
Medication Reconciliation Post-Discharge														
18-64 years	H		28	30	93.33%	95th	-6.67%		100.00%	29	95th	96.67%	97.78%	97.78%
65+ years	H	1	377	381	98.95%	95th	1.04%		97.91%	382	95th	97.90%	98.09%	98.09%
TOTAL (Ages 18+)	H		405	411	98.54%	95th	0.49%		98.05%	411	95th	97.81%	98.05%	98.05%
Patient Engagement After Inpatient Discharge														
18-64 years	H		26	30	86.67%	75th	-9.88%	-2	96.55%	29	95th	96.67%	95.56%	95.56%
65+ years	H	1	366	381	96.06%	95th	0.51%		95.55%	382	95th	97.64%	96.72%	96.72%
TOTAL (Ages 18+)	H		392	411	95.38%	95th	-0.24%		95.62%	411	95th	97.57%	96.59%	96.59%
Receipt of Discharge Information														
18-64 years	H		18	30	60.00%	95th	-12.41%		72.41%	29	95th	70.00%	60.00%	60.00%
65+ years	H	1	260	381	68.24%	95th	3.06%		65.18%	382	95th	71.39%	76.50%	76.50%
TOTAL (Ages 18+)	H		278	411	67.64%	95th	1.95%		65.69%	411	95th	71.29%	74.70%	74.70%

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Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions **(FMC)**														
18-64 years	A		3,834	5,720	67.03%	90th	7.17%	3	59.86%	4,629	50th	59.13%	47.36%	46.59%
65+ years	A	1	45,560	66,877	68.13%	90th	8.61%	3	59.52%	59,069	50th	61.83%	51.41%	51.74%
TOTAL (Ages 18+)	A		49,394	72,597	68.04%	90th	8.49%	3	59.55%	63,698	50th	61.57%	51.04%	51.27%
Effectiveness of Care: Overuse/Appropriateness														
Non-Recommended PSA Screening in Older Men **(PSA)** *Lower Rate is favorable*	A	1	21,514	145,367	14.80%	75th	1.12%	-1	13.68%	141,440	90th	12.13%	12.59%	11.86%
Appropriate Treatment for Upper Respiratory Infection **(URI)** *Inverted Rate*														
3 mos-17 years	A(I)		-	-										
18-64 years	A(I)		119	906	86.87%	90th								
65+ years	A(I)		1,358	10,414	86.96%	90th								
TOTAL (Ages 3 mos+)	A(I)	1	1,477	11,320	86.95%	90th								
Avoidance of Antibiotic Treatment with Acute Bronchitis **(AAB)** *Inverted Rate*														
3 mos-17 years	A(I)		-	-										
18-64 years	A(I)		27	77	64.94%	95th								
65+ years	A(I)		362	921	60.69%	95th								
TOTAL (Ages 3 mos+)	A(I)	1	389	998	61.02%	95th								
Potentially Harmful Drug Interactions in the Elderly **(DDE)** *Lower Rate is favorable*														
Falls + Tricyclic Antidepressants or Antipsychotics	A		9,616	35,156	27.35%	90th	1.15%		26.20%	30,649	90th	24.83%	25.65%	37.41%
Dementia + Antiemetics,Tricyclic Antidepressants or Anticholinergic Agents	A		4,581	23,092	19.84%	95th	-0.11%		19.95%	22,471	95th	20.47%	30.02%	33.25%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Nonaspirin NSAIDs	A		620	15,702	3.95%	75th	0.91%	-1	3.04%	14,798	90th	1.66%	2.00%	2.24%
TOTAL	A	1	14,817	73,950	20.04%	95th	0.95%		19.09%	67,918	95th	19.44%	23.47%	30.97%
Use of High Risk Medications in the Elderly **(DAE)** *Lower Rate is favorable*														
High Risk Medications to Avoid	A		21,401	537,070	3.98%	95th	-0.18%		4.16%	521,488	95th	4.35%	4.37%	6.06%
High Risk Medication to avoid except for Appropriate diagnos	A		16,022	537,070	2.98%	66.67th	0.00%	-1	2.98%	521,488	75th	5.06%		
Total	A	1	35,688	537,070	6.64%	95th	-0.17%		6.81%	521,488	95th	8.77%		
Use of Opioids at High Dosage **(HDO)** *Lower Rate is favorable*	A	1	465	41,464	1.12%	90th	-0.28%		1.40%	40,829	90th	1.47%	1.73%	1.66%
Use of Opioids From Multiple Providers **(UOP)** *Lower Rate is favorable*														
Multiple Prescribers	A		11,230	48,613	23.10%	0th	2.83%	-1	20.27%	49,749	5th	16.65%	19.59%	20.35%
Multiple Pharmacies	A		988	48,613	2.03%	10th	-1.78%	1	3.81%	49,749	5th	2.34%	1.93%	2.89%
Multiple Prescribers and Multiple Pharmacies	A	1	593	48,613	1.22%	10th	-1.83%	2	3.05%	49,749	0th	1.20%	1.20%	1.97%
Risk of Continued Opioid Use **(COU)** *Lower Rate is favorable*														
Ages 18-64: ≥15 Days Covered	A		382	5,842	6.54%	95th	-1.58%		8.12%	4,260	95th	8.70%		
Ages 18-64: ≥31 Days Covered	A		201	5,842	3.44%	95th	-0.88%		4.32%	4,260	95th	5.08%		
Ages 65+: ≥15 Days Covered	A		4,272	62,628	6.82%	95th	-1.19%	1	8.01%	60,446	90th	8.42%		
Ages 65+: ≥31 Days Covered	A		1,999	62,628	3.19%	90th	-0.77%		3.96%	60,446	90th	3.89%		
TOTAL (Ages 18+): ≥15 Days Covered	A		4,654	68,470	6.80%	95th	-1.21%	1	8.01%	64,706	90th	8.44%		
TOTAL (Ages 18+): ≥31 Days Covered	A	1	2,200	68,470	3.21%	95th	-0.78%	1	3.99%	64,706	90th	3.99%		
Access & Availability of Care														
Initiation and Engagement of Substance Abuse Disorder **(IET)**														
13-17 Years														
TOTAL: Initiation of SUD (NA)	A		-	-						-				
Engagement of SUD (NA)	A		-	-						-				
18-64 Years														
Alcohol: Initiation of SUD	A		269	571	47.11%	66.67th								
Engagement of SUD	A		107	571	18.74%	95th								
Opioid: Initiation of SUD	A		139	367	37.87%	50th								
Engagement of SUD	A		45	367	12.26%	66.67th								
Other: Initiation of SUD	A		289	659	43.85%	66.67th								
Engagement of SUD	A		109	659	16.54%	95th								
TOTAL: Initiation of SUD	A		697	1,597	43.64%	66.67th								
Engagement of SUD	A		261	1,597	16.34%	95th								
65+ Years									18+ Years			18+ Years		
Alcohol: Initiation of SUD	A		1,763	4,335	40.67%	50th	8.48%		32.19%	4,595		36.38%	34.90%	33.23%
Engagement of SUD	A		388	4,335	8.95%	95th	-1.78%		10.73%	4,595		11.61%	9.33%	8.96%
Opioid: Initiation of SUD	A		296	965	30.67%	50th	5.38%		25.29%	1,542		29.56%	28.52%	27.12%
Engagement of SUD	A		69	965	7.15%	75th	-1.09%		8.24%	1,542		10.80%	7.70%	6.47%
Other: Initiation of SUD	A		418	1,252	33.39%	50th	4.46%		28.93%	1,891		34.35%	35.44%	33.61%
Engagement of SUD	A		112	1,252	8.95%	95th	-1.52%		10.47%	1,891		12.22%	10.76%	11.11%
TOTAL: Initiation of SUD	A		2,477	6,552	37.81%	50th	8.32%		29.49%	7,841		33.54%	33.07%	26.06%
Engagement of SUD	A		569	6,552	8.68%	90th	-1.23%		9.91%	7,841		11.11%	9.06%	8.55%
TOTAL (Ages 13+)														
Alcohol: Initiation of SUD	A		2,032	4,906	41.42%	50th	9.23%	2	32.19%	4,595	25th	36.38%	34.90%	33.23%
Engagement of SUD	A		495	4,906	10.09%	90th	-0.64%		10.73%	4,595	90th	11.61%	9.33%	8.96%

MEDICARE RISK Measures HEDIS Measurement Year 2022	METHOD	^ MY 2022 Rating Wt.	HEDIS MY2022 NUM	HEDIS MY2022 DEN	HEDIS MY2022 RATE	MY2022 Percentile Rank	Change from Prior Yr	Percentile Change (Scale Diff) from Prior Yr*	HEDIS MY2021 RATE	HEDIS MY2021 DEN	MY2021 Percentile Rank	HEDIS MY2020 RATE	HEDIS 2020 RATE	HEDIS 2019 RATE
Opioid: Initiation of SUD	A		435	1,332	32.66%	33.33rd	7.37%		25.29%	1,542	33.33rd	29.56%	28.52%	27.12%
Engagement of SUD	A		114	1,332	8.56%	66.67th	0.32%		8.24%	1,542	66.67th	10.80%	7.70%	6.47%
Other: Initiation of SUD	A		707	1,911	37.00%	50th	8.07%	1	28.93%	1,891	33.33rd	34.35%	35.44%	33.61%
Engagement of SUD	A		221	1,911	11.56%	95th	1.09%		10.47%	1,891	95th	12.22%	10.76%	11.11%
TOTAL: Initiation of SUD	A		3,174	8,149	38.95%	50th	9.46%	1	29.49%	7,841	33.33rd	33.54%	33.07%	26.06%
Engagement of SUD	A	1	830	8,149	10.19%	90th	0.28%		9.91%	7,841	90th	11.11%	9.06%	8.55%

Notes: ^ MY 2022 Star Rating Weight: Bold **3** indicates maximum weight value of 3, others are 1 in the overall score calculation.
Risk-Adjusted Utilization not included in this report are: PCR, EDU, AHU, HPC, and HFS. FVO and PNU (Prevention) are not in this report. They all have weight value of 1.
(NA) indicates the denominator was < 30 and a rate is not reported.

indicates measure lookback period overlaps with COVID-19 pandemic during 2020-2022.

*The percentile change from prior year presents the difference in percentile performance based on the national benchmark scaling. National Benchmark scaling: 0th, 5th, 10th, 25th, 33.33rd, 50th, 66.67th, 75th, 90th, 95th.

MEDICAID San Diego GMC Measures HEDIS Measurement Year 2022	METHOD	Held MPL	HEDIS MY2022 NUM	HEDIS MY2022 DEN	HEDIS MY2022 RATE	MY2022 Percentile Rank	Change from Prior Yr	Percentile Change (Scale Diff) from Prior Yr*	HEDIS MY2021 RATE	HEDIS MY2021 DEN	MY2021 Percentile Rank	HEDIS MY2020 RATE	HEDIS 2020 RATE	HEDIS 2019 RATE
Effectiveness of Care: Prevention and Screening		Y												
Childhood Immunization Status **(CIS)**		Y												
DTaP	A		817	1,026	79.63%	75th	-1.35%	-1	80.98%	978	90th	82.80%	84.91%	83.79%
IPV	A		913	1,026	88.99%	75th	-1.40%		90.39%	978	75th	91.02%	93.62%	91.17%
MMR	A		904	1,026	88.11%	75th	-0.54%		88.65%	978	75th	90.91%	92.67%	90.39%
HiB	A		906	1,026	88.30%	75th	-1.68%		89.98%	978	75th	91.13%	92.35%	90.68%
Hepatitis B	A		945	1,026	92.11%	90th	-1.24%	-1	93.35%	978	95th	92.99%	93.62%	93.40%
VZV	A		907	1,026	88.40%	75th	-0.86%	-1	89.26%	978	90th	90.80%	92.88%	90.97%
Penumococcal Conjugate	A		796	1,026	77.58%	75th	-1.25%		78.83%	978	75th	81.49%	82.89%	81.84%
Hepatitis A	A		903	1,026	88.01%	90th	-0.23%	-1	88.24%	978	95th	91.02%	91.82%	
Rotavirus	A		798	1,026	77.78%	90th	-1.67%		79.45%	978	90th	79.74%	79.60%	
Influenza	A		624	1,026	60.82%	90th	-6.26%		67.08%	978	90th	71.41%	69.50%	
Combination #10	A	Y	523	1,026	50.97%	95th	-4.35%		55.32%	978	95th	58.60%	57.07%	
Immunizations for Adolescents **(IMA)**		Y												
Meningococcal	A		955	1,115	85.65%	66.67th	-0.66%		86.31%	1,103	66.67th	90.08%	88.41%	88.88%
Tdap (no TD beginning HEDIS 2017)	A		1,050	1,115	94.17%	95th	0.15%		94.02%	1,103	95th	95.48%	95.75%	94.44%
HPV	A		642	1,115	57.58%	95th	0.64%		56.94%	1,103	95th	58.55%	60.39%	58.69%
Combination 2 (Meningococcal, Tdap, HPV)	A	Y	630	1,115	56.50%	95th	0.38%		56.12%	1,103	95th	56.97%	58.65%	57.30%
Lead Screening **(LSC)**	A	Y	510	1,028	49.61%	25th								
Breast Cancer Screening **(BCS)**		Y												
Ages 50-64			2,793	3,646	76.60%		3.79%		72.81%	3,104		75.01%	83.70%	
Ages 65-74			1,252	1,598	78.35%		2.00%		76.35%	1,442		76.00%	84.72%	
TOTAL (Ages 50-74)	A	Y	4,045	5,244	77.14%	95th	3.21%		73.93%	4,546	95th	75.32%	84.02%	82.64%
Cervical Cancer Screening **(CCS)**	A	Y	11,337	15,043	75.36%	95th	-0.83%		76.19%	13,476	95th	74.23%	83.12%	84.52%
Colorectal Cancer Screening **(COL)**														
Ages 46-49	A		766	1,757	43.60%									
Ages 50-75	A		7,803	10,411	74.95%									
TOTAL (Ages 50-75)	A		8,569	12,168	70.42%									
Chlamydia Screening in Women **(CHL)**		Y												
Ages 16-20	A		592	1,076	55.02%	50th	-4.05%	-1	59.07%	1,070	66.67th	53.15%	63.31%	
Ages 21-24	A		831	1,130	73.54%	90th	-1.78%	-1	75.32%	1,005	95th	71.56%	83.42%	
TOTAL (Ages 16-24)	A	Y	1,423	2,206	64.51%	75th	-2.43%		66.94%	2,075	75th	61.53%	72.21%	
Effectiveness of Care: Respiratory Conditions														
Asthma Medication Ratio **(AMR)**														
Ages 5-11	A		89	97	91.75%	95th	-2.93%		94.68%	94	95th	93.60%	95.80%	92.70%
Ages 12-18	A		57	59	96.61%	95th	-1.78%		98.39%	62	95th	94.37%	92.31%	95.51%
Ages 19-50	A		281	321	87.54%	95th	-1.63%		89.17%	277	95th	83.20%	85.19%	85.78%
Ages 51-64	A		168	199	84.42%	95th	-3.01%		87.43%	175	95th	82.96%	83.96%	86.67%
TOTAL (Ages 5-64)	A		595	676	88.02%	95th	-2.44%		90.46%	608	95th	86.78%	88.44%	89.23%
Effectiveness of Care: Cardiovascular Care		Y												
Controlling High Blood Pressure **(CBP)**		Y												
Ages 18-64	A		1,649	2,157	76.45%		-1.00%		77.45%	1,796		74.67%	81.73%	
Ages 65-85	A		1,438	1,753	82.03%		-0.27%		82.30%	1,542		80.95%	87.23%	
TOTAL (Ages 18-85)	A	Y	3,087	3,910	78.95%	95th	-0.74%		79.69%	3,338	95th	77.65%	84.23%	84.78%
Effectiveness of Care: Diabetes		Y												
Hemoglobin A1c Control for Patients With Diabetes **(HBD)**		Y												
HbA1c poor control >9% *Lower Rate is favorable*														
Ages 18-64	A		754	2,900	26.00%		2.08%		23.92%	2,567		26.93%	22.09%	
Ages 65-75	A		128	1,028	12.45%		3.23%		9.22%	933		12.86%	9.33%	
TOTAL (Ages 18-75)	A	Y	882	3,928	22.45%	95th	2.45%		20.00%	3,500	95th	22.91%	18.45%	19.58%
Effectiveness of Care: Behavioral Health		Y												
Antidepressant Medication Management **(AMM)**														
Effective acute phase (12-week) treatment														
Ages 18-64	A		787	970	81.13%		-0.28%		81.41%	877		76.33%	73.10%	
Ages 65+	A		171	192	89.06%		0.60%		88.46%	182		84.88%	82.84%	
TOTAL (Ages 18+)	A		958	1,162	82.44%	95th	-0.19%		82.63%	1,059	95th	77.88%	74.98%	
Effective continuation (6-month) treatment														
Ages 18-64	A		554	970	57.11%		-1.95%		59.06%	877		50.19%	51.58%	
Ages 65+	A		126	192	65.63%		1.34%		64.29%	182		56.98%	57.35%	
TOTAL (Ages 18+)	A		680	1,162	58.52%	90th	-1.44%		59.96%	1,059	90th	51.43%	52.69%	
Follow-Up Care for Children Prescribed ADHD Medication **(ADD)**														
Initiation Phase	A		133	174	76.44%	95th	-6.89%		83.33%	168	95th	74.59%	63.21%	
Continuation and Maintenance Phase	A		31	45	68.89%	90th	-5.11%	-1	74.00%	50	95th	61.22%	63.79%	
Follow-Up After ED Visit for Mental Illness **(FUM)**		Y												
6-17 years: 30-day follow-up	A		36	58	62.07%	33.33rd	-6.82%	-1	68.89%	45	50th			
6-17 years: 7-day follow-up	A		29	58	50.00%	33.33rd	5.56%		44.44%	45	33.33rd			
18-64 years: 30-day follow-up	A		135	204	66.18%	75th	6.97%		59.21%	228	75th			
18-64 years: 7-day follow-up	A		92	204	45.10%	75th	3.87%	1	41.23%	228	66.67th			
65+ years: 30-day follow-up (NA)	A		4	6	66.67%	75th	6.67%		60.00%	10	75th			

MEDICAID San Diego GMC Measures HEDIS Measurement Year 2022	METHOD	Held MPL	HEDIS MY2022 NUM	HEDIS MY2022 DEN	HEDIS MY2022 RATE	MY2022 Percentile Rank	Change from Prior Yr	Percentile Change (Scale Diff) from Prior Yr*	HEDIS MY2021 RATE	HEDIS MY2021 DEN	MY2021 Percentile Rank	HEDIS MY2020 RATE	HEDIS 2020 RATE	HEDIS 2019 RATE
65+ years: 7-day follow-up (NA)	A		2	6	33.33%	33.33rd	-6.67%	-2	40.00%	10	66.67th			
TOTAL (Ages 6+): 30-day follow-up	A	Y	175	268	65.30%	75th	4.52%	1	60.78%	283	66.67th			
TOTAL (Ages 6+): 7-day follow-up	A		123	268	45.90%	50th	4.20%		41.70%	283	50th			
Follow-Up After ED Visit for Substance Use **(FUA)**		Y												
13-17 years: 30-day follow-up (NA)	A		3	19	15.79%	5th	3.29%	-5	12.50%	8	66.67th			
13-17 years: 7-day follow-up (NA)	A		2	19	10.53%	5th	10.53%		0.00%	8	5th			
18+ years: 30-day follow-up	A		93	242	38.43%	50th	12.99%	-1	25.44%	228	66.67th			
18+ years: 7-day follow-up	A		62	242	25.62%	50th	13.78%	1	11.84%	228	33.33rd			
TOTAL (Ages 13+): 30-day follow-up	A	Y	96	261	36.78%	50th	11.78%	-1	25.00%	236	66.67th			
TOTAL (Ages 13+): 7-day follow-up	A		64	261	24.52%	50th	13.08%	1	11.44%	236	33.33rd			
Pharmacotherapy for Opioid Use Disorder (**POD**)														
Ages 16-64			6	32	18.75%	10th								
Ages 65+			4	11	36.36%	33.33rd								
TOTAL (Ages 16+)			10	43	23.26%	25th								
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications **(SSD)**	A		350	398	87.94%	95th	1.43%	1	86.51%	341	90th	74.80%		
Metabolic Monitoring for Children and Adolescents on Antipsychotics **(APM)**														
Ages 1-11 Blood Glucose (NA)	A		12	18	66.67%	**95th**	-12.28%		78.95%	19	**95th**	58.33%		
Ages 1-11 Cholesterol (NA)	A		11	18	61.11%	**95th**	-17.84%		78.95%	19	**95th**	50.00%		
Ages 1-11 Blood Glucose and Cholesterol (NA)	A		11	18	61.11%	**95th**	-17.84%		78.95%	19	**95th**	50.00%		
Ages 12-17 Blood Glucose	A		36	46	78.26%	95th	8.26%	1	70.00%	50	90th	67.86%		
Ages 12-17 Cholesterol	A		32	46	69.57%	95th	5.57%		64.00%	50	95th	51.79%		
Ages 12-17 Blood Glucose and Cholesterol	A		31	46	67.39%	95th	3.39%		64.00%	50	95th	51.79%		
TOTAL (Ages 1-17) Blood Glucose	A		48	64	75.00%	95th	2.54%	1	72.46%	69	90th	66.18%		
TOTAL (Ages 1-17) Cholesterol	A		43	64	67.19%	95th	-0.93%		68.12%	69	95th	51.47%		
TOTAL (Ages 1-17) Blood Glucose and Cholesterol	A		42	64	65.63%	95th	-2.50%		68.12%	69	95th	51.47%		
Access/Availability of Care		Y												
Adults' Access to Preventive/Ambulatory Health Services **(AAP)**														
Ages 20-44	A		13,631	18,563	73.43%	66.67th								
Ages 45-64	A		9,156	10,784	84.90%	75th								
Ages 65+	A		5,029	5,561	90.43%	75th								
Total (Ages 20+)	A		27,816	34,908	79.68%	75th								
Prenatal and Postpartum Care **(PPC)** *		Y												
Timeliness of Prenatal Care	A	Y	591	621	95.17%	95th	1.41%		93.76%	561	95th	95.31%	92.15%	92.53%
Postpartum Care	A	Y	507	621	81.64%	66.67th	-1.60%	-1	83.24%	561	75th	81.22%	80.89%	74.75%
Utilization		Y												
Well-Child Visits in the First 30 Months of Life **(W30)**		Y												
First 15 Months	A	Y	427	568	75.18%	95th	6.94%	1	68.24%	529	90th	74.12%		
15 Months-30 Months	A	Y	701	1,028	68.19%	50th	8.50%	3	59.69%	965	10th	70.74%		
Child and Adolescent Well-Care Visits **(WCV)**		Y												
3-11 years	A		5,818	10,191	57.09%	50th	-1.76%		58.85%	9,566	50th	45.98%		
12-17 years	A		3,621	7,058	51.30%	50th	-0.21%		51.51%	6,734	50th	39.15%		
18-21 years	A		996	4,340	22.95%	33.33rd	0.75%		22.20%	4,040	33.33rd	14.33%		
TOTAL (Ages 3-21)	A	Y	10,435	21,589	48.33%	50th	-0.81%		49.14%	20,340	50th	38.00%		
Ambulatory Care **(AMB)**			Visit Count	MemberMon	12000*VstCnt/MM					MemberMon		12000 * VisitCnt / MbrMon		
Age less than 1 Outpatient														
Emergency Dept Visits	A		590	8,676	816.04		262.31		553.73	9,297		447.61	680.40	
Ages 1-9 Outpatient														
Emergency Dept Visits	A		3,376	126,549	320.13		98.83		221.30	120,920		173.08	290.62	
Ages 10-19 Outpatient														
Emergency Dept Visits	A		2,674	144,557	221.97		46.83		175.14	138,880		146.12	199.92	
Ages 20-44 Outpatient														
Emergency Dept Visits	A		7,515	234,919	383.88		0.59		383.29	209,449		355.74	419.70	
Ages 45-64 Outpatient														
Emergency Dept Visits	A		5,106	136,435	449.09		8.69		440.40	126,022		444.39	517.23	
Ages 65-74 Outpatient														
Emergency Dept Visits	A		1,401	36,675	458.40		32.87		425.53	32,458		436.70	536.36	
Ages 75-84 Outpatient														
Emergency Dept Visits	A		1,017	19,933	612.25		25.68		586.57	18,678		499.13	616.07	
Ages 85+ Outpatient														
Emergency Dept Visits	A		533	7,938	805.74		71.62		734.12	7,748		700.00	779.09	
Unknown Outpatient														
Emergency Dept Visits	A		-	-						-				
Total Outpatient														
Total Emergency Dept Visits	A		22,212	715,682	372.43	5th	37.11		335.32	663,452		305.05	383.37	
Measures Collected Using Electronic Clinical Data Systems (ECDS)														
Depression Screening and Follow-Up for Adolescents and Adults (**DSF-E**)														
Screening														
Ages 12-17	E		2,774	6,456	42.97%									

MEDICAID San Diego GMC Measures HEDIS Measurement Year 2022	METHOD	Held MPL	HEDIS MY2022 NUM	HEDIS MY2022 DEN	HEDIS MY2022 RATE	MY2022 Percentile Rank	Change from Prior Yr	Percentile Change (Scale Diff) from Prior Yr*	HEDIS MY2021 RATE	HEDIS MY2021 DEN	MY2021 Percentile Rank	HEDIS MY2020 RATE	HEDIS 2020 RATE	HEDIS 2019 RATE
Ages 18-64	E		4,387	25,733	17.05%									
Ages 65+	E		1,209	3,722	32.48%									
Total (Ages 12+)	E		8,370	35,911	23.31%									
Follow-Up														
Ages 12-17	E		272	283	96.11%									
Ages 18-64	E		1,650	1,817	90.81%									
Ages 65+	E		63	74	85.14%									
Total (Ages 12+)	E		1,985	2,174	91.31%									
Depression Remission or Response for Adolescents and Adults (**DRR-E**)														
Follow-Up														
Ages 12-17	E		20	61	32.79%									
Ages 18-44	E		530	1,020	51.96%									
Ages 45-64	E		292	544	53.68%									
Ages 65+	E		108	198	54.55%									
Total (Ages 12+)	E		950	1,823	52.11%									
Remission														
Ages 12-17	E		2	61	3.28%									
Ages 18-44	E		65	1,020	6.37%									
Ages 45-64	E		45	544	8.27%									
Ages 65+	E		19	198	9.60%									
Total (Ages 12+)	E		131	1,823	7.19%									
Response														
Ages 12-17	E		7	61	11.48%									
Ages 18-44	E		166	1,020	16.27%									
Ages 45-64	E		85	544	15.63%									
Ages 65+	E		39	198	19.70%									
Total (Ages 12+)	E		297	1,823	16.29%									
Prenatal Immunization Status (**PRS-E**)														
Influenza	E		328	610	53.77%	95th								
Tdap	E		522	610	85.57%	95th								
Combination	E		323	610	52.95%	95th								
Prenatal Depression Screening and Follow-Up (**PND-E**)														
Depression Screening	E		599	610	98.20%	95th								
Follow Up on Positive Screening	E		85	140	60.71%	75th								
Postpartum Depression Screening and Follow-Up (**PDS-E**)														
Depression Screening	E		612	649	94.30%	95th								
Follow Up on Positive Screening	E		70	91	76.92%	75th								
Non HEDIS Measures														
Contraceptive Care - Postpartum Women **(CCP)**														
Most or Moderately Effective Contraception - 60 Days														
Ages 15-20 (NA)	A		12	20	60.00%		17.14%		42.86%	21		34.78%	46.43%	
Ages 21-44	A		251	522	48.08%		-1.29%		49.37%	474		54.15%	47.58%	
Contraceptive Care - All Women **(CCW)** - Most or Moderately Effective Contraception														
Ages 15-20	A		814	3,399	23.95%		1.01%		22.94%	3,138		23.24%	25.41%	
Ages 21-44	A		3,542	10,249	34.56%		3.17%		31.39%	8,596		30.31%	33.87%	
Developmental Screening in the First Three Years of Life **(DEV)**									Survey instrument from prior year not approved.					
1st Birthday	A		100	498	20.08%		18.13%		1.95%	513		0.00%	99.82%	
2nd Birthday	A		96	1,019	9.42%		8.39%		1.03%	973		0.66%	86.25%	
3rd Birthday	A		82	1,059	7.74%		6.86%		0.88%	1,017		0.32%	59.35%	
TOTAL (Ages 1-3)	A		278	2,576	10.79%		9.63%		1.16%	2,503		0.38%	78.72%	
Topical Fluoride for Children **(TFL-CH)**														
Rate 1—Dental or Oral Health Services														
Ages 1-2	A		231	1,796	12.86%									
Ages 3-5	A		744	3,336	22.30%									
Ages 6-7	A		539	2,204	24.46%									
Ages 8-9	A		349	2,249	15.52%									
Ages 10-11	A		331	2,156	15.35%									
Ages 12-14	A		517	3,352	15.42%									
Ages 15-18	A		381	4,624	8.24%									
Ages 19-20	A		98	2,245	4.37%									
Total Ages 1-20	A		3,190	21,962	14.53%									
Rate 2—Dental Services														
Ages 1-2	A		174	1,796	9.69%									
Ages 3-5	A		666	3,336	19.96%									
Ages 6-7	A		489	2,204	22.19%									
Ages 8-9	A		321	2,249	14.27%									
Ages 10-11	A		307	2,156	14.24%									
Ages 12-14	A		478	3,352	14.26%									
Ages 15-18	A		357	4,624	7.72%									

MEDICAID San Diego GMC Measures HEDIS Measurement Year 2022	METHOD	Held MPL	HEDIS MY2022 NUM	HEDIS MY2022 DEN	HEDIS MY2022 RATE	MY2022 Percentile Rank	Change from Prior Yr	Percentile Change (Scale Diff) from Prior Yr*	HEDIS MY2021 RATE	HEDIS MY2021 DEN	MY2021 Percentile Rank	HEDIS MY2020 RATE	HEDIS 2020 RATE	HEDIS 2019 RATE
Ages 19-20	A		95	2,245	4.23%									
Total Ages 1-20	A		2,887	21,962	13.15%									
Rate 3—Oral Health Services														
Ages 1-2	A		35	1,796	1.95%									
Ages 3-5	A		29	3,336	0.87%									
Ages 6-7	A		13	2,204	0.59%									
Ages 8-9	A		3	2,249	0.13%									
Ages 10-11	A		6	2,156	0.28%									
Ages 12-14	A		9	3,352	0.27%									
Ages 15-18	A		5	4,624	0.11%									
Ages 19-20	A		1	2,245	0.04%									
Total Ages 1-20	A		101	21,962	0.46%									

Notes: (NA) indicates the denominator was < 30 and a rate is not reported.

indicates measure lookback period overlaps with COVID-19 pandemic during 2020-2022.

*The percentile change from prior year presents the difference in percentile performance based on the national benchmark scaling. National Benchmark scaling: 0th, 5th, 10th, 25th, 33.33rd, 50th, 66.67th, 75th, 90th, 95th.

KPSC HEDIS MY 2022 Effectiveness of Care (EOC) Results
Medicare SNP - Special Need Population (8301)
CONFIDENTIAL AND PRIVILEGED INFORMATION. NOT FOR EXTERNAL CIRCULATION OR DISTRIBUTION.

MEDICARE SNP Measures HEDIS Measurement Year 2022	METHOD	HEDIS MY2022 NUM	HEDIS MY2022 DEN	HEDIS MY2022 RATE	Change from Prior Yr	HEDIS MY2021 RATE	HEDIS MY2021 DEN	HEDIS MY2020 RATE	HEDIS 2020 RATE	HEDIS 2019 RATE
Effectiveness of Care: Prevention and Screening										
Colorectal Cancer Screening **(COL)**		Ages 46-75 years				Ages 51-75 years		Ages 51-75 years		
Non-LIS/DE, Nondisability (NA)	A	12	16	75.00%	-9.44%	84.44%	45	72.41%	88.89%	88.66%
LIS/DE	A	5,079	5,596	90.76%	-0.18%	90.94%	5,386	88.47%	90.34%	91.43%
Disability (NA)	A	16	20	80.00%	5.45%	74.55%	55	83.95%	85.71%	79.41%
LIS/DE and Disability	A	5,688	6,871	82.78%	-2.70%	85.48%	5,997	84.41%	86.64%	87.84%
Other	A	84	101	83.17%	-5.29%	88.46%	78	81.93%	86.52%	90.18%
Unknown (NA)	A	1	1	100.00%	38.46%	61.54%	13		100.00%	80.00%
TOTAL	A	10,880	12,605	86.31%	-1.65%	87.96%	11,574	86.26%	88.52%	89.72%
Care for Older Adults **(COA)**		73 SCAL out of 172 CA combined hybrid								
Advanced Care Planning						95.71%	20,128	96.39%	94.65%	89.54%
Medication Review	H	71	73	97.26%	-0.71%	97.97%	20,128	97.28%	98.42%	98.54%
Functional Status Assessment	H	70	73	95.89%	-2.38%	98.27%	20,128	98.22%	97.09%	90.27%
Pain Assessment	H	72	73	98.63%	0.03%	98.60%	20,128	98.42%	98.07%	93.92%
Effectiveness of Care: Respiratory Conditions										
Use of Spirometry Testing in the Assessment and Diagnosis of COPD **(SPR)**	A	87	268	32.46%	-0.64%	33.10%	290	57.23%	77.68%	75.00%
Pharmacotherapy Management of COPD Exacerbation **(PCE)**										
Systemic Corticosteroid	A	154	173	89.02%	0.97%	88.05%	159	86.29%	92.06%	88.58%
Bronchodilator	A	168	173	97.11%	-1.63%	98.74%	159	96.57%	99.05%	98.03%
Effectiveness of Care: Cardiovascular										
Controlling High Blood Pressure (Age 18-85) **(CBP)**	A	8,575	10,324	83.06%	0.66%	82.40%	9,814	79.21%	87.21%	86.62%
Persistence of Beta Blocker Treatment after a Heart Attack **(PBH)**	A	46	52	88.46%	-2.61%	91.07%	56	91.49%	94.83%	97.10%
Effectiveness of Care: Musculoskeletal										
Osteoporosis Management in Women Who Had a Fracture **(OMW)**	A	60	81	74.07%	-4.24%	78.31%	83	82.61%	90.91%	93.71%
Effectiveness of Care: Behavioral Health										
Antidepressant Medication Management **(AMM)**										
Effective acute phase (12-week) treatment	A	1,176	1,338	87.89%	1.49%	86.40%	1,316	86.12%	82.90%	80.55%
Effective continuation (6-month) treatment	A	866	1,338	64.72%	3.32%	61.40%	1,316	60.08%	55.52%	53.42%
Follow-Up After Hospitalization for Mental Illness **(FUH)**										
6-17 years: 30-day follow-up (NA)	A	-	-				-			
6-17 years: 7-day follow-up (NA)	A	-	-				-			
18-64 years: 30-day follow-up	A	93	112	83.04%	-1.96%	85.00%	120	73.79%	74.86%	72.61%
18-64 years: 7-day follow-up	A	81	112	72.32%	2.32%	70.00%	120	59.31%	59.78%	58.26%
65+ years: 30-day follow-up	A	24	29	82.76%	-9.55%	92.31%	39	78.95%	78.79%	82.22%
65+ years: 7-day follow-up	A	18	29	62.07%	-17.42%	79.49%	39	52.63%	60.61%	68.89%
TOTAL: 30-day follow-up	A	117	141	82.98%	-3.81%	86.79%	159	74.39%	75.47%	74.18%
TOTAL: 7-day follow-up	A	99	141	70.21%	-2.12%	72.33%	159	58.54%	59.91%	60.00%
Effectiveness of Care: Medication Management and Care Coordination										
Advance Care Planning **(ACP)**	A	12,327	12,564	98.11%						
Transitions of Care **(TRC)**		126 SCAL out of 395 CA combined hybrid							*Rotated from*	
Notification of Inpatient Admission									*HEDIS2019*	
18-64 years	H	29	33	87.88%	4.39%	83.49%	109	84.35%	63.49%	63.49%
65+ years	H	85	93	91.40%	1.66%	89.74%	302	94.59%	78.95%	78.95%
TOTAL (Ages 18+)	H	114	126	90.48%	2.40%	88.08%	411	91.73%	74.21%	74.21%
Medication Reconciliation Post-Discharge										
18-64 years	H	31	33	93.94%	-2.39%	96.33%	109	97.39%	95.24%	95.24%
65+ years	H	92	93	98.92%	3.56%	95.36%	302	97.97%	98.25%	98.25%
TOTAL (Ages 18+)	H	123	126	97.62%	2.00%	95.62%	411	97.81%	97.32%	97.32%
Patient Engagement After Inpatient Discharge										
18-64 years	H	31	33	93.94%	-2.39%	96.33%	109	94.78%	87.30%	87.30%
65+ years	H	85	93	91.40%	-1.65%	93.05%	302	96.28%	95.79%	95.79%
TOTAL (Ages 18+)	H	116	126	92.06%	-1.86%	93.92%	411	95.86%	93.19%	93.19%

KPSC HEDIS MY 2022 Effectiveness of Care (EOC) Results
Medicare SNP - Special Need Population (8301)
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MEDICARE SNP Measures HEDIS Measurement Year 2022	METHOD	HEDIS MY2022 NUM	HEDIS MY2022 DEN	HEDIS MY2022 RATE	Change from Prior Yr	HEDIS MY2021 RATE	HEDIS MY2021 DEN	HEDIS MY2020 RATE	HEDIS 2020 RATE	HEDIS 2019 RATE
Receipt of Discharge Information										
18-64 years	H	22	33	66.67%	6.12%	60.55%	109	60.00%	53.97%	53.97%
65+ years	H	60	93	64.52%	-0.38%	64.90%	302	70.95%	75.09%	75.09%
TOTAL (Ages 18+)	H	82	126	65.08%	1.33%	63.75%	411	67.88%	68.61%	68.61%
Effectiveness of Care: Overuse/Appropriateness										
Potentially Harmful Drug Interactions in the Elderly **(DDE)** *Lower rate is better*										
Falls + Tricyclic Antidepressants or Antipsychotics	A	436	1,534	28.42%	-0.11%	28.53%	1,374	28.27%	27.55%	41.84%
Dementia + Antiemetics,Tricyclic Antidepressants or Anticholinergic Agents	A	356	1,642	21.68%	-0.51%	22.19%	1,717	23.24%	33.02%	38.00%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Nonaspirin NSAIDs	A	76	1,178	6.45%	0.31%	6.14%	1,156	2.43%	2.94%	4.32%
TOTAL	A	868	4,354	19.94%	0.07%	19.87%	4,247	21.09%	25.69%	34.53%
Use of High Risk Medications in the Elderly **(DAE)** *Lower rate is better*										
High Risk Medications to Avoid	A	920	18,930	4.86%	-0.01%	4.87%	18,749	5.06%	5.23%	7.12%
High Risk Medication to avoid except for Appropriate diagnosis	A	786	18,930	4.15%	-0.08%	4.23%	18,749	7.22%		
Total	A	1,617	18,930	8.54%	-0.16%	8.70%	18,749	11.48%		

Notes: (NA) indicates the denominator was < 30 and a rate is not reported.

 indicates measure lookback period overlaps with COVID-19 pandemic during 2020-2022.

EXCHANGE Measures HEDIS Measurement Year 2022	METHOD	HEDIS MY2022 NUM	HEDIS MY2022 DEN	HEDIS MY2022 RATE	MY2022 Percentile Rank	Change from Prior Yr	Percentile Change (Scale Diff) from Prior Yr*	HEDIS MY2021 RATE	HEDIS MY2021 DEN	MY2021 Percentile Rank	HEDIS MY2020 RATE	HEDIS 2020 RATE	HEDIS 2019 RATE
Effectiveness of Care: Prevention and Screening													
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents **(WCC)**													
BMI Percentile													
3-11 Years	A	5,861	6,007	97.57%		-0.27%		97.84%	5,328		96.76%	98.97%	95.55%
12-17 years	A	4,092	4,169	98.15%		-0.04%		98.19%	3,699		97.25%	99.31%	94.39%
TOTAL (Ages 3-17)	A	9,953	10,176	97.81%		-0.17%		97.98%	9,027		96.96%	99.11%	95.06%
Counseling for Nutrition													
3-11 Years	A	5,477	6,007	91.18%		-1.93%		93.11%	5,328		92.65%	94.92%	94.10%
12-17 years	A	3,714	4,169	89.09%		-0.75%		89.84%	3,699		90.79%	93.66%	91.92%
TOTAL (Ages 3-17)	A	9,191	10,176	90.32%		-1.45%		91.77%	9,027		91.89%	94.42%	93.17%
Counseling for Physical Activity													
3-11 Years	A	5,529	6,007	92.04%		-1.86%		93.90%	5,328		93.52%	95.67%	94.26%
12-17 years	A	3,814	4,169	91.48%		-0.68%		92.16%	3,699		92.32%	95.49%	92.77%
TOTAL (Ages 3-17)	A	9,343	10,176	91.81%		-1.38%		93.19%	9,027		93.03%	95.60%	93.62%
Childhood Immunization Status **(CIS)**													
DTaP	A	727	825	88.12%		2.15%		85.97%	784		87.48%	89.69%	88.86%
IPV	A	772	825	93.58%		1.23%		92.35%	784		91.22%	92.66%	92.81%
MMR	A	763	825	92.48%		2.68%		89.80%	784		92.52%	93.18%	92.54%
HiB	A	773	825	93.70%		1.61%		92.09%	784		91.94%	93.18%	93.26%
Hepatitis B	A	775	825	93.94%		1.72%		92.22%	784		90.94%	93.18%	92.90%
VZV	A	770	825	93.33%		3.02%		90.31%	784		90.94%	92.48%	92.18%
Pneumococcal Conjugate	A	715	825	86.67%		1.21%		85.46%	784		86.91%	87.06%	88.23%
Hepatitis A	A	765	825	92.73%		2.30%		90.43%	784				
Rotavirus	A	726	825	88.00%		2.54%		85.46%	784				
Influenza	A	579	825	70.18%		-2.91%		73.09%	784				
Combination #10	A	530	825	64.24%	75th	-1.07%		65.31%	784				
Immunizations for Adolescents **(IMA)**													
Meningococcal	A	815	976	83.50%		-2.83%		86.33%	856		86.93%	86.80%	86.61%
Tdap/Td	A	908	976	93.03%		0.39%		92.64%	856		93.94%	92.28%	92.43%
HPV	A	462	976	47.34%		-2.08%		49.42%	856		50.40%	51.04%	55.31%
Combination 2	A	453	976	46.41%	90th	-1.72%	-1	48.13%	856	95th	48.65%	49.85%	53.68%
Breast Cancer Screening **(BCS)**	A	22,324	27,817	80.25%	90th	4.06%		76.19%	24,388	90th	75.79%	82.96%	83.63%
Cervical Cancer Screening **(CCS)**	A	41,258	52,340	78.83%	95th	-1.14%		79.97%	47,386	95th	65.10%	79.00%	79.09%
Colorectal Cancer Screening **(COL)**													
Ages 46-49	A	4,756	10,732	44.32%									
Ages 50-75	A	49,743	65,714	75.70%									
TOTAL (Ages 46-75)	A	54,499	76,446	71.29%	90th	-4.67%	-1	75.96%	59,041	95th	72.71%	75.10%	76.46%
Chlamydia Screening in Women **(CHL)**													
Ages 16-20	A	517	1016	50.89%		-2.10%		52.99%	1002		50.06%	63.02%	63.72%
Ages 21-24	A	2051	3006	68.23%		-2.16%		70.39%	2830		64.51%	78.41%	76.86%
TOTAL (Ages 16-24)	A	2,568	4,022	63.85%	95th	-1.99%	1	65.84%	3,832	90th	60.52%	73.85%	73.13%
Effectiveness of Care: Respiratory Conditions													
Appropriate Testing for Pharyngitis **(CWP)**	A												
Ages 3-17	A	93	117	79.49%		32.05%		47.44%	78		84.03%	90.85%	93.27%
Ages 18-64	A	1,176	2,096	56.11%		27.72%		28.39%	1,532		54.96%	64.65%	
Ages 65+ (NA)	A	3	4	75.00%		55.00%		20.00%	5		33.33%	50.00%	
TOTAL (Ages 3+)	A	1,272	2,217	57.37%	25th	28.08%	3	29.29%	1,615	0th	57.94%	67.72%	
Asthma Medication Ratio **(AMR)**	A												
Ages 5-11	A	46	46	100.00%		2.63%		97.37%	38		93.02%		
Ages 12-18	A	32	35	91.43%		-8.57%		100.00%	37		100.00%		
Ages 19-50	A	679	813	83.52%		-2.97%		86.49%	755		85.10%		
Ages 51-64	A	740	845	87.57%		-0.59%		88.16%	819		89.00%		
TOTAL (Ages 5-64)	A	1,497	1,739	86.08%	50th	-1.79%	-2	87.87%	1,649	75th	87.63%		
Effectiveness of Care: Cardiovascular													
Controlling High Blood Pressure **(CBP)** Ages 18-85	A	8,549	11,387	75.08%	90th	0.11%	1	74.97%	10,037	75th	66.90%	80.74%	80.72%
Effectiveness of Care: Diabetes													
Hemoglobin A1c Control for Patients With Diabetes **(HBD)**	A	9,461	14,907	63.47%	50th	-0.47%	-1	63.94%	13,448	66.67th	64.09%	68.90%	70.19%
Eye Exam for Patients With Diabetes **(EED)**	A	11,101	14,907	74.47%	95th	4.98%		69.49%	13,448	95th	67.04%	79.91%	77.28%
Kidney Health Evaluation for Patients With Diabetes **(KED)**													
Ages 18-64	A	11,545	14,765	78.19%									
Ages 65-74	A	326	388	84.02%									
Ages 75-85	A	31	38	81.58%									
TOTAL (Ages 18-85)	A	11,902	15,191	78.35%									
Effectiveness of Care: Behavioral Health													
Antidepressant Medication Management **(AMM)**													
Effective acute phase (12-week) treatment	A	3,351	3,915	85.59%		-1.91%		87.50%	3,112		84.64%	83.49%	80.27%

EXCHANGE Measures HEDIS Measurement Year 2022	METHOD	HEDIS MY2022 NUM	HEDIS MY2022 DEN	HEDIS MY2022 RATE	MY2022 Percentile Rank	Change from Prior Yr	Percentile Change (Scale Diff) from Prior Yr*	HEDIS MY2021 RATE	HEDIS MY2021 DEN	MY2021 Percentile Rank	HEDIS MY2020 RATE	HEDIS 2020 RATE	HEDIS 2019 RATE
Effective continuation (6-month) treatment	A	2,454	3,915	62.68%		-2.20%		64.88%	3,112		62.76%	60.57%	58.44%
Follow-Up After Hospitalization for Mental Illness **(FUH)**													
6-17 years: 30-day follow-up	A	53	54	98.15%				100.00%	47				
6-17 years: 7-day follow-up	A	52	54	96.30%		2.68%		93.62%	47		82.50%	71.43%	84.52%
18-64 years: 30-day follow-up	A	351	387	90.70%				87.68%	406				
18-64 years: 7-day follow-up	A	321	387	82.95%		7.58%		75.37%	406		72.73%	79.58%	70.19%
65+ years: 30-day follow-up (NA)	A	2	2	100.00%		0.00%		100.00%	2				
65+ years: 7-day follow-up (NA)	A	2	2	100.00%		0.00%		100.00%	2		50.00%	-	75.00%
TOTAL (Ages 6+): 30-day follow-up	A	406	443	91.65%				89.01%	455				
TOTAL (Ages 6+): 7-day follow-up	A	375	443	84.65%		7.29%		77.36%	455		73.68%	78.95%	71.88%
Effectiveness of Care: Overuse/Appropriateness													
Appropriate Treatment for Upper Respiratory Infection **(URI)** *Inverted Rate*													
3 mos-17 years	A(I)	57	2,697	97.89%		-0.54%		98.43%	637		98.34%	98.36%	98.69%
18-64 years	A(I)	519	5,283	90.18%		-1.79%		91.97%	1,919		92.69%	92.53%	
65+ years (NA)	A(I)	2	22	90.91%		2.02%		88.89%	9		96.55%	95.00%	
TOTAL (Ages 3 mos+)	A(I)	578	8,002	92.78%	90th	-0.79%	1	93.57%	2,565	75th	93.85%	93.91%	
Avoidance of Antibiotic Treatment for Acute Bronchitis **(AAB)** *Inverted Rate*													
3 mos-17 years (NA)	A(I)	11	108	89.81%		-10.19%		100.00%	10		86.59%	89.01%	
18-64 years	A(I)	102	372	72.58%		10.23%		62.35%	162		83.52%	79.94%	52.57%
65+ years (NA)	A(I)	-	2	100.00%		-			-		100.00%		
TOTAL (Ages 3 mos+)	A(I)	113	482	76.56%	95th	12.03%	1	64.53%	172	90th	84.35%	82.00%	
Use of Imaging Studies for Low Back Pain **(LBP)** *Inverted Rate*													
Ages 18-64	A(I)	1083	8831	87.74%									
Ages 65-75	A(I)	37	244	84.84%									
TOTAL (Ages 18-75)	A(I)	1120	9075	87.66%	95th	1.41%	1	86.25%	4,188	90th	88.30%	86.01%	84.96%
Access/Availability of Care													
Initiation and Engagement of Substance Abuse Disorder **(IET)**													
13-17 Years													
Alcohol: Initiation of SUD (NA)	A	1	3	33.33%		33.33%		0.00%	1		50.00%	45.45%	52.94%
Engagement of SUD (NA)	A	-	3	0.00%		0.00%		0.00%	1		16.67%	36.36%	23.53%
Opioid: Initiation of SUD (NA)	A	1	1	100.00%		-			-		100.00%	-	100.00%
Engagement of SUD (NA)	A	1	1	100.00%		-			-		100.00%	-	100.00%
Other: Initiation of SUD (NA)	A	9	21	42.86%		-15.96%		58.82%	17		61.54%	45.45%	50.98%
Engagement of SUD (NA)	A	6	21	28.57%		-12.61%		41.18%	17		34.62%	33.33%	25.49%
TOTAL: Initiation of SUD (NA)	A	11	25	44.00%		-11.56%		55.56%	18		57.14%	40.00%	49.18%
Engagement of SUD (NA)	A	7	25	28.00%		-10.89%		38.89%	18		32.14%	27.50%	22.95%
18-64 Years								18+ Years				18+ Years	
Alcohol: Initiation of SUD	A	736	1,471	50.03%		5.55%		44.48%	1,558		55.54%	49.40%	48.07%
Engagement of SUD	A	344	1,471	23.39%		-2.99%		26.38%	1,558		32.29%	25.00%	23.66%
Opioid: Initiation of SUD	A	72	149	48.32%		6.01%		42.31%	182		57.69%	45.08%	52.15%
Engagement of SUD	A	40	149	26.85%		-1.72%		28.57%	182		36.54%	26.94%	31.14%
Other: Initiation of SUD	A	399	922	43.28%		3.56%		39.72%	1,133		47.27%	44.13%	42.65%
Engagement of SUD	A	212	922	22.99%		1.63%		21.36%	1,133		28.13%	24.43%	20.45%
TOTAL: Initiation of SUD	A	1,207	2,542	47.48%		6.55%		40.93%	2,678		51.21%	46.01%	44.57%
Engagement of SUD	A	596	2,542	23.45%		0.00%		23.45%	2,678		29.94%	24.31%	22.42%
65+ Years													
Alcohol: Initiation of SUD (NA)	A	2	6	33.33%									
Engagement of SUD (NA)	A	1	6	16.67%									
Opioid: Initiation of SUD (NA)	A	-	-										
Engagement of SUD (NA)	A	-	-										
Other: Initiation of SUD (NA)	A	1	2	50.00%									
Engagement of SUD (NA)	A	-	2	0.00%									
TOTAL: Initiation of SUD (NA)	A	3	8	37.50%									
Engagement of SUD (NA)	A	1	8	12.50%									
TOTAL (Ages 13+)													
Alcohol: Initiation of SUD	A	739	1,480	49.93%		5.48%		44.45%	1,559		55.51%	49.35%	48.10%
Engagement of SUD	A	345	1,480	23.31%		-3.05%		26.36%	1,559		32.20%	25.12%	23.66%
Opioid: Initiation of SUD	A	73	150	48.67%		6.36%		42.31%	182		57.96%	45.08%	52.27%
Engagement of SUD	A	41	150	27.33%		-1.24%		28.57%	182		36.94%	26.94%	31.31%
Other: Initiation of SUD	A	409	945	43.28%		3.28%		40.00%	1,150		47.73%	44.19%	42.92%
Engagement of SUD	A	218	945	23.07%		1.42%		21.65%	1,150		28.34%	24.81%	20.62%
TOTAL: Initiation of SUD	A	1,221	2,575	47.42%		6.40%		41.02%	2,696		51.31%	45.87%	44.64%
Engagement of SUD	A	604	2,575	23.46%		-0.09%		23.55%	2,696		29.98%	24.39%	22.43%
Prenatal and Postpartum Care **(PPC)**													
Timeliness of Prenatal Care	A	2,123	2,237	94.90%	90th	1.67%	1	93.23%	1,876	75th	96.83%	95.50%	95.78%
Postpartum Care	A	2,034	2,237	90.93%	75th	-1.07%		92.00%	1,876	75th	90.86%	91.93%	87.63%
Utilization													
Well-Child Visits in the First 30 Months of Life **(W30)**													
First 15 Months	A	763	863	88.41%		5.46%		82.95%	645		83.74%		

KPSC HEDIS MY 2022 Effectiveness of Care (EOC) / Use of Services Results
Marketplace / Exchange Population (12014)

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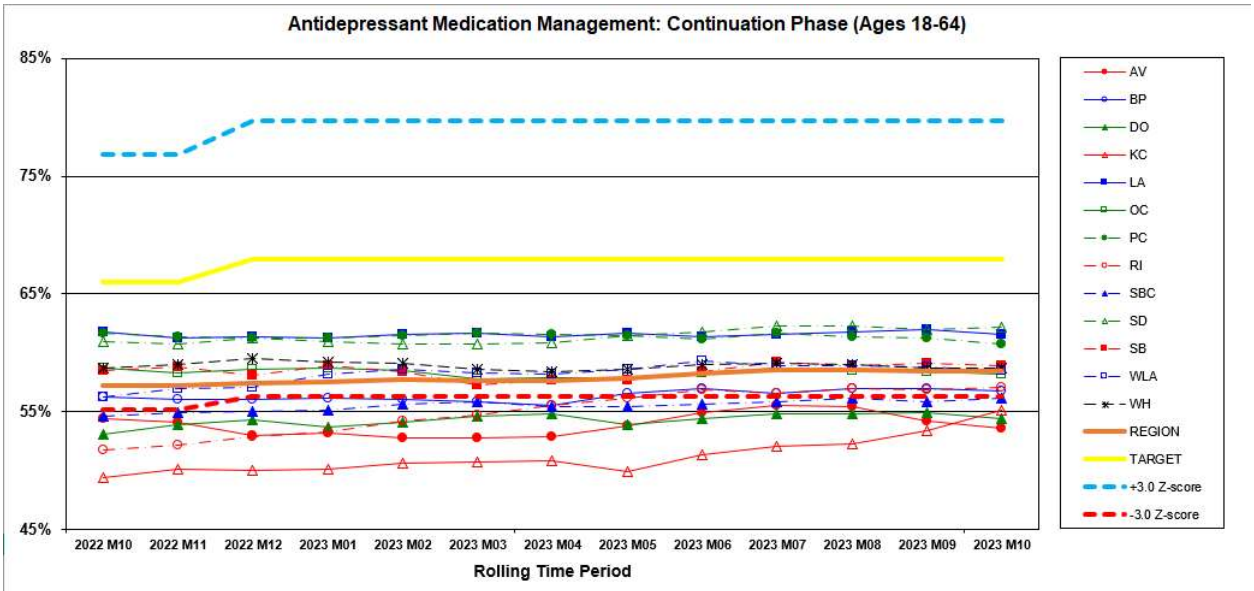
EXCHANGE Measures HEDIS Measurement Year 2022	METHOD	HEDIS MY2022 NUM	HEDIS MY2022 DEN	HEDIS MY2022 RATE	MY2022 Percentile Rank	Change from Prior Yr	Percentile Change (Scale Diff) from Prior Yr*	HEDIS MY2021 RATE	HEDIS MY2021 DEN	MY2021 Percentile Rank	HEDIS MY2020 RATE	HEDIS 2020 RATE	HEDIS 2019 RATE
15 Months-30 Months	A	629	787	79.92%		13.11%		66.81%	720		74.52%		
Child and Adolescent Well-Care Visits **(WCV)**	A												
3-11 years	A	5,071	8,281	61.24%		-1.14%		62.38%	7,712		47.31%		
12-17 years	A	3,411	6,619	51.53%		-0.43%		51.96%	6,108		40.46%		
18-21 years	A	1,543	6,035	25.57%		2.80%		22.77%	6,000		14.61%		
TOTAL (Ages 3-21)	A	10,025	20,935	47.89%	33.33rd	0.71%		47.18%	19,820	33.33rd	35.07%		
Non-HEDIS													
Proportion of Days Covered **(PDC)**													
RAS Antagonists	A	16,977	21,097	80.47%	50th	-1.30%	-2	81.77%	20100	75th	80.92%	80.94%	80.86%
Diabetes All Class	A	7,856	10,329	76.06%	50th	-2.54%		78.60%	9375	50th	74.36%	69.85%	78.02%
Statins	A	17,437	22,586	77.20%	50th	-1.60%		78.80%	21737	50th	78.52%	75.51%	76.06%
International Normalized Ratio (INR) Monitoring for Individuals on Warfarin **(INR)**	A	245	378	64.81%	75th	2.70%	2	62.11%	454	50th	83.40%	87.98%	
Annual Monitoring for Persons on Long-term Opioid Therapy **(AMO)** *Lower Rate is favorable*	A	367	1,260	29.13%	75th	-0.22%		29.35%	1,288	75th	36.83%		

Notes: * Percentile Rank is based on the average results.
(NA) indicates the denominator was < 30 and a rate is not reported.

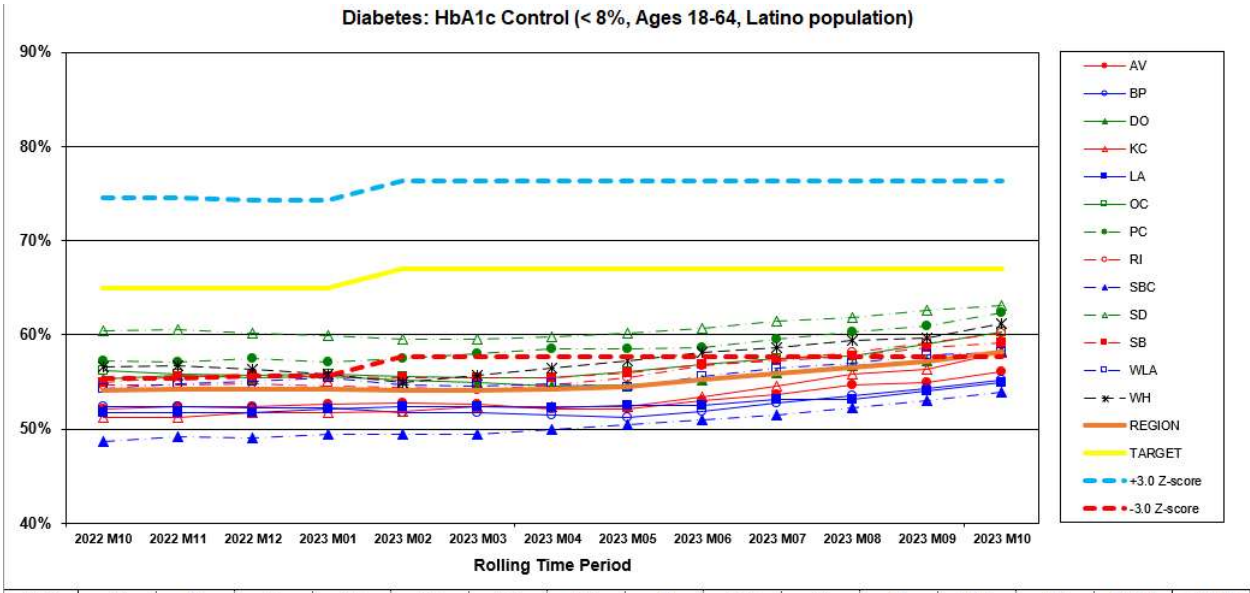
indicates measure lookback period overlaps with COVID-19 pandemic during 2020-2022.

*The percentile change from prior year presents the difference in percentile performance based on the national benchmark scaling. National Benchmark scaling: 0th, 5th, 10th, 25th, 33.33rd, 50th, 66.67th, 75th, 90th, 95th.

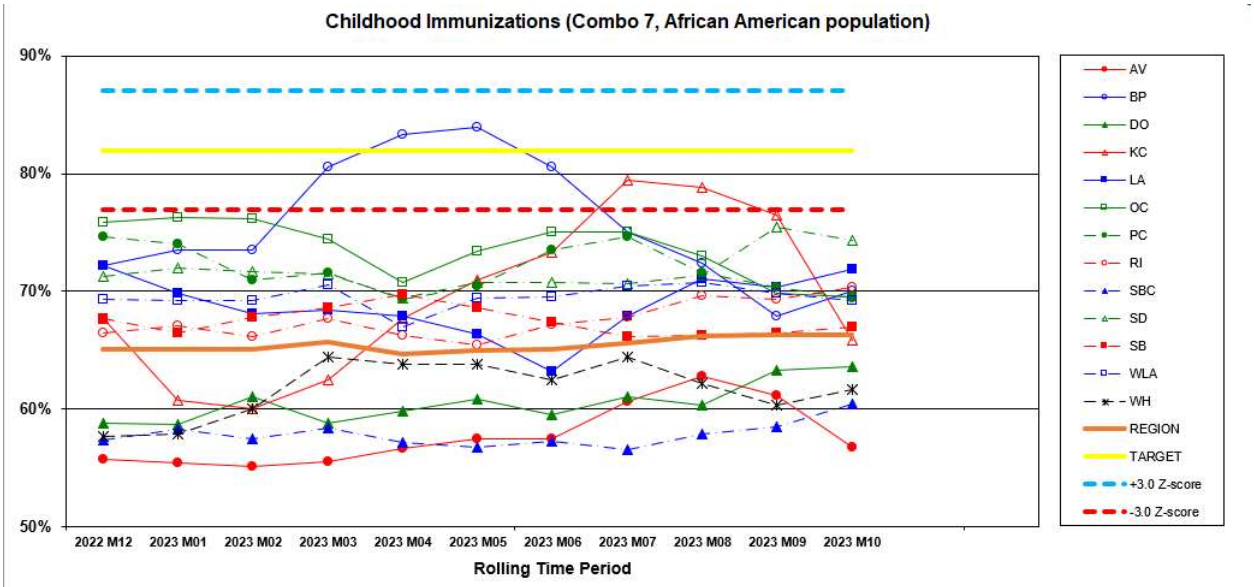
ATTACHMENT 2: Clinical Strategic Goals – Measure Rates by Area



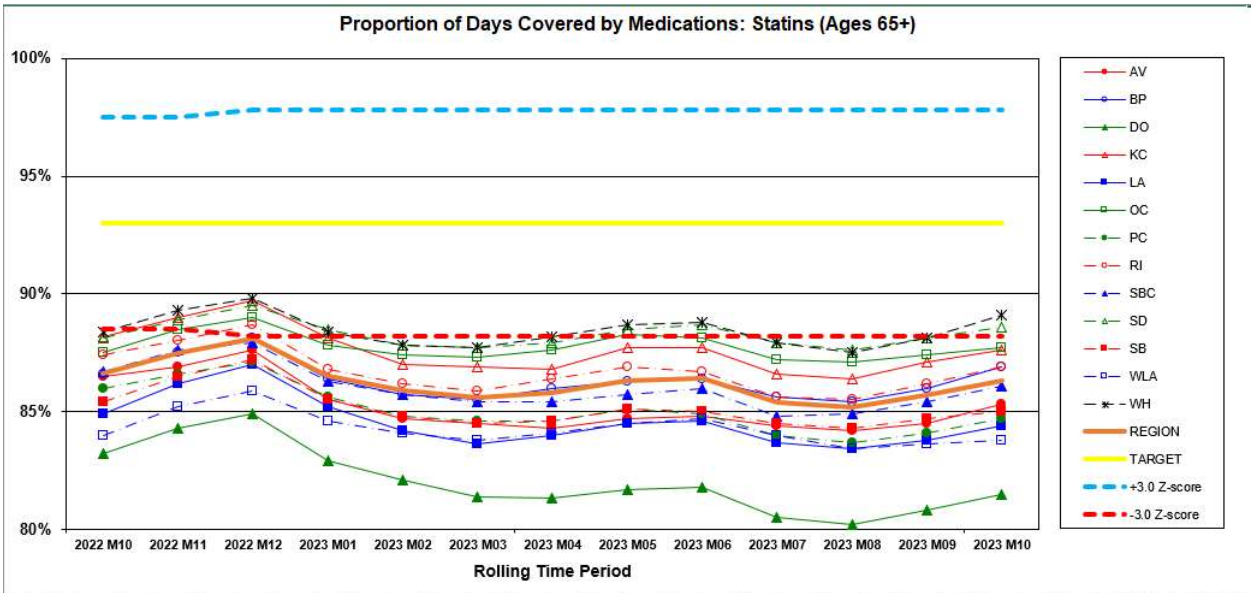
Period	AV	BP	DO	KC	LA	OC	PC	RI	SBC	SD	SB	WLA	WH	REGION	TARGET
2022 M10	54.4%	56.2%	53.1%	49.4%	61.8%	58.7%	61.7%	51.7%	54.6%	60.9%	58.5%	56.2%	58.7%	57.2%	66.0%
2022 M11	54.1%	56.0%	53.9%	50.1%	61.3%	58.3%	61.4%	52.1%	54.9%	60.7%	58.8%	57.0%	59.0%	57.2%	66.0%
2022 M12	53.0%	56.0%	54.3%	50.0%	61.4%	58.6%	61.3%	52.9%	55.0%	61.2%	58.1%	57.1%	59.5%	57.4%	68.0%
2023 M01	53.2%	56.1%	53.7%	50.1%	61.3%	58.7%	61.3%	53.3%	55.1%	60.9%	58.9%	58.2%	59.2%	57.5%	68.0%
2023 M02	52.8%	56.0%	54.1%	50.6%	61.6%	58.5%	61.5%	54.2%	55.6%	60.7%	58.4%	58.6%	59.1%	57.7%	68.0%
2023 M03	52.8%	55.8%	54.6%	50.7%	61.7%	57.8%	61.7%	54.7%	55.8%	60.7%	57.3%	58.3%	58.6%	57.6%	68.0%
2023 M04	52.9%	55.5%	54.8%	50.8%	61.4%	57.9%	61.6%	55.5%	55.4%	60.8%	57.7%	58.2%	58.4%	57.6%	68.0%
2023 M05	53.8%	56.5%	53.9%	49.9%	61.7%	57.9%	61.5%	56.1%	55.4%	61.5%	57.7%	58.6%	58.6%	57.8%	68.0%
2023 M06	54.9%	57.0%	54.4%	51.3%	61.4%	58.3%	61.1%	56.9%	55.6%	61.8%	58.4%	59.3%	59.0%	58.2%	68.0%
2023 M07	55.5%	56.5%	54.8%	52.0%	61.6%	58.7%	61.7%	56.5%	55.8%	62.3%	59.2%	58.9%	59.1%	58.5%	68.0%
2023 M08	55.4%	57.0%	54.8%	52.3%	61.8%	58.5%	61.4%	57.0%	56.1%	62.3%	58.9%	58.9%	59.0%	58.5%	68.0%
2023 M09	54.2%	57.0%	54.9%	53.4%	62.0%	58.4%	61.2%	56.9%	55.8%	62.0%	59.1%	58.8%	58.7%	58.4%	68.0%
2023 M10	53.6%	56.7%	54.4%	55.1%	61.6%	58.2%	60.7%	57.1%	56.1%	62.2%	58.9%	58.5%	58.7%	58.4%	68.0%



Period	AV	BP	DO	KC	LA	OC	PC	RI	SBC	SD	SB	WLA	WH	REGION	TARGET
2022 M10	52.1%	52.4%	55.3%	51.3%	51.7%	56.2%	57.2%	54.7%	48.7%	60.5%	55.0%	54.3%	56.6%	54.1%	65.0%
2022 M11	52.4%	52.4%	55.7%	51.3%	51.7%	55.9%	57.1%	54.7%	49.2%	60.6%	55.6%	54.8%	56.7%	54.3%	65.0%
2022 M12	52.4%	52.3%	55.5%	51.7%	51.7%	55.7%	57.5%	54.8%	49.1%	60.2%	55.7%	55.1%	56.4%	54.3%	65.0%
2023 M01	52.6%	52.2%	55.6%	51.7%	52.1%	55.9%	57.1%	54.6%	49.5%	59.9%	55.6%	55.5%	55.8%	54.3%	65.0%
2023 M02	52.8%	51.7%	55.2%	51.9%	52.4%	55.6%	57.5%	54.4%	49.4%	59.6%	55.4%	54.7%	54.9%	54.1%	67.0%
2023 M03	52.7%	51.8%	54.9%	52.4%	52.4%	55.4%	58.0%	54.2%	49.4%	59.5%	55.4%	54.5%	55.7%	54.1%	67.0%
2023 M04	52.1%	51.5%	54.5%	52.4%	52.3%	55.5%	58.5%	54.7%	49.9%	59.8%	55.5%	54.8%	56.5%	54.2%	67.0%
2023 M05	52.1%	51.3%	54.7%	52.4%	52.5%	56.1%	58.5%	55.5%	50.5%	60.2%	56.0%	54.4%	57.2%	54.5%	67.0%
2023 M06	53.0%	51.9%	55.2%	53.4%	52.5%	56.9%	58.6%	56.7%	51.0%	60.7%	56.8%	55.6%	58.2%	55.2%	67.0%
2023 M07	53.7%	52.8%	56.0%	54.5%	53.2%	57.5%	59.5%	57.4%	51.5%	61.5%	57.2%	56.5%	58.7%	55.9%	67.0%
2023 M08	54.7%	53.5%	56.7%	55.8%	53.2%	57.8%	60.3%	58.1%	52.2%	61.9%	57.8%	57.0%	59.4%	56.5%	67.0%
2023 M09	55.0%	54.3%	57.2%	56.3%	54.1%	59.0%	61.0%	59.1%	53.0%	62.6%	58.6%	57.9%	59.7%	57.2%	67.0%
2023 M10	56.1%	55.2%	58.3%	58.2%	54.9%	60.3%	62.3%	60.2%	53.9%	63.1%	59.2%	58.2%	61.2%	58.2%	67.0%

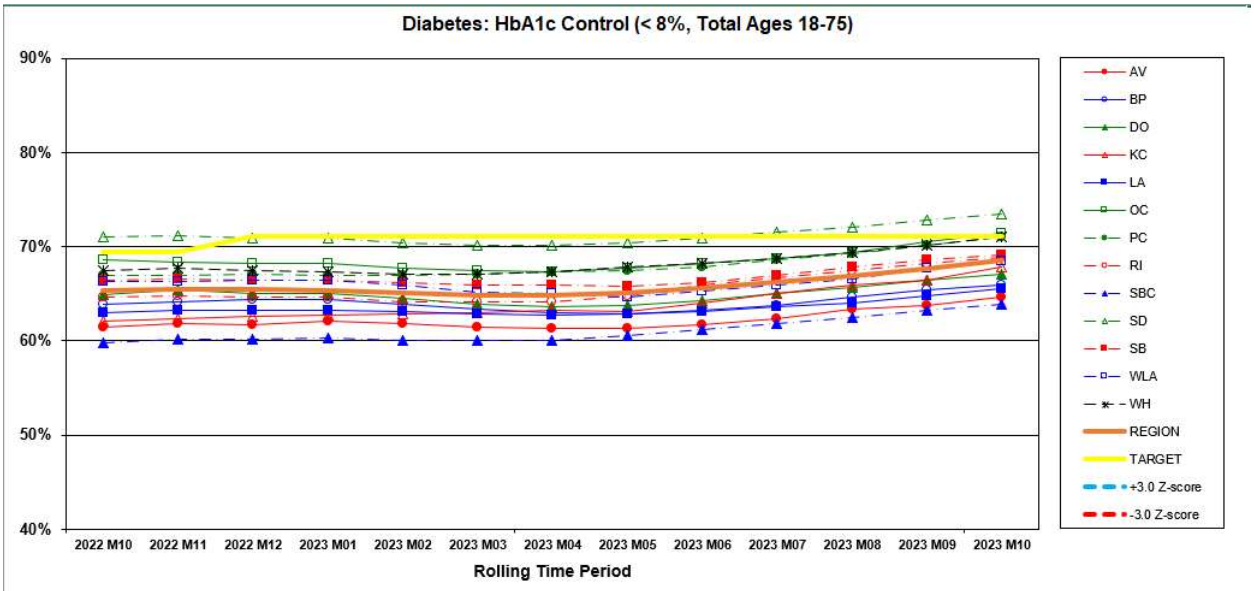


Period	AV	BP	DO	KC	LA	OC	PC	RI	SBC	SD	SB	WLA	WH	REGION	TARGET
2022 M12	55.7%	72.2%	58.8%	67.7%	72.2%	75.9%	74.6%	66.5%	57.4%	71.3%	67.7%	69.3%	57.7%	65.1%	82.0%
2023 M01	55.4%	73.5%	58.7%	60.7%	69.8%	76.3%	74.0%	67.1%	58.3%	72.0%	66.5%	69.2%	57.9%	65.1%	82.0%
2023 M02	55.1%	73.5%	61.0%	60.0%	68.1%	76.2%	71.0%	66.1%	57.5%	71.7%	67.8%	69.2%	60.0%	65.1%	82.0%
2023 M03	55.5%	80.6%	58.8%	62.5%	68.4%	74.4%	71.6%	67.7%	58.4%	71.5%	68.6%	70.5%	64.4%	65.7%	82.0%
2023 M04	56.6%	83.3%	59.8%	67.7%	67.9%	70.7%	69.3%	66.2%	57.1%	69.4%	69.7%	67.0%	63.8%	64.7%	82.0%
2023 M05	57.5%	83.9%	60.8%	71.0%	66.4%	73.4%	70.4%	65.4%	56.7%	70.8%	68.6%	69.4%	63.8%	65.0%	82.0%
2023 M06	57.5%	80.6%	59.5%	73.3%	63.2%	75.0%	73.5%	67.2%	57.3%	70.7%	67.4%	69.5%	62.5%	65.1%	82.0%
2023 M07	60.6%	75.0%	61.0%	79.4%	67.9%	75.0%	74.6%	67.8%	56.5%	70.6%	66.1%	70.4%	64.4%	65.6%	82.0%
2023 M08	62.8%	72.4%	60.3%	78.8%	71.1%	73.0%	71.6%	69.6%	57.9%	71.4%	66.2%	70.7%	62.2%	66.2%	82.0%
2023 M09	61.1%	67.9%	63.3%	76.5%	70.3%	69.8%	70.3%	69.3%	58.5%	75.5%	66.5%	69.8%	60.3%	66.3%	82.0%
2023 M10	56.7%	70.0%	63.6%	65.8%	71.9%	69.5%	69.4%	70.3%	60.4%	74.3%	67.0%	69.2%	61.6%	66.3%	82.0%



Period	AV	BP	DO	KC	LA	OC	PC	RI	SBC	SD	SB	WLA	WH	REGION	TARGET
2022 M10	86.5%	86.6%	83.2%	88.2%	84.9%	87.5%	86.0%	87.4%	86.7%	88.1%	85.4%	84.0%	88.4%	86.6%	93.0%
2022 M11	86.9%	87.5%	84.3%	89.0%	86.2%	88.5%	86.6%	88.0%	87.6%	88.9%	86.5%	85.2%	89.3%	87.5%	93.0%
2022 M12	87.6%	88.1%	84.9%	89.7%	87.0%	89.0%	87.1%	88.7%	87.9%	89.5%	87.2%	85.9%	89.8%	88.1%	93.0%
2023 M01	85.5%	86.4%	82.9%	88.1%	85.2%	87.8%	85.6%	86.8%	86.3%	88.5%	85.5%	84.6%	88.4%	86.5%	93.0%
2023 M02	84.7%	85.7%	82.1%	87.0%	84.2%	87.4%	84.8%	86.2%	85.7%	87.8%	84.8%	84.1%	87.8%	85.9%	93.0%
2023 M03	84.5%	85.5%	81.4%	86.9%	83.6%	87.3%	84.6%	85.9%	85.4%	87.7%	84.5%	83.8%	87.7%	85.6%	93.0%
2023 M04	84.3%	86.0%	81.3%	86.8%	84.0%	87.6%	84.6%	86.4%	85.4%	87.9%	84.6%	84.1%	88.2%	85.8%	93.0%
2023 M05	84.7%	86.3%	81.7%	87.7%	84.5%	88.3%	85.1%	86.9%	85.7%	88.5%	85.1%	84.5%	88.7%	86.3%	93.0%
2023 M06	84.8%	86.4%	81.8%	87.7%	84.6%	88.1%	84.9%	86.7%	86.0%	88.7%	85.0%	84.7%	88.8%	86.4%	93.0%
2023 M07	84.4%	85.6%	80.5%	86.6%	83.7%	87.2%	84.0%	85.6%	84.8%	87.9%	84.5%	84.0%	87.9%	85.4%	93.0%
2023 M08	84.2%	85.4%	80.2%	86.4%	83.4%	87.1%	83.7%	85.5%	84.9%	87.6%	84.3%	83.4%	87.5%	85.2%	93.0%
2023 M09	84.5%	86.0%	80.8%	87.1%	83.8%	87.4%	84.1%	86.2%	85.4%	88.1%	84.7%	83.6%	88.1%	85.7%	93.0%
2023 M10	85.3%	86.9%	81.5%	87.6%	84.4%	87.7%	84.7%	86.9%	86.1%	88.6%	85.0%	83.8%	89.1%	86.3%	93.0%

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation



Period	AV	BP	DO	KC	LA	OC	PC	RI	SBC	SD	SB	WLA	WH	REGION	TARGET
2022 M10	61.5%	63.9%	64.9%	62.1%	63.0%	68.6%	66.9%	64.7%	59.8%	71.1%	66.5%	66.3%	67.5%	65.4%	69.5%
2022 M11	61.9%	64.2%	65.4%	62.3%	63.2%	68.4%	67.0%	64.8%	60.2%	71.2%	66.6%	66.3%	67.7%	65.5%	69.5%
2022 M12	61.7%	64.4%	65.1%	62.6%	63.2%	68.3%	67.1%	64.7%	60.2%	70.9%	66.5%	66.4%	67.5%	65.5%	71.1%
2023 M01	62.1%	64.4%	65.0%	62.8%	63.2%	68.2%	66.9%	64.6%	60.3%	70.9%	66.4%	66.5%	67.3%	65.4%	71.1%
2023 M02	61.8%	63.9%	64.5%	62.9%	63.1%	67.7%	67.0%	64.2%	60.1%	70.4%	66.2%	65.9%	67.1%	65.1%	71.1%
2023 M03	61.5%	63.4%	63.9%	63.0%	62.9%	67.5%	67.1%	64.1%	60.1%	70.1%	65.9%	65.2%	67.1%	64.9%	71.1%
2023 M04	61.3%	63.0%	63.6%	63.2%	62.8%	67.4%	67.3%	64.2%	60.1%	70.1%	65.9%	65.0%	67.4%	64.8%	71.1%
2023 M05	61.3%	62.9%	63.8%	63.1%	62.9%	67.7%	67.5%	64.8%	60.6%	70.4%	65.8%	64.7%	67.8%	65.1%	71.1%
2023 M06	61.7%	63.2%	64.3%	64.0%	63.1%	68.3%	67.8%	66.0%	61.2%	70.9%	66.2%	65.3%	68.3%	65.6%	71.1%
2023 M07	62.4%	63.8%	65.1%	65.0%	63.6%	68.7%	68.6%	66.7%	61.8%	71.5%	66.9%	65.9%	68.8%	66.2%	71.1%
2023 M08	63.4%	64.6%	65.7%	65.9%	64.0%	69.4%	69.3%	67.5%	62.5%	72.1%	67.8%	66.6%	69.4%	66.9%	71.1%
2023 M09	63.8%	65.4%	66.4%	66.4%	64.8%	70.5%	70.2%	68.3%	63.2%	72.9%	68.6%	67.7%	70.1%	67.7%	71.1%
2023 M10	64.7%	65.9%	67.1%	67.8%	65.5%	71.4%	71.0%	68.9%	63.9%	73.5%	69.1%	68.5%	71.0%	68.5%	71.1%

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Medicare Star Rating CSG Results through December 31, 2023	Wt	Antelope Valley	Baldwin Park	Downey	Kern County	Los Angeles	Orange County	Panorama City	Riverside	San Bernardino County	San Diego	South Bay	West Los Angeles	Woodland Hills	Total Denominator	SC REGION
Medicare Projected Stars - Rounded		**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**		**4**
Monthly and Annual Weighted Average plus Reward		**4.044**	**4.196**	**4.087**	**4.152**	**4.065**	**4.228**	**4.120**	**4.218**	**4.087**	**4.196**	**4.120**	**4.065**	**4.239**		**4.174**
Medicare Star Average (Monthly Measures)	**30**	**3.667**	**4.133**	**3.800**	**4**	**3.733**	**4.233**	**3.900**	**4.200**	**3.800**	**4.133**	**3.900**	**3.733**	**4.267**		**4.067**
Medicare Star Average (Annual Measures)	**62**	**4.226**	**4.226**	**4.226**	**4.226**	**4.226**	**4.226**	**4.226**	**4.226**	**4.226**	**4.226**	**4.226**	**4.226**	**4.226**		**4.226**
Estimated Reward Factor	**0**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**		**0.00**
C01: Breast Cancer Screening	**1**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**		**5**
Rates		**84.48**	**89.38**	**89.18**	**87.03**	**86.83**	**87.62**	**86.31**	**86.12**	**85.14**	**85.51**	**87.60**	**85.93**	**86.45**	**179,608**	**86.61**
Buffer before dropping star (in %)		3.5	8.4	8.2	6.0	5.8	6.6	5.3	5.1	4.1	4.5	6.6	4.9	5.4		
Gap to next star (in %)		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
C02: Colorectal Cancer Screening	**1**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**		**5**
Rates		**85.31**	**89.74**	**88.67**	**86.52**	**88.45**	**89.78**	**87.65**	**88.83**	**87.07**	**87.97**	**88.19**	**88.20**	**88.52**	**364,544**	**88.25**
Buffer before dropping star (in %)		3.3	7.7	6.7	4.5	6.4	7.8	5.6	6.8	5.1	6.0	6.2	6.2	6.5		
Gap to next star (in %)		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
C06: COA - Med Review (SNP only)	**1**	**5**	**5**	**5**	**5**	**4**	**5**	**5**	**5**	**5**	**5**	**4**	**5**	**5**		**5**
Rates		**98.59**	**98.31**	**99.04**	**98.60**	**97.76**	**98.96**	**98.24**	**99.01**	**98.24**	**98.24**	**97.99**	**98.69**	**98.31**	**27,915**	**98.42**
Buffer before dropping star (in %)		0.6	0.3	1.0	0.6	4.8	1.0	0.2	1.0	0.2	0.2	5.0	0.7	0.3		0.0
Gap to next star (in %)		0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
DMC25: COA - Functional Status Asses. (SNP only)	**0**	**4**	**4**	**5**	**4**	**5**	**5**	**4**	**5**	**5**	**5**	**4**	**5**	**5**		**5**
Admin Rates - 2023 YTD only		**80.0**	**84.8**	**96.6**	**86.8**	**91.1**	**93.6**	**89.4**	**98.5**	**96.3**	**93.6**	**89.0**	**93.6**	**96.0**	**27,915**	**92.0**
Buffer before dropping star (in %)		4.0	8.8	5.6	10.8	0.1	2.6	13.4	7.5	5.3	2.6	13.0	2.6	5.0		0.0
Gap to next star (in %)		11.0	6.2	0.0	4.2	0.0	0.0	1.6	0.0	0.0	0.0	2.0	0.0	0.0		0.0
C07: COA - Pain Screening (SNP only)	**1**	**3**	**3**	**4**	**4**	**4**	**3**	**3**	**5**	**4**	**3**	**3**	**4**	**4**		**4**
Admin Rates - 2023 YTD only		**88.8**	**89.5**	**97.7**	**94.7**	**94.0**	**91.4**	**89.9**	**98.4**	**97.1**	**91.2**	**91.3**	**93.2**	**94.7**	**27,915**	**93.2**
Buffer before dropping star (in %)		3.8	4.5	4.7	1.7	1.0	6.4	4.9	0.4	4.1	6.2	6.3	0.2	1.7		0.0
Gap to next star (in %)		4.2	3.5	0.3	3.3	4.0	1.6	3.1	0.0	0.9	1.8	1.7	4.8	3.3		0.0
C08: Osteoporosis Mngt in Women w/ Fracture	**1**	**5**	**5**	**5**	**5**	**4**	**5**	**4**	**5**	**5**	**5**	**5**	**5**	**4**		**5**
Rates		**73.49**	**88.94**	**91.59**	**78.38**	**69.30**	**81.89**	**67.71**	**79.93**	**84.47**	**83.78**	**75.31**	**83.70**	**59.87**	**3,330**	**79.04**
Buffer before dropping star (in %)		0.5	15.9	18.6	5.4	12.3	8.9	10.7	6.9	11.5	10.8	2.3	10.7	2.9		
Gap to next star (in %)		0.0	0.0	0.0	0.0	3.7	0.0	5.3	0.0	0.0	0.0	0.0	0.0	13.1		
C09: Diabetes Care- Retinal Eye Exam	**1**	**5**	**5**	**5**	**4**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**4**	**4**		**5**

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Rates		**86.14**	**84.86**	**86.29**	**82.57**	**83.09**	**87.07**	**84.34**	**83.85**	**84.94**	**83.76**	**83.50**	**81.28**	**82.68**	**114,579**	**84.44**
Buffer before dropping star (in %)		3.1	1.9	3.3	7.6	0.1	4.1	1.3	0.8	1.9	0.8	0.5	6.3	7.7		
Gap to next star (in %)		0.0	0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.7	0.3		
C11: Diabetes Care-Blood Sugar Poor Control (HbA1C > 9)	3	**4**	**4**	**5**	**4**	**4**	**5**	**5**	**5**	**4**	**5**	**5**	**4**	**5**		**5**
Rates		**13.58**	**11.19**	**10.39**	**13.42**	**12.26**	**8.46**	**10.66**	**10.01**	**12.56**	**9.04**	**10.47**	**12.21**	**9.96**	**114,567**	**10.76**
Buffer before dropping star (in %)		4.4	6.8	0.6	4.6	5.7	2.5	0.3	1	5.4	2	0.5	5.8	1		
Gap to next star (in %)		-2.6	-0.2	0.0	-2.4	-1.3	0.0	0.0	0.0	-1.6	0.0	0.0	-1.2	0.0		
C12: Controlling Blood Pressure (< 140/90) *new guideline	3	**5**	**5**	**5**	**5**	**4**	**5**	**5**	**5**	**4**	**5**	**5**	**5**	**5**		**5**
Rates		**84.81**	**86.30**	**87.27**	**84.75**	**83.94**	**85.33**	**86.87**	**85.44**	**82.61**	**84.52**	**85.51**	**87.22**	**86.53**	**263,805**	**85.29**
Buffer before dropping star (in %)		0.8	2.3	3.3	0.7	7.9	1.3	2.9	1.4	6.6	0.5	1.5	3.2	2.5		
Gap to next star (in %)		0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	1.4	0.0	0.0	0.0	0.0		
C15: Medication Reconciliation Post-Discharge	1	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**		**5**
Rates		**97.99**	**97.08**	**97.67**	**97.23**	**97.18**	**98.30**	**96.09**	**97.03**	**97.55**	**96.81**	**97.17**	**96.98**	**97.05**	**59,414**	**97.25**
Buffer before dropping star (in %)		14.0	13.1	13.7	13.2	13.2	14.3	12.1	13.0	13.5	12.8	13.2	13.0	13.1		
Gap to next star (in %)		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
DMC23: SCAL Estimated Plan All-Cause Readmission Rates* (PCR) Lower is Better	3	**2**	**2**	**2**	**2**	**2**	**3**	**2**	**2**	**3**	**2**	**2**	**2**	**2**		**2**
Rates		**11.08**	**11.64**	**11.76**	**11.22**	**12.05**	**10.75**	**11.74**	**11.53**	**10.99**	**11.69**	**12.52**	**12.02**	**12.24**	**79,349**	**11.61**
Buffer before dropping star (in %)		1.9	1.4	1.2	1.8	1	0.3	1.3	1.5	0	1.3	0.5	1	0.8		
Gap to next star (in %)		-0.1	-0.6	-0.8	-0.2	-1.0	-0.7	-0.7	-0.5	-1.0	-0.7	-1.5	-1.0	-1.2		
C16: Statin Therapy for Patients with Cardiovascular Disease	1	**4**	**5**	**4**	**4**	**5**	**4**	**4**	**4**	**4**	**4**	**4**	**5**	**3**		**4**
Rates		**87.82**	**93.00**	**90.81**	**87.22**	**92.06**	**90.34**	**90.55**	**89.88**	**89.16**	**88.81**	**88.25**	**91.66**	**86.72**	**22,262**	**89.67**
Buffer before dropping star (in %)		0.8	2	3.8	0.2	1.1	3.3	3.5	2.9	2.2	1.8	1.2	0.7	1.7		
Gap to next star (in %)		3.2	0.0	0.2	3.8	0.0	0.7	0.5	1.1	1.8	2.2	2.8	0.0	0.3		
DMC20: Transitions of Care (TRC) - Average	1	**4**	**5**	**5**	**4**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**		**5**
Rates		**71.59**	**89.95**	**90.48**	**72.53**	**90.38**	**92.91**	**88.80**	**84.33**	**89.90**	**86.76**	**89.67**	**89.97**	**84.55**	**59,414**	**87.74**
Buffer before dropping star (in %)		6.6	11.0	11.5	7.5	11.4	13.9	9.8	5.3	10.9	7.8	10.7	11.0	5.6		
Gap to next star (in %)		7.4	0.0	0.0	6.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
DMC15: Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions	1	**4**	**5**	**4**	**4**	**4**	**4**	**4**	**4**	**3**	**4**	**4**	**3**	**4**		**4**
Rates		**69.45**	**71.79**	**62.68**	**67.58**	**62.67**	**65.00**	**69.43**	**62.27**	**59.01**	**68.51**	**65.02**	**61.61**	**67.39**	**78,762**	**65.07**

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Buffer before dropping star (in %)		7.4	1.8	0.7	5.6	0.7	3.0	7.4	0.3	4.0	6.5	3.0	6.6	5.4		
Gap to next star (in %)		0.6	0.0	7.3	2.4	7.3	5.0	0.6	7.7	3.0	1.5	5.0	0.4	2.6		
D08: Medication Adherence for Oral Diabetes Medications	3	**2**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**2**	**4**		**3**
Rates		**84.36**	**88.58**	**85.31**	**87.97**	**86.51**	**88.54**	**86.85**	**86.97**	**86.69**	**88.48**	**85.55**	**83.38**	**89.01**	**111,509**	**87.08**
Buffer before dropping star (in %)		4.4	3.6	0.3	3	1.5	3.5	1.8	2	1.7	3.5	0.5	3.4	0		
Gap to next star (in %)		0.6	0.4	3.7	1.0	2.5	0.5	2.2	2.0	2.3	0.5	3.5	1.6	2.0		
D09: Medication Adherence for Hypertension -ACEI or ARB (RAS Agents)	3	**3**	**4**	**3**	**4**	**3**	**4**	**3**	**4**	**3**	**4**	**3**	**3**	**5**		**4**
Rates		**87.64**	**89.90**	**87.38**	**89.47**	**88.55**	**90.05**	**87.85**	**89.10**	**88.52**	**90.46**	**88.52**	**88.87**	**91.02**	**290,126**	**89.21**
Buffer before dropping star (in %)		1.6	0.9	1.4	0.5	2.5	1	1.8	0.1	2.5	1.5	2.5	2.9	0		
Gap to next star (in %)		1.4	1.1	1.6	1.5	0.5	1.0	1.2	1.9	0.5	0.5	0.5	0.1	0.0		
D10: Medication Adherence for Cholesterol (Statins)	3	**3**	**4**	**2**	**4**	**3**	**4**	**3**	**4**	**3**	**4**	**3**	**3**	**4**		**3**
Rates		**86.60**	**88.76**	**83.03**	**88.47**	**86.59**	**89.08**	**86.16**	**88.68**	**87.67**	**90.00**	**86.92**	**86.05**	**90.64**	**419,465**	**87.94**
Buffer before dropping star (in %)		0.6	0.8	0	0.5	0.6	1.1	0.2	0.7	1.7	2	0.9	0.1	2.6		
Gap to next star (in %)		1.4	2.2	3.0	2.5	1.4	1.9	1.8	2.3	0.3	1.0	1.1	1.9	0.4		
D11: MTM Program Completion Rate for CMR	1	**5**	**5**	**3**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**		**5**
2024 YTD Rates - Through Mar		**31.19**	**41.22**	**21.96**	**44.36**	**35.93**	**26.46**	**31.19**	**30.04**	**47.36**	**23.71**	**31.50**	**28.14**	**36.88**	**26,732**	**32.03**
Buffer before dropping star (in %)		8.2	18.2	2	21.4	12.9	3.5	8.2	7.0	24.4	0.7	8.5	5.1	13.9		
Gap to next star (in %)		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
D12: Statin Use in Persons with Diabetes (SUPD)	1	**3**	**5**	**4**	**4**	**4**	**4**	**4**	**4**	**3**	**4**	**4**	**4**	**4**		**4**
Rates		**87.47**	**93.22**	**92.70**	**90.47**	**90.86**	**91.74**	**92.00**	**91.60**	**88.82**	**90.74**	**90.73**	**90.37**	**90.65**	**93,275**	**90.99**
Buffer before dropping star (in %)		0.5	0.2	3.7	1.5	1.9	2.7	3	2.6	1.8	1.7	1.7	1.4	1.7		
Gap to next star (in %)		1.5	0.0	0.3	2.5	2.1	1.3	1.0	1.4	0.2	2.3	2.3	2.6	2.3		

* Estimated PCR rates were derived by multiplying the KP Observed to Expected Ratios by the National Average Observed rate of 0.109719901931738 times 100.

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
ACCESS					
Availability of Practitioners: Primary and Specialty Care (NET 1B & NET 1C)					
NCQA	NET 1B: Practitioners Providing Primary Care To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization: • Establishes measurable standards for the number of each type of practitioner providing primary care. • Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care. • Annually analyzes performance against the standards for the number of each type of practitioner providing primary care. • Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care.	Ratios: 2000:1 for Family Medicine, Internal Medicine, and Pediatrics GeoAccess: 95% of members within 15 miles or 30 minutes of Family Medicine, Internal Medicine, Pediatrics	Q2 2023	• Conduct an annual ratio analysis and an annual Geo Access analysis for primary care and high-volume/high-impact specialties • Identify and address gaps with local areas to meet GeoAccess standards • Report annual findings to the SCAL Regional Access Committee	SCPMG Regional Access Department SCAL Regional Access Committee Wadie Marcos, DO Assistant Regional Medical Director, Care Experience (Regional Service and Access) Rebecca Grant, Regional Administrative Leader, Care Experience (Regional Service and Access)
NCQA	NET 1C: Practitioners Providing Specialty Care To evaluate the availability of specialists in its delivery system, the organization: • Defines the types of high-volume and high-impact specialists. • Establishes measurable standards for the number of each type of high- volume specialists. • Establishes measurable standards for the geographic distribution of each type of high-volume specialists.	Ratios: 35,000 members:1 Cardiologist 40,000 members:1 Dermatologist 10,000 members:1 OB/GYN 28,000 members:1 Ophthalmologist 26,000 members:1 Orthopedist	Q2 2023	• Conduct an annual ratio analysis and an annual Geo Access analysis for primary care and high-volume/high-impact specialties • Identify and address gaps with local areas to meet GeoAccess standards • Report annual findings to the SCAL Regional Access Committee	SCPMG Regional Access Department SCAL Regional Access Committee Wadie Marcos, DO Assistant Regional Medical Director, Care Experience (Regional Service and Access) Rebecca Grant, Regional Administrative Leader, Care Experience (Regional Service and Access)

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	• Establishes measurable standards for the geographic distribution of each type of high-impact specialist. • Analyzes its performance against the established standards at least annually.	GeoAccess: 80% of members within 15 miles or 30 minutes of High-Volume/High-Impact Specialty Care			

ANALYSIS

Member to Practitioner Ratios

The following Member to Practitioner Ratio Analysis was presented to the SCAL Regional Access Committee in May 2023. The 2023 analysis will be reported to the Regional Access Committee in May 2024.

Standards:

- 2,000 members:1 PCP (Family Medicine, Internal Medicine, Pediatrics)
- Cardiology - 35,000 members:1 physician, Dermatology - 40,000 members:1 physician, OB/GYN - 10,000 members:1 physician, Ophthalmology - 28,000 members:1 physician, Orthopedics - 26,000 members:1 physician

DATA/RESULTS

- **Primary Care:** The goals for Family Medicine, Internal Medicine and Pediatrics were met in 2022.
- **High Volume Specialty Care:** The goals for High Volume Specialty Care Practitioners were met in 2022.

Primary Care:
Primary Care includes Family Medicine, Internal Medicine, Pediatrics

Year	Family Medicine	Internal Medicine	Pediatrics
2021	1,808	1,481	1,349
2022	1,833	1,514	1,415
Goal	2,000	2,000	2,000

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

High Volume Specialty Care Practitioners (SCP):
High Volume Specialties include Cardiology, Dermatology, OB/GYN, Ophthalmology, Orthopedics

Year	Cardiology	Dermatology	OB/GYN	Ophthalmology	Orthopedics
2021	18,915	20,581	7,932	13,741	18,394
2022	18,012	17,741	8,012	12,069	18,579
Goal	35,000	40,000	10,000	28,000	26,000

GeoAccess

The following GeoAccess Analysis was presented to the SCAL Regional Access Committee in May 2023. The 2023 analysis will be reported to the Regional Access Committee in May 2024.

Standards:

- 95% of members live within 15 miles/30 minutes of primary care services (Family Medicine, Internal Medicine, and Pediatrics)
- 80% of members live within 15 miles/30 minutes of high volume and high impact specialty care services

DATA/RESULTS

- **Primary Care:** For 2022, 13 out of 13 areas met the standard for Family Medicine, Internal Medicine, and Pediatrics.
- **High Volume Specialty Care:** For 2022, all areas met the standard for Cardiology, Dermatology, OB/GYN, Ophthalmology, and Orthopedics.
- **High Impact Specialty Care:** For 2022, 13 out of 13 areas met the standard for Oncology.

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Section 1: 2021 GeoAccess Results *(based on December 2021 Membership)*

		Access within 15 miles or 30 minutes															
		Family Medicine		Internal Medicine		Pediatrics		Cardiology		Dermatology		Obstetrics		Ophthalmology		Orthopedics		Oncology	
MCA	Total	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Antelope Valley	149392	146172	98%	146172	98%	144095	97%	142858	96%	143987	96%	144656	97%	144313	97%	142884	96%	143552	96%
Baldwin Park	280181	280181	100%	280181	100%	280181	100%	280181	100%	280181	100%	280181	100%	280181	100%	280181	100%	280181	100%
Downey	390415	390415	100%	390415	100%	390415	100%	390415	100%	390415	100%	390415	100%	390415	100%	390415	100%	390415	100%
Kern County	114944	112600	98%	111076	97%	112600	98%	92365	80%	98921	86%	102891	90%	98798	86%	95453	83%	95451	83%
Los Angeles	337078	337078	100%	337078	100%	337078	100%	337078	100%	337078	100%	337078	100%	337078	100%	337078	100%	337078	100%
Orange County	584504	584504	100%	584370	100%	584504	100%	584504	100%	584504	100%	584504	100%	584504	100%	584504	100%	584272	100%
Panorama City	274315	273134	100%	273134	100%	273134	100%	273134	100%	273134	100%	273134	100%	273134	100%	273134	100%	273134	100%
Riverside	546348	545394	100%	544016	100%	542372	99%	501673	92%	543867	100%	501673	92%	543962	100%	529547	97%	543410	100%
San Bernardino County	658705	656161	100%	655190	100%	655060	99%	654469	99%	655651	100%	654469	99%	655023	99%	654909	99%	551436	84%
San Diego	630971	628515	100%	628515	100%	628515	100%	586021	93%	613101	97%	625423	99%	627518	100%	625423	99%	623390	99%
South Bay	260936	260899	100%	260899	100%	260899	100%	260899	100%	260899	100%	260899	100%	260899	100%	260899	100%	260899	100%
West Los Angeles	241436	241436	100%	241436	100%	241436	100%	241436	100%	241436	100%	241436	100%	241436	100%	241436	100%	241436	100%
Woodland Hills	272691	271951	100%	271951	100%	271951	100%	271949	100%	271733	100%	271532	100%	271974	100%	271532	100%	271532	100%

Section 1: 2022 GeoAccess Results *(based on December 2022 Membership)*

		Access within 15 miles or 30 minutes															
		Family Medicine		Internal Medicine		Pediatrics		Cardiology		Dermatology		Obstetrics		Ophthalmology		Orthopedics		Oncology	
MCA	Total	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Antelope Valley	153043	149607	98%	149582	98%	147734	97%	146259	96%	149362	98%	147929	97%	147629	97%	146279	96%	146961	96%
Baldwin Park	281448	281448	100%	281448	100%	281448	100%	281448	100%	281448	100%	281448	100%	281448	100%	281448	100%	281448	100%
Downey	397043	397043	100%	397043	100%	397043	100%	397043	100%	397043	100%	397043	100%	397043	100%	397043	100%	397043	100%
Kern County	116349	112575	97%	112596	97%	108608	93%	93270	80%	108411	93%	107435	92%	99970	86%	96545	83%	99129	85%
Los Angeles	338518	338518	100%	338518	100%	338518	100%	338518	100%	338518	100%	338518	100%	338518	100%	338518	100%	338518	100%
Orange County	582144	582144	100%	582031	100%	582144	100%	582144	100%	582144	100%	582144	100%	582144	100%	582144	100%	581928	100%
Panorama City	274164	272957	100%	272957	100%	272957	100%	272957	100%	272957	100%	272957	100%	272957	100%	272957	100%	272957	100%
Riverside	556700	555720	100%	555720	100%	552855	99%	511540	92%	555731	100%	554105	100%	554380	100%	539709	97%	553831	100%
San Bernardino County	669152	666024	100%	665489	100%	665379	99%	664684	99%	666182	100%	664932	99%	665493	100%	665159	99%	558390	83%
San Diego	630616	628164	100%	628164	100%	628164	100%	585384	93%	618007	98%	625178	99%	626721	99%	624984	99%	622952	99%
South Bay	263548	263526	100%	263526	100%	263526	100%	263526	100%	263526	100%	263526	100%	263526	100%	263526	100%	263526	100%
West Los Angeles	240176	240176	100%	240176	100%	240176	100%	240176	100%	240176	100%	240176	100%	240176	100%	240176	100%	240176	100%
Woodland Hills	271964	271180	100%	271180	100%	271180	100%	271180	100%	269794	99%	271224	100%	271224	100%	270781	100%	270781	100%

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

QUANTITATIVE ANALYSIS

- Member to Physician Ratio Analysis (2021 & 2022)
  - The standard for Family Medicine, Internal Medicine, and Pediatrics was met for 2022, which is consistent with performance in 2021. Therefore, no further analysis was conducted.
  - The standard for each High Volume Specialty was met in 2022, which is consistent with performance in 2021. High volume specialties are confirmed by conducting a data query to identify the top 4 physician-based specialties with the largest appointment volume, in addition to OB/GYN, for the appropriate time interval.

- GeoAccess (2021 & 2022)
  - Primary Care
    - For 2022, all areas met the standard of 95% within 15 miles/30 minutes for Family Medicine, Internal Medicine, and Pediatrics, which is consistent with performance in 2021.
  - High Volume Specialty Care
    - For 2022, all areas met the standard of 80% within 15 miles/30 minutes for Cardiology, Dermatology, OB/GYN, Ophthalmology, and Orthopedics, which is consistent with performance in 2021.
  - High Impact Specialty Care
    - For 2022, all areas met the standard of 80% within 15 miles/30 minutes for Oncology, which was consistent with performance in 2021.

QUALITATIVE ANALYSIS

- Member to Physician Ratio Analysis (2021 & 2022)
  - There were no barriers identified in reaching the goals for Family Medicine, Internal Medicine, or Pediatrics.
  - There were no barriers identified in reaching the goals for High Volume Specialty Care.

- GeoAccess (2021 & 2022)
  - Primary Care
    - There were no barriers identified in reaching the goals for Primary Care.
  - High Volume Specialty Care
    - There were no barriers identified in reaching the goals for High Volume Specialty Care.
  - High Impact Specialty Care
    - There were no barriers identified in reaching the goal for High Impact Specialty Care.

NEXT STEPS AND PRIORITY AREA

- Ratio analysis will continue to be done semi-annually.
- The GeoAccess analysis will continue to be performed annually.

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
Accessibility of Services: Primary and Specialty Care (NET 2A & NET 2C)					
NCQA	NET 2A: Access to Primary Care Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: • Regular and routine care appointments • Urgent care appointments • After hours care	80% of non-urgent primary care appointments within 10 bus days 80% of urgent care appointments are within 48 hours KP OnCall Nurse Triage - *Fast Track Abandonment Rate: <5% *Fast Track Service Level: 60% within 60 seconds	Q1 2023 Q1 2023 Q2 2023	• Monitor percent booked in standard performance • Report monthly booked within standard performance to the SCAL Regional Access Committee • Report KP OnCall Nurse Triage performance to the SCAL Regional Access Committee • Regional Senior Leaders to have performance dialogues with each local area as needed	SCPMG Regional Access Department SCAL Regional Access Committee Wadie Marcos, DO Assistant Regional Medical Director, Care Experience (Regional Service and Access) Rebecca Grant, Regional Administrative Leader, Care Experience (Regional Service and Access)
NCQA	NET 2C: Access to Specialty Care Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for: • High-volume specialty care • High-impact specialty care	80% of non-urgent specialty care appointments are booked within 15 business days 80% of ancillary (radiology) appointments are booked within 15 business days	Q1 2023 Q1 2023	• Monitor percent booked within standard performance • Report monthly booked within standard performance to the SCAL Regional Access Committee • Discuss and review action plans developed by the local areas within the SCAL Regional Access Committee • Regional Senior Leaders to have performance dialogues with each local area to ensure action plans are adhered to and yield results	SCPMG Regional Access Department SCAL Regional Access Committee Wadie Marcos, DO Assistant Regional Medical Director, Care Experience (Regional Service and Access) Rebecca Grant, Regional Administrative Leader, Care Experience (Regional Service and Access)

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

ANALYSIS

Urgent & Non-Urgent Primary Care Access

The following Primary Care Access Analysis was presented to the SCAL Regional Access Committee in January 2023.

Access Reporting Overview:

KPSC reports timely access performance based on a 100% sample of all appointments booked for Urgent Primary Care, Non-urgent Primary Care, Non-urgent Cardiology, Non-urgent Dermatology, Non-urgent Ophthalmology, Non-urgent OB/GYN, Non-urgent Orthopedics, and Non-urgent Oncology. We utilize the CADENCE booking system, which is a part of HealthConnect, to book all appointments with our practitioners.

We utilized Percent (%) Booked within Standard for reporting access:

Percent (%) Booked within Standard: Using a 100% sample of appointments, each booked appointment within an access category (e.g., non-urgent, urgent) is evaluated to determine if it was booked within standard. The CADENCE system calculates the "% within Standard" by dividing the number of appointments that met the standard (e.g., 10 business days) by the total number of booked appointments in the access category.

Please note, KPSC experienced dramatic shifts in appointment volumes and non-urgent specialty care access in 2022 driven by the post-pandemic demand.

Primary Care Access Standards:
SCPMG defines the practitioners who serve as primary care practitioners within its delivery system as those who serve in Family Practice, Internal Medicine, and Pediatrics.

- 80% of urgent primary care appointments are within 48 hours
- 80% of non-urgent primary care appointments are within 10 business days

Total Volume of Appointments Evaluated:

	Primary Care					
	Urgent			Non-Urgent		
	Family Medicine	Internal Medicine	Pediatrics	Family Medicine	Internal Medicine	Pediatrics
2021	1,499,436	473,716	516,834	2,945,603	1,226,396	500,431
2022	1,449,626	384,997	614,181	3,011,247	1,196,365	506,703

DATA/RESULTS

- **Urgent primary care:** Metric met at a Regional level in 2021 and 2022 for urgent Family Medicine, urgent Internal Medicine, and urgent Pediatrics.
- **Non-urgent primary care:** Metric met at a Regional level in 2021 and 2022 for non-urgent Family Medicine, non-urgent Internal Medicine, and non-urgent Pediatrics.

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Urgent & Non-Urgent Primary Care Data:

KPSC Regional Access Report Detail
Percent Booked Within Standard for Urgent Primary Care
2021

	FM	IM	Peds
	Urgent		
REGION	99%	99%	100%

DMHC STANDARD	48 hours

Green — Identified area and/or specialty that meets DMHC standard

KPSC Regional Access Report Detail
Percent Booked Within Standard for Urgent Primary Care
2022

	FM	IM	Peds
	Urgent		
REGION	99%	99%	99%

DMHC STANDARD	48 hours

Green — Identified area and/or specialty that meets DMHC standard

KPSC Regional Access Report Detail
Percent Booked Within Standard for Non-Urgent Primary Care
2021

	FM	IM	Peds
	Non-Urgent		
REGION	87%	88%	98%

DMHC STANDARD	10 bus days

Green — Identified area and/or specialty that meets DMHC standard

KPSC Regional Access Report Detail
Percent Booked Within Standard for Non-Urgent Primary Care
2022

	FM	IM	Peds
	Non-Urgent		
REGION	86%	87%	96%

DMHC STANDARD	10 bus days

Green — Identified area and/or specialty that meets DMHC standard

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

After Hours Access

The following After Hours Analysis was presented to the SCAL Regional Access Committee in March 2023. The 2023 analysis will be reported to the Regional Access Committee in March 2024.

After Hours Reporting Overview:

- KPSC will measure after-hours access via nurse triage data from KP OnCall. For these purposes, after-hours is defined as KP OnCall Nurse Triage Access from 7pm – 7am Monday through Friday and 24/7 on weekends and holidays.

After Hours Definitions:

- Fast Track Abandonment Rate (%): The total number of abandoned calls waiting on hold to speak to a nurse divided by the total number of calls
- Fast Track Service Level: Percentage of calls answered within 1 minute

After Hours Access Standards:

- Abandonment Rate (%): 5% or Less
- Fast Track Service Level: 60% or Greater within 1 minute
    - This standard was changed in January 2022 to align with call centers in regions outside of California. The change was reviewed and approved by KP OnCall Leadership.

DATA/RESULTS

- **13 months of data:**
    - 11 of 13 months met goal for total Fast Track Abandon of 5% or less
    - 5 of 13 months met goal for Fast Track Service Level of 60% or greater within 1 minute


NCQA Dashboard | Description

KPOnCall

NCQA Dashboard

The data presented is ONLY showing data for the following:
Monday - Friday, 7pm - 7am
Saturday - Sunday, All Day

Fast Track Abandonment

	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
ABN %	2.9%	2.3%	2.1%	3.5%	2.4%	2.5%	5.0%	3.7%	6.0%	5.3%	1.4%	2.9%	2.6%

Fast Track SL

	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
SVL	74.27%	66.57%	58.76%	54.49%	56.49%	59.13%	39.77%	48.67%	27.07%	27.13%	68.26%	67.62%	72.44%

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

QUANTITATIVE ANALYSIS

- **Urgent primary care:** Metric met at a Regional level in 2021 and 2022 for urgent Family Medicine, urgent Internal Medicine, and urgent Pediatrics. Urgent Primary Care continues to perform consistently at or above 80%.
- **Non-Urgent primary care:** Metric met at a Regional level in 2021 and 2022 for non-urgent Family Medicine, non-urgent Internal Medicine, and non-urgent Pediatrics. Non-urgent Primary Care continues to perform consistently at or above 80%.
- **After Hours:** The Abandonment Rate metric was met for 11 of 13 months and the Fast Track Service Level metric was met for 5 of 13 months.

QUALITATIVE ANALYSIS

- **Urgent primary care:** Metric met at a Regional level in 2021 and 2022 for urgent Family Medicine, urgent Internal Medicine, and urgent Pediatrics. Urgent Primary Care continues to perform consistently at or above 80%. Overall, there were no barriers identified in reaching the goal for urgent Family Medicine, urgent Internal Medicine, or urgent Pediatrics.
- **Non-urgent primary care:** Metric met at a Regional level in 2021 and 2022 for non-urgent Family Medicine, non-urgent Internal Medicine, and non-urgent Pediatrics. Non-urgent Primary Care continues to perform consistently at or above 80%. Overall, there were no barriers identified in reaching the goal for non-urgent Family Medicine, non-urgent Internal Medicine, or non-urgent Pediatrics.
- **After Hours:** KP OnCall experienced challenges meeting the performance metrics in 2022. COVID created a surge of calls that began in March 2020; and post-pandemic demand, high attrition rate of staff, and high number of sick calls resulted in an overall increase in call volume. The department is working on the following to improve access:
    - Looking at opportunities to reduce call handle times (supervisor monthly coaching)
    - IT is working to improve system (continued efforts on ITS functionality)
        - CCSTI key infrastructure was moved, work underway to stabilize the telephony systems
        - Adopted new system, Intradiem, which has improved Average Handle Time (AHT) efficiencies
        - Continuing to actively replace attrition
            - Hiring 12 RN staff positions
        - Hiring contingent workers to help increase department workforce and supply

NEXT STEPS AND PRIORITY AREA

- The Regional Access Committee meets monthly to provide oversight of access performance and to review corrective action plans for those departments that are not achieving 80% booked within standard for 2 consecutive months. The committee chairs assess mid-month data to determine which medical centers are likely to not achieve compliance by the close of the month. These areas are required to present their planned actions for improvement to the committee.
- The percentage of appointments booked within standard will continue to be monitored in the monthly Regional Access Committee meetings.
- After Hours Access performance will be reported to the Regional Access Committee at least twice per year.
- Performance dialogues continue with regional and local leaders regarding the implementation of best practices for performance improvement and maintenance.

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

High Volume & High Impact Specialty Care Access

The following Specialty Care Access Analysis was presented to the SCAL Regional Access Committee in January 2023.

Access Reporting Overview:

KPSC reports timely access performance based on a 100% sample of all appointments booked for Urgent Primary Care, Non-urgent Primary Care, Non-urgent Cardiology, Non-urgent Dermatology, Non-urgent OB/GYN, Non-urgent Ophthalmology, Non-urgent Orthopedics, and Non-urgent Oncology. We utilize the CADENCE booking system, which is a part of HealthConnect, to book all appointments with our practitioners.

We utilized Percent (%) Booked within Standard for reporting access:

Percent (%) Booked within Standard: Using a 100% sample of appointments, each booked appointment within an access category (e.g., non-urgent, urgent) is evaluated to determine if it was booked within standard. The CADENCE system calculates the "% within Standard" by dividing the number of appointments that met the standard (e.g., 10 business days) by the total number of booked appointments in the access category.

Please note, KPSC experienced dramatic shifts in appointment volumes and non-urgent specialty care access in 2022 driven by the post-pandemic demand.

Specialty Care Access Standard:

High volume departments are reviewed each year and are determined by the number of visits to the specialty. The four physician-based departments with the highest volume, plus OB/GYN, are included in the analysis.

KPSC defines Oncology as high-impact specialty care. This determination was made by assessing the high morbidity and mortality rates, as well as the significant resources required for treatment within this specialty.

- 80% of specialty care appointments are within 15 business days

Total Volume of Appointments Evaluated:

High Volume Specialties					
Non-Urgent					
	CRD	DRM	GYN	OPH	ORP
2021	32,402	155,943	26,251	129,762	244,453
2022	34,281	163,401	24,979	131,326	252,762

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

High Impact Specialties	
Non-Urgent	
	ONC
2021	26,925
2022	27,330

DATA/RESULTS

- **High Volume Specialty Care:** Metric met at a Regional level in 2021 and 2022 for non-urgent Cardiology, non-urgent OB/GYN, non-urgent Ophthalmology, and non-urgent Orthopedics. Metric met at a Regional level in 2021 but did not meet in 2022 for non-urgent Dermatology.
- **High Impact Specialty Care:** Metric met at a Regional level in 2021 and 2022.

<u>High Volume Specialty Care Data:</u>

KPSC Regional Access Report Detail

Percent Booked Within Standard for High-Volume Specialties

2021

	CRD	DRM	GYN	OPH	ORP
	Non-Urgent				
REGION	89%	84%	87%	85%	82%
DMHC STANDARD	15 bus days				

Green — Identified area and/or specialty that meets DMHC standard

Consult appointments booked by all providers in high volume specialties:
Cardiology, Dermatology, Gynecology, Ophthalmology, Orthopedics

KPSC Regional Access Report Detail

Percent Booked Within Standard for High-Volume Specialties

2022

	CRD	DRM	GYN	OPH	ORP
	Non-Urgent				
REGION	87%	79%	81%	84%	81%
DMHC STANDARD	15 bus days				

Green — Identified area and/or specialty that meets DMHC standard

Consult appointments booked by all providers in high volume specialties:
Cardiology, Dermatology, Gynecology, Ophthalmology, Orthopedics

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

High Impact Specialty Care Data:

KPSC Regional Access Report Detail
Percent Booked Within Standard for High-Impact Specialties
2021

	ONC
	Non-Urgent
REGION	91%
DMHC STANDARD	15 bus days

Green — Identified area and/or specialty that meets DMHC standard

Consult appointments booked by all providers in high impact specialties:
Hematology/Oncology

KPSC Regional Access Report Detail
Percent Booked Within Standard for High-Impact Specialties
2022

	ONC
	Non-Urgent
REGION	88%
DMHC STANDARD	15 bus days

Green — Identified area and/or specialty that meets DMHC standard

Consult appointments booked by all providers in high impact specialties:
Hematology/Oncology

QUANTITATIVE ANALYSIS

- **High Volume Specialty Care:** Metric met at a Regional level in 2021 and 2022 for non-urgent Cardiology, non-urgent OB/GYN, non-urgent Ophthalmology, and non-urgent Orthopedics. These high-volume specialty departments continue to perform consistently at or above 80%. Metric met at a Regional level in 2021 but did not meet in 2022 for non-urgent Dermatology.
- **High Impact Specialty Care:** Metric met at a Regional level in 2021 and 2022. Non-urgent Oncology continues to perform consistently at or above 80%.

QUALITATIVE ANALYSIS

- **High Volume Specialty Care:**
  - When comparing 2021 to 2022, the volume of non-urgent appointments booked increased for Cardiology, Dermatology, Ophthalmology, and Orthopedics by 6%, 5%, 1% and 3% respectively. The volume of non-urgent appointments booked decreased by 5% for OB/GYN.
  - When comparing 2021 to 2022, the percentage of appointments booked within standard decreased for each of the high-volume specialty care departments. Non-urgent Cardiology decreased by 2%, non-urgent Dermatology decreased by 5%, non-urgent OB/GYN decreased by 6%, non-urgent Ophthalmology decreased by 1% and non-urgent Orthopedics decreased by 1%. Overall, there were no barriers identified in reaching the goal for non-urgent Cardiology, non-urgent OB/GYN, non-urgent Ophthalmology, or non-urgent Orthopedics.
  - At a regional level, non-urgent Dermatology experienced a decrease in access performance in 2022, which was primarily driven by an increase in demand compared to 2021, physician medical leaves, retirements, and resignations. The region took action by leveraging additional clinics, external contracts, per diems, and hired replacement physicians to close the gap.

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• **High Impact Specialty Care:**
  ○ The volume of non-urgent appointments booked in Oncology increased by 2% when comparing 2021 to 2022.
  ○ In comparing 2021 to 2022, the percentage of non-urgent Oncology appointments booked within standard decreased by 3%. Overall, there were no barriers identified in reaching the goal for non-urgent Oncology.
 	
NEXT STEPS AND PRIORITY AREA
• The Regional Access Committee meets monthly to provide oversight of access performance and to review corrective action plans for those departments that are not achieving 80% booked within standard for 2 consecutive months. The committee chairs assess mid-month data to determine which medical centers are likely to not achieve compliance by the close of the month. These areas are required to present their planned actions for improvement to the committee.
• The percentage of appointments booked within standard will continue to be monitored in the monthly Regional Access Committee meetings.
• Performance dialogues continue with regional and local leaders regarding the implementation of best practices for performance improvement and maintenance.					

Assessment of Network Adequacy (NET 3A & 3B)					
NCQA	NET 3A: Assessment of Member Experience Accessing the Network The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by: • Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services from ME 7, Element C and Element D. • Compiling and analyzing nonbehavioral requests for and utilization of out-of-network services. NET 3B: Opportunities to Improve Access to Nonbehavioral Healthcare Services The organization annually: • Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements B and C), accessibility (NET 2, Elements A and C), and member experience accessing the network (NET 3, Element A, factors 1 and 3).	Conduct an assessment of member complaints and appeals, CAHPS surveys, out-of-network requests, network availability, and appointment access data to assess network adequacy and member experience with their care and services.	Q2 2023 Q2 2023	• Report findings to the SCAL Regional Access Committee • Identify opportunities for improvement and implement interventions to address performance gaps	SCPMG Regional Access Department SCAL Regional Access Committee Wadie Marcos, DO Assistant Regional Medical Director, Care Experience (Regional Service and Access) Rebecca Grant, Regional Administrative Leader, Care Experience (Regional Service and Access)

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	• Implements interventions on at least one opportunity, if applicable. • Measures the effectiveness of interventions, if applicable				

ANALYSIS

Assessment of Network Adequacy (Non-Behavioral Health)

The following Assessment of Network Adequacy was presented to the SCAL Regional Access Committee in May 2023. The 2023 analysis will be reported to the Regional Access Committee in May 2024.

KPSC conducted an assessment of member grievances and appeals, CAHPS surveys, out of network requests, network availability and appointment access data to assess network adequacy and member experience with their care and services.

Methodology and Data Sources
The following data sources were used to assess network adequacy:

- All Access to Care grievances and appeals filed by Commercial (includes Covered CA), Medicare and Medi-Cal members in 2022.
  - Obtained from Health Plan Member Services. Data are presented to the SCAL Member Concerns Committee and the SCAL Regional Access Committee.
- 2022 CAHPS results for Commercial, Medicare, Marketplace, and Medi-Cal (CalOptima and LA Care).
  - Obtained from SCPMG Performance Assessment. Results were reported to the Southern California Quality Committee (SCQC).
- 2022 Requests for Out of Network Services.
  - Obtained from Health Plan Member Services. Data are presented to the SCAL Member Concerns Committee.
- 2022 Appointment Access and After-Hours analysis.
  - Appointment Access data obtained from SCPMG Regional Access and After-Hours analysis obtained from KP OnCall. Results are reported to the SCAL Regional Access Committee.
- Availability Analysis of calendar year 2022 GeoAccess standards and Enrollee to Provider Ratios.
  - Obtained from SCPMG Regional Access. Results are reported to the SCAL Regional Access Committee.

QUANTITATIVE ANALYSIS SUMMARY

Analysis of all available data sources used to assess network adequacy reveals the following:

- Grievances and Appeals
  - Compared to the overall rate of Commercial, Medicare and Medi-Cal grievances filed (Access to Care, Attitude/Service, Billing/Finance, Quality of Care, Practitioner Office), the volume of Access to Care issues represented 11% of the total.
  - The analysis of Access to Care grievances and appeals revealed the following opportunities:
    - Access to Appointments – Unable to schedule timely appointment and Appointment cancellation
    - Access to Appointments complaints/grievances in the San Bernardino County and Woodland Hills Medical Center Areas
    - Access to Appointments complaints/grievances in the departments of Neurosurgery and Pain Management

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- The San Bernardino County and Woodland Hills Medical Center Areas surfaced as the top 2 areas when normalized by 10K members in 2022.
  - Additional drill-down by area revealed opportunities in high-volume departments for both areas based on the complaint/grievance volume (i.e., Family Practice, OB/GYN, Orthopedics).
  - Additional drill-down by Access to Appointments issue subtype revealed Unable to schedule timely appointment as #1 for both San Bernardino County and Woodland Hills Medical Center Areas.
- Further drill-down by Department revealed Unable to schedule timely appointment as the #1 Access to Appointment Issue subtype in Neurosurgery and Pain Management.

- Member Experience
  - Response rates were highest among Medicare CAHPS members (39.4%), followed by QHP CAHPS members (17.3%), and Commercial CAHPS members (12.2%). This reflects a decrease in response rates among Commercial and Marketplace members and is reflective of an ongoing trend for all KP opinion surveys and across the industry. Declining response rates have been a known issue in recent years.
  - Note that survey measurement periods cover time periods when KP members were still experiencing the effects of the COVID-19 pandemic. Members experienced unusual patterns of getting care, increases in the availability of virtual appointments, delays in care when facilities were not fully operational due to pandemic-related shutdowns, and the subsequent influx of patients as they returned to obtain delayed care.
    - This was seen throughout the United States health care system, which reduced national average scores—as well as KP scores—for Access.
    - Patterns of pandemic-related shutdowns differed across regions and health plans, which may have influenced member experience survey results.
  - Access to care continues to be an opportunity for improvement given the data across all three surveys. For Commercial CAHPS, scores for access composite measures (Getting Needed Care and Getting Care Quickly) were at the 10th and 5th Pacific percentiles, respectively. Medicare CAHPS measures Getting Appointments and Care Quickly and Getting Needed Care each gained stars from the previous year but dropped in score. Lastly, the Getting Needed Care Quickly composite for the QHP Enrollee Experience Survey earned scores at the national average, but Getting Needed Care was below the national average.
  - Performance remains high for Medi-Cal CAHPS, with KP earning top scores among LA Care and CalOptima managed care plans.
  - Given these results, opportunities for improvement include:
    - Access to routine care
    - Access to urgent care
    - Access to specialty care
  - All opportunities listed above are known areas of focus for KPSC and are currently being addressed by the organization. Operational teams that support patient access have been notified of these survey results and are actively implementing strategies to address these areas of opportunity. There is continued work on improving access to multiple areas of care.

- Out of Network Requests
  - In 2022, 1,965 Commercial out of network requests were sent for review at a rate of .15 per 1K members, 144 Covered CA out of network requests were sent for review at a rate of .14 per 1K members, 1,489 Medicare out of network requests were sent for review at a rate of .56 per 1K members and 533 Medi-Cal out of network requests were sent for review at a rate of .24 per 1K members.
  - The established goal for the 2022 reporting period was to maintain or decrease the 2021 rate per 1K for each line of business. The goal was met for the Covered CA business line. The goal was not met for the Commercial, Medicare and Medi-Cal lines of business.
  - Of the 1,965 Commercial out of network requests sent for review, 85% were submitted as a grievance, 2% were submitted as an appeal, and 13% were submitted as a pre-grievance. 417 of the grievances were approved at a rate of .032 per 1K members, 10 of the appeals were approved at a rate of .001 per 1K members, and 22 of the pre-grievances were approved at a rate of 0.002 per 1 K members.

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- Of the 144 Covered CA out of network requests sent for review, 80% were submitted as a grievance, 5% were submitted as an appeal, and 15% were submitted as a pre-grievance. 32 of the grievances were approved at a rate of .032 per 1K members, 0 of the appeals were approved, and 1 pre-grievance was approved at a rate of 0.001 per 1K members.
- Of the 533 Medi-Cal out of network requests sent for review, 77% were submitted as a grievance, 11% as an appeal, and 12% were submitted as a pre-grievance. 138 of the grievances were approved at a rate of .063 per 1K members, 7 of the appeals were approved at a rate of .003 per 1K members, and 7 of the pre-grievances were approved at a rate of 0.003 per 1K members.
- Of the 1,489 Medicare out of network requests sent for review, 71% were submitted as a grievance, 19% as an appeal, and 10% as outside medical review. 320 of the grievances were approved at a rate of .121 per 1K members, 136 of the appeals were approved at a rate of .051 per 1K members, and 16 of the outside medical review requests were approved at a rate of 0.006 per 1K members.
- The top drivers for out of network requests were Referral to Specialty Care and Second Opinion/Consult.
- The Medical Centers with the highest rate per 1K members were Los Angeles at .31 per 1K members and Woodland Hills at .26 per 1K members.

- Availability
  - KPSC met the Primary Care GeoAccess and Ratio standards for Family Medicine, Internal Medicine and Pediatrics.
  - KPSC met the high volume and high impact specialty care GeoAccess and Ratio standards for Cardiology, Dermatology, OB/GYN, Ophthalmology, Orthopedics, and Oncology in all areas.

- Accessibility
  - KPSC met the accessibility standards for non-urgent and urgent Primary Care. KPSC met the Fast Track Abandonment standard 11 of 12 months and met the Fast Track Service Level standard 5 of 12 months.
  - KPSC met access standards for Cardiology, OB/GYN, Ophthalmology, Orthopedics, and Oncology. KPSC did not meet access standards for Dermatology. Dermatology experienced a decrease in access performance in 2022, which was primarily driven by an increase in demand compared to 2021, physician medical leaves, retirements, and resignations. The region took action by leveraging additional clinics, external contracts, per diems, and hired replacement physicians to close the gap.

QUALITATIVE ANALYSIS

Opportunities to Improve Access to Non-Behavioral Healthcare Services

Top areas of network adequacy opportunities were gleaned from KPSC's review of Commercial (includes Covered CA), Medicare and Medi-Cal grievances and appeals in Section 1, Commercial, Covered CA (Marketplace/QHP), Medicare and Medi-Cal CAHPS surveys in Section 2, requests for out of network services in Section 3 and network adequacy in Section 4. From a review of the various data sources, the areas of opportunity include the following, prioritized based on member need and risk to access:

- Grievances
  - Access to Appointments – Unable to schedule timely appointment and Appointment cancellation
  - Access to Appointments complaints/grievances in the San Bernardino County and Woodland Hills Medical Center Areas
  - Access to Appointments complaints/grievances in the departments of Neurosurgery and Pain Management
- Member Experience
  - Access to routine care
  - Access to urgent care
  - Access to specialty care

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- Out of Network Requests
  - Out of Network Requests for Referral to Specialty Care and Second Opinion/Consult
  - Out of Network Requests in Los Angeles and Woodland Hills Medical Center Areas
- Accessibility
  - Fast Track Service Level of 60% or greater within 1 minute

NEXT STEPS AND PRIORITY AREA

Planned Interventions

KPSC saw a significant reduction in demand for access to care from our members in 2020 due to the COVID-19 pandemic. Throughout 2021 and 2022, members regained confidence through vaccinations and awareness, and began to seek new and deferred appointments. We continue to experience a substantial increase in demand for care above pre-pandemic levels that resulted in increased complaints.

Based on the areas of opportunity identified, KPSC has implemented the following interventions:

1. The Regional Care Experience, Service and Access Department and the Medical Center Leadership continue to focus on the reduction and prevention of Complaints, Grievances and Appeals (CGAs). Our work collaborates with Medical Center Leadership and the Regional Service Line Leaders to improve member experience for access to Non-Behavioral Healthcare Services. Throughout 2023, analysis demonstrated that CGA trends continued to be member concerns for diagnosis/treatment to care and access to care concerns. Planned interventions for all complaints are addressed by the physician leaders and managers that respond to all complaints. To address access complaints, all access levers are reviewed and monitored through the Regional Access Committee and include but are not limited to leveraging external contracts, utilizing additional clinics, and actively recruiting to fill open positions to add supply.
   The 2023 CGA performance goal takes into consideration prior year performance, operational volume realities, and the service improvement focus for KPSC. Each year, the goal is set to reduce member concerns and is cascaded regionwide. CGA performance goal progress is monitored and distributed on a monthly basis to all the medical center areas, providing the CGA reduction goal year-to-date progress for each service area. CGA goals are reestablished for each medical center, ranging from 0.5% to 2.5% goal reduction (2.94 to 3.00 cases per 1k members), based on each area's membership and average rate per 1k member. An analysis of the medical center areas' performance and progress will be conducted at the end of the year.
2. To improve the Fast Track Service Level of 60% or greater within 1 minute, KPSC is working on hiring 12 new RN staff in 2023 and hiring three new contingent workers to help increase the department workforce and supply. KPSC is also looking at opportunities to reduce call handle times through supervisor monthly coaching. Additionally, KPSC is continuing efforts on working with IT to improve system functionality, stabilizing telephony systems, and adopting a new system to improve average handle time efficiencies.

Prior Interventions

KPSC identified the following interventions in the prior Assessment of Network Adequacy:

1. In an effort to reduce CGA (complaints, grievances and appeals) and improve member experience, the Regional Access Department and Medical Center Leadership continue to monitor and identify gaps in performance monthly. We are working with the Regional Service Line Leaders and Regional Administrative Leaders (representing the Adult Primary Care, Medical, Surgical, and OB GYN Service Lines) to identify concerns and themes and implement resolutions. To reduce Access to Appointments grievances, we continue to pull all levers such as leveraging external contracts and recruiting to fill open positions to add additional supply to meet our predicted demand. For 2022, CGA goals will be reassessed and established for each medical center, ranging from 1% to 5% goal reduction, based on each area's membership and average rate per 1k member. An analysis of the medical center areas' performance and progress will be conducted at the end of the year.

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2. To improve the Fast Track Service Level of 80% within 60 seconds, KPSC is working on hiring 26 net new RN staff over the next two years, hiring contingent workers to help bridge staffing needs, and working with IT to improve systems to reduce call handle times.

Effectiveness of Prior Intervention(s)

In 2022, due to the continued significant increased demand for care, KPSC focused on efforts to improve member experience specifically for access to care. KPSC reviewed the CGAs monthly and met with each Medical Center and Service Line Leaders to address their specific member concerns. We implemented resolutions to expedite care with continued virtual offerings, escalations for member access, and leveraged our external network to increase supply. Due to the increase in visit volume, KPSC member complaints, grievances, and appeals increased in volume and cases per 1k member, beginning in March 2021 to current as we managed the ambulatory surge with encounters exceeding pre-COVID 2019 volumes. In 2022, the KPSC CGA reduction goal was not achieved with CGA volumes reaching historical highs and a 26% volume increase over prior year. The KPSC performance year ended at 3.02 cases per 1k members. Non-BH Access to Care Grievances by NCQA category 2021 vs. 2022 are as follows - Commercial: rate increased from 7.0 to 9.9 per 10K members (increase in rate is higher as compared to previous year), Medicaid: rate increased from 6.7 to 9.0 per 10K members (increase in rate comparable to the previous year), and Medicare: rate increased from 21.4 to 27.9 per 10K members (increase in rate is lower as compared to the previous year.

In 2022, the Fast Track Abandonment Rate goal was met 11 of 12 months, and the Fast Track Service Level goal was partially met during the same period. Contributing factors that impacted performance include increased overall call volume, high attrition rate of staff, and high number of sick calls. KPSC continued to pull all available levers to improve access, improving system functionality, reducing call handle times, and hiring RN staff. 12 RN staff positions are currently open.

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
BEHAVIORAL HEALTH					
Availability of Practitioners: Behavioral Health Care (NET 1D)					
NCQA	NET 1D: Practitioners Providing Behavioral Healthcare To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: Factor 1. Defines the types of high-volume behavioral healthcare practitioners. (see BH Program Description) High volume Behavioral Health Practitioners are grouped into 5 major common types as follows: • **Adult Psychiatrists**: includes Physicians and Physician Extenders whose primary practice is adult patients in Psychiatry • **Child Psychiatrists:** includes Physicians and Physician Extenders whose primary practice is children ages 0-17 in Psychiatry • **Psychiatric Therapists:** includes LCSWs, LMFTs, MSWs, and PhDs who provide therapy services in Psychiatry • **Addiction Medicine Physicians:** includes Physicians and Physician Extenders in Addiction Medicine • **Substance Use Practitioners:** includes LCSWs, LMFTs, MSWs, PhDs, Clinical Nurse Specialists, and substance use counselors in Addiction Medicine	Annual review of definitions as part of the BH Program Description submission	Annual March 2024	Annual review of definitions as part of the BH Program Description submission.	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	Factor 2. Establishes measurable standards for the number of each type of high-volume behavioral healthcare practitioner. Factor 4. Analyzes performance against the standards annually.		Annual March 2024	Conduct an annual ratio analysis for Behavioral Health high-volume practitioners.	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	• **Adult Psychiatrists**: includes Physicians and Physician Extenders whose primary practice is adult patients in Psychiatry • **Child Psychiatrists:** includes Physicians and Physician Extenders whose primary practice is children ages 0-17 in Psychiatry • **Psychiatric Therapists:** includes LCSWs, LMFTs, MSWs, and PhDs who provide therapy services in Psychiatry • **Addiction Medicine Physicians:** includes Physicians and Physician Extenders in Addiction Medicine • **Substance Use Practitioners:** includes LCSWs, LMFTs, MSWs, PhDs, Clinical Nurse Specialists, and substance use counselors in Addiction Medicine	1 budgeted Adult psychiatrist per 18,500 members 1 budgeted Child psychiatrist per 18,500 members 1 budgeted Therapist per 5,900 members 1 budgeted physician per 135,000 members 1 budgeted Substance Use Practitioner per 30,000 members			
NCQA	Factor 3. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner. Factor 4. Analyzes performance against the standards annually. **Mental Health Providers:** • Adult Psychiatrists • Child Psychiatrists • Psychiatric Therapists **Addiction Medicine Program:** • Addiction Medicine Physicians • Substance Use Practitioners	80% of Membership within 15 miles or 30 minutes 80% of Membership within 30 miles or 60 minutes	Annual March 2024	Identify and address gaps with local areas to meet GeoAccess standards.	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)

ANALYSIS

The following Ratio and GeoAccess Analysis was completed in March of 2023. The 2023 analysis will be completed in March 2024.

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2023 Ratio Analysis

Availability of Behavioral Health Practioners Analysis

2022 Year-End Analysis based on YE 2022 Actual Membership

Practitioner Type	YE 2022 Staffing	YE 2022 Membership	2022 Staffing Ratio	Ratio Standard	Met/Not Met
Adult Psychiatrists (MD) (Ages 18 and above)	328.2	3,848,172	11,725	18,500	Met
Child Psychiatrists (MD) (Ages 0 - 17)	81.3	947,563	11,655	18,500	Met
Psychiatry Therapists (Ages 0 and above)	1140.2	4,795,735	4,206	5,900	Met
Addiction Medicine Physician (MD) (Ages 13 and above)	33.4	4,146,068	124,134	135,000	Met
Substance Abuse Practioners (LCSW, LMFT or CADC) (Ages 13 and above)	157.9	4,146,068	26,258	30,000	Met

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Practitioner Type: Psychiatry Physicians - Year-End 2022 Outpatient Staffing
Targeted Membership: All Ages

AREA	YE 2022 Membership	YE 2022 Budgeted Staffing	2022 Current Staffing Ratio	2022 Area Staffing Goal	2022 Internal Unique MRN's	Penetration Rate (Physician only)
REGION	4,795,735	286.0	16,766	18,500	209,410	4.37%
Antelope Valley	153,043	10.9	14,005	20,503	6,030	3.94%
Baldwin Park	281,448	14.2	19,791	23,167	9,814	3.49%
Downey	397,043	23.8	16,718	17,641	18,181	4.58%
Kern County	116,349	8.0	14,505	15,831	5,937	5.10%
Los Angeles	338,518	19.5	17,322	16,176	16,905	4.99%
Orange County	582,147	34.8	16,728	19,599	23,995	4.12%
Panorama City	274,165	17.8	15,403	14,548	15,224	5.55%
Riverside	556,715	23.7	23,490	22,983	19,568	3.51%
San Bernardino County	669,152	39.3	17,006	24,735	21,854	3.27%
San Diego	630,620	40.4	15,620	14,069	36,208	5.74%
South Bay	263,548	14.7	17,889	19,053	11,174	4.24%
West Los Angeles	240,176	16.2	14,806	15,381	12,614	5.25%
Woodland Hills	271,964	22.6	12,034	17,093	12,853	4.73%

*NOTE: Ratios are not used to determine staffing but are used as a reference after staffing decisions have been made. Staffing allocations are based on many factors including demand for new intakes, forecast of return visits, clinical programs, provider productivity, patient/member satisfaction, evaluation of external drivers (e.g., economic conditions affecting employers) and other factors. These ratios represent a minimum level of budgeted staffing.

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Practitioner Type: Psychiatry Therapists - Year-End 2022 Outpatient Staffing
Targeted Membership: All Ages

AREA	YE 2022 Membership	YE 2022 Budgeted Staffing	2022 Current Staffing Ratio	2022 Area Staffing Goal	2022 Internal Unique MRN's	Penetration Rate (Non-Physician only)
REGION	4,795,735	1,060.6	4,522	5,900	255,599	5.33%
Antelope Valley	153,043	33.6	4,562	5,082	9,469	6.19%
Baldwin Park	281,448	50.4	5,583	6,279	14,096	5.01%
Downey	397,043	87.0	4,563	5,873	21,257	5.35%
Kern County	116,349	29.8	3,908	5,325	6,871	5.91%
Los Angeles	338,518	86.3	3,923	5,381	19,783	5.84%
Orange County	582,147	120.3	4,841	6,620	27,652	4.75%
Panorama City	274,165	51.2	5,352	7,101	12,140	4.43%
Riverside	556,715	100.2	5,556	8,020	21,828	3.92%
San Bernardino County	669,152	154.7	4,325	5,156	40,808	6.10%
San Diego	630,620	162.4	3,882	4,796	41,349	6.56%
South Bay	263,548	50.6	5,210	6,430	12,888	4.89%
West Los Angeles	240,176	57.8	4,159	5,628	13,419	5.59%
Woodland Hills	271,964	76.4	3,560	5,704	14,994	5.51%

*NOTE: Ratios are not used to determine staffing but are used as a reference after staffing decisions have been made. Staffing allocations are based on many factors including demand for new intakes, forecast of return visits, clinical programs, provider productivity, patient/member satisfaction, evaluation of external drivers (e.g., economic conditions affecting employers) and other factors. These ratios represent a minimum level of budgeted staffing.

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

2022 Physician Staffing Update

- KPSC has a comprehensive Behavioral Health Therapist and Physician recruitment program.
- Demand for licensed Behavioral Health Practitioners remains very competitive within California and nationwide.
- Status as of 12/31/22:

Positions filled			
Specialty	New Positions	Replacement Positions	Self-Funded Positions
Addiction Medicine	2	2	1
Adult Psychiatry	8	16	
Child Psychiatry	1	3	
Geriatrics Psychiatry			
Inpatient Psychiatry	1	1	
TOTAL	12	22	1

OPEN POSITIONS			
Specialty	New Positions	Replacement Positions	Self-Funded Positions
Addiction Medicine	2	2	
Adult Psychiatry	23	17	2
Child Psychiatry	7	8	1
Geriatrics Psychiatry	1		
Inpatient Psychiatry			
TOTAL	33	27	3

2022 Non-Physician Staffing Update

- In 2022, SCPMG funded 354 new hire non-physician positions in Psychiatry. The remaining positions were filled as in-region transfers with an additional sub-set of rehire positions filled. This bolus of new positions demonstrates KPSC's efforts to address the need to increase appointment availability and member satisfaction with non-physician providers in Psychiatry.
- Status as of 12/25/22:

Filled Requisitions	Total
In-Region Transfer	262
New Hire	354
Rehire	24
Transfer Between Regions	6
Grand Total	**648**

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

GeoAccess Analysis

KPSC evaluates our members' access to our behavioral health facilities at least annually. This analysis is conducted at the medical center area level to ensure identification of opportunities in specific geographic areas.

Quantitative Analysis

- All 13 Medical Center Areas met the GeoAccess goals for our high-volume Psychiatry and Addiction Medicine practitioners as defined in our annual BHC Quality Program description. There were also some improvements when comparing Access from 2021 vs. 2022.

There were improvements in 3 of the Medical Center areas:

- Antelope Valley improved access for: Child Psychiatry from **96% to 97%**
- Kern County improved access for: Child Psychiatry from **84% to 91%,** Adult Psychiatry from **89% to 91%,** Addiction Medicine MDs from **98% to 100%** and Sub Abuse Providers from **99% to 100%**
- Woodland Hills improved access for: Addiction Medicine MDs from **90% to 100%**
- Overall, Access improved and there was no Medical Center area that declined in Access

2022 GeoAccess Analysis

		Access within 15 miles of Service						Access within 30 miles of Service			
		Child Psychiatry		Adult Psychiatry		Psych Therapist		Addiction Medicine MDs		Sub Abuse Provider	
Service Area	Total Members	Members with access	% of members with access	Members with access	% of members with access	Members with access	% of members with access	Members with access	% of members with access	Members with access	% of members with access
Antelope Valley	153043	148782	97%	151359	99%	151174	99%	152817	100%	152817	100%
Baldwin Park	281448	281448	100%	281448	100%	281448	100%	281448	100%	281448	100%
Downey	397043	397043	100%	397043	100%	397043	100%	397043	100%	397043	100%
Kern County	116349	106189	91%	106211	91%	110544	95%	115940	100%	114681	99%
Los Angeles	338518	338518	100%	338518	100%	338518	100%	338518	100%	338518	100%
Orange County	582144	582144	100%	582144	100%	582144	100%	582144	100%	582144	100%
Panorama City	274164	272957	100%	272957	100%	272971	100%	274164	100%	274164	100%
Riverside	556700	554169	100%	554352	100%	555890	100%	513233	92%	556465	100%
San Bernardino County	669152	667432	100%	668068	100%	668136	100%	666446	100%	669013	100%
San Diego	630616	628365	100%	628382	100%	629327	100%	591024	94%	628900	100%
South Bay	263548	263526	100%	263526	100%	263526	100%	263548	100%	263548	100%
West Los Angeles	240176	240176	100%	240176	100%	240176	100%	240176	100%	240176	100%
Woodland Hills	271964	271259	100%	271259	100%	271256	100%	271230	100%	271620	100%

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Quantitative & Qualitative Analysis:

Ratio Analysis

There are no national standards to use as guidelines for ratios. KPSC does not use ratios (we define as staffing goals) as a sole metric to determine necessary staffing. Ratios of provider categories can be greatly impacted by changing external economics, changing clinical programs, new service delivery models (e.g., telehealth services), improved practitioner productivity, etc. To incorporate consideration of ratios, the goals may change from year to year if the measure is to be considered relevant.

Quantitative Analysis

- KPSC met its regional staffing forecast for adult Psychiatrist, child Psychiatrist, Psychiatry Therapist, Addiction Medicine Physicians and Substance Abuse Practitioners.

Qualitative Analysis

- Given the focus on mental health services, KPSC additionally analyzes staffing at the Area/Medical Center level.
    - The actual staffing forecasts for medical centers are adjusted from the regional average based on differences in member utilization of services.
    - Member utilization of services is analyzed based on the percent of members accessing mental health services (penetration rate) in a local area.

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Accessibility of Services: Behavioral Health Care (NET 2B)					
NCQA	NET 2B: Access to Behavioral Healthcare Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: <u>Factor 1</u>. Care for a Non-Life-Threatening Emergency within 6 hours • Standard = 6 hours • Policy as outlined in 2022 BH Annual Program Description Excerpt from 2022 BH Annual Program Description: *"Our standard for emergent behavioral appointments is immediate. Patients are directed to an emergency department for either life threatening or non-life threatening behavioral health emergency needs.* *<u>Emergent</u> – Sudden, unforeseen illness or injury that requires immediate medical attention – or which if left untreated could result in serious disability or death. The following clarifying statements were added for our behavioral health departments:* • ***Psychiatry:** A behavioral health life threatening or non-life threatening crisis that may result in a danger to self or others or concern of further decompensation (e.g. intra-psychic or environmental)* • ***Addiction Medicine:** May include components of a medical or psychiatric emergency."*	See Policy Statement in BH Program Description	Annual March 2024	**BHC Non-Life-Threatening Access** • Review policy as evidenced by statement in Annual BH Program Description	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)

ANALYSIS

Quantitative & Qualitative Analysis:

<u>Behavioral Health Care (BHC) Non-Life-Threatening Access</u>

1. Standard = 6 hours
2. Policy as outlined in BHC Annual Program Description

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	"Our standard for emergent behavioral appointments is immediate. Patients are directed to an emergency department for either life threatening or non-life-threatening behavioral health emergency needs." *"Emergent - Sudden, unforeseen illness or injury that requires immediate medical attention—or which if left untreated could result in serious disability or death. The following clarifying statements were added for our behavioral health departments:* • *Psychiatry: A behavioral health life threatening or non-life-threatening crisis that may result in a danger to self or others or concern of further decompensation (e.g., intra-psychic or environmental)* • *Addiction Medicine: May include components of a medical or psychiatric emergency."* **NCQA - BHC Non-Life-Threatening Access within 6 hours Analysis:** This standard is met because we treat both life threatening and non-life-threatening emergencies the same – A member is referred to the nearest emergency department.				

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
NCQA	Factor 2. Urgent care within 48 hours.	Physician and Non-Physician >= 80% Booked within 48 hours	Quarterly Review March 2024	**BHC Urgent Appointment Access** • Review access data on a minimum of quarterly basis • Ensure Access Corrective Action Plans are requested of Departments in a timely manner • Oversight of Access CAP's until resolved • Identify opportunities for access improvement	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)

ANALYSIS

NCQA Physician Urgent Access Performance

	Physician Behavioral Health			
	Urgent			
	Q1 2022	Q2 2022	Q3 2022	Q4 2022
REGION	99%	98%	99%	99%
NCQA Standard	48 hours			

	Physician Behavioral Health			
	Urgent			
	Q1 2023	Q2 2023	Q3 2023	Q4 2023
REGION	99%	99%	99%	99%
NCQA Standard	48 hours			

NCQA Non-Physician Urgent Access Performance

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

	Non-Physician Behavioral Health			
	Urgent			
	Q1 2022	Q2 2022	Q3 2022	Q4 2022
REGION	99%	99%	99%	99%
NCQA Standard	48 hours			

	Non-Physician Behavioral Health			
	Urgent			
	Q1 2023	Q2 2023	Q3 2023	Q4 2023
REGION	100%	100%	100%	100%
NCQA Standard	48 hours			

Quantitative & Qualitative Analysis:

Physician Urgent Appointments

- Regionally, KPSC met the urgent access performance standard for physician behavioral health appointments for all 4 quarters in 2023, which was consistent with performance in 2022. Therefore, no further analysis was conducted.

Non-Physician Urgent Appointments

- Regionally, KPSC met the urgent access performance standard for non-physician behavioral health appointments for all 4 quarters in 2023, which was consistent with performance in 2022. Therefore, no further analysis was conducted.

NCQA	Factor 3. Initial visit for routine care within 10 business days.	Physician and Non-Physician	Quarterly Review	**BHC Routine Appointment Access** • Review access data on a minimum of quarterly basis	• Regional Behavioral Health

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
		>= 80% Booked within 10 Business Days	March 2024	• Ensure Access Corrective Action Plans are requested of Departments in a timely manner • Oversight of Access CAP's until resolved • Identify opportunities for access improvement	• Behavioral Health Quality Oversight Committee (BHQOC)

ANALYSIS

NCQA Physician Non-Urgent Access Performance

	Physician Behavioral Health			
	Non-Urgent			
	Q1 2022	Q2 2022	Q3 2022	Q4 2022
REGION	72%	67%	69%	76%
NCQA Standard	10 bus days			

	Physician Behavioral Health			
	Non-Urgent			
	Q1 2023	Q2 2023	Q3 2023	Q4 2023
REGION	73%	73%	74%	80%
NCQA Standard	10 bus days			

NCQA Non-Physician Non-Urgent Access Performance

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

	Non-Physician Behavioral Health			
	Non-Urgent			
	Q1 2022	Q2 2022	Q3 2022	Q4 2022
REGION	90%	87%	90%	90%
NCQA Standard	10 bus days			

	Non-Physician Behavioral Health			
	Non-Urgent			
	Q1 2023	Q2 2023	Q3 2023	Q4 2023
REGION	91%	91%	90%	91%
NCQA Standard	10 bus days			

Quantitative & Qualitative Analysis:

Physician Non-Urgent (Consult) Appointments

- Regionally, KPSC did not meet the NCQA non-urgent access performance standard for physician behavioral health appointments for quarters 1 to 3 in 2023; however, KPSC did meet the DMHC standards. KPSC experienced an increase in performance for all quarters in 2023 compared to 2022 and met the 80% performance threshold in quarter 4 of 2023.
  - KPSC experienced multiple physician openings, retirements, and medical leaves during this lookback period. To close the gap, KPSC worked to add additional clinics by using per diems, assistance from the Virtual Medical Center, and is working closely on recruitment to fill the physician openings.

Non-Physician Non-Urgent (Routine Behavioral Medicine) Appointments

- Regionally, KPSC met the non-urgent access performance standard for non-physician behavioral health appointments for all 4 quarters in 2023, which was consistent with performance in 2022. Therefore, no further analysis was conducted.

NCQA	Factor 4. Follow up routine care. **Follow Up Routine Appointment Access:**	Physician and Non-Physician	Quarterly Review March 2024	**Follow-up Routine Appointment Access** • Review access data on a minimum of quarterly basis	• Regional Behavioral Health

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	Member we want to see again in 8 weeks or less because there is an active issue we are managing; all ambulatory individual and group visits are included. Follow Up visit within 5 business days	>= 80% Booked within 5 Business Days		• Behavioral Health Quality Oversight Committee (BHQOC) to determine appropriate action for access that is out of standard • Review of the Follow-Up standard will be conducted to align with the DMHC Follow-Up standard	• Behavioral Health Quality Oversight Committee (BHQOC)

ANALYSIS

NCQA Physician Follow-Up Access Performance

	Physician Behavioral Health Follow Up			
	Q1 2022	Q2 2022	Q3 2022	Q4 2022
REGION	77%	77%	76%	78%
KP Standard	5 Business Days			

	Physician Behavioral Health Follow Up			
	Q1 2023	Q2 2023	Q3 2023	Q4 2023
REGION	79%	78%	75%	80%
KP Standard	5 Business Days			

NCQA Non-Physician Follow-Up Access Performance

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

	Non-Physician Behavioral Health Follow Up			
	Q1 2022	Q2 2022	Q3 2022	Q4 2022
REGION	91%	91%	90%	91%
KP Standard	5 Business Days			

	Non-Physician Behavioral Health Follow Up			
	Q1 2023	Q2 2023	Q3 2023	Q4 2023
REGION	91%	87%	85%	88%
KP Standard	5 Business Days			

Quantitative & Qualitative Analysis:

Physician Follow-Up Appointments

- Regionally, KPSC did not meet the NCQA follow-up access performance standard for physician behavioral health appointments for quarters 1 to 3 in 2023; however, KPSC did meet the DMHC standards. KPSC experienced an overall increase in performance in 2023 compared to 2022 and met the 80% performance threshold in quarter 4 of 2023.
  - KPSC experienced multiple physician openings, retirements, and medical leaves during this lookback period. To close the gap, KPSC worked to add additional clinics by using per diems, assistance from the Virtual Medical Center, and is working closely on recruitment to fill the physician openings.

Non-Physician Follow Up Appointments

- Regionally, KPSC met the follow up access performance standard for non-physician behavioral health appointments for all 4 quarters in 2023, which was consistent with performance in 2022. Therefore, no further analysis was conducted.

Assessment of Network Adequacy (NET 3A & 3C)

NCQA	The organization provides members adequate network access for needed healthcare services:	Analysis of BH availability, accessibility, complaints, and appeals, and the BH	Annual March 2024	Prioritizes improvement opportunities. Implement interventions on at least one opportunity, if applicable.	• Regional Behavioral Health

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	Element A: Assessment of Member Experience Accessing the Network **Factor 2:** Using analysis results related to member experience with network adequacy for behavioral healthcare services from ME 7, Element E **Factor 4:** Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services **Element C:** Opportunities to Improve Access to Behavioral Healthcare Services **Factor 1:** Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A&D), accessibility (NET 2, Element B), and member experience accessing the network (NET 3, Element A, factor 2 and 4). **Factor 2:** Implements interventions on at least one opportunity, if applicable **Factor 3:** Measures the effectiveness of the interventions, if applicable	Member Experience survey to identify opportunities for improvement. Review to identify if opportunities are geographic specific. Grievances and Appeals related to Access to Care and Access Appointments by Area. Physician and non-physician staffing by area.			• Behavioral Health Quality Oversight Committee (BHQOC)

ANALYSIS

Background
KPSC assessed member grievances and appeals, out of network requests, network availability and appointment access data to assess network adequacy and member experience with their care and services.

Methodology and Data Sources
The following data sources were used to assess network adequacy:

- All Access to Care grievances and appeals filed by Commercial (includes Exchange), Medicare, and Medi-Cal members in 2023
  - Obtained from Health Plan Member Services. Data are presented to the SCAL Member Concerns Committee.
- 2023 Behavioral Health Member Experience Survey Results
  - Obtained from SCPMG Performance Assessment. Results are presented to the Behavioral Health Quality Oversight Committee.
- 2023 Behavioral Health Requests for Out of Network Services
  - Obtained from Health Plan Member Services. Data are presented to the SCAL Member Concerns Committee.
- 2023 Behavioral Health Appointment Access data
  - Obtained from SCPMG Regional Access. Results are reported to the SCAL Regional Access Committee.
- 2023 GeoAccess and Enrollee to Provider Ratios
  - Obtained from SCPMG Regional Access and Regional Behavioral Health. Results are reported to the Behavioral Health Quality Oversight Committee.

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Quantitative & Qualitative Analysis:

Commercial Access to Care Grievances

Membership	Category	Volume	% of Total	Rate per 10K
Commercial	Appointments	823	74%	0.64
	Cancellations	242	22%	0.19
	Hours of Operation	7	1%	0.01
	Location	16	1%	0.01
	Network Adequacy	31	3%	0.02
Commercial Total		**1119**	**100%**	**0.87**

Medi-Cal Access to Care Grievances

Membership	Category	Volume	% of Total	Rate per 10K
Medi-Cal	Appointments	244	78%	1.02
	Cancellations	55	18%	0.23
	Hours of Operation	1	0%	0.00
	Location	4	1%	0.02
	Network Adequacy	8	3%	0.03
Medi-Cal Total		**312**	**100%**	**1.30**

Medicare Access to Care Grievances

Membership	Category	Volume	% of Total	Rate per 10K
Medicare	Appointments	238	81%	0.87
	Cancellations	42	14%	0.15
	Location	6	2%	0.02
	Network Adequacy	8	3%	0.03
Medicare Total		**294**	**100%**	**1.07**

Access to Appointments Grievances by Subtype

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

NCQA Category	Grievances by Subtype	Volume	% of Total
Access	Unable to schedule timely appointment	395	29%
	Type of appointment	183	14%
	Unable to schedule routine/ non urgent appointment	163	12%
	Mental Health-Unable to schedule initial appointment	160	12%
	Mental Health-Unable to schedule 10-day follow-up appointment	135	10%
	Unable to schedule timely appointment w/ specialist	114	8%
	Unable to see provider of choice	76	6%
	Turned away - Not seen as requested	41	3%
	Error in scheduling	40	3%
	Expected different provider type	18	1%
	Unable to schedule urgent/ same day appointment	9	1%
	Unable to schedule at requested location	8	1%
	Unable to schedule timely appointment (non PCP/non Specialist)	6	0%
	Unable to schedule second opinion	4	0%
	Unable to establish with PCP / No open practices	1	0%
Grand Total		1353	100%

Appointment Routine/Non-Urgent Grievances by Department

NCQA Category	Grievances by Department	Volume	% of Total
Access	ADDICTION MEDICINE	22	2%
	BEHAVIORAL HEALTH SERVICES	1	0%
	CHEMICAL DEPENDENCY RCVRY PRGM	1	0%
	CHEMICAL DEPENDENCY RECOVERY	2	0%
	CONTRACT MENTAL HEALTH	71	5%
	MENTAL HEALTH	21	2%
	PSYCHIATRY	1235	91%
Grand Total		1353	100%

Appointment Routine/Non-Urgent Grievances by Medical Center

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

NCQA Category	Grievances by Medical Center	Volume	Rate per 10K
Access	ANTELOPE VALLEY MED CTR AREA	23	0.40
	BALDWIN PARK MED CENTER AREA	33	0.27
	DOWNEY MEDICAL CENTER AREA	60	0.37
	KERN COUNTY MED CENTER AREA	19	0.41
	LOS ANGELES MEDICAL CENTER AREA	201	1.39
	ORANGE COUNTY MED CENTER AREA	156	0.64
	PANORAMA MEDICAL CENTER AREA	85	0.78
	RIVERSIDE MEDICAL CENTER AREA	128	0.64
	SAN BERNARDINO COUNTY AREA	144	0.54
	SAN DIEGO MEDICAL CENTER AREA	218	0.84
	SOUTH BAY MEDICAL CENTER AREA	94	0.86
	WEST LA MEDICAL CENTER AREA	47	0.54
	WOODLAND HILLS MED CENTER AREA	135	1.20
Grand Total		**1343**	**0.70**

Appeals by Line of Business

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BH Appeals by NCQA Category

Commercial	2022			2023				
Category	Volume	% of Total	Rate per 10K	Volume	% of Total	Rate per 10K	Threshold Rate per 10K Goal	Met/Not Met
Access	3	1%	0.0	5	1%	0.00	0.002	Not Met
Attitude/Service	0	0%	0.0	0	0%	0.00	0.0	Met
Billing/Financial	262	98%	0.19	331	97%	0.26	0.17	Not Met
Quality of Practitioner Office Site	0	0%	0.0	0	0%	0.00	0.0	Met
Quality of Care	2	1%	0.0	5	1%	0.00	0.0	Not Met
Medicaid	**2022**			**2023**				
Category	Volume	% of Total	Rate per 10K	Volume	% of Total	Rate per 10K	Threshold Rate per 10K Goal	Met/Not Met
Access	13	27%	0.1	13	27%	0.05	0.05	Not Met
Attitude/Service	0	0%	0.0	0	0%	0.00	0.00	Met
Billing/Financial	30	61%	0.1	31	65%	0.13	0.12	Not Met
Quality of Practitioner Office Site	0	0%	0.0	0	0%	0.00	0.00	Met
Quality of Care	6	12%	0.0	4	8%	0.02	0.02	Met
Medicare	**2022**			**2023**				
Category	Volume	% of Total	Rate per 10K	Volume	% of Total	Rate per 10K	Threshold Rate per 10K Goal	Met/Not Met
Access	2	0%	0.0	1	0%	0.00	0.01	Met
Attitude/Service	1	0%	0.0	0	0%	0.00	0.00	Met
Billing/Financial	8	1%	0.0	10	1%	0.04	0.03	Not Met
Quality of Practitioner Office Site	0	0%	0.0	0	0%	0.00	0.00	Met
Quality of Care	2	0%	0.0	0	0%	0.00	0.01	Met

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Access to Care Grievances and Appeals

- Access to Care was the third NCQA issue category for Commercial (includes Exchange), Medicare, and Medi-Cal grievances, following Attitude/Service and Quality of Care.
- Access to Care was the second NCQA issue category for Commercial (includes Exchange), Medicare, and Medi-Cal appeals following Billing/Financial.
- Within the Access to Care category, Appointments was the top issue type for Commercial (includes Covered CA), Medi-Cal and Medicare members.
- Further analysis of behavioral health grievances revealed Unable to Schedule Timely Appointment as the top issue subtype, accounting for 29% of the total (395).
- Drilldown analysis for Appointments grievances revealed Psychiatry as the top department accounting for 91% of the volume (1,235).
- Further analysis of Appointments grievances revealed Los Angeles and Woodland Hills Areas as the geographic areas with the top 2 rates per 10K members (1.39 and 1.20 respectively).

Behavioral Health Member Experience Survey: 2022 vs. 2023

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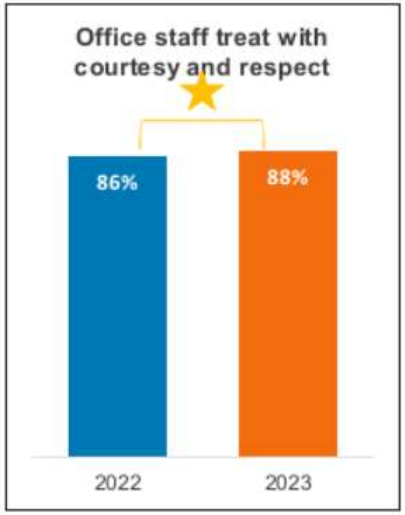
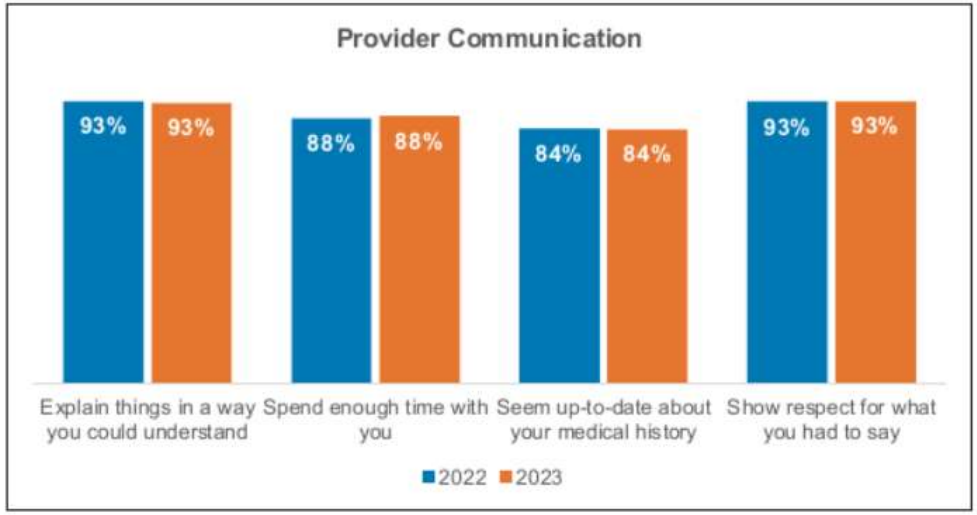
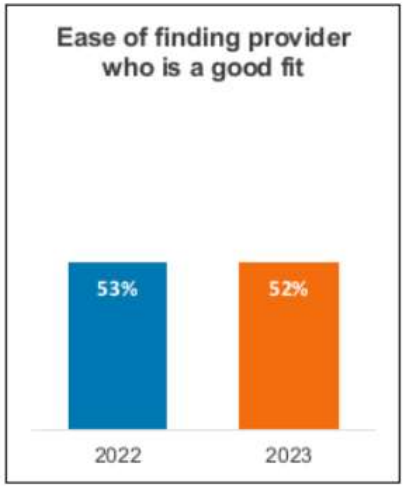
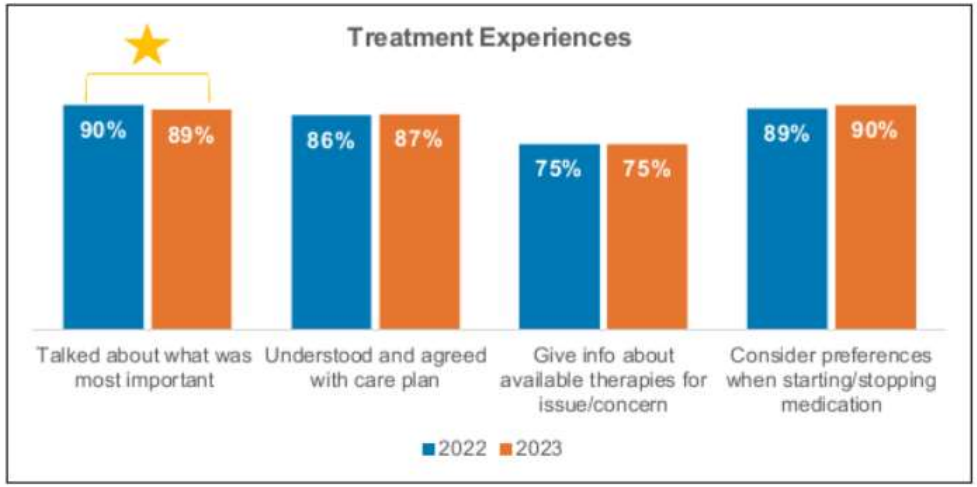
2022 vs 2023

★ = Significant differences between subgroup categories









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2022 vs 2023 (continued)

★ = Significant differences between subgroup categories

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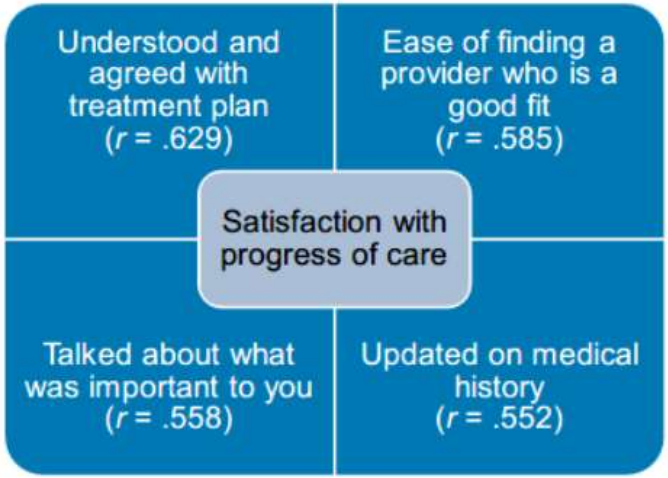
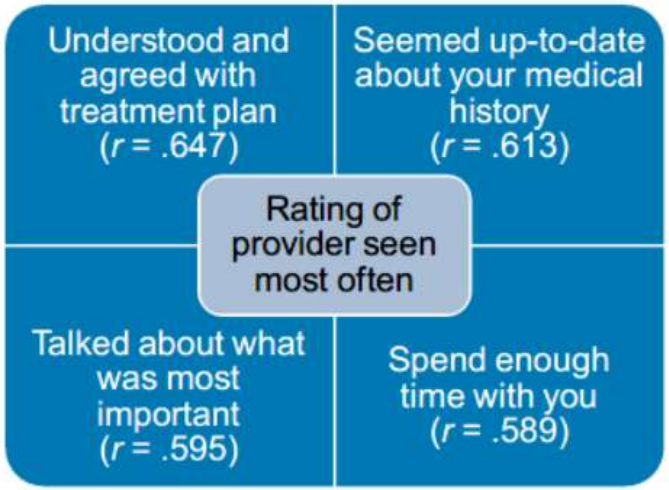
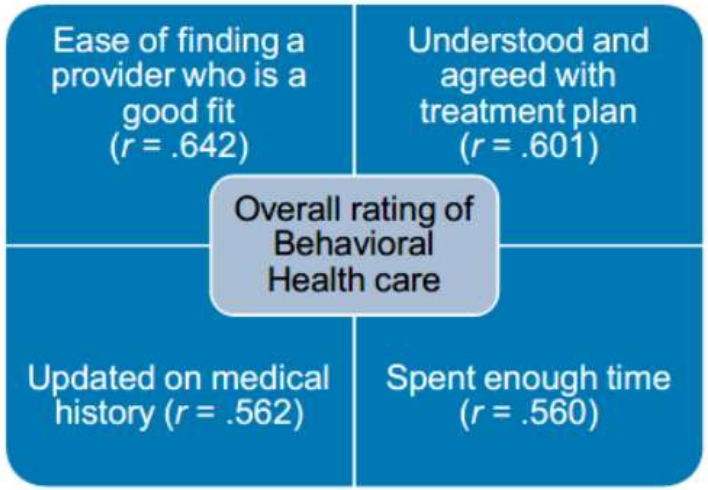
Behavioral Health Member Experience Survey: 2023 Key Drivers

Key Drivers



Strength of correlations among the key drivers of Satisfaction with progress of care, Rating of provider seen most often, and Overall rating of behavioral health care were moderate





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Behavioral Health Member Experience Survey Results

- Key drivers for overall rating items (Satisfaction with Progress of Care, Rating of Provider Seen Most Often, Overall Rating of Behavioral Health Care) included the following:
  - Ease of finding a provider who is a good fit
  - Understood/agreed with treatment plan
  - Seemed up-to-date about your medical history
  - Spend enough time with you
  - Talked about what was most important
- Understood/agreed with treatment plan had an incline from 2022 to 2023. Seemed up-to-date about your medical history and Spend enough time with you remained the same. Ease of finding a provider who is a good fit and Talked about what was most important had a decline. Most items trended towards stability or improvement from 2022 to 2023.

Behavioral Health Out of Network Requests

BH Out of Network Requests	2022		2023		Goal Met/Not Met
	Volume	Rate per 1K	Volume	Rate per 1K	
Commercial	796	0.062	785	0.061	Met
Marketplace	23	0.023	54	0.055	Not met
Medi-Cal	168	0.070	197	0.082	Not met
Medicare	97	0.035	98	0.036	Not met

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Behavioral Health Out of Network Requests by Resolution

2023 Out of Network Requests by Resolution

		Commercial			Covered CA			Medi-Cal			Medicare		
Level Category	Resolution	Volume	% of Total	Rate per 1K	Volume	% of Total	Rate per 1K	Volume	% of Total	Rate per 1K	Volume	% of Total	Rate per 1K
Grievance	Approved	323	42%	0.025	23	43%	0.023	54	30%	0.023	37	42%	0.013
	Denied	433	56%	0.034	29	54%	0.029	119	66%	0.050	48	55%	0.018
	Deny Request to Expedite	8	1%	0.001	1	2%	0.001	6	3%	0.003	2	2%	0.001
	Dismiss	0	0%	0.000	0	0%	0%	0	0%	0.000	0	0%	0.000
	Partial	7	1%	0.001	1	2%	0%	0	0%	0.000	1	1%	0.000
	Withdrawn	0	0%	0.000	0	0%	0.000	0	0%	0.000	0	0%	0.000
	Total	771	100%	0.060	54	100%	0.055	179	100%	0.075	88	100%	0.032
Appeal	Approved	0	0%	0.000	0	0%	0.000	0	0%	0.000	2	25%	0.001
	Deny Request to Expedite	0	0%	0.000	0	0%	0.000	0	0%	0.000	0	0%	0.000
	Denied	8	100%	0.001	0	0%	0.000	15	100%	0.006	6	75%	0.002
	Withdrawn	0	0%	0.000	0	0%	0.000	0	0%	0.000	0	0%	0.000
	Dismiss	0	0%	0.000	0	0%	0.000	0	0%	0.000	0	0%	0.000
	Total	8	100%	0.001	0	0%	0.000	15	100%	0.006	8	100%	0.003
Outside Medical Review	Denial Overturned	0	0%	0.000	0	0%	0.000	0	0%	0.000	0	0%	0.000
	Denial Partially Overturned	0	0%	0.000	0	0%	0.000	0	0%	0.000	0	0%	0.000
	Denied	0	0%	0.000	0	0%	0.000	0	0%	0.000	2	100%	0.001
	Partial Approval	0	0%	0.000	0	0%	0.000	0	0%	0.000	0	0%	0.000
	Total	0	0%	0.000	0	0%	0.000	0	0%	0.000	2	100%	0.001
Others	Approved	1	17%	0.000	0	0%	0.000	2	67%	0.001	0	0%	0.000
	Denied	5	83%	0.000	0	0%	0.000	1	33%	0.000	0	0%	0.000
	Total	6	100%	0.000	0	0%	0.000	3	100%	0.001	0	0%	0.000
Total		785	100%	0.061	54	100%	0.055	197	100%	0.082	98	100%	0.036

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Behavioral Health Out of Network Requests by Resolution

Covered CA	Volume	1K Rate
Request Subtype	**2023**	**2023**
Mental Health- Outpatient Services	29	0.03
Behavior Health Therapy	15	0.02

Commercial	Volume	1K Rate
Request Subtype	**2023**	**2023**
Mental Health- Outpatient Services	313	0.02
Behavior Health Therapy	233	0.02
Applied Behavior Analysis	99	0.01

Medi-Cal	Volume	1K Rate
Request Subtype	**2023**	**2023**
Applied Behavior Analysis	68	0.03
Mental Health- Outpatient Services	32	0.01
Behavior Health Therapy	48	0.02

Medicare	Volume	1K Rate
Request Subtype	**2023**	**2023**
Mental Health- Outpatient Services	48	0.02
Behavior Health Therapy	32	0.01
Mental Health-Residential Care	3	0.00

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Behavioral Health Out of Network Requests by Area

Out of Network Requests by Area	Volume	2023 Membership	Rate per 1K
ANTELOPE VALLEY MED CTR AREA	23	143,557	0.04
BALDWIN PARK MED CENTER AREA	33	303,951	0.03
DOWNEY MEDICAL CENTER AREA	60	408,428	0.04
KERN COUNTY MED CENTER AREA	19	115,206	0.04
LOS ANGELES MEDICAL CENTER AREA	201	361,939	0.14
ORANGE COUNTY MED CENTER AREA	156	610,581	0.06
PANORAMA MEDICAL CENTER AREA	85	272,225	0.08
RIVERSIDE MEDICAL CENTER AREA	128	502,482	0.06
SAN BERNARDINO COUNTY AREA	144	663,476	0.05
SAN DIEGO MEDICAL CENTER AREA	218	645,832	0.08
SOUTH BAY MEDICAL CENTER AREA	94	272,208	0.09
WEST LA MEDICAL CENTER AREA	47	218,900	0.05
WOODLAND HILLS MED CENTER AREA	135	281,588	0.12

Out of Network Requests

- In 2023, 785 Commercial out of network requests were sent for review at a rate of .061 per 1K members, 54 Marketplace out of network requests were sent for review at a rate of .055 per 1K members, 197 Medi-Cal out of network requests were sent for review at a rate of 0.082 per 1K members, and 98 Medicare out of network requests were sent for review at a rate of 0.036 per 1K members.
- The established goal for 2023 reporting period was to maintain or decrease the 2022 rate per 1K for each line of business. The goal was not met for Marketplace, Medicare, and Medi-Cal lines of business.
- The volume of requests for out of network services was very low relative to the Commercial, Marketplace, Medi-Cal, and Medicare membership counts. KPSC does not maintain different networks based on product line.
- In reviewing the Commercial out-of-network requests, 771 were submitted as a Grievance, 8 as an Appeal, 0 for outside medical review and 6 as Others. 42% (323) of the requests submitted as a grievance were approved and 56% (433) were denied.
- For Marketplace (Covered CA/Exchange), 43% (23) of the requests submitted as a grievance were approved and 54% (29) were denied. Medi-Cal, 30% (54) of the requests submitted as a grievance were approved and 66% (119) were denied. Medicare, 42% (37) of the requests submitted as a grievance were approved and 55% (48) were denied.
- In reviewing out-of-network requests by Sub-type, the number one sub-type for Commercial, Marketplace (Covered CA/Exchange) and Medicare was Mental Health-Outpatient Services. The number one sub-type for Medi-Cal was, Applied Behavior Analysis.
- In reviewing out-of-network requests by Area, Los Angeles had the highest rate per 1K members.

Opportunities to Improve Access to Behavioral Healthcare Services

Top areas of behavioral health network adequacy opportunities were gleaned from KPSC's review of Commercial, Marketplace (Covered CA/Exchange), Medi-Cal and Medicare grievances and appeals, the Behavioral Health Member Experience Survey, requests for out of network services, accessibility data, and availability data. From a review of the various data sources, the areas of opportunity, prioritized based on member need and risk to access:

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1. **Grievances**
   - Appointments - Appointment-Routine/Non-Urgent grievances in Psychiatry
   - Appointments - Appointment-Routine/Non-Urgent grievances in the Los Angeles and Woodland Hills Medical Center areas
2. **Accessibility**
   - Physician Non-Urgent (Consult) appointments and Physician Follow-Up appointments
3. **Out of Network Requests**
   - Out of Network Requests for Mental Health-Outpatient Services
   - Out of Network Requests in Los Angeles
4. **BH Member Experience Survey**
   - Ease of finding a provider who is a good fit
   - Understood/agreed with treatment plan
   - Seemed up-to-date about your medical history
   - Spend enough time with you
   - Talked about what was most important

Planned Interventions
Based on the areas of opportunity identified, KPSC has implemented the following interventions

- Ease of finding a provider who is a good fit:
  - Southern California has embraced the Mental Health Scholars Academy (MHSA) and developed a Behavioral Health Training Institute (BHTI). The MHSA and BHTI aim to increase diversity in the professional mental health workforce to address gaps in linguistic, ethnic, and minority representation.
  - Since 2022, students in MHSA pipeline:
    - BHTI inaugural practicum cohort had 10 MHSA students who started in January 2022
    - 32 BHTI graduates
    - 8 BHTI graduates hired into KP Associate positions in PSY and ADM; the remainder are pending Associate registration
    - 89 are regionally supervised Associates across ADM, PSY, SM and Dyadic work
    - 60 Trainees since inception
    - MHSA trainees contributed to improving access by completing a total of 7,410 appointments across 12 services areas in BH since inception

- Understood/agreed with treatment plan/Talked about what was most important:
  - Continuing to focus on the fidelity of the Feedback Informed Care model and retraining for FIC therapists on collaborative goal setting with patients focused on specific functional improvements and FIC provider care review redesign is aimed at re-aligning the treatment plan (and needed changes in the treatment plan) with the patient's goals and reason for seeking care.

- Seemed up-to-date about medical history:
  - The ADAPT program operates on a collaborative care model and includes a team of professionals such as therapists, pharmacists, a consulting psychiatrist, and population management support coordinators as support staff. Patients with anxiety and/or depression can receive focused problem-solving therapy from licensed therapists or supervised associates. Additionally, patients have the option to meet with pharmacists who can prescribe medications if necessary. This collaborative team approach allows providers to be up to date with patients' medical history.

- Spend enough time with you:
  - We continue to create and reinforce clinical and operational resources for supporting FIC regional implementation:
    - Expanded Resources: Introduced updated clinical care review model, updated and trained on collaborative goal setting, standard FIC training for all new students/trainees and Associate therapists
    - Continued Cultural Humility trainings which aligns with FIC efforts that focus on the therapeutic alliance

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- Continued training and content-building through monthly FIC Therapists, Managers, Psychiatrist Champions meeting

Prior Interventions:

- The launch of the ADAPT program is making it possible for patients to see a KP provider in structured, weekly appointments.

1. ADAPT is a virtual based, collaborative care, mental health treatment program that serves patients with anxiety and/or depression as well as related diagnosis. The program was originally developed at the AIM's Center at the University of Washington and uses evidence based/empirically validated therapeutic modalities and measures to target treatment on the reduction of unwanted symptoms.

2. The ADAPT program serves patients who can benefit from Problem Solving Therapy as well as Cognitive Behavioral Therapy and Behavioral Activation. Patients who agree to treatment are directly booked into our therapist schedules by the Psychiatry call center. ADAPT treats patients who experience mild to moderate anxiety and depressive symptoms, which is determined by the Depression Index (PHQ9) and the Generalized Anxiety Disorder Scale (GAD7).

3. At the onset of treatment, in a 60-minute Intake, the treating provider takes a full assessment of the patients' history to gain a full picture of the patients' needs and to create a direction for treatment. During the initial stages of therapy patients are educated about the treatment modality used in session to ensure that patients feel knowledgeable and confident in the program.

4. Patients are seen, by the treating therapist, in "rounds" of therapy dependent on the acuity of their symptoms. First patients are seen weekly on 30-minute sessions until the therapist and the patient see a 50% reduction in the patients' symptoms as demonstrated by patient self-report and the measures mentioned above. The goal of the ADAPT program is that patients are seen quickly, often and are treated to remission.

Effectiveness of Prior Intervention(s)

The ADAPT program has rolled out across the entire Southern California region. Los Angeles Medical Centers have gone live as of June 12, 2023, within a year. ADAPT continues to streamline the patient experience by booking directly from the call center. ADAPT has seen over 30,000 patients with over 70,000 visits.

To fully support the roll out this new program, ADAPT has provided over 115 trainings across the Southern California market and has onboarded 200 staff. Patients have seen a 55% reduction in their anxiety symptoms and a 55% reduction in their depressive symptoms after an average of 14 sessions.

Conclusion

Throughout 2024, we will continue to optimize the most efficient and evidenced based practices to support our members in Psychiatry and Addiction Medicine. The above measures are some of the practices KPSC have been utilizing to improve upon our interventions in elevating our Behavioral Healthcare.

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Member Experience (ME 7E & 7F)					
NCQA	**Element E:** Using valid methodology, the organization annually: **Factor 1:** Evaluates behavioral healthcare member complaints and appeals for each of the five required categories: • quality of care • access • attitude and service • billing and financial issues • quality of practitioner office sites **Factor 2:** Conducts a member experience survey *Analysis must be conducted separately for each product line*	Analysis of Behavioral Health grievances and appeals Survey of patient experiences including some who have accessed BH services both internally and externally	Quarterly Review March 2024	If not meeting goal, provide analysis and target systemic issues; develop appropriate interventions and action plans.	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	**Element F:** The organization works to improve members' experience with behavioral healthcare and service by annually: **Factor 1:** Assessing data from complaints and appeals or from member experience surveys **Factor 2:** Identifying opportunities for improvement **Factor 3:** Implementing interventions, if applicable **Factor 4:** Measuring effectiveness of interventions if applicable *Analysis must be conducted separately for each product line*	Identification of opportunities Documentation of interventions Measure progress over time	Annual March 2024	If not meeting goal, provide analysis and target systemic issues; develop appropriate interventions and action plans.	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)

ANALYSIS

Behavioral Health Grievances and Appeals

In 2023, Kaiser Permanente Southern California (KPSC) evaluated member complaints/grievances in relationship to membership in the represented product lines. Our methodology looks at the performance related to Complaints, Grievances and Appeals data for all members. Data is stratified for comparative quantitative analysis in the following five categories:

- Quality of Care
- Access
- Attitude & Service
- Billing & Financial Issues

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- Quality of Practitioner Office Site

Background

- Behavioral Health grievances and appeals are analyzed by Health Plan Member Services. Data is presented to the SCAL Regional Access Committee and the SCAL Member Concerns Committee.
- Grievances are defined as any expression of dissatisfaction from a member or advocate concerning any aspect of KPs operations, activities, behavior, or services, regardless of whether remedial action is requested. This includes a request for reimbursement or waiver of payment due to perceived dissatisfaction or failure in care delivery. In this analysis, complaints and grievances have been combined. Appeals are defined as a request to change an adverse decision made by the organization.
- The goals for 2023 were determined by the volume of grievances/appeals 10% less than the previous year per 10K members.

Quantitative & Qualitative Analysis:

Membership by Line of Business

Membership	2022	2023
Commercial	3,491,543	3,217,938
Medi-Cal	547,819	598,659
Medicare	662,117	685,698

(Commercial includes Covered CA)

Overall Grievances by Line of Business

(Comparative quantitative analysis 2022 vs. 2023)

	2022			2023			
Membership	Total Issues	Average Membership	Rate per 10K	Total Issues	Average Membership	Rate per 10K	% Change
Commercial	6,056	3,491,543	4.3	5,423	3,217,938	4.2	-3%
Medi-Cal	1,537	547,819	7.0	1,482	598,659	6.2	-12%
Medicare	1,301	662,117	4.9	1,284	685,698	4.7	-5%

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Grievances by Line of Business

BH Grievances by NCQA Category								
Commercial	**2022**			**2023**				
Category	**Volume**	**% of Total**	**Rate per 10K**	**Volume**	**% of Total**	**Rate per 10K**	**Threshold Rate per 10K Goal**	**Met/Not Met**
Access	1,539	25%	1.1	1,191	22%	0.9	1.0	Met
Attitude/Service	2,445	40%	1.8	2,146	40%	1.7	1.6	Not Met
Billing/Financial	157	3%	0.1	139	3%	0.1	0.1	Not Met
Quality of Practitioner Office Site	9	0%	0.0	7	0%	0.0	0.0	Met
Quality of Care	1,906	31%	1.4	1,940	36%	1.5	1.2	Not Met
Medicaid	**2022**			**2023**				
Category	**Volume**	**% of Total**	**Rate per 10K**	**Volume**	**% of Total**	**Rate per 10K**	**Threshold Rate per 10K Goal**	**Met/Not Met**
Access	338	22%	1.5	312	21%	1.3	1.4	Met
Attitude/Service	622	40%	2.8	590	40%	2.5	2.6	Met
Billing/Financial	30	2%	0.1	25	2%	0.1	0.12	Met
Quality of Practitioner Office Site	3	0%	0.0	5	0%	0.0	0.0	Not Met
Quality of Care	544	35%	2.5	550	37%	2.3	2.2	Not Met
Medicare	**2022**			**2023**				
Category	**Volume**	**% of Total**	**Rate per 10K**	**Volume**	**% of Total**	**Rate per 10K**	**Threshold Rate per 10K Goal**	**Met/Not Met**
Access	324	25%	1.2	294	23%	1.1	1.1	Met
Attitude/Service	569	44%	2.1	544	42%	2.0	1.9	Not Met
Billing/Financial	21	2%	0.1	12	1%	0.0	0.1	Met
Quality of Practitioner Office Site	11	1%	0.0	7	1%	0.0	0.0	Met
Quality of Care	376	29%	1.4	427	33%	1.6	1.3	Not Met

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Appeals by Line of Business

BH Appeals by NCQA Category								
Commercial	**2022**			**2023**				
Category	**Volume**	**% of Total**	**Rate per 10K**	**Volume**	**% of Total**	**Rate per 10K**	**Threshold Rate per 10K Goal**	**Met/Not Met**
Access	3	1%	0.0	5	1%	0.00	0.002	Not Met
Attitude/Service	0	0%	0.0	0	0%	0.00	0.0	Met
Billing/Financial	262	98%	0.19	331	97%	0.26	0.17	Not Met
Quality of Practitioner Office Site	0	0%	0.0	0	0%	0.00	0.0	Met
Quality of Care	2	1%	0.0	5	1%	0.00	0.0	Not Met
Medicaid	**2022**			**2023**				
Category	**Volume**	**% of Total**	**Rate per 10K**	**Volume**	**% of Total**	**Rate per 10K**	**Threshold Rate per 10K Goal**	**Met/Not Met**
Access	13	27%	0.1	13	27%	0.05	0.05	Not Met
Attitude/Service	0	0%	0.0	0	0%	0.00	0.00	Met
Billing/Financial	30	61%	0.1	31	65%	0.13	0.12	Not Met
Quality of Practitioner Office Site	0	0%	0.0	0	0%	0.00	0.00	Met
Quality of Care	6	12%	0.0	4	8%	0.02	0.02	Met
Medicare	**2022**			**2023**				
Category	**Volume**	**% of Total**	**Rate per 10K**	**Volume**	**% of Total**	**Rate per 10K**	**Threshold Rate per 10K Goal**	**Met/Not Met**
Access	2	0%	0.0	1	0%	0.00	0.01	Met
Attitude/Service	1	0%	0.0	0	0%	0.00	0.00	Met
Billing/Financial	8	1%	0.0	10	1%	0.04	0.03	Not Met
Quality of Practitioner Office Site	0	0%	0.0	0	0%	0.00	0.00	Met
Quality of Care	2	0%	0.0	0	0%	0.00	0.01	Met

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Overview of Grievances and Appeals

- With respect to analyzing 2023 Behavioral Health grievances by line of business, the rates per 10K decreased for the Commercial (includes Exchange) members by 0.1, decreased for the Medicare members by 0.2, and decreased for the Medi-Cal members by 0.8.
- Additionally, in reviewing 2023 Behavioral Health appeals by line of business, the volume of appeals increased from 2022 to 2023. There were 329 appeals in 2022 compared to 400 in 2023, however, the rate per 10K volume averages were no more than 0.1.

Commercial (includes Exchange) Grievances and Appeals

- During this reporting cycle, the Commercial grievance rate per 10K members was 4.2 compared to 4.3 in 2022.
- Results reveal a per 10K member appeals rate of 0.05 in 2023 and with a raw volume of 341.
- In analyzing behavioral health grievances for Commercial members by NCQA category, Attitude/Service represented the highest rate per 10K, followed by Quality of Care.
- The grievance threshold was met for Access and Quality of Practitioner Office Site, and the Appeals threshold was met for Attitude/Service and Quality of Care.

Medicare Grievances and Appeals

- During this reporting cycle, the Medicare grievance rate was 4.7 compared to 4.9 in 2022.
- Results reveal a per 10K member appeals rate of 0.01 in 2023 with a raw volume of 11.
- In analyzing behavioral health grievances for Medicare members by NCQA category, Attitude/Service represented the highest rate per 10K, followed by Quality of Care.
- The grievance threshold was not met for Access, Billing/Financial, and Quality of Practitioner Office Site, and the Appeals threshold was met for Access, Attitude/Service, Quality of Practioner Office Site, and Quality of Care.

Medi-Cal Grievances and Appeals

- During this reporting cycle, the Medi-Cal grievance rate was 6.2 compared to 7.0 in 2022.
- Results reveal a per 10K member appeals rate of 0.04 in 2022 with a raw volume of 48.
- In analyzing behavioral health grievances for Medi-Cal members by NCQA category, Attitude/Service represented the highest rate per 10K, followed by Quality of Care.
- The grievance threshold was met for Access, Attitude/Service, and Billing/Financial, and the Appeals threshold was met for Attitude/Service, Quality of Practioner Office Site, and Quality of Care.

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Access to Care Grievances by Subtype

Commercial			
Complaint	4 Quarter Totals	2023	
ACCESS AND AVAILABILITY	Volume	% of total	Rate per 10K
Appointment cancellation	259	21.7%	0.80
Unable to schedule timely appointment	228	19.1%	0.71

Medi-Cal			
Complaint	4 Quarter Totals	2023	
ACCESS AND AVAILABILITY	Volume	% of total	Rate per 10K
Appointment cancellation	55	17.6%	0.92
Unable to schedule timely appointment	45	14.4%	0.75

Medicare			
Complaint	4 Quarter Totals	2023	
ACCESS AND AVAILABILITY	Volume	% of total	Rate per 10K
Appointment cancellation	42	16.7%	0.61
Unable to schedule timely appointment	122	48.4%	1.78

Grievances Analysis by Subtype

The highest rate of grievances was related to:

- **Attitude and Service was the number 1 issue subtype for Commercial, Medicare and Medi-Cal members.**
  - Commercial - Primary driver of Attitude & Service grievances are related to behavior.
  - Medi-Cal members - Primary driver of Attitude & Service grievances are related to behavior.
  - Medicare – Primary driver of Attitude & Service grievances are related to delay/failure in contacting.
- **Quality of Care was the secondary issue subtype for Commercial, Medicare and Medi-Cal members.**
  - Commercial- Primary driver of Quality of Care grievances are related to diagnosis treatment or care.
  - Medi-Cal members- Primary driver of Quality of Care grievances are related to diagnosis treatment or care.
  - Medicare- Primary driver of Quality of Care grievances are related to diagnosis treatment or care.

Opportunities

- Analysis of 2023 member grievances and appeals indicated that the majority were attributed to two specific categories: 1. Attitude and Service and 2. Quality of Care.

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- A drilldown analysis of Attitude and Service grievances determined that the primary drivers stemmed from issues with Behavior. (Commercial: 0.03 increase from 2022, Medicare: 0.01 increase from 2022) and Delay/Failure in Contacting.
- In depth analysis of Quality of Care grievances indicates the primary driver stemmed from diagnosis treatment or care.

Planned Interventions

- Members at KPSC receive care through an integrated model. KPSC does not differentiate care or services based on the line of business at the point of service. Therefore, opportunities for improvement and interventions impact members across all product lines.

1. Attitude and Service – Behavior and Delay/Failure in Contacting:
   - We are currently monitoring and evaluating areas of derivation within the Member Services staff, providing recommendations, and refreshing guidelines for practice support work, to improve turnaround times and message efficiency. Our planned strategy will place emphasis on observation and recognition to encourage teams as well as offer guidance. Additionally, we added back office staff, and completed our specialty care efficiency guide to optimizing workflows for quicker follow up for patients.

2. Quality of Care - diagnosis treatment or care:
   - In 2023, we have initiated to also have all Case Managers who make "higher levels of care" decisions/referrals, in particular those who make referrals to residential treatment centers to be trained in Level of Care Utilization System (LOCUS) and Child/Adolescent Level of Care Utilization System (CALOCUS).

Prior Interventions

1. Attitude and Service – Delay/Failure in Contacting:
   - In 2022, we were met with some communication challenges that we identified that led to delays in patient response time. In 2023, we plan to monitor and evaluate areas of derivation within the Member Services staff, provide recommendations, and refresh guidelines for practice support work, to improve turnaround times and message efficiency. Our planned strategy will place emphasis on observation and recognition to encourage teams as well as offer guidance. Additionally, we added back office staff, and completed our specialty care efficiency guide to optimizing workflows for quicker follow up for patients.

2. Quality of Care- diagnosis treatment or care:
   - In, 2022 we ramped up our requirements for training of managers and providers in the use of ***Level of Care Utilization System (LOCUS***) and ***Child/Adolescent Level of Care Utilization System (CALOCUS)*** and ensuring that we focused on "new hires" getting trained within the appropriate criteria tools shortly upon hiring. Other criteria trainings provided are American society of Addiction Medicine (ASAM), Early Childhood Service Intensity Instrument (ECSII), National Autism Spectrum Disorder (NAC II) and Transgender: World Professional Association for Transgender (WPATH), where we have worked to provide resources and training applicable to clinical management and designees in our medical centers.
   - In 2023, we have initiated to also have all *Case Managers* who make "higher levels of care" decisions/referrals, particularly those who make referrals to residential treatment centers to be trained as well.

Measuring Effectiveness

In 2023, KPSC continued close monitoring of grievances and appeals focusing on Attitude and Service as the primary root cause of patient dissatisfaction. The strategy included staff observations with direct feedback, training tools, weekly coaching sessions with both front office staff and therapists, as well as weekly meetings for accountability.

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1. Coaching and development: In 2023, we were able to identify areas of improvement and quickly focus on how to mitigate those opportunities moving forward. We continued to utilize training tools such as, AIDET (Acknowledge, Introduce, Duration, Explanation and Thank You and offering internal bolstering of skills through service line communication, direct management feedback and KP learn systems.

2. Level of Care Utilization System (LOCUS) and Child/Adolescent Level of Care Utilization System (CALOCUS trainings for clinical management. By the end of 2023, majority of the staff were trained across the various criteria tools with the majority trained in LOCUS, CALOCUS-CASII and American society of Addiction Medicine (ASAM), respectively. In 2024, the focus will remain on delegated case managers and on-boarding new hires.

Due to the focus on patient grievances over the past year, including meetings with local area leaders, Behavioral Health rate per 1K encounter decreased by 21.2% YOY (4.7 to 3.6). KPSC experienced a decrease to the volume of Attitude and Service grievances by approximately 10% compared to 2023. We will continue to bring awareness and training to our staff and education around providing exemplary treatment and care for our members, who matter the most.

Behavioral Health Member Experience Survey

Brief Summary/Background:
The BH Member Experience Survey was designed to capture information about experiences that are important to service delivery, such as patient engagement with their treatment plan, appointment access, telehealth experiences, and other topics. To meet regulatory/accreditation requirements, results were analyzed by product line (NCQA) and provider type (DMHC).

The analysis of the 2023 Behavioral Health Services Survey suggests that patients have good experiences with their providers and office staff, their behavioral health treatment, and that their needs were met during a time when behavioral health service delivery settled into the shift to mostly virtual appointment modes and more Kaiser Permanente members received care from external providers. However, some subgroups showed significant differences in scores.

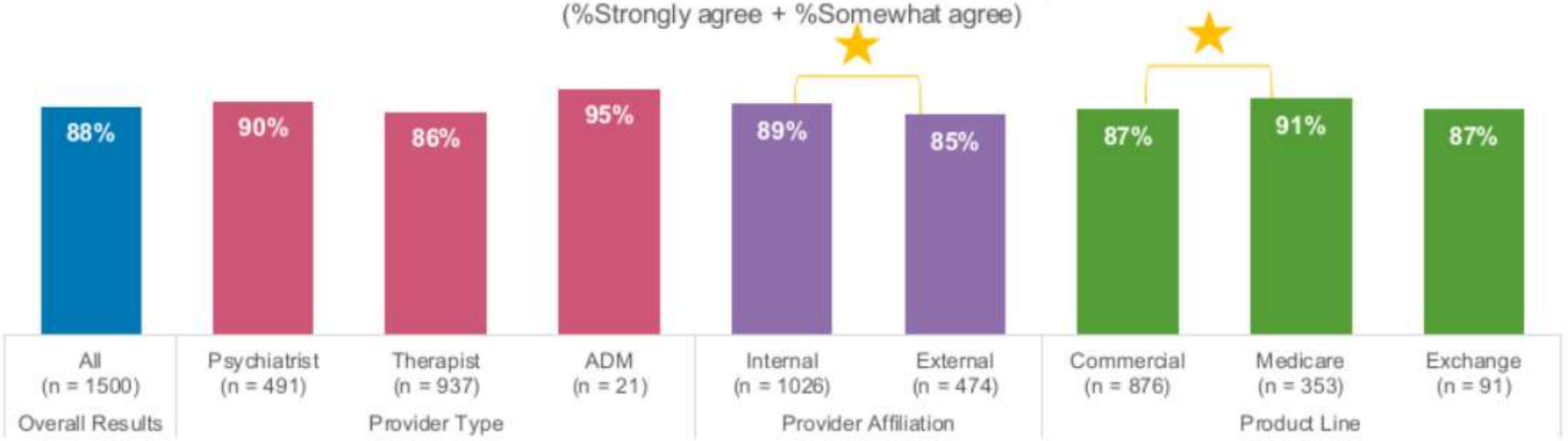
Additionally, most items trended towards stability or improvement from 2022 to 2023.

Sampling and Methodology
The online survey was sent via email to KP members who received mental health services. Members were eligible if they were from the SCAL region and had been seen in the psychiatry department between September 2022 and August 2023. Respondents were removed if they indicated that they were not KP members or that they had not had any mental health-related discussions with a provider. The valid sample for this analysis is 2,534, and the resulting response rate is 5%. The 2023 administration will allow for year-to-year comparisons with 2022 data. The 5% response rate is a result of all completed surveys out of all eligible members invited to take the survey. Due to confidentiality concerns, patients seen in Addiction Medicine departments were not targeted for sampling. However, results include a breakdown of patients who were captured as having received care for mental health conditions but identified that an Addiction Medicine (ADM) doctor or therapist was the provider that they saw most often.

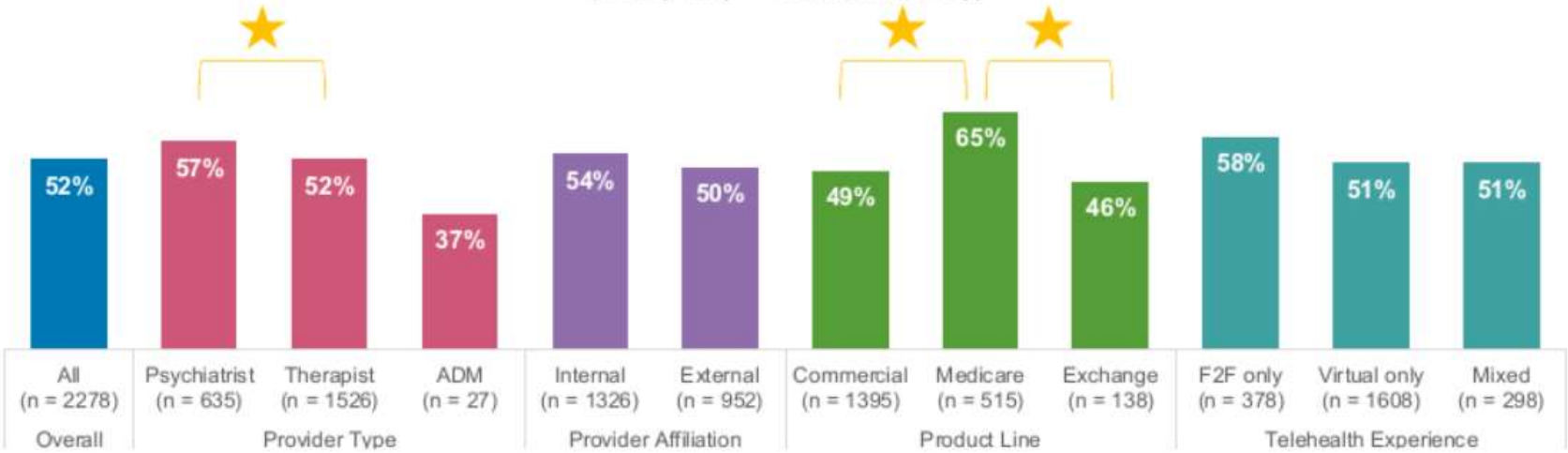
Office Staff & Ease of Finding Provider

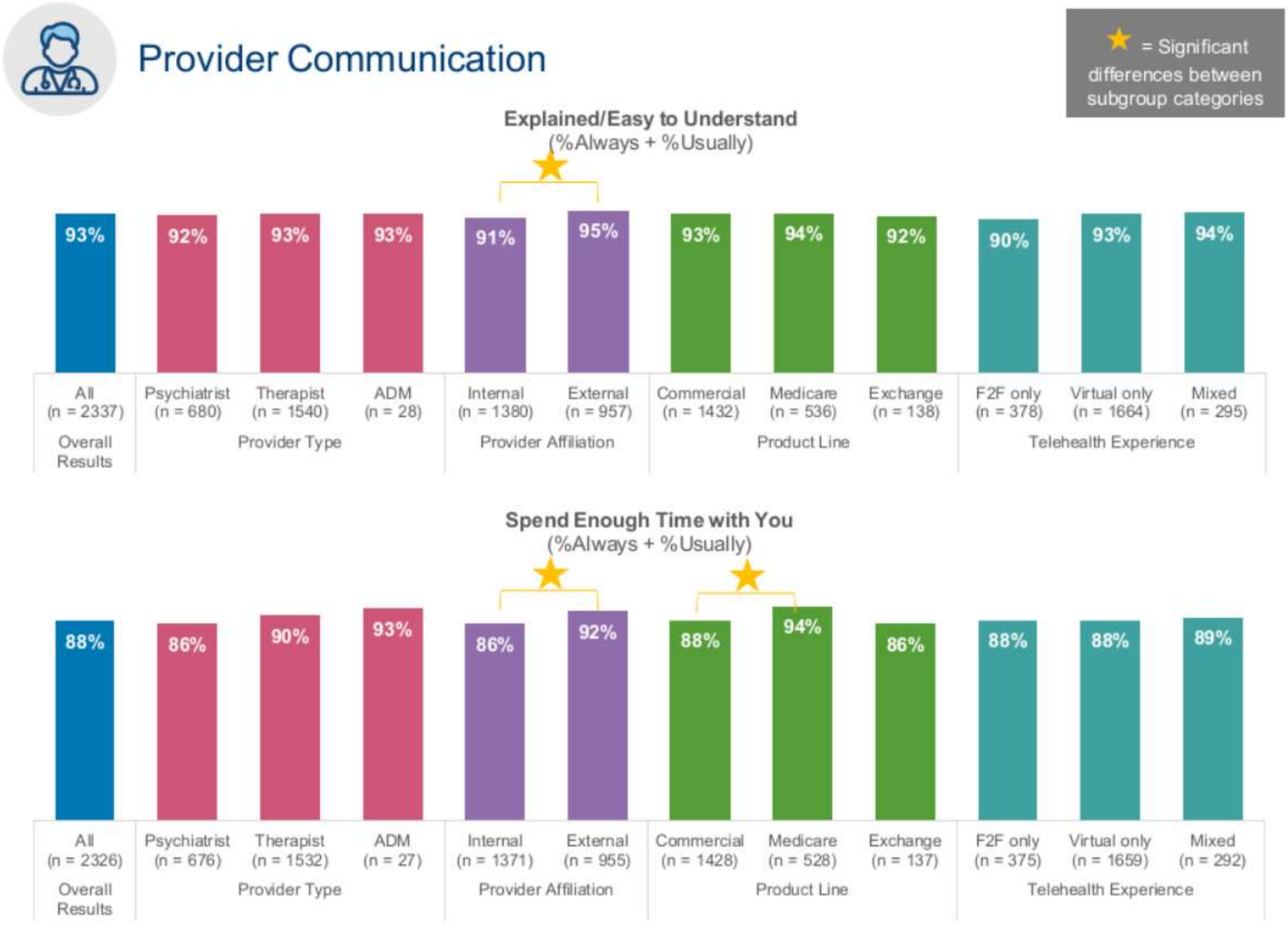
★ = Significant differences between subgroup categories

Office staff treated me with courtesy and respect
(%Strongly agree + %Somewhat agree)



Ease of Finding a Provider Who Is a Good Fit
(%Very easy + %Somewhat easy)




Provider Communication
★ = Significant differences between subgroup categories
Explained/Easy to Understand
(%Always + %Usually)
93%
92%
93%
93%
91%
95%
93%
94%
92%
90%
93%
94%
All (n = 2337)
Psychiatrist (n = 680)
Therapist (n = 1540)
ADM (n = 28)
Internal (n = 1380)
External (n = 957)
Commercial (n = 1432)
Medicare (n = 536)
Exchange (n = 138)
F2F only (n = 378)
Virtual only (n = 1664)
Mixed (n = 295)
Overall Results
Provider Type
Provider Affiliation
Product Line
Telehealth Experience
Spend Enough Time with You
(%Always + %Usually)
88%
86%
90%
93%
86%
92%
88%
94%
86%
88%
88%
89%
All (n = 2326)
Psychiatrist (n = 676)
Therapist (n = 1532)
ADM (n = 27)
Internal (n = 1371)
External (n = 955)
Commercial (n = 1428)
Medicare (n = 528)
Exchange (n = 137)
F2F only (n = 375)
Virtual only (n = 1659)
Mixed (n = 292)
Overall Results
Provider Type
Provider Affiliation
Product Line
Telehealth Experience

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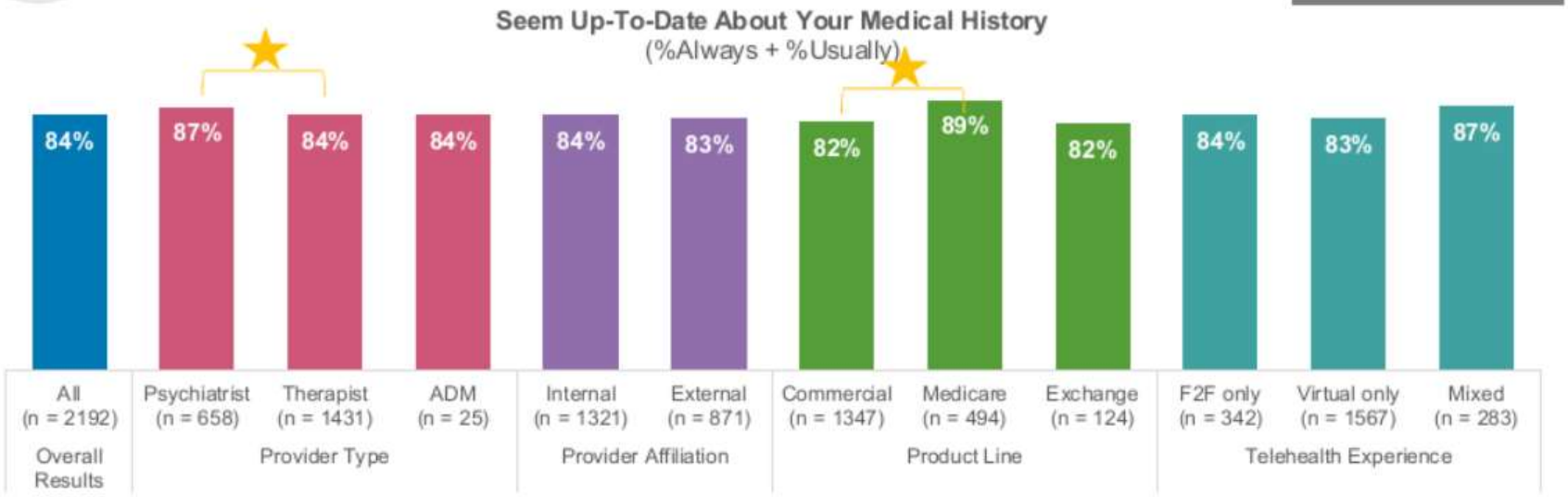
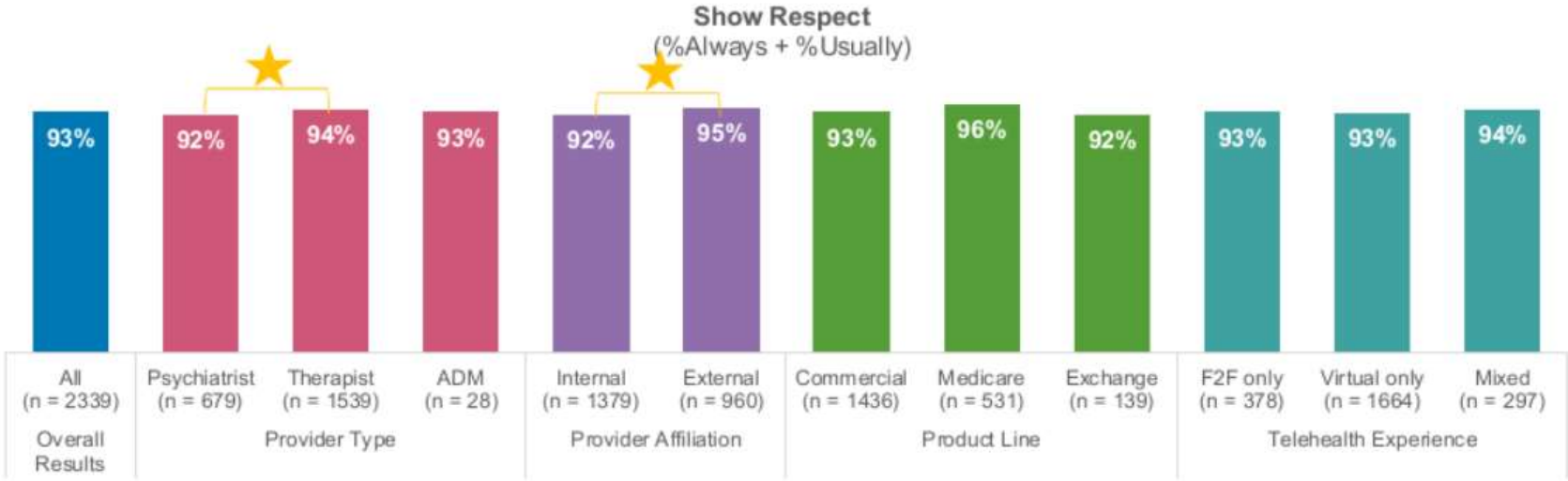
Provider Communication (continued)

★ = Significant differences between subgroup categories





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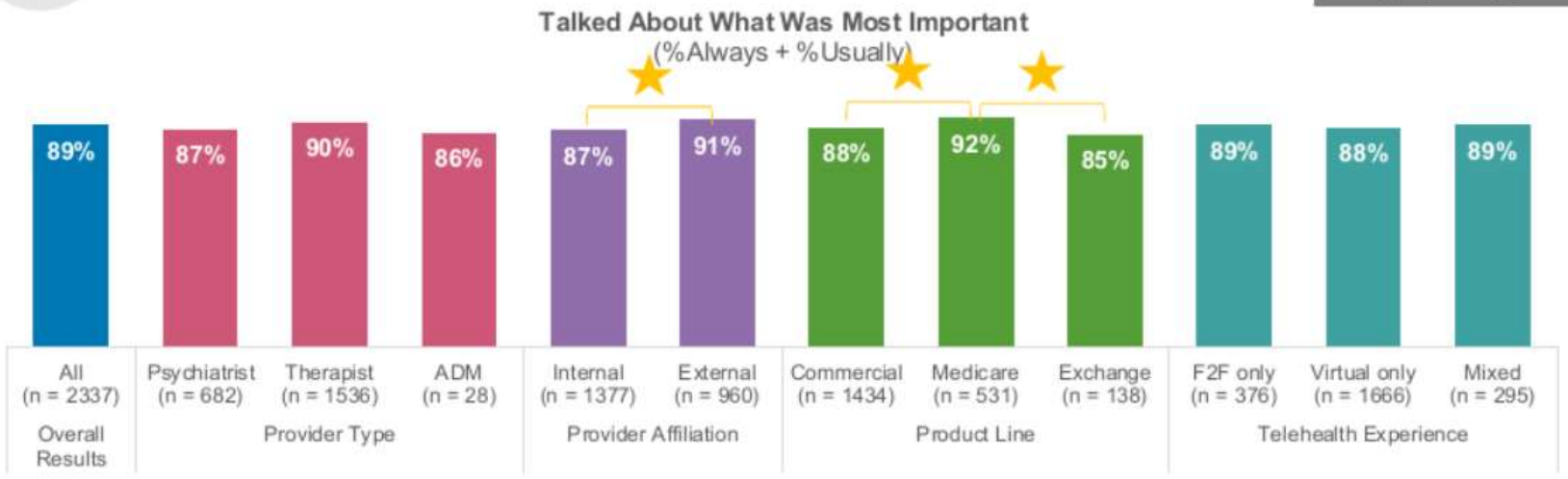
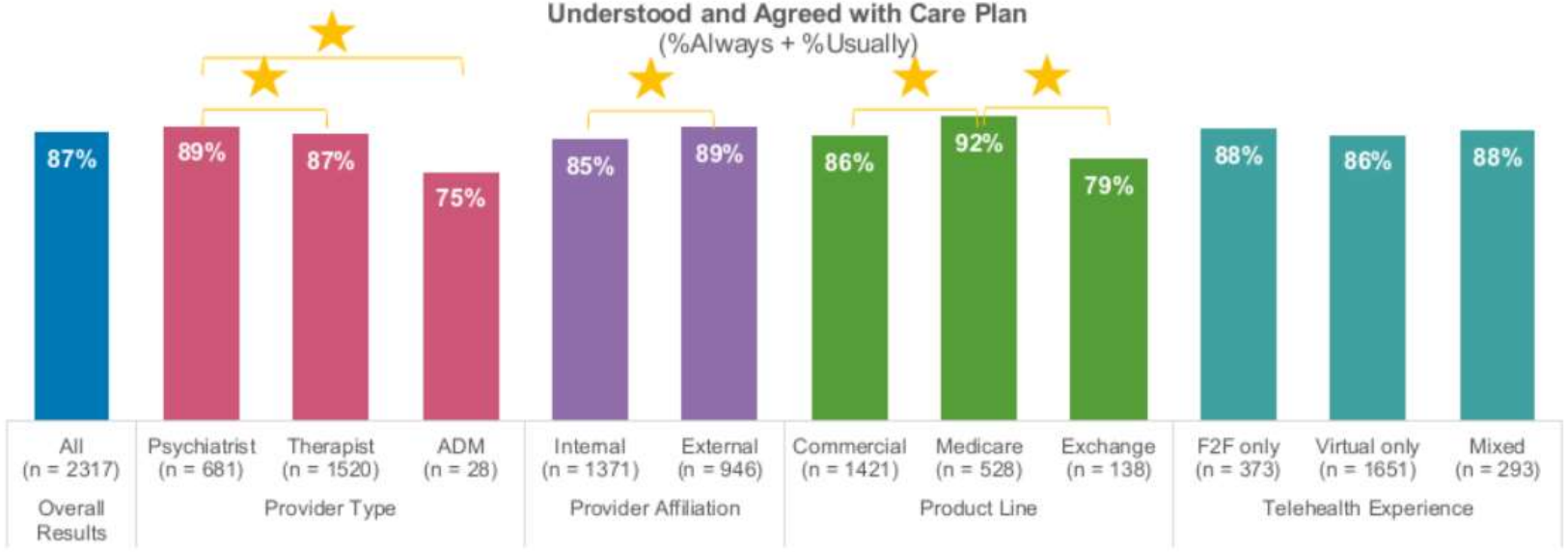
Treatment Experience

★ = Significant differences between subgroup categories

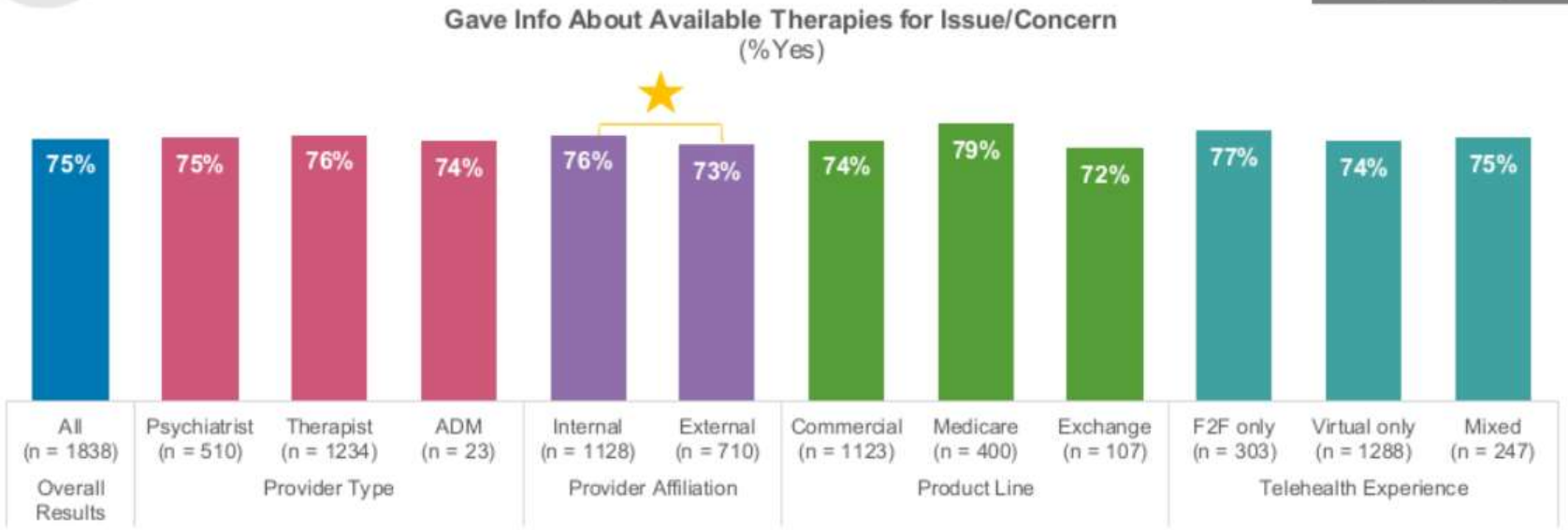


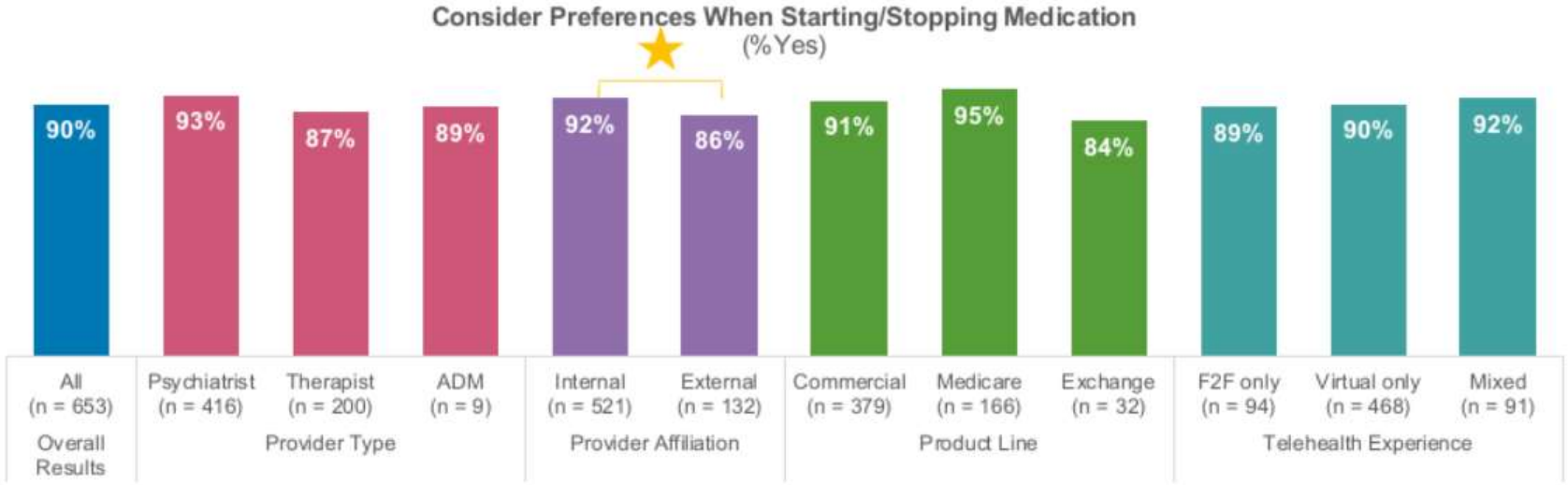


Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Treatment Experience (continued)

★ = Significant differences between subgroup categories



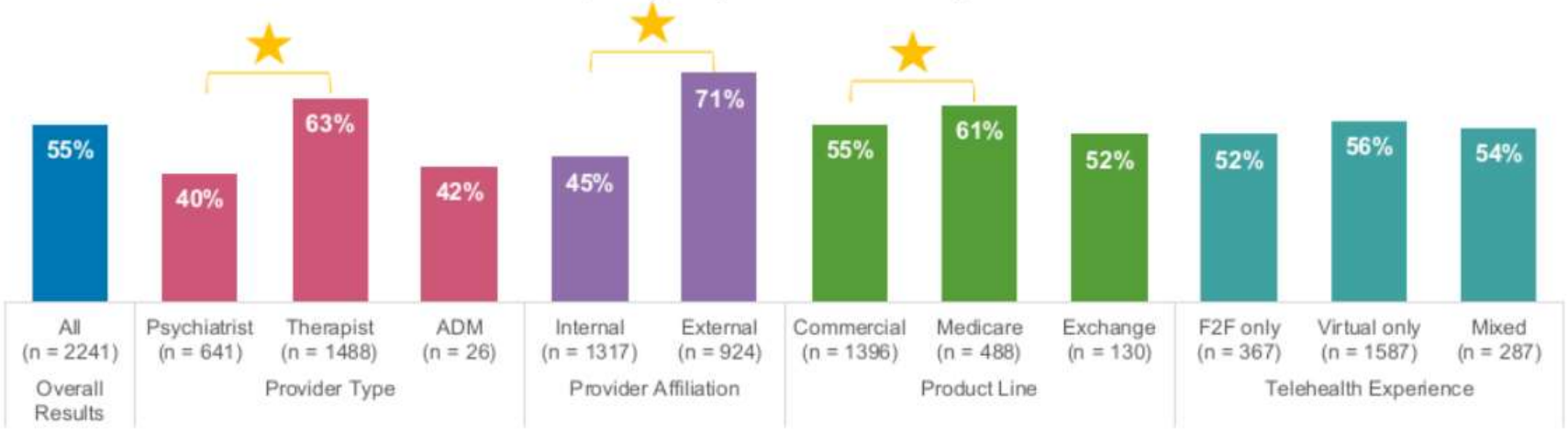


Access

★ = Significant differences between subgroup categories

Get Appointment During Convenient Day/Time
(%Very Easy + %Somewhat Easy)

Get Appointment As Soon As Wanted
(%Very Easy + %Somewhat Easy)



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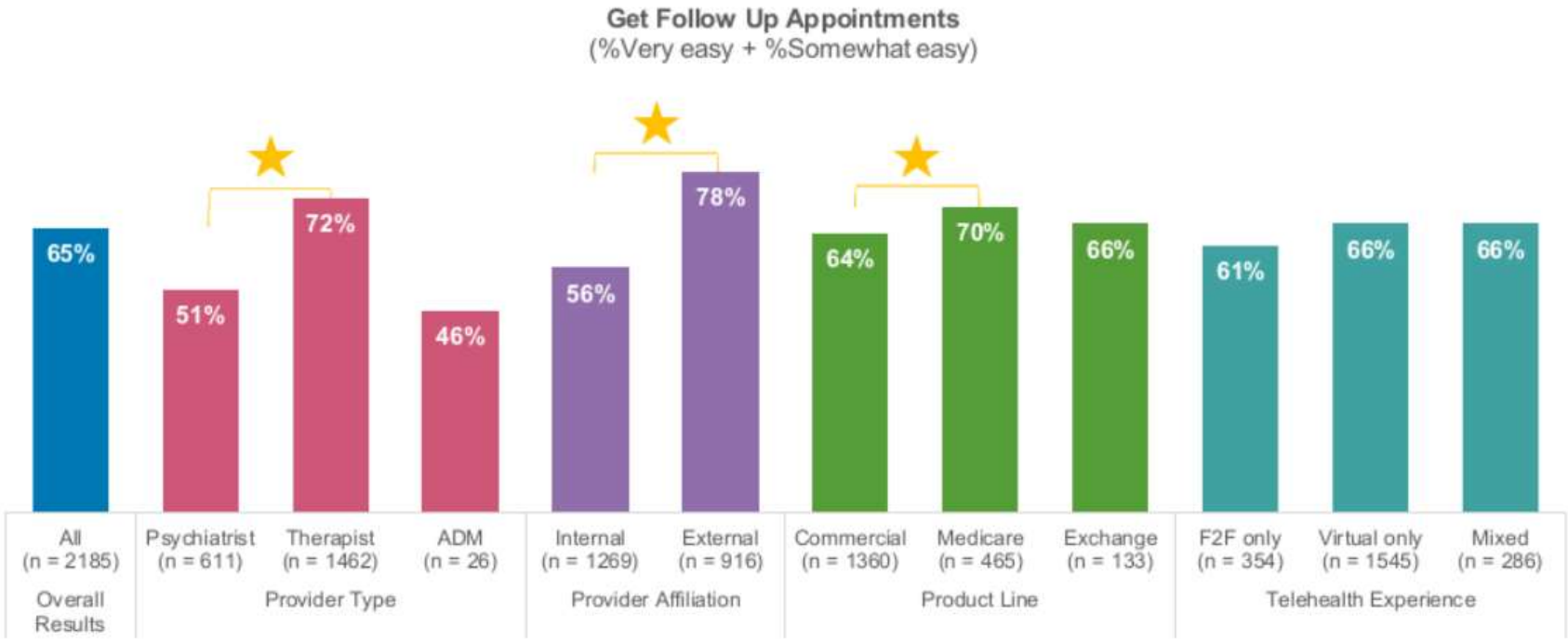
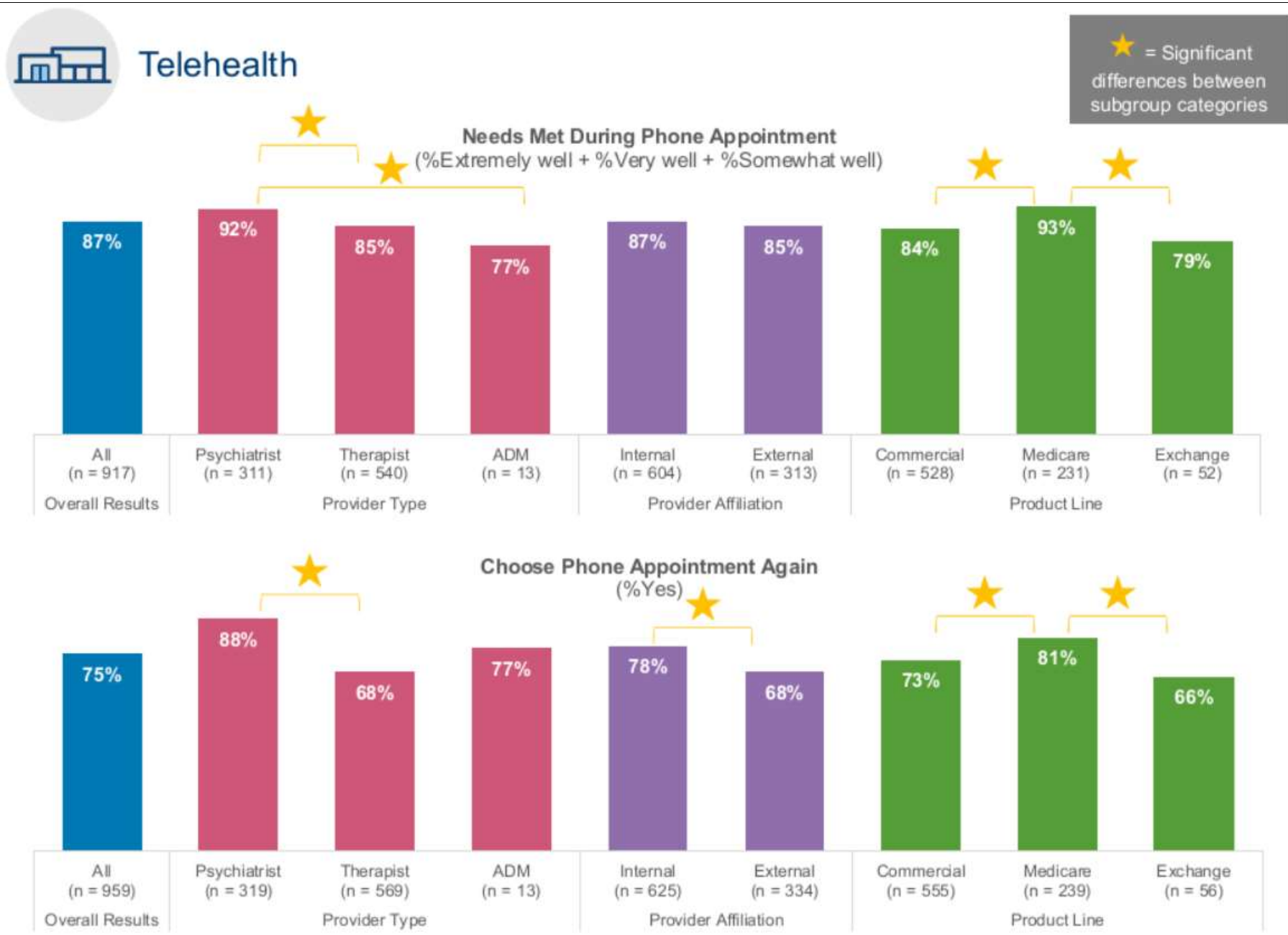
Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Access (continued)

★ = Significant differences between subgroup categories



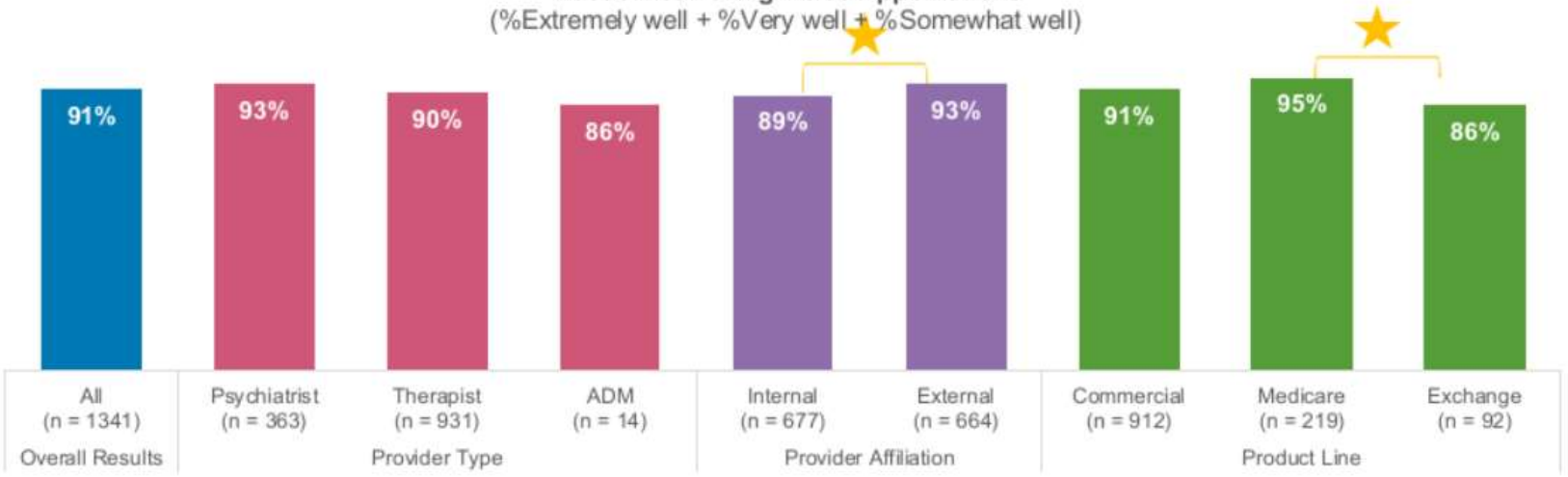

Telehealth
★ = Significant differences between subgroup categories
Needs Met During Phone Appointment
(%Extremely well + %Very well + %Somewhat well)
87%
92%
85%
77%
87%
85%
84%
93%
79%
All (n = 917)
Overall Results
Psychiatrist (n = 311)
Therapist (n = 540)
ADM (n = 13)
Provider Type
Internal (n = 604)
External (n = 313)
Provider Affiliation
Commercial (n = 528)
Medicare (n = 231)
Exchange (n = 52)
Product Line
Choose Phone Appointment Again
(%Yes)
75%
88%
68%
77%
78%
68%
73%
81%
66%
All (n = 959)
Overall Results
Psychiatrist (n = 319)
Therapist (n = 569)
ADM (n = 13)
Provider Type
Internal (n = 625)
External (n = 334)
Provider Affiliation
Commercial (n = 555)
Medicare (n = 239)
Exchange (n = 56)
Product Line

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Telehealth (continued)

★ = Significant differences between subgroup categories

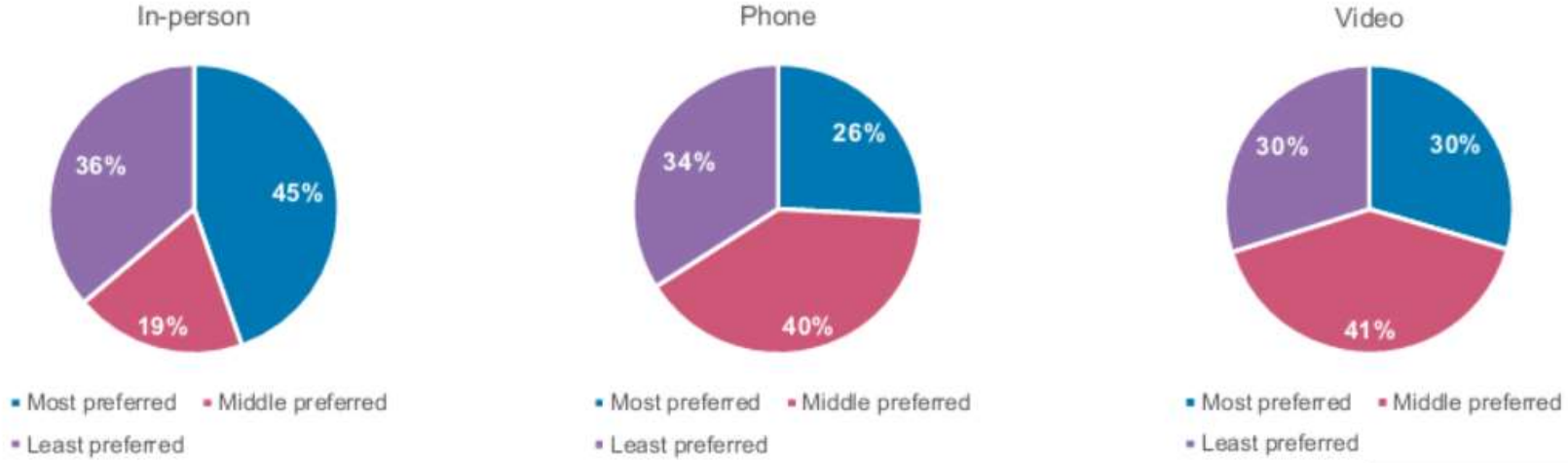
Needs Met During Video Appointment
(%Extremely well + %Very well + %Somewhat well)



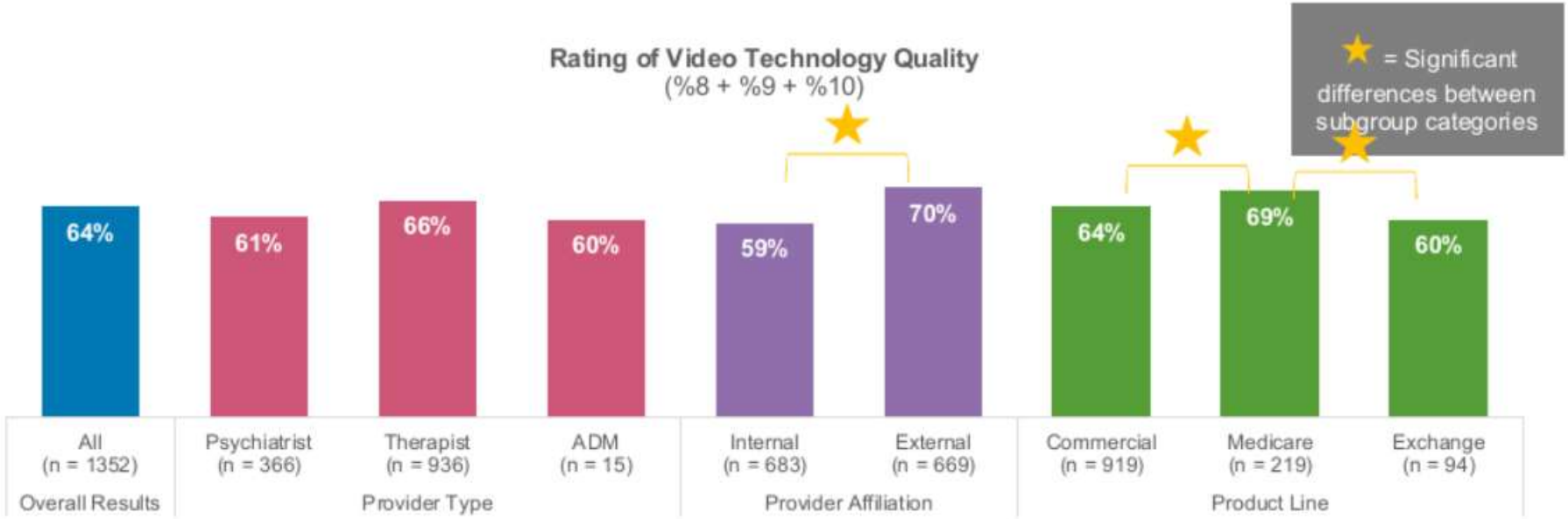
Choose Video Appointment Again
(%Yes)

Telehealth (continued)

Ranking of most preferred visit modes
F2F, phone, and video (n = 2452)

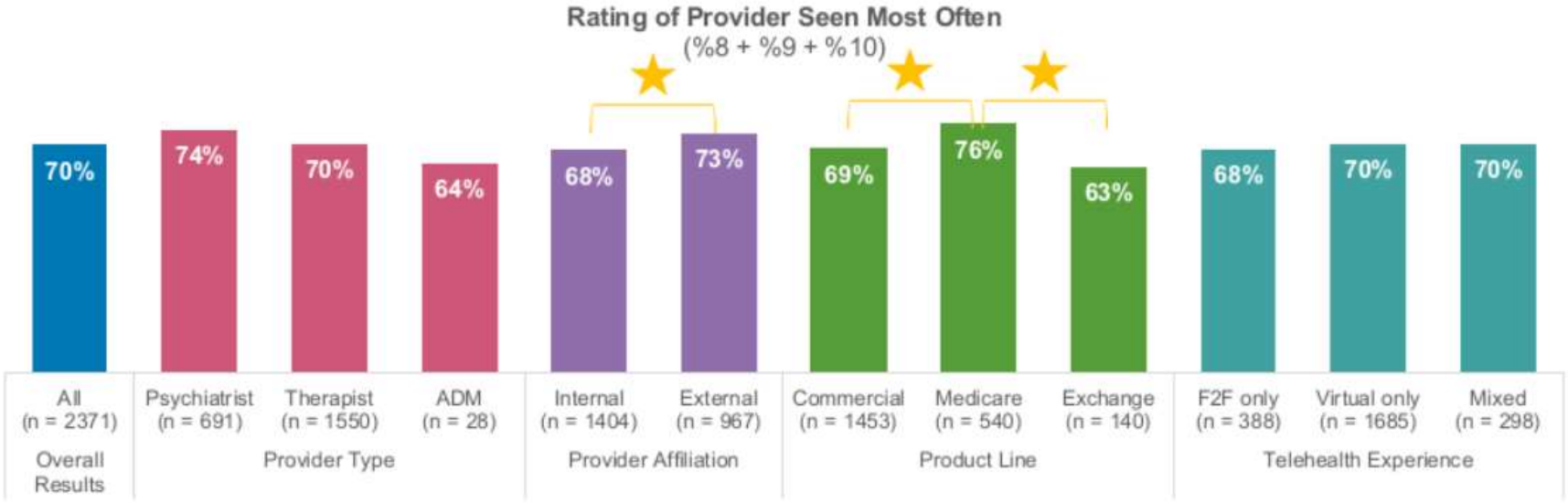


Rating of Video Technology Quality
(%8 + %9 + %10)



Overall Ratings

★ = Significant differences between subgroup categories



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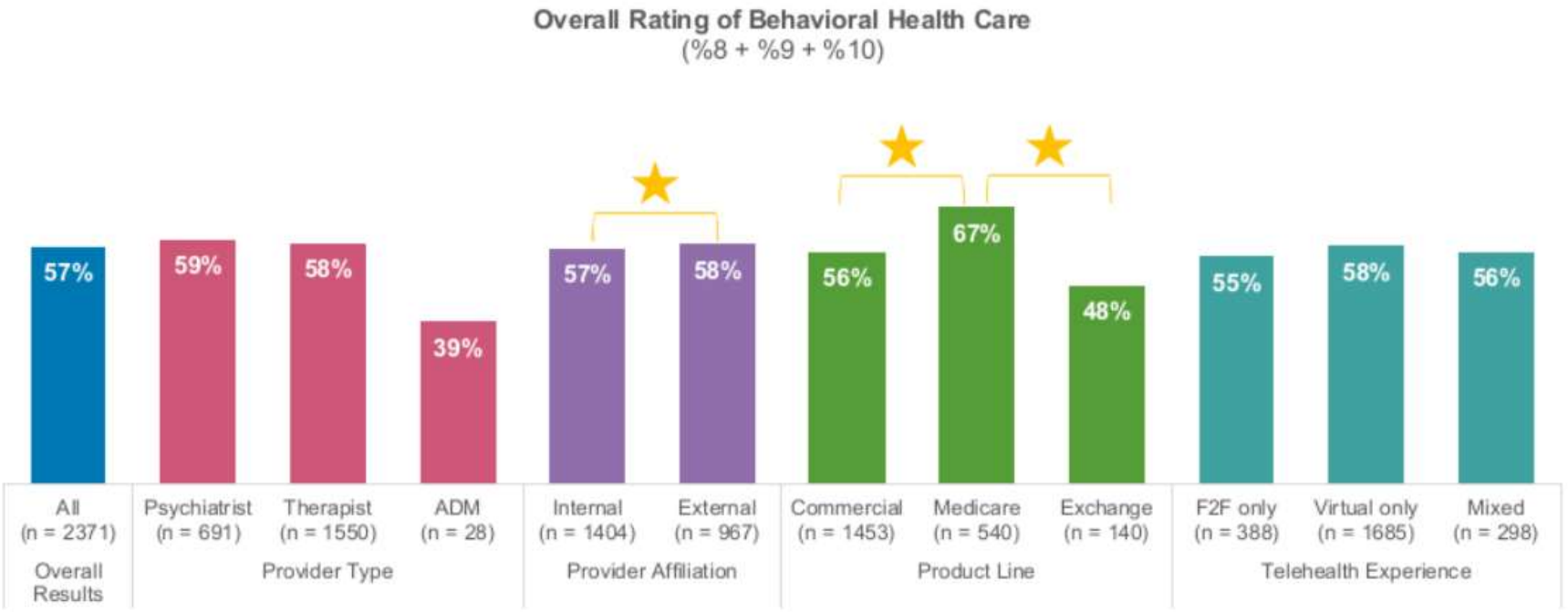
Overall Ratings (continued)

★ = Significant differences between subgroup categories



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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Quantitative Analysis

- Key drivers for overall rating items (Satisfaction with Progress of Care, Rating of Provider Seen Most Often, Overall Rating of Behavioral Health Care) included the following:
  - Ease of finding a provider who is a good fit
  - Understood/agreed with treatment plan
  - Spend enough time with you
  - Seemed up-to-date about your medical history
  - Talked about what was most important
- Most items trended towards stability or improvement from 2022 to 2023.
- Respondents provided high ratings for office staff with 88% reporting that they were treated with courtesy and respect.
- Overall, 52% of respondents reported that it was easy to find a provider who is a good fit.
- Overall, respondents rated their provider's communication highly
  - 93% reported that they explained things in way they could understand
  - 88% said that they spent enough time with them
  - 84% noted that they seemed up to date with their medical history
  - 93% reported that they showed respect for what they had to say
- Respondents rated their treatment experience highly
  - 89% reported that they talked about what was most important to them
  - 87% understood and agreed with their care plan
  - For those for whom this was applicable, 75% reported that they were given information about available therapies for their issue or concern
  - For those taking medications, 90% noted that their preferences were considered when starting/stopping medication
- Appointment access continues to be an area of opportunity
  - 62% of respondents said it was easy to get an appointment during a convenient day or time
  - 55% reported that it was easy to get an appointment as soon as they wanted
  - 65% noted it was easy to get follow up appointments
- Most respondents ranked in-person as the most desired visit mode, followed by phone, then video
  - Of those who experienced a phone appointment, 87% indicated that their needs were met; 75% said they would choose this visit mode again
  - Of those who experienced a video appointment, 91% felt their needs were met; 89% said they would choose this visit mode again
  - 64% provided a high rating (8 or higher) for the video technology quality
- 60% of respondents provided a rating of 8 or higher for their satisfaction with the progress of their care
- 70% provided a rating of 8 or higher for the provider they see most often
- 57% provided a rating of 8 or higher for their overall rating of behavioral health care from KP

Qualitative analysis

- For the qualitative analysis, analyses were conducted to see whether there were differences from 2022 to 2023, as well as whether there were any differences between subgroups that could explain the overall results (e.g., analyses between psychiatrists vs. therapists, external vs. internal providers, or Commercial vs. Medicare LOBs.

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- There were statistically significant improvements in performance in 2023 for the following items:
  - Office staff treat with courtesy and respect
  - All Access items – Got appointment during convenient day/time, Got appointment as soon as wanted, and Got follow up appointments
  - Would choose video appointment again

- There was a statistically significant decrease in Talked about what was most important

- Patients who saw a psychiatrist most often provided lower scores for appointment access

- Patients seeing external contracted providers were more likely to rate provider communication, treatment experience, appointment access, and phone appointment experiences items higher, but scored items lower related to office staff, ease of finding a provider who was a good fit, and video appointment experiences.

- Patients under Medicare lines of business provided higher ratings for office staff, ease of finding a provider who was a good fit, provider communication, treatment experiences, appointment access, telehealth, and overall rating of care; this is a pattern seen with other member experience surveys (e.g., CAHPS).

KPSC Performance Thresholds

The following measures were identified as items for setting 2023 performance targets due to them being identified as key drivers for overall rating items. The target for all items is 75%. The table below details the measures, the result from 2023 surveys, and whether the 75% threshold was met for the measure.

Measure (Overall results)	2023 Result	Threshold met for 2023?
Ease of finding a provider who is a good fit	52%	No
Understood/agreed with treatment plan	87%	Yes
Talked about what was most important	89%	Yes
Spent enough time with you	88%	Yes
Seemed up-to-date about medical history	84%	Yes

Opportunities

The opportunities identified through the analysis of these survey results will benefit all members regardless of product line or provider affiliation. Although there is one “opportunity” outlined we use the plural opportunities to indicate preventions within our internal organization and within our external provider network panel.

Findings from analyses performed over these last few years suggest that, like in other health care settings, **finding a provider that patients are happy with** has implications for their satisfaction with treatment outcomes and overall rating of behavioral health care.

These findings confirm the opportunities that have already been identified; thus, interventions are already in place to address these opportunities.

Opportunities & Interventions

Ease of finding a provider who is a good fit

OPPORTUNITY: Ease of finding a provider who is a good fit

Interventions in Place

Mental Health Scholars Awards Program

- In 2019, we launched the Mental Health Scholars Academy (MHSA), a Kaiser Permanente initiative to support the training of hundreds of new mental health professionals across KP's Northern and Southern California regions. The MHSA works with affiliated academic programs to provide master's and doctoral degrees in mental health fields of study for eligible Kaiser Permanente employees. For those who are accepted, the MHSA provides 75 percent tuition assistance, mentoring, and networking support.
- The Mental Health Scholars Academy also aims to increase diversity in the professional mental health workforce to address gaps in linguistic, ethnic, and minority representation.
- The program includes students pursuing master's degrees in marriage and family therapy, clinical counseling, and social work and doctorate degrees in clinical psychology, social work, and marriage and family therapy.
- To support these employees as they undertake this academic and professional journey, we have established mentorship groups consisting of an experienced Kaiser Permanente licensed mental health professional and 5 to 8 student "scholars" from the MHSA cohort.
- The MHSA will provide academic opportunities for hundreds of employees through the MHSA program within the next three years and will be graduating students into associates' positions in 2024.
- How are we measuring effectiveness for the MHSA program?
    - Program retention: 95% for master's degree programs
    - Cohort Diversity: Race/Ethnicity Goal 60%, current 71%
    - Cohort Language Skills: Goal 25% bilingual, current 39% bilingual
- Since 2023, students in MHSA pipeline:
    - BHTI inaugural practicum cohort had 10 MHSA students who started in 01/2022
    - 32 BHTI graduates
        - 8 BHTI graduates hired into KP Associate positions in PSY and ADM; the remainder are pending Associate registration
        - 89 are regionally supervised Associates across ADM, PSY, SM and Dyadic work
    - 60 Trainees since inception
    - MHSA trainees contributed to improving access by completing a total of 7,410 appointments across 12 services areas in BH since inception

Opportunities & Interventions

Ease of finding a provider who is a good fit

OPPORTUNITY: Ease of finding a provider who is a good fit (continued)

Interventions continued

Feedback Informed Care (FIC)

- In 2023, we continued to expand the work of implementing Feedback Informed Care (FIC). FIC is an evidence-based approach to individual therapy. It is a collaborative therapy treatment model which involves routinely and formally soliciting feedback from patients regarding therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery.

Resources: We continue to create and reinforce clinical and operational resources for supporting FIC regional implementation:

a. Expanded Resources:
   - Introduced updated clinical care review model
   - Updated and trained on collaborative goal setting
   - Standard FIC training for all new students/trainees and Associate therapists

b. Continued Cultural Humility trainings which aligns with FIC efforts that focus on the therapeutic alliance

c. Continued training and content-building through monthly FIC Therapists, Managers, Psychiatrist Champions meeting

Implementation & Consultation:

- Smart phrases have been developed for FIC patients to have smoother transition from one provider to another if not a good fit: less barriers.
- FIC care reviews in ADM will encourage providers to speak and investigate alliance directly through consultation with patient and peers.
- Standard 9-hour monthly FIC training for all providers and managers
- Collaboration with KPEP to ensure standardized FIC trainings internally and with EPNs
- Refreshed training decks and centralized resource with interactive supplemental materials (SharePoint)
- On demand video library
- Bi-monthly regional champion meeting with alternating local champion meeting to strategize local implementation
- All areas have FIC providers at 100% FIC returns except OC.
- 112 providers trained in Cultural Humility
- Launched first CH Community of Practice
- Cultural Humility collaboration with National EID to share the good work in RBH and encourage employees to pursue MHSA benefits to increase # of internal KP providers
- Increase of harm reduction culture/knowledge/resources/groups may increase alliance as not all patients are seeking abstinence.
  - Plan: Continued trainings, development of curriculum, regional classes
  - Plan: Increase awareness/training for MHSA in ADM. Currently, only one student (starting 1/9/24) are involved in addiction department.

2024 Outlook: Continue to optimize implementation in year 5 of regional support for FIC

a. Practicing FIC Playbook
b. Manager Training
c. SmartPhrase refresh
d. Physician re-engagement

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Continuity and Coordination Between Medical Care and Behavioral Healthcare (QI 4)					
NCQA	The organization collaborates with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare. The organization collaborates with behavioral healthcare practitioners and uses information at its disposal to coordinate medical care and behavioral healthcare. **Element A:** The organization annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: **Factor 1:** Exchange of information	HealthConnect access review to ensure information allowed by Federal & State laws is available to all practitioners	Annual March 2024	If not meeting standard, investigate HealthConnect functionality issues and develop action plan. On-going sharing of HealthConnect successful practices to maximize sharing of information between BHC and medical care departments.	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	**Factor 2:** Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care **Factor 3:** Appropriate uses of psychotropic medications	Documentation of collaboration with BH practitioners Identifying & selecting opportunities: **Factor 2:** Improve performance with patients being diagnosed with an SUD diagnosis using: HEDIS ADD and KPSC (CSG) ADD Initiation Measure for follow-up contact within 14 days or less. Taking collaborative actions & interventions **Factor 3:** Improving antidepressant medication management care using HEDIS AMM and KPSC (CSG)	Annual March 2024	Review HEDIS and CSG ADD results and if not meeting goals implements interventions to improve performance. Review HEDIS and CSG AMM performance and initiate collaborative actions if not meeting goals.	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
		AMM measures to monitor performance. Taking collaborative actions and interventions			
NCQA	**Factor 4:** Management of treatment access and follow-up for members with coexisting medical and behavioral disorders	Improve follow-up care for patients discharged from the Emergency Department with an SUD diagnosis using: **Factor 4:** HEDIS and KPSC (CSG) Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) Measure reports to monitor performance	Annual March 2024	Review HEDIS and CSG FUA results and if not meeting goals implements interventions to improve performance.	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	**Factor 5:** Primary or secondary preventive behavioral health program implementation	HEDIS and KPSC (CSG) measures: **Factor 5:** Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS): The percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter. Depression Remission or Response for Adolescents and Adults (DRR): The percentage of members 12 years of	Annual March 2024	Review PHQ9 collection rates for members newly diagnosed with depression and take collaborative actions if not meeting goal.	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
		age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4-8 months of the elevated score.			
NCQA	**Factor 6:** Special Needs of Members with Severe & Persistent Mental Illness	**Factor 6:** Continue to track ED Referrals from the 24/7 KPSC Behavioral Health Helpline to ensure they follow through on initial treatment plan. **Factor 6:** HEDIS IET performance (Commercial & Medicare) • Initiation Phase – 90th Percentile • Engagement Phase – 90th Percentile	Annual March 2024	Review definition of Severe Mental Illness. Obtain KPSC ED referral report to determine metrics related to completing the initial assessment and triaging to an appropriate level of care for those with acute and persistent mental illness. Review HEDIS and CSG IET results and if not meeting goals implements interventions to improve performance.	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	**Element B:** The organization annually conducts activities to improve the coordination of behavioral healthcare and general medical care, including: **Factor 1:** Collaborating with behavioral healthcare practitioners **Factor 2:** Quantitative and causal analysis of data to identify improvement opportunities **Factor 3:** Identifying and selecting one opportunity for improvement from Element A **Factor 4:** Identifying and selecting a second opportunity for improvement from Element A **Factor 5:** Taking collaborative action to address identified opportunity for improvement from Element A	**Factor 1:** HealthConnect access review to ensure information allowed by Federal & State laws is available to all practitioners **Factor 2:** HEDIS ADD performance (Commercial & Medicare) • Initiation Phase – 90th percentile • Engagement Phase – 90th percentile **Factor 3:** HEDIS AMM performance • Acute Phase – 90th percentile	Annual March 2024	If not meeting standard, investigate HealthConnect functionality issues and develop action plan. On-going sharing of HealthConnect successful practices to maximize sharing of information between BHC and medical care departments. Review HEDIS and CSG ADD results and if not meeting goals implements interventions to improve performance. Review HEDIS and CSG AMM performance and initiate collaborative actions if not meeting goals. Review HEDIS and CSG FUA results and if not meeting goals implements interventions to improve performance. Review PHQ9 collection rates for members newly diagnosed with depression and take collaborative actions if not meeting goal.	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	Factor 6: Taking collaborative action to address a second identified opportunity for improvement from Element A	• Continuation Phase – 90th percentile **Factor 4:** HEDIS FUA Performance • Within 7 Days – 95th percentile • Within 30 Days – 95th percentile **Factor 5:** CSG DMS & DRR Performance • DMS – 60% • DRR – 24.0% Initial & Follow-up (Ages 12-17) • DRR – 51% Initial and Follow-up (Ages 18+) **Factor 6:** Continue to track ED referrals from the 24/7 KPSC Behavioral Health Helpline to ensure they follow through on their treatment plan. **Factor 6:** HEDIS IET performance (Commercial & Medicare) • Initiation Phase – 90th percentile • Engagement Phase – 90th percentile		Review definition of Severe Mental Illness. Obtain KPSC ED referral report to determine metrics related to completing the initial assessment and triaging to an appropriate level of care for those with acute and persistent mental illness. Review HEDIS and CSG IET results and if not meeting goals implements interventions to improve performance.	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	**Element C:** The organization annually measures the effectiveness of improvement actions taken for: **Factor 1:** The first opportunity identified in Element B	Areas of opportunity to be determined based on assessment of Element B: Factors 1-6.	Annual March 2024	Prioritizes improvement opportunities.	• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	Factor 2: The second opportunity identified in Element B				

ANALYSIS

The following Continuity and Coordination Between Medical Care and Behavioral Healthcare Analysis was completed in March of 2023. The 2023 analysis will be completed in March 2024.

QI 4 – Continuity and Coordination Between Medical Care and Behavioral Healthcare

Quantitative & Qualitative Analysis: Elements A-C

Factor 1: Exchange of information

- Area of Focus: KP HealthConnect Electronic Medical Record (EMR)
- Quantitative and causal analysis of data to identify improvement opportunities: None required
- Conclusion: Auto credit since all Practitioners use the KP HealthConnect EMR.

Factor 2: Appropriate diagnosis, treatment, and referral of behavioral disorders commonly seen in primary care.

- Area of Focus: Improving ADHD care using HEDIS ADD and KPSC CSG ADD measures to monitor performance.
- Quantitative and causal analysis of data to identify improvement opportunities:
  - HEDIS ADD Commercial performance for All Ages:
    - Initiation Phase: KPSC met its' goal of achieving the 90th national percentile and exceeded it by meeting the 95th percentile National Commercial benchmark.
      - The KPSC MY2021 performance was 69.28% which met the 95th National Commercial benchmark.
      - Comparing MY2021 HEDIS to MY2020 HEDIS results, KPSC has improved by 2.65 percentage points.
    - Continuation and Maintenance Phase: KPSC met its' goal of achieving the 90th national percentile and exceeded it by meeting the 95th percentile National Commercial benchmark.
      - The KPSC MY2021 performance was 68.88% which met the 95th National Commercial benchmark.
      - Comparing MY2021HEDIS to MY2020 HEDIS results, KPSC performance slightly decreased by 0.09 percentage points.
  - HEDIS ADD Exchange (Marketplace) performance for All Ages: Reporting was not required for this measure per MY2021 QRS specifications.
  - KPSC CSG ADD performance for All Ages:
    - Initiation Phase: KPSC exceeded the internal 2022 CSG goal of 51.0% by 19.6 percentage points. The 2022 KPSC Regional CSG performance for "Follow-Up Care for Children Prescribed ADHD Medication (ADD)" Initiation measure was 70.6%; this represented an increase of 1.5 percentage points compared to the previous year.
    - Continuation and Maintenance Phase: KPSC exceeded the internal CSG 2022 goal of 61.0% by 10.5 percentage points. The 2022 KPSC CSG for "Follow-Up Care for Children Prescribed ADHD Medication (ADD)" continuation measure was 71.5%; this represented an increase of 2.1 percentage points compared to the previous year.
- Interventions to improve ADD measures:
  - Primary Intervention:
    - The KPSC ADHD outreach list began in late 2017 and continues to be used in the Psychiatry and Pediatric Departments. The outreach list is distributed to all Medical Centers every two weeks for use by the Pediatrics and Psychiatry Departments. This list identifies all members who meet requirements for both the Initiation and Continuation/Management measures. Each medical center works with their clinical departments and prescribing providers to alert them a follow-up appointment is needed for specific patients.
  - Secondary Intervention:

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- In late 2018, KPSC created a quarterly ADHD Initiation report showing differences in performance by Clinical Departments. The goal of the report is to identify opportunities to focus improvement efforts on specific groups of providers and to help monitor operational changes that occur at the department level. The new report looked back retrospectively to provide a baseline at both the Area Medical Center level and the SCAL Region level.

- Additional Interventions:
  - KPSC developed a monthly performance report in early 2018 that continues to be distributed, along with the bi-weekly ADHD outreach lists. This report allows KPSC and Area Medical Centers to monitor performance more frequently and would alert KPSC leadership to further investigate if performance would begin to decline.
  - KPSC will continue to use the HEDIS reports and KPSC CSG Reports for primary monitoring of performance.
  - KPSC will continue to distribute the ADHD outreach list to medical centers and work with our Pediatricians, Developmental/Behavioral Pediatricians and Child Psychiatrists to maximize the use of the lists to proactively outreach to patients to schedule timely follow-up visits where possible.
  - KPSC will continue to use the quarterly ADHD Initiation Phase by Department and Medical Center and Monthly Performance Trend reports to assist with identifying successful practices and targeting improvement efforts.
    - For 2023, KPSC will explore better processes to identify successful practices at the local level and communicate those practices to the other Pediatric and Psychiatry departments.
  - Continual review of the pediatric workflow in collaboration with pediatric partners to ensure consistency in process and adjust as needed.

Factor 3: Appropriate use of psychotropic medications.

- Area of Focus: Improving antidepressant medication management care using HEDIS AMM and KPSC CSG AMM measures to monitor performance.

- Quantitative and causal analysis of data to identify improvement opportunities:
  - HEDIS AMM Commercial Results
    - Effective Acute Phase: KPSC met its' goal of achieving the 90th national percentile. The KPSC MY2021 performance was 83.28% which met the 90th National Commercial benchmark. Comparing MY2021 HEDIS to MY2020 HEDIS results, KPSC has improved by 1.97 percentage points.
    - Effective Continuation Phase: KPSC did not meet its goal of achieving the 90th national percentile. The KPSC MY2021 performance was 56.80% which met the 25th national percentile. Comparing MY2021 HEDIS to MY2020 HEDIS results, KPSC has improved by 3.48 percentage points.
  - HEDIS AMM Exchange (Marketplace) Results
    - Effective Acute Phase: KPSC met its' goal of achieving the 90th national percentile. The KPSC MY2021 performance was 87.50% which met the 90thth National Commercial benchmark. Comparing MY2021 HEDIS to MY2020 HEDIS results, KPSC has improved by 2.86 percentage points.
    - Effective Continuation Phase: KPSC met its goal of achieving the 90th national percentile. The KPSC MY2021 performance was 64.88% which met the 90th national percentile. Comparing MY2021 HEDIS to MY2020 HEDIS results, KPSC has improved by 2.12 percentage points.
  - HEDIS AMM Medicare Results
    - Effective Acute Phase: KPSC exceeded its goal of achieving the 90th national percentile. The KPSC MY2021 performance was 88.72% which met the 90th National Commercial benchmark. Comparing MY2021 HEDIS to MY2020 HEDIS results, KPSC has improved by 0.87 percentage points.
    - Effective Continuation Phase: KPSC did not meet its goal of achieving the 90th national percentile. The KPSC MY2021 performance was 65.73% which met the 33rd national percentile. Comparing MY2021 HEDIS to MY2020 HEDIS results, KPSC has improved by 1.78 percentage points.
  - Clinical Strategic Goal (CSG) Results – AMM Acute and Continuation Phase Performance Report
    - Acute Phase: KPSC exceeded the CSG goal of 82.4%. KPSC performance was 84.9% or 2.5 percentage points above the CSG goal. This was a 0.3 percentage point improvement when compared to the November 2021 CSG performance report.
    - Continuation Phase: KPSC did not meet the CSG goal of 68.0%. KPSC performance was 59.9% or 8.1 percentage points below the CSG goal. This was a 0.5 percentage point increase when compared to the November 2021 CSG performance report.

- Interventions to improve AMM measures:

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- Regional DCM MD Co-leads developed a health connect smart set targeting primary care providers set that includes best practices for alternative diagnoses to MDD, options for treatment, DCM exclusion, follow up recommendations, and medication recommendations and best practices.
- Continue to promote use of patient facing flyer in English and Spanish detailing diagnosis, treatment and medication expectations: "Depression Care, What's Right for me?" Flyer
- Developed and deployed best practices for use of Panel Management Tool in Health Connect for reaching out to patients at risk for falling out of Continuation Phase with DSR between -14 and -52 days with no refills.
- Continue communication on prescribing 100-day supply to satisfy continuation phase HEDIS metric. Specific antidepressants have been defaulted to 100-day supply on KPHC.
- Stress communication to all providers "If you are treating depression with medications, we suggest that to improve medication adherence that you prescribe a 100 days' supply with one refill. Before prescribing the medication, it is also best, to ensure that patient understands that depression is being diagnosed, and that the patient is *willing to take* the medication. In addition, when considering an antidepressant, for new onset depression patients, we have a great resource available-- send a referral to POP CARE for depression management.
- Developed a Regional Surenet campaign to reach out to patients at risk for falling out of the Continuation Phase WITH refills. This campaign supplements the work being done by local areas from the Panel Management tool. Surenet staff will remind patients to pick up their refills, place the refill if it's not yet filled or connect patients with prescribing physicians if they have any questions.
- Developed a Behavioral Health Community of Practice workgroup that includes both Behavioral Health and Complete Care leaders. This workgroup was developed to support Kaiser Permanente Behavioral Health initiatives to improve patient care across the continuum and identify and prioritize opportunities of improvement. AMM has been an area of focus for this group as well as other CSG improvement plans for local areas.

- Additional Interventions:
  - Improve overall Antidepressant medication adherence and address low performance on the HEDIS AMM Continuation phase measure by using the following strategies:
    - KPSC will continue to use the HEDIS AMM and KPSC CSG Measure Reports for primary monitoring of performance.
    - Support all 13 Medical Centers and implement a Regional SureNet outreach campaign to conduct live calls that will assist patients to refill existing antidepressant prescriptions to improve medication adherence within the continuation phase of treatment for six months. Local areas will also have access to a patient list that is focused on patients who are in the continuation phase cohort. This list will be housed on PowerBI designed by Complete Care Support Programs tech team and local teams will have the ability to do outreach via phone calls and letters. Support Programs tech team and local teams will have the ability to do outreach via phone calls and letters.
    - Development of an Antidepressant Medication Management provider level dashboard for all Medical Centers to provide local provider data on success rates for both AMM acute and continuation phase.

Factor 4: Management of treatment access and follow-up for members with coexisting medical and behavioral disorders

- Area of Focus: Improve follow-up care for patients discharged from the Emergency Department with a Substance Use Disorder (SUD) diagnosis using the HEDIS and KPSC CSG Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) Measure reports to monitor performance.

- Quantitative and causal analysis of data to identify improvement opportunities:
  - HEDIS Commercial FUA Performance Results
    - FUA within 7-Days: KPSC met its goal of achieving the 95th national percentile. KPSC performance was 24.61% which exceeded the 90th national percentile. KPSC performance decreased by 2.43 percentage points when comparing MY2021 HEDIS to MY2020 HEDIS.
    - FUA within 30-Days: KPSC met its goal of achieving the 95th national percentile. KPSC performance was 36.49% which exceeded the 90th national percentile. KPSC performance decreased by 1.68 percentage points when comparing MY2021 HEDIS to MY2020 HEDIS.
  - HEDIS Exchange (Marketplace) Reporting was not required for this measure per MY2021 QRS specifications.
  - HEDIS Medicare FUA Performance Results: Given the small denominator (550) for the Medicare membership on this measure, rates may vary noticeably year-to-year.
    - FUA within 7-Days: KPSC's performance did not meet our goal of achieving the 95th national percentile. KPSC performance was 21.45% which met the 90th national percentile. KPSC MY2021 HEDIS performance decreased by 8.87% percentage points when compared to MY2020 HEDIS performance.
    - FUA within 30-Days: KPSC's performance met our goal of achieving the 95th national percentile. KPSC performance was 35.64% which met the 95th national percentile. However, KPSC MY2021 HEDIS performance decreased by 8.54% when compared to MY2020 HEDIS performance.
  - KPSC CSG FUA Performance Results

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- FUA within 7-Days: KPSC's performance met our internal CSG goal of 29%. KPSC 2022 CSG performance was 39.9%. Compared to 2021, KPSC performance improved by 2.4 percentage points in 2022.
- FUA within 30-Days: KPSC's performance met our internal CSG goal of 23%. KPSC 2022 CSG performance was 28.4%. Compared to 2021, KPSC performance improved by 3.5 percentage points in 2022.

- Interventions to improve FUA measures:
  - Primary Intervention:
    - KPSC Regional SUD Workgroup focuses on identifying successful practices and disseminating them in Addiction Medicine, Emergency Medicine, Primary Care and Psychiatry departments throughout the region. The KPSC FUA Trend Reports are helpful to identify successful practices. KPSC focuses messaging on improving the 7-day performance.
  - Secondary Intervention:
    - KPSC will continue to support the Regional SUD Workgroup with multispecialty (ADM, PSY, ED, Primary Care) involvement The workgroup is sponsored and chaired by the SCPMG Regional Chief of Addiction Medicine (ADM) and Regional Behavioral Health Addiction Medicine Practice Specialist.
  - Additional Interventions:
    - Bridge to Treatment/BHNs- KP is a grantee to the related CA Bridge program, the Bridge to Treatment program, which funds and trains Emergency Department-based navigators with a particular focus on linking ED patients with SUDs, more than half of whom will also have mental illness, with ongoing BH treatment and recovery services as well as other needed social supports and resources.
    - Alcohol e-visit- Member-facing tool on KP.org where patients can explore their alcohol use and receive feedback about their placement on the risk spectrum (low-risk, high-risk, alcohol use disorder). It will provide them with personalized advice based on their answers to questions and connect them to resources for education/treatment. These will be piloted in a few areas and later scaled across the region.
    - ATTAIN Screening Tool- Alcohol screening tool for Adult Primary Care to assess patient's level of alcohol use. ATTAIN validated screening tool is used to assist with Screening, Assessment, and Brief Intervention and Treatment (SABIRT) efforts.
    - Collaborative Care - Partnerships of focus in 2022:
    - Primary Care
      - Goal: SUD is a chronic health condition that can be treated in Primary Care (prevention and early intervention, and to some degree, ongoing maintenance)
    - ED
      - Goal: Empowering ED physicians and team to recognize self-stigma and bias that SUD is not urgent/emergent care. Partnership with Bridge to Treatment
    - Psychiatry Dept
      - Dual diagnosis patients have no wrong door, workflows developed to work cohesively
      - Work through the ping pong of following patients: non-chem addictions, patients that use substances but can be treated by psych without ADM involvement
    - Pediatrics
      - All 13 areas have identified a pediatrician as a subject matter expert on SUD. KPSC continues to effectively collaborate and increase confidence of ADM providers to treat Peds, and Peds providers to treat SUD patients with screenings and interventions.

Factor 5: Primary or secondary preventive behavioral healthcare program implementation.

- Area of Focus: Improve primary and secondary screening of members for depression using the PHQ 9 tool and measured by the HEDIS and KPSC CSG performance reports.

- Quantitative and causal analysis of data to identify improvement opportunities:
  - KPSC Primary Performance Goals: Clinical Strategic Goal (CSG) Reports – These reports align with the HEDIS methodology as best as possible, are calculated monthly and are published approximately two months after the end of the reporting period (e.g., CSG results for November are published the following January). These reports are useful in tracking performance improvements more frequently and are leading indicators of how our HEDIS results will trend.
    - Clinical Strategic Goal (CSG) reports: Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS).

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- KPSC established a goal of 60% for this measure. Given the KPSC CSG measure align as best as possible with the HEDIS measures, 2022 CSG data is broken down into 3 reporting periods.
- KPSC met its' performance goal for all 3 assessment periods. The goal improved in period 1 by 8.1, in period 2 by 16.5 and period 3 by 21.9 percentage points.
- KPSC Clinical Strategic Goal (CSG) reports: Depression Remission or Response for Adolescents and Adults (DRR) measures.
- Initial & Follow-Up PHQ 9: The percentage of members who have an initial & follow-up PHQ-9 score documented within 4–8 months after the initial elevated PHQ-9 score.
- KPSC established the following goals for these two measures:
  - Depression Remission or Response (DRR): Initial & Follow-up (Ages 12-17) = 24.0%
  - Depression Remission or Response (DRR): Initial & Follow-up (Ages 18+) = 51.0%
- Had an Initial and a Follow-Up PHQ-9. (Ages 12-17)
  - KPSC CSG 2022 performance was 22.3%; this did not meet the KPSC CSG goal of 24.0%.
  - When comparing KPSC CSG 2021 to CSG 2022, there was a 4.4 percentage point decrease.
- Had an Initial and a Follow-Up PHQ-9. (Ages 18+)
  - KPSC CSG 2022 performance was 46.3%; this did not meet the KPSC CSG goal of 51.0%.
  - When comparing KPSC CSG 2021 to CSG 2022; however, there was a 1.4 percentage point improvement

- KPSC Secondary Performance Goals: A-TPI and Y-TPI = 90% of patients with a completed visit have an A-TPI/Y-TPI in the HealthConnect EMR (patients that were eligible to complete a TPI, factors include individual visits)
  - KPSC Psychiatry Department performance for Adult and Youth patients with a completed A-TPI/Y-TPI at every individual practitioner visit was a regional average of 64%; this did not meet the goal of 90%.
  - 0 of 13 Areas met the goal
- KPSC Secondary Performance Goals: A-SATSS and Y-SATSS= 90% of patients with a completed visit have an A-TPI/Y-TPI in the HealthConnect EMR (patients that were eligible to complete a TPI, factors include individual visits)
  - KPSC Addiction Medicine Department performance for Adult and Youth patients with a completed A-SATSS/Y-SATSS at every individual practitioner visit was a regional average of 52%; this did not meet the goal of 90%.
  - 0 of 13 Areas met the goal.

- Interventions:
  - To address mandatory reporting for HEDIS PHQ9 utilization and Universal Screening measures as well as declining PHQ-9 utilization results, the following strategies have been implemented:
    - Include HEDIS PHQ-9 metrics as an area of focus for Behavioral Health Complete Care Community of Practice.
    - Make site visits to our medical centers to discuss challenges and review workflows to provide recommendations and direction specific to that medical center's concerns and issues.

  - The following strategies will be explored:
    - Investigate implementing pre-visit assessment with Smart Triage or triage hub workflows.
    - Request to include PHQ-9 flowsheet as part of vital signs on navigator in KPHC.
    - Revisit additional Depression screening POE for patients 65+ by Q2 2022 once adequate DCM resources are in place to manage anticipated increased volumes.
    - Revisit existing Depression Screening POE logic to better align with HEDIS population.
    - Collaborate with Regional Surenet to support the DRR (Depression remission and response) to assist with obtaining follow up PHQ-9s 4-8 month after initial elevated PHQ-9 score.

Factor 6: Special needs of members with severe and persistent mental illness.

- Area of Focus: Improve performance with patients being diagnosed with a SUD and initiating treatment within 14 days or less of diagnosis (HEDIS IET – Initiation).

- Quantitative and causal analysis of data to identify improvement opportunities:
  - HEDIS IET Commercial performance for All Ages:

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- Initiation Phase: KPSC met its' goal of achieving the 90th national percentile and achieved the 95th national percentile. KPSC MY2021 performance was 45.71% which exceeded the 90th national percentile. When comparing HEDIS MY2021 results with HEDIS MY2020 results, there was a decrease of 6.94% in performance rate.
- Engagement Phase: KPSC met its' goal of achieving the 90th national percentile and achieved the 95th national percentile. KPSC MY2021 performance was 25.98% which exceeded the 90th national percentile. When comparing HEDIS MY2021 results with HEDIS MY2020 results, there was a decrease of 3.98% in performance rate.

- HEDIS IET Exchange (Marketplace) performance for All Ages: Reporting was not required for this measure per MY2021 QRS specifications.
- HEDIS IET Medicare performance for All Ages:
  - Initiation Phase: KPSC did not meet its' goal of achieving the 90th national percentile. KPSC MY2021 performance was 29.49% which is in the 33rd national percentile. When comparing HEDIS MY2021 results with HEDIS MY2020 results, there was a decrease of 4.05% in performance rate.
  - Engagement Phase: KPSC met its' goal of achieving the 90th national percentile. KPSC MY2021 performance was 9.91% which is in the 90th national percentile. When comparing HEDIS MY2021 results with HEDIS MY2020 results, there was a decrease of 1.20% in performance rate.
- KPSC CSG IET performance for All Ages:
  - Initiation Phase: KPSC exceeded the CSG goal of 44.6%. KPSC performance was 47.0% or 2.4 percentage points above the CSG goal. This was a 3.2 percentage point improvement when compared to the November 2021 CSG performance report.
  - Engagement Phase: KPSC exceeded the CSG goal of 18.3%. KPSC performance was 21.7% or 3.4 percentage points above the CSG goal. This was a 0.7 percentage point decline when compared to the November 2021 CSG performance report.

- Interventions to improve IET measures:
  - Primary Intervention:
    - Beginning in Q1 2018, KPSC began to rollout an outreach tool for patients diagnosed in ANY department the previous day. The report tracks patients for 14 days after an index event. Staff from ANY department can access the reports on demand; recommendation is for the lists to be checked at least once per day.
    - Beginning in 2019, KPSC created a similar dashboard to be used outside of ADM, to comply with federal regulations and expand the number of clinicians who diagnose patients outside of ADM. (Primary Care, ED, Pediatrics and Psychiatry etc.) Workflows have been developed in each local ADM area to support outreach for referrals received by other departments, due to diagnosis.
  - Additional Interventions:
    - Developed a region-wide cannabinoid (cannabis) clinical reference guide, lunch & learns, Smart Rx
    - KPSC will continue to use the HEDIS IET and KPSC CSG Measure Reports for primary monitoring of performance.
    - KPSC will continue to leverage and enhance the Primary Care SUD Champions in each Medical Center to improve performance in Primary Care
      - Produce consistent parity with how we treat other medical conditions, example: (diabetes or depression care management)
    - In (2022), we went live with the SUD Learning Module (last updated 2017)
      - Multiple, specialty specific physician learning modules focused on: proper diagnosis, documentation, and follow-up from an all-specialty perspective, not ADM specifically.
      - The module will include video and audio interviews.

Additional Area of Focus: Continue to track ED Referrals from the 24/7 KPSC Behavioral Health Helpline to insure they follow through on initial treatment plan and continued implementation of our Suicide Prevention initiatives.

- Quantitative and causal analysis of data to identify improvement opportunities:
  - In 2022 the Behavioral Healthcare Helpline received a total of 130,691calls. This represents an 9.7% decrease from 2021.
- Suicidal calls:
  - We actively engaged members in utilizing the Stanley Brown Safety plan and facilitating urgent appointments to our clinic providers.
  - The BHC Helpline served 6,464- suicidal calls defined as Homicidal Ideation, Suicidal Ideation, Suicidal Thought or Suicide attempt.
  - Safety plans Initiated 426
  - Safety plans reviewed 639 (+14% from 2021)
- Wellness checks: 536 (+3% from 2021) Wellness check initiated, meaning police/paramedics contacted

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	Primary Intervention: Suicide Prevention o Suicide Prevention Program: KPSC has implemented a suicide prevention workflow in our Psychiatry and Addiction Medicine departments. Collaboration with the Emergency departments is leading to similar workflows. Given the research that indicates Borderline personality disorder, anorexia nervosa, depression and bipolar disorder had the highest suicide risks, our suicide prevention program is very relevant to our patients with serious mental illness. Additional Interventions: o Increased performance monitoring on Universal Screening of all patients (assessment completed via TPI/SATSS, PHQ-9, and/or C-SSRS) for any appointment 30 min or longer by a provider. o Continue staff training on the use of the Columbia Suicide Safety Rating Scale (CSSR-S) and the required documentation. o Enhance performance monitoring reports to ensure safety plans are being developed when a high CSSR-S score occurs. o Analyze the percent of patients screened with CSSR-S and with a safety plan also have severe/serious mental illness and substance use disorders. o Continued to provide guidance regarding how to monitor scores generated from remote clinical questionnaires, facilitate appropriate follow-ups for patients who score a 3+ on the C-SSRS, but do not show for their appointment o Provided a copy of the completed Safety Plan to patients in remote settings.				

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
CLINICAL PRACTICE GUIDELINES					
Clinical Practice Guidelines					
	Update two (2) evidence-based Clinical Practice Guidelines (CPGs) for chronic conditions (Blood Pressure, Coronary Artery Disease) and two (2) for behavioral health (ADHD, Depression) at least every two (2) years	Timely completion of updates for Blood Pressure, Coronary Artery Disease, Depression and ADHD guidelines, as needed, based on 2-year review cycle	Q4 2023	Work with KP National Guideline Program (CMI) to ensure timely updating of guidelines	Benjamin Broder, MD Marguerite Koster Yerado Abrahamian SCPMG Evidence-Based Medicine Services
	Distribute revised CPGs for these conditions to practitioners via email, if substantive changes have been made since the previous update	Distribute revised CPGs with substantive changes	Q4 2023		
ANALYSIS					
Blood Pressure was updated in November of 2023; Coronary Artery Disease in September of 2023, Depression in September of 2023; and ADHD was still current in its 2 year cycle having been updated in March 2022. Changes were announced when needed.					

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OUTPATIENT CLINICAL QUALITY KEY MEASURES					
Outpatient Clinical Quality Key Measures					
KP	**2023 Key Clinical Quality Goals:** To address the growing challenge of publicly reported data, the Southern California Health Plan and Medical Group leaders identify clinical quality goals as areas of focused improvement. These are "Clinical Quality of Care Key Measures", which include several HEDIS-like measures as well as other performance measures which are only for internal monitoring. 2023 Clinical Quality Key Measures: <u>Ambulatory Quality Composite</u> Proportion of Areas meeting AQC <u>Behavioral Health</u> • Antidepressant Medication Management – Continuation Phase (18+ y/o) <u>Equitable Care</u> • HbA1c < 8.0% - Hispanic/Latino Population (18-<65 y/o) • Childhood Vaccinations: Combo 7 – AA/Black Population <u>Staying Healthy</u> • Proportion of Days Covered: Statins (18-85) • HbA1c < 8.0% Total population (18-75 y/o)	Targets: 100.0 13/13 63.0% 57.0% 70.0% 85.0% 67.0%	Achieve targets by the measurement period ending 10/31/2023	The 2023 Clinical Quality of Care Key measures reports are updated monthly and are available in the SCAL Clinical Strategic Goals (CSG) Sharepoint website: https://sp-cloud.kp.org/sites/teams-sccaa/CSG/CSG%20Report%20Library/CSG%20Current%20Monthly%20Reports Complete Care Initiatives with strategic plans are available at: https://sp-cloud.kp.org/sites/teams-scpmgcc-secure/complete%20care/SitePages/Home.aspx	Clinical Strategic Goals Planning & Measurement Group Timothy S Ho, MD, SCPMG Regional Assistant Medical Director, Quality & Complete Care Tracy Imley, MD, SCPMG Regional Assistant Medical Director, Quality & Clinical Analysis Nancy Gin, MD, SCPMG Medical Director of Quality and Clinical Analysis Giselle Willick, PharmD, SCPMG Chief Officer, Quality and Systems of Care Tania Tang, PhD, Executive Leader, SCPMG Clinical Analysis Ralph Vogel, PhD, Director, SCPMG Clinical Analysis Tara Harder, KFH/HP VP, Quality, Safety & Regulatory Services

ANALYSIS

The CSG Ambulatory Quality Composite (AQC) Score represents the performance of over one hundred CSG/HEDIS measures and reflects on the broad score of ambulatory quality of care. This is an important indicator and part of the Key Clinical Quality Goals; our performance on the AQC increased in 2023 to exceed the target by seven points. Targets were achieved on the measures related to diabetic care and good hemoglobin (HbA1c) control. Our year end evaluation is based on the CSG 2023 M10 reports. The memo can be accessed on SharePoint: https://sp-cloud.kp.org/sites/teams-sccaa/CSG/CSG%20Report%20Library/CSG%20Current%20Monthly%20Reports/Archival%20CSG%20Reports/CSG_2023_Archives/CSG__Memo_2023_M10_October_v2023-12-13.pdf
The excel report with the rates, denominator counts and trend from prior year end is also on SharePoint: https://sp-cloud.kp.org/sites/teams-sccaa/CSG/CSG%20Report%20Library/CSG%20Current%20Monthly%20Reports/Archival%20CSG%20Reports/CSG_2023_Archives/Clinical_Quality_Key_Measures_2023_M10_20231211.xlsx?d=w98054ef549e847aeb83faf2bedc551b7

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
HEDIS/CSG					
HEDIS					
NCQA	Report SCAL HEDIS MY 2022 data to NCQA, IHA, and HSAG	Data submission to NCQA and other agencies once a year for more than 75 measures	End of Q2 2023	• Review HEDIS specifications for changes and new metrics • Seek NCQA ASCR Measure Certification for all reported measures • Participate in audits by external agencies • Submit data to NCQA via IDSS, IHA via Onpoint, and Medi-Cal MCAS via IDSS/HSAG	Timothy Ho, MD Tania Tang, PhD Ralph Vogel, PhD Veronica Corrales Nick Alcivar
SCPMG KP HP	Report HEDIS-like and other metrics in monthly Clinical Strategic Goals (CSG) reporting	Report results for over 75 measures as part of CSG monthly reporting	Monthly, approx. six weeks after the end of each monthly measurement period	• Report monthly data in CSG reports https://sp-cloud.kp.org/sites/teams-sccaa/CSG/CSG%20Report%20Library/CSG%20Current%20Monthly%20Reports • Complete Care Initiatives https://sp-cloud.kp.org/sites/teams-scpmgcc-secure/complete%20care/SitePages/Home.aspx	Timothy Ho, MD Tania Tang, PhD Ralph Vogel, PhD Veronica Corrales
ANALYSIS					
The HEDIS reporting teams successfully passed NCQA MY 2023 Measure Certification and HEDIS audits on MY 2022 reporting by external auditing groups. The KPSC HEDIS results for Commercial, Medicare Risk, Medi-Cal (SD GMC), and Exchange (Covered California) populations were reported for MY 2022. The results were recorded in a report by product line with trending from prior years which was shared with stakeholders (see embedded object: KPSC_HEDIS_MY2022_EOCplus_measures_Trended_Results_MY22percentile_2023-12-01.pdf).  KPSC_HEDIS_MY2022_EOCplus_measure The monthly CSG reports with the HEDIS-like metrics were successfully produced according to the CSG Reporting Calendar. https://sp-cloud.kp.org/sites/teams-sccaa/CSG/CSG%20Report%20Library/CSG%20Current%20Monthly%20Reports/Archival%20CSG%20Reports/CSG_2023_Archives/CSG_Reporting_Calendar_2023.pdf					

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
CONTINUITY AND COORDINATION OF CARE					
Continuity and Coordination of Care (QI 3)					
NCQA	The organization monitors and takes actions, as necessary, to improve continuity and coordination of care across the health care network. **Ambulatory POSH Post Discharge Visit Evaluation (POSH Timeliness)** The performance goals are as follows: 1. A Scheduled POSH physician visit within 7 days of discharge: ≥ 90% (2020) 2. A Completed POSH physician visit within 7 days of discharge: ≥ 80% (2020) **Ambulatory Visit Medications Reconciliation Assessment (Med-Adherence)** The target goal for successful medication reconciliation is defined as > 60% of visits have successful medication reconciliations. **Comprehensive Diabetes Care – Eye Exams** The performance target is 87% (for all lines of business) of the eligible population where	**POSH Timeliness** – Timely visit within 7 days of discharge for members identified as having a high LACE score and discharging from the medicine service **Med Adherence** – Percent of medications documented in KPHC on the patient's medication list at the beginning of the office visit that have a check mark as "member taking" by the end of the visit after the medication review (measure of medication concordance). Successful medication reconciliation occurs when >75% of the medications on the list at the beginning of the visit have a check mark by the end of the visit (medication concordance). **Comprehensive Diabetes Care – Eye Exams**	Q4 2023	**Ambulatory POSH Post Discharge Visit Evaluation** 1. Aggregate and member-specific data are distributed weekly at the member level and reviewed by each of the Medical Center's readmission teams: physicians, nurses, managers, unit-based teams, etc. 2. Daily call lists are generated and reviewed by a core team at each of the Medical Centers, with a monthly dashboard review of performance by Medical Center Leaders, Medical Center Improvement Advisors, and Medical Center Initiative Leads. 3. Monthly HEDIS OE performance is generated and includes each of the metrics in the Readmission Reduction Program in addition to other intermediate process measures to monitor operations. 4. All reports and statistics, by Medical Center and in aggregate, are posted and accessible in a secure shared document library available to Leadership and members of the Care teams. 5. Reports are also reviewed monthly by the Medical Center Leadership and Regional Leadership through the monthly Readmission Steering Committee and monthly Readmission Improvement Advisor webinar and the bi-monthly Readmission Reduction Champion meetings. 6. Regional oversight and ongoing monitoring are also conducted by the Hospital Clinical Improvement Team (HCIT) and the Medicare 5-Star workgroup. 7. Regional Leadership is responsible to ensure outcomes are achieved as well as providing feedback and strategies to address performance gaps. 8. Annually an evaluation and strategic plan is developed to assess the impact of the program and improve effectiveness in reducing readmissions. **Medication Reconciliation** 1. Engagement of Medical Center champions, as well as determining priority areas and activities	**POSH Timeliness** • Dan Huynh, MD • Michelle Pruitt • Fredy Medina **Med Adherence** • Steven Steinberg, MD • Jose Becerra • SCAL Medication Adherence and Reconciliation Committee **Comprehensive Diabetes Care – Eye Exams** • John Martin, MD • Tim Hsieh, MD • Bobeck Modjtahedi, MD • Diane Simon • Shalini Rao • Jennifer Tran **Total Joint Replacement and Recovery** • Ronald Navarro, MD • Nithin Reddy, MD • P. Martin Yuson, PT, DPT, JD

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	members with retinopathy have a qualifying eye exam in the calendar year and those without diabetic retinopathy have a qualifying eye exam in the calendar year or year prior or bilateral eye enucleation any time up to the measurement year end. **Total Joint Replacement and Recovery** The overarching objective of the same-day Total Joint program is to reduce length of stay while maintaining or improving quality compared to inpatient Total Joint patient cases. The specific goals of the same-day Total Joint program include: • Length of stay (LOS) goal – at least 80% same-day surgery, 5% or less 2-midnight stay, and the remainder (approx. 15%) 1-midnight stay. • Quality balancing measures – 8% or less return to Urgent Care or Emergency Department within 7 days and 3% or less hospital readmissions within 30 days. **QI 3A. The organization annually identifies opportunities to improve coordination of medical care by:** 1. Collecting data on member movement between practitioners. 2. Collecting data on member movement across settings. 3. Conducting quantitative and causal analysis of data to identify improvement opportunities. 4. Identifying and selecting one opportunity for improvement.	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) and where members with retinopathy have a qualifying eye exam in the calendar year and those without diabetic retinopathy have a qualifying eye exam in the calendar year or year prior. **Total Joint Replacement and Recovery** 8% or less return to Urgent Care or Emergency Department within 7 days and 3% or less hospital readmissions within 30 days.		2. Development of workflow with input and agreement from physicians, RNs, pharmacy, and collaboration among other disciplines including hospital champions 3. Development of a training "tool kit" that promotes consistency and offers sufficient flexibility to accommodate differences that maybe unique to a particular clinic or sub-specialty 4. Access to real-time data and information so that staff are effectively monitoring fulfillment of the program protocols; and 5. Development and dissemination of physician level reports as well as analysis that calculates performance rates for each specialty or clinic type, including each Medical Center. **Comprehensive Diabetes Care – Eye Exams** The Diabetic Retinal Screening (DRS) Work Group will evaluate performance on retinal screening and plan quality improvement initiatives as appropriate. Primary care providers capture digital retinal photos within the primary care setting and send to optometry to review and share findings. Photos illustrating eye complications elicit an outreach from the eye care professional to the patient to come in for further evaluation; and those follow-up results and subsequent care plan are shared with the primary care provider. **Total Joint Replacement and Recovery** Key activities for Total Joint Replacement and Recovery take place in the following three general areas: 1. Pre-op – The "Pre-op" process begins when the orthopedic surgeon and patient agree that surgery is the appropriate option and ends when the patient presents for surgery. 2. In the hospital – The "In the Hospital" process begins when the patient presents for surgery and ends when the patient is discharged to home or a skilled nursing facility. This process also applies to patients who may have surgery in an ambulatory surgery facility. 3. At home – The "At Home" process encapsulates all care provided at the patient's home after discharge from the hospital.	

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	5. Identifying and selecting a second opportunity for improvement. 6. Identifying and selecting a third opportunity for improvement. 7. Identifying and selecting a fourth opportunity for improvement.				
NCQA	**QI 3B. The organization annually acts to improve coordination of medical care by:** 1. Acting on a first opportunity for improvement identified in Element A, factors 4-7. 2. Acting on a second opportunity for improvement identified in Element A, factors 4-7. 3. Acting on a third opportunity for improvement identified in Element A, factors 4-7.	If opportunities are identified in QI 3A, then actions will be taken, at which point the metric will be: Met or Not Met	Q4 2023	Opportunities will be identified throughout the year and action plans will be developed if necessary	**POSH Timeliness** • Dan Huynh, MD • Michelle Pruitt • Fredy Medina **Med Adherence** • Steven Steinberg, MD • Jose Becerra • SCAL Medication Adherence and Reconciliation Committee **Comprehensive Diabetes Care – Eye Exams** • John Martin, MD • Tim Hsieh, MD • Bobeck Modjtahedi, MD • Diane Simon • Shalini Rao • Jennifer Tran **Total Joint Replacement and Recovery** • Ronald Navarro, MD • Nithin Reddy, MD • P. Martin Yuson, PT, DPT, JD
NCQA	**QI 3C. The organization annually measures the effectiveness of improvement actions taken for:** 1. The first opportunity identified in Element B. 2. The second opportunity identified in Element B.	If opportunities are identified in QI 3B, then the effectiveness of the actions will be measured, at which point the metric will be: Met or Not Met	Q4 2023	For opportunities identified throughout the year, improvement actions will be evaluated on at least 3 related key opportunities.	**POSH Timeliness** • Dan Huynh, MD • Michelle Pruitt • Fredy Medina **Med Adherence** • Steven Steinberg, MD • Jose Becerra

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	3. The third opportunity identified in Element B.				• SCAL Medication Adherence and Reconciliation Committee **Comprehensive Diabetes Care – Eye Exams** • John Martin, MD • Tim Hsieh, MD • Bobeck Modjtahedi, MD • Diane Simon • Shalini Rao • Jennifer Tran **Total Joint Replacement and Recovery** • Ronald Navarro, MD • Nithin Reddy, MD • P. Martin Yuson, PT, DPT, JD

ANALYSIS

Ambulatory POSH Post Discharge Visit Evaluation (POSH Timeliness)

Performance is as follows:

1. Leadership continued last year's (2021) goal for POSH scheduling at 90% and POSH completion at 80% for high LACE, medicine discharges.
2. For high LACE, medicine discharges during 2022: KP SCAL consistently did meet the 90% performance goal of having a scheduled POSH physician visit within 7 days of discharge, demonstrating a year end performance of 93%. Performance rates for each month during 2022 ranged from 92% to 94%. Year-End rates improved as compared to 2021. Performance rates were met throughout all 2022.

For high LACE, medicine discharges during 2022: KP SCAL did not meet the 80% performance goal of having a Completed POSH physician visit within 7 days of discharge, demonstrating a year end performance of 76%. Performance rates ranged from 72% to 75%. Stronger rates in 2022 were seen during the first half of the year.

Table 2. 2019, 2020, 2021, 2022 regional POSH performance

Year	POSH Scheduled	POSH Completed
2019	94%	71%
2020	91%	78%
2021	91%	76%
2022	93%	76%

Summary of Findings, Opportunity for Improvement

The focus to reduce unplanned readmissions has been an ongoing effort for over 10 years. To assist patients with receiving timely follow-up after discharge, the scheduling of POSH appointments has been an effort in place that has achieved the target for the prior 4 years. For the year 2022, the performance in POSH Scheduled continues to reflect to be a reliable process exceeding the 90% goal.

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Integrating consistently this component into the work that occurs prior to discharge along with continual staff training has contributed to the success of this measure. However POSH Completed rates did not meet the 2022 target of 80% by four percentage points. Efforts to consolidate post discharge appointments were made which contributed to not seeing a decline in performance but rather flat performance compared to the prior year. Instead of patients having multiple appointments after discharge for the recent hospitalization, patients received and completed a single POSH appointment with the appropriate clinician. This had a positive impact on reducing the number of unnecessary appointments for patients post discharge. To further streamline post discharge appointments for patients, there is a need to further evaluate other specialty departments that can take on the POSH appointments. Building agreements with these departments will help with potentially developing new workflows. Through ongoing staff education, reinforcement of processes and communication of improvement opportunities we'll be able to further drive the completion of the POSH appointments. A POSH scheduling educational training was identified as a best practice. The training was shared with front line teams to provide the skills necessary to schedule the appropriate appointments and bring clarity to the various appointment options. One of the objectives of the training is to optimize the scheduling process by eliminating multiple appointments made for a single patient. These materials were shared and adopted at medical centers to build additional awareness in POSH appointment scheduling. Additional discussion on barriers and initiatives below:

Barriers to improvement:

- Front-line staff deviating from POSH booking guidelines.
- Limited number of available POSH appointments with specialty providers.
- Limited ability to drill down into local processes that impact POSH completion.

Initiatives to improve POSH completion

- Continue weekly reports to monitor performance and address fall outs. These reports can be used to identify opportunities for improvement.
- Continue with regularly scheduled performance dialogue sessions with medical center teams where POSH completion performance is reviewed to allow medical center champions and regional leadership an opportunity to review performance and develop an action plan.
- Continue monthly local medical center team meetings to assess performance and provide a forum for review of processes and performance.
- Assessing best practices from higher performing medical centers and possibly sharing the approach of reviewing prescheduled POSH appointments and updating to appropriate appointment type when necessary to improve POSH completion rates.

In conclusion, KP SCAL will continue to use the LACE risk scoring method to identify and prioritize members when scheduling follow-up appointments with physicians after discharge. The nurse follow-up call has been expanded to include high LACE members discharges and observation stays for medicine & general surgery, members discharging from a skilled nursing facility and any LACE members aged 65+. With added outreach to patients who are discharged from Affiliate Hospitals and non-KFH hospitals. Adjustments to the workflow will continue and accommodate the different needs associated with these members.

In 2023, the program will continue to assess HEDIS Plan All-Cause Readmission (PCR) performance as trended data becomes available. Focus on improving reliability of the POSH visit completion and the 72-hour nurse call will continue. Continuously assess availability of POSH appointment to leverage telephone appointments given the unpredictability in face-to-face encounters due to COVID-19. Also, leveraging the availability of specialty POSH appointments when applicable. The program will also continue to socialize the Post-Discharge Program guidebook, which serves as an excellent tool and resource for the program.

The overall program will be re-assessed as part of the annual evaluation process.

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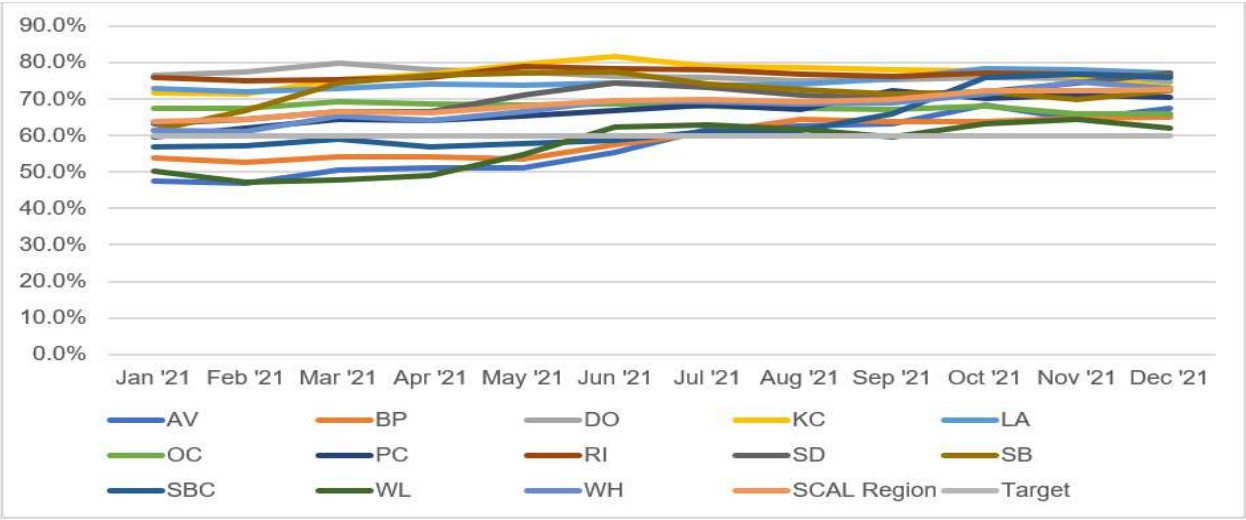
Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Ambulatory Visit Medications Reconciliation Assessment (Med-Adherence)

December 2021 Ambulatory Medication Reconciliation Summary Report

		AV	BP	DOW	KC	LA	OC	PC	RIV	SD	SB	SBC	WLA	WH	SC Region	Target
Successful Medication Reconcilation*																
Adult Primary Care Successful Med R	Dec 21	67.6%	65.2%	74.8%	73.3%	77.0%	66.1%	70.6%	76.1%	77.2%	72.3%	76.0%	62.1%	73.0%	72.6%	60.0%
Change from previous month		3.2%	0.3%	-0.8%	-2.8%	-1.0%	0.1%	-0.4%	-0.6%	2.8%	2.3%	-0.8%	-2.5%	-1.7%	0.3%	
Target		60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%		

December 2021 Year End Monthly
Snapshot above and monthly trend below



Medical Center	Jan '21	Feb '21	Mar '21	Apr '21	May '21	Jun '21	Jul '21	Aug '21	Sep '21	Oct '21	Nov '21	Dec '21
AV	47.4%	46.8%	50.5%	51.2%	51.1%	55.5%	61.8%	62.7%	63.2%	68.4%	64.4%	67.6%
BP	53.9%	52.6%	54.1%	54.2%	53.7%	57.4%	60.8%	64.4%	63.9%	63.8%	64.9%	65.2%
DO	76.5%	77.6%	79.9%	78.0%	77.5%	76.1%	75.9%	74.9%	75.4%	76.0%	75.6%	74.8%
KC	71.6%	71.3%	75.4%	76.9%	79.7%	81.7%	79.0%	78.6%	78.1%	77.8%	76.1%	73.3%
LA	72.9%	72.0%	72.8%	74.1%	73.7%	74.4%	73.7%	74.0%	75.5%	78.3%	78.0%	77.0%
OC	67.4%	67.5%	69.2%	68.8%	68.3%	68.7%	68.0%	67.6%	67.2%	68.0%	66.0%	66.1%
PC	59.7%	62.1%	64.5%	64.2%	65.4%	66.9%	68.5%	67.1%	72.2%	70.3%	71.0%	70.6%
RI	76.0%	75.0%	75.2%	75.9%	79.1%	78.5%	78.2%	76.7%	76.2%	77.3%	76.7%	76.1%
SD	63.2%	64.5%	66.5%	66.6%	71.2%	74.3%	73.2%	71.1%	70.1%	71.9%	74.4%	77.2%
SB	61.4%	67.0%	74.4%	76.5%	77.3%	77.6%	74.2%	72.6%	71.5%	72.0%	70.0%	72.3%
SBC	57.0%	57.3%	59.0%	56.9%	57.8%	58.8%	61.0%	61.3%	66.0%	75.8%	76.8%	76.0%
WL	50.1%	47.3%	47.9%	48.9%	54.9%	62.3%	62.9%	61.8%	59.6%	63.3%	64.6%	62.1%
WH	61.4%	61.2%	65.3%	64.0%	66.6%	69.6%	69.2%	68.6%	69.1%	71.4%	74.7%	73.0%
SCAL Region	63.8%	64.4%	66.7%	66.4%	68.0%	69.7%	69.9%	69.3%	69.8%	72.2%	72.3%	72.6%
Target	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%

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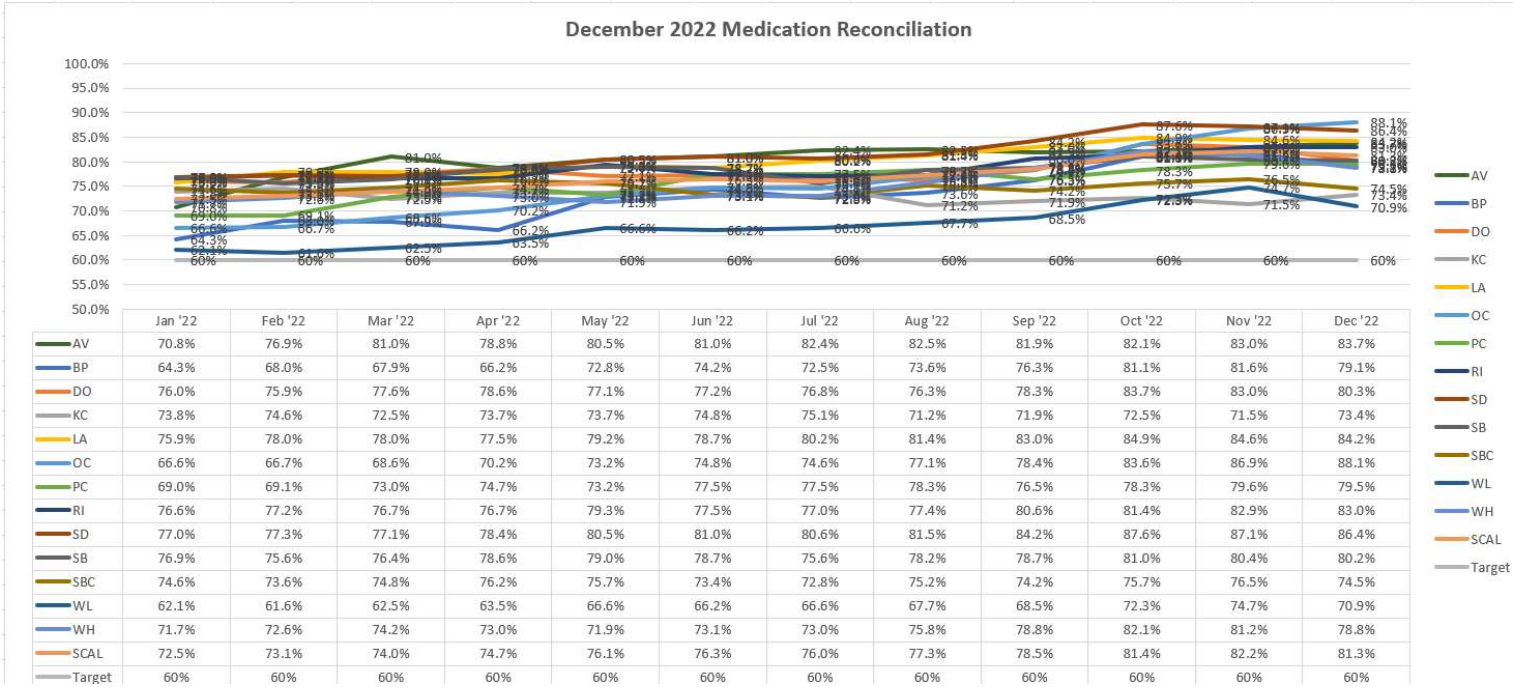
Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

December 2022 Ambulatory Medication Reconciliation Summary Report

	AV	BP	DOW	KC	LA	OC	PC	RIV	SB	SBC	SD	WH	WLA	SC Regio	GCN	Target*
Successful Medication Reconciliation (Targets as Noted)																
Adult Primary Care Successful Med Rec*	83.7%	79.1%	80.3%	73.4%	84.2%	88.1%	79.5%	83.0%	80.2%	74.5%	86.4%	78.8%	70.9%	81.3%		60.0%
Change from previous month	0.7%	-2.6%	-2.7%	1.9%	-0.4%	1.2%	-0.1%	0.1%	-0.1%	-2.0%	-0.7%	-2.5%	-3.8%	-0.8%		
Virtual Visits	76.5%	77.1%	82.1%	71.0%	86.2%	76.6%	60.4%	81.0%	64.3%	74.7%	75.1%	65.1%	54.2%	67.9%	44.2%	N/A
Change from previous month	-0.7%	0.1%	-1.6%	-1.4%	3.0%	-2.9%	0.8%	1.6%	4.5%	-0.9%	0.1%	-1.5%	-1.5%	0.2%	0.5%	

December 2022 Year End Monthly
Snapshot above and monthly trend below



	Jan '22	Feb '22	Mar '22	Apr '22	May '22	Jun '22	Jul '22	Aug '22	Sep '22	Oct '22	Nov '22	Dec '22
AV	70.8%	76.9%	81.0%	78.8%	80.5%	81.0%	82.4%	82.5%	81.9%	82.1%	83.0%	83.7%
BP	64.3%	68.0%	67.9%	66.2%	72.8%	74.2%	72.5%	73.6%	76.3%	81.1%	81.6%	79.1%
DO	76.0%	75.9%	77.6%	78.6%	77.1%	77.2%	76.8%	76.3%	78.3%	83.7%	83.0%	80.3%
KC	73.8%	74.6%	72.5%	73.7%	73.7%	74.8%	75.1%	71.2%	71.9%	72.5%	71.5%	73.4%
LA	75.9%	78.0%	78.0%	77.5%	79.2%	78.7%	80.2%	81.4%	83.0%	84.9%	84.6%	84.2%
OC	66.6%	66.7%	68.6%	70.2%	73.2%	74.8%	74.6%	77.1%	78.4%	83.6%	86.9%	88.1%
PC	69.0%	69.1%	73.0%	74.7%	73.2%	77.5%	77.5%	78.3%	76.5%	78.3%	79.6%	79.5%
RI	76.6%	77.2%	76.7%	76.7%	79.3%	77.5%	77.0%	77.4%	80.6%	81.4%	82.9%	83.0%
SD	77.0%	77.3%	77.1%	78.4%	80.5%	81.0%	80.6%	81.5%	84.2%	87.6%	87.1%	86.4%
SB	76.9%	75.6%	76.4%	78.6%	79.0%	78.7%	75.6%	78.2%	78.7%	81.0%	80.4%	80.2%
SBC	74.6%	73.6%	74.8%	76.2%	75.7%	73.4%	72.8%	75.2%	74.2%	75.7%	76.5%	74.5%
WL	62.1%	61.6%	62.5%	63.5%	66.6%	66.2%	66.6%	67.7%	68.5%	72.3%	74.7%	70.9%
WH	71.7%	72.6%	74.2%	73.0%	71.9%	73.1%	73.0%	75.8%	78.8%	82.1%	81.2%	78.8%
SCAL	72.5%	73.1%	74.0%	74.7%	76.1%	76.3%	76.0%	77.3%	78.5%	81.4%	82.2%	81.3%
Target	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%

Conclusion and Program Effectiveness

- Overall Southern California Region exceeded Target above 60% for all 12 months of 2022.
- The year ended higher at 81.3% compared to 72.6% the previous year.
    - Attributed increase due to large emphasis on importance of medication reconciliation at chief and department meetings; distribution of reports; leadership key messages; and more face-to-face visits and virtual visits as well, allowing for traditional staff-preparatory workflow.
- By the end of the 2022 year, all medical centers exceeded the 60% target.

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- Medication reconciliation is the process of identifying the most accurate list of all medications that the patient is taking. It is a formal, systematic approach to overcome medication information communication challenges and reduce unintended discrepancies that occur at transitions in care for patients. As interactions can occur between prescribed medication, over-the-counter medications, or dietary supplements, all medications and supplements should be part of a patient's medication history and included in the reconciliation process. In 2023 the goal for adult primary care medication reconciliation will increase to further drive performance given the success at medication reconciliation in 2022. Successful will be raised to 67%, Excellent to 70%, and Exceptional to 76%.

2022 YE Analysis provided key insight into areas of opportunity for improvement in the medication reconciliation space. Below are some key areas identified for improvement along with dates of intervention implementation.

Opportunity for Improvement	Intervention	Date	Context
Enhanced Specialty Department reporting for Medication Reconciliation	The med recon quality team has created curated list of medication classes for which specialty is responsible to reconcile. This was done to more accurately accountable for meds reconciled and generate better "buy in" for reports and initiative in these specialty departments. We have been able to meet with Specialty Chiefs across the region to create a specific medication list that will provide specialty departments with a curated list of specialty medications that should be addressing at each visit. This in turn helps maintain a clean and accurate list for each patient at each visit.	Q1 2022 And ongoing	Some medications are outside of specialist's purview to modify medication sig when patient reports not taking as directed, and may wish to have patient discuss with prescribing physicians prior to discontinuing meds
Ongoing educational meetings with departments to help identify high opportunity and reinforce workflow protocols	Meet with chiefs of departments to share updated reports, prioritizing those with high visit volume from patients who may not visit PCP – such as urgent care, to ensure understanding of workflow in med rec to ensure completeness of record	Q1 2022 and Ongoing	Although areas continue to exceed target, regular virtual rounding with departmental regional chiefs can help continue focus on importance of an accurate patient medication list. The regular rounding allows the quality consultants to stay engaged with frontline providers and offer education and guidance as needed.
Provide Timely Working Data	Collect and incorporate feedback on reports, SharePoint, and other resources for medication reconciliation.	Q2/Q3 2022	To make med reconciliation work more doable and efficient, it is prudent to collect feedback on data, how/where data is provided, and what other resources would be useful to help. Monthly, data reports are evaluated by quality consultant team to help identify service areas that would require support and intervention. Quality consultants

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				have been increased MAR team meeting cadence to ensure accuracy in data reports that are distributed across the region.	

Comprehensive Diabetes Care – Eye Exams

Commercial

	HEDIS 2023 (2022 performance)	HEDIS 2022 (2021 performance)	HEDIS 2021 (2020 performance)
Eligible Population	177,700	171,845	171,281
Performance Rate	74.66%	69.17%	67.24%
KP Performance Target	73.6%	71.6%	79%
Target Met	Yes	No	No

Medicare

	HEDIS 2023 (2022 performance)	HEDIS 2022 (2021 performance)	HEDIS 2021 (2020 performance)
Eligible Population	109,030	105,154	102,722
Performance Rate	84.73%	80.37%	77.41%
KP Performance Target	73.6%	71.6%	79%
Target Met	Yes	Yes	No

Exchange

	HEDIS 2023 (2022 performance)	HEDIS 2022 (2021 performance)	HEDIS 2021 (2020 performance)
Eligible Population	14,907	13,448	11,125
Performance Rate	74.47%	69.49%	67.04%
KP Performance Target	73.6%	71.6%	79%
Target Met	Yes	No	No

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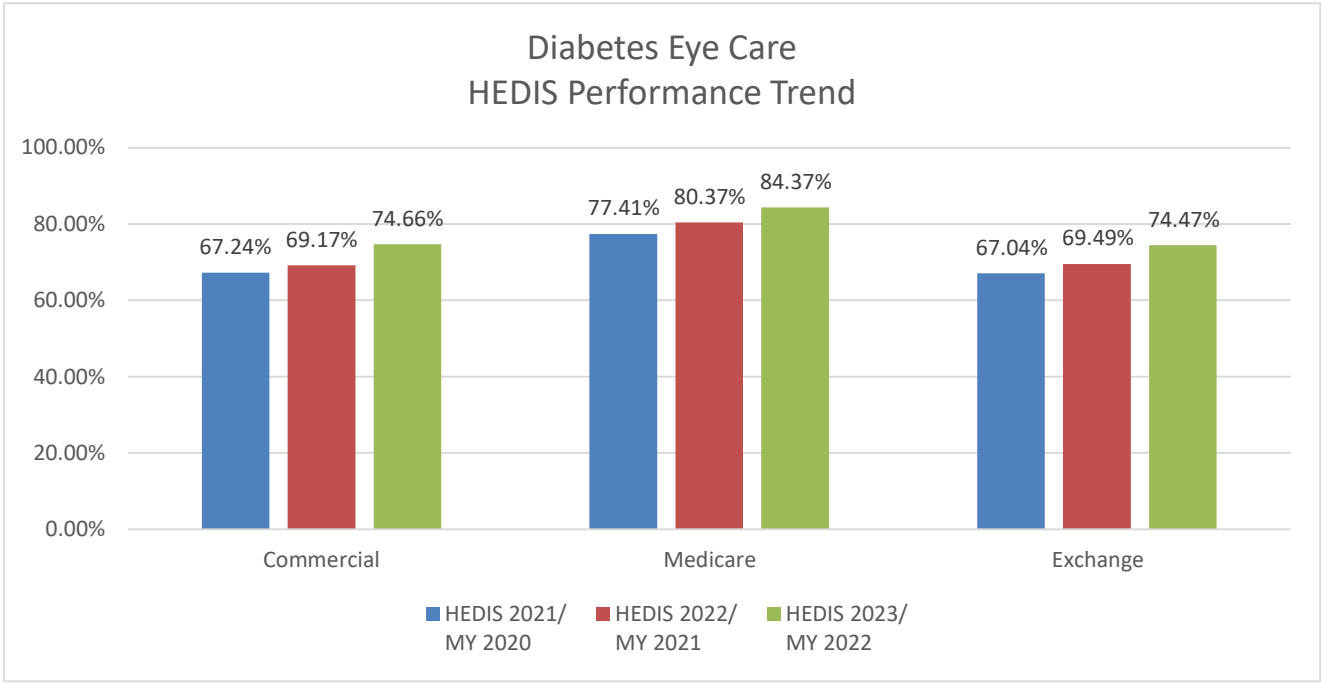
Trended HEDIS Rates 2021 – 2023 (reflecting performance in MY 2020-2022)



Annual Analysis

Quantitative Analysis
2023 (2022 performance) results showed an increase in all lines of business from the previous year. Commercial line of business had the greatest improvement at 5.49%, followed by Exchange, and then Medicare. KP targets for Medicare were increased, decreased for Commercial and, remained the same for Exchange.

Medicare, Commercial and Exchange all met their 2022 KP targets. Commercial and Exchange were in the HEDIS Measurement Year (MY) 2021 95th percentile. Medicare was at the HEDIS MY 2021 90th HEDIS percentile.

Qualitative Analysis
The large improvement in HEDIS percentile for all lines of business was likely due to increase in in-person appointments compared to prior years virtual appointments due to COVID-19. The increase could also be due to the renewed emphasis on capturing photos during visits and the option for patients to self-schedule their eye exams.

Barriers / Opportunities for Improvement
- Large number of virtual visits which cut down on photo in-reach during primary care and eye-related specialty visits
- High staff turnover and continuous need to retrain due to inconsistencies in workflows
- Dilation drops recall and shortage

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Initiatives to Improve

- Continued emphasis on capturing photos during visits (data sharing, rounding, training new staff)
- Additional facilities for patient self-scheduling
- Utilize reports to identify underused camera resources that previously had higher traffic to prioritize photographer assignments
- Continue utilizing the Diabetic Retinal Screening Quarterly meetings to educate on proper workflows

Total Joint Replacement and Recovery

Return to Care – Urgent Care/Emergency Department within 7 days

	2022	2021
Eligible Population	11,667	10,132
Performance Rate	3.8%	4%
KP Performance Target	<8%	<8%
Goal Met	Yes	Yes

Readmission – Inpatient within 30 days

	2022	2021
Eligible Population	11,667	10,132
Performance Rate	2.7%	2.7%
KP Performance Target	<3%	<3%
Goal Met	Yes	Yes

Annual Analysis

Quantitative Analysis
In 2022, the Return to Care measure had a slight improvement in performance rate from 4% in 2021 to 3.8% in 2022. Goals were met for both Return to Care and Readmission.

Qualitative Analysis
In 2022, deep-dive chart reviews of Q4 2021 returns to ED/UC and hospital readmissions was performed. Between 2019 and 2021, returns to ED/UC within 7 days had incrementally dropped from 6% in 2019 to 5% in 2020 to 4% in 2021. At the same time, hospital readmissions within 30 days had remained flat at 3% in 2019, 2020, and 2021. Although targeted goals of 8% or less returns to care within 7 days and 3% or less hospital readmissions within 30 days were met, the potential for further improvement was sought. Thus, a deep dive into chart reviews was performed to try to understand the root causes of these returns. Additionally, there was interest to know whether there were any racial or ethnic disparities involving returns to care and readmissions.

The Q4 2021 chart reviews consisted of reviewing the patient record within KP HealthConnect (an Epic-based electronic health record). Each patient's demographic information was reviewed. Included in the review was each patient's past medical history, including reasons for which the patient was referred to Ortho and ultimately considered a candidate for primary total knee or hip replacement. The focus then turned to the patient's total joint journey from preop to periop to postop, including any home health, outpatient visits, communications with providers (e.g., KP On Call for nurse advice, phone calls to the Ortho department, etc.), and ultimately returns to the ED or UC or hospital readmission.

In total, 287 individual patients were reviewed. Given that a number of these patients returned more than once to the ED or UC or were readmitted within the 30-day postop time frame, there were a total of 341 returns and readmissions that were reviewed.

The most common reasons for returns to care or readmissions included the following:

- Pain (49)

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- Urological issues (32) – these included UTIs, hematuria, prostatitis, urinary incontinence, urinary retention, dysuria, catheter malfunction, and urinary hesitancy
- Swelling (28)
- Wound-related concerns (26) – these included surgical site infection, rash, wound drainage, and surgical site concern
- Medication-related complications (16)
- Constipation (13)
- Falls (11)
- Syncopal episodes (10)

An assessment of each of the above common reasons for returns and readmissions was completed in collaboration with the SCPMG regional lead for same-day total joint procedures. Upon review of these cases, the following were concluded to be avoidable returns to care that could have been more optimally managed:

- Pain (36)
- Constipation (12)
- Wound-related issues (12)
- Swelling (9)
- Medication-related complications (7)
- Urological issues (4)
- Syncopal episodes (2)
- Fall (1)

Key findings included that some of these avoidable returns to care occurred in the following contexts:

- 4 returns involved KP On Call providers who could have directed the patients to Ortho providers without the patients having to go to the ED or UC
- 6 returns could have been resolved with patient education reinforcement of post-procedural symptoms/pain
- 30 returns could have been avoided if there was a weekend Orthopedic Provider on call available
- 3 avoidable after hours returns may have been resolved if there was an after-hours Orthopedic Provider on call

Barriers/Opportunities for Improvement

In addition to the opportunities to improve our KP on Call processes as well as after-clinic hours and weekend hours procedures to avoid unnecessary returns to care, we identified the following opportunities and engaged in the following actions:

- Reviewed and updated patient education materials and procedures to determine how to effectively educate and empower patients regarding post-op pain and/or swelling issues
- Collaborated with Urology to review evidence-based and best practices that can be implemented to reduce post-op urological issues (e.g., post-op urinary retention ("POUR") protocol, developed in collaboration with Urology)
- Develop after-clinic hours and weekend Orthopedic provider on call program to guide patients and avoid unnecessary returns to the ED/UC – This is an ongoing challenge that we continue to discuss
- Racial/ethnic disparities in returns to care/readmissions:
    - Findings were inconclusive with respect to care provided related to the patient's reason for return
    - Language barriers may have been an issue in some cases
    - More analysis on overall health outcomes is needed- We continue to work with our Orthopedic Registry to better understand whether race or ethnicity is causing disparities in our orthopedic care.

Conclusion

In conclusion, there were three specific opportunities identified for reducing returns to ED/UC and hospital readmissions, some of which have been addressed and others of which are ongoing:

- More effectively addressing common reasons for return (e.g., pain, urological, swelling, wound-related concerns, etc.)
- Pre-op Education: Better educating members and caregivers through written materials, in-person education, and real-time communication

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	• Better addressing member needs during after-clinic and weekend hours				

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CONTRACT OVERSIGHT & CONTRACTED PROVIDERS					
Contract Oversight & Contracted Providers					
NCQA DMHC CMS KP-SCAL Goal	Ensure safety of patients in contracted facilities. Meet 100% of required elements by NCQA re: Health Services Contracting on an ongoing basis.	Met/Not through evidence of reports on an annual basis to RCC and SCQC	Q4 2023	Expand the contract quality oversight repository to capture ongoing quality metrics and evaluations for contracted providers and incorporate new In-Scope providers. Develop ongoing quality oversight workgroup with representatives from each SCAL service area to ensure continual quality oversight.	Paula Kraft Regional Director Quality Oversight
NCQA DMHC CMS KP-SCAL Goal	Ensure safety of patients in contracted facilities. Meet 100% of required elements by NCQA re: Health Services Contracting on an ongoing basis.	100% review of all KP contracted providers	Ongoing Reports on an annual basis to RCC and SCQC & QHIC	Ongoing monitoring of quality oversight process as evidenced by Executive Summaries to Regional Credentialing, SCQC and QHIC. Continue development of site visit tools and protocols to ensure quality and standardized approach. Clearly define Site Visit Requirements and Recommendations for key stakeholders.	Paula Kraft Regional Director Quality Oversight
NCQA DMHC CMS KP-SCAL Goal	Continue to widen scope of the ongoing partnership between KFH and other plan facilities' quality, patient safety and infection control program.	Implementation of action items as outlined	Q4 2023	Joint Operations meeting between KP Leaders and Affiliated Hospitals to reflect quality oversight dialogue. Quality Reporting for Affiliated Hospital key metrics within SharePoint. Ongoing monitoring of goals and reporting to SCQC and KPAHC. Continue Affiliated Hospital Quality Subcommittee revised structure to focus on improvement opportunities through collaborative efforts and the sharing successful strategies focused on key quality metrics.	Paula Kraft Regional Director Quality Oversight
ANALYSIS					
QI Workplan goals met. Oversight and quality analysis for contracted providers completed and reported to SCQC and QHIC. Affiliated Hospital JOC participation and Quarterly meetings held throughout the year. Participation, as needed in Affiliated Hospital Council Meetings to report on quality metrics and strategy, Annual audits for ASH and Delta Dental completed and reported to SCQC.					

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
CREDENTIALING					
Credentialing					
NCQA KP	• 100% of practitioners are credentialed prior to providing services to members. • 100% of practitioners are re-credentialed at least every 24 months for hospital practitioners. • and every 36 months for ambulatory practitioners. • As applicable, 100% of practitioners are reappointed/privileged at least every 24 months. • All privileged files are reviewed by Regional Credentialing personnel prior to action by C&P. • Credentialing errors are corrected prior to C&P Committee action as required per regulatory standards/requirements.	100% Goal Monitored Quarterly	Ongoing	2023 Action Plans and Next Steps: • Continue to monitor through Tableau and MSO reports. • Regional onboarding team established to review resignation process to ensure all handoffs and updates. • Credentialing Staff is utilizing reports to ensure that all files are processed in a timely manner.	Monique Ferguson SCAL Regional Credentials Director Regional Credentials Committee Christopher Distasio, MD and Margie Harrier, SVP

ANALYSIS

- 100% of practitioners are credentialed prior to providing services to members.
- 100% of practitioners are re-credentialed at least every 24 months for hospital practitioners.
- 99% of ambulatory practitioners credentialed in 36 months.
- 99% of practitioners are re privileged at least every 24 months.
- 100% All privileged files are reviewed by Quality Assurance prior to action by C&P.
- Credentialing errors are corrected prior to C&P Committee action as required per regulatory standards/requirements.

2024 Action Plans and Next Steps:

- Re-evaluate monitoring program and implement process improvement opportunities to ensure 100% compliance in privilege adherence and reappointment timeliness. Continue to monitor through Tableau and MSO reports.
- Regional monthly reports will communicate any noncompliance and action plans will be required if improvement plans are not successful.
- A new standardized process will be developed to monitor, track and communicate compliance and or areas of improvement for errors being corrected prior to C& P Committee.

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
KFHP Care Coordination and Case Management					
Seniors and Persons with Disabilities (SPD) and Whole Child Model (WCM) Regulatory Requirements					
Health Plan Partners and DHCS	Perform Health Risk Assessment (HRA) for Whole Child Model (WCM) and Seniors and Persons with Disabilities (SPD) per regulatory requirements: 1. For WCM a. initial HRA completed within 90- days of enrollment b. Reassessment within 365 days from the last assessment 2. For SPD a. Initial HRA for members stratified as High Risk started within 30 days of risk stratification and completed within 60 days of risk stratification b. annual HRA for members stratified as High Risk started within 30 days of risk stratification and completed within 60 days of risk stratification	KFHP case managers outreach to SPD and WCM members to complete the HRA.: 1. 100% Outreach to the newly enrolled WCM and High Risk SPD members 2. 100% Outreach to the existing WCM members and High Risk SPD	December 31, 2023	Health Risk Assessment (HRA): 1. KFHP case managers utilize the WCM enrollment worklist to outreach to WCM members 2. KFHP case managers utilize Compass Rose target tasks to guide outreach to SPD members 3. Department manager to monitor completion performance of the HRA 4. HRA chart reviews	Sloane Petrillo, Director of Care Coordination / Case Management
ANALYSIS					
1. WCM Outreach Goal: 100% a. The newly enrolled WCM members outreach percentage within 90 days of enrollment was 75.45% in 2023. Late outreach attempts were not counted. The goal of 100% outreach was not met. b. The existing WCM members outreach percentage within 365 days from last assessment was 69.17% in 2023. Late outreach attempts were not counted. The goal of 100% outreach was not met. 2. SPD Outreach Goal: 100% a. The newly enrolled SPD members outreach percentage within 60 days of risk stratification was 70.86% in 2023. Late outreach attempts were not counted. The goal of 100% was not met. b. The existing high risk SPD members outreach percentage within 60 days of risk stratification was 69.17% in 2023. Late outreach attempts were not counted. The goal of 100% was not met.					
KFHP Complex Case Management (CCM) and Community-Based Adult Services (CBAS)					
Health Plan Partners,	CCM: Comply with NCQA QI5/PHM 5 & 6 Standards	CCM:	December 31, 2023	CCM: 1. Random monthly chart reviews	Sloane Petrillo, Director of Care Coordination / Case Management

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DHCS and/or NCQA	CBAS: 1. Compliance with CBAS Referral Process and Turn Around Time (TAT) 2. Improve CBAS workflow process and ensure using the correct HCPC codes.	Pass Health Plan Partners audit with a score of at least 95% CBAS Process and TAT: 1. CBAS CEDT TAT Goal: 100% 2. CBAS Authorization TAT Goal: 98%		2. Follow up education for case managers, as needed. CBAS Process and TAT: 1. Complete CEDT with RN signatures within thirty (30) calendar days from receipt of benefit inquiry. 2. CBAS Authorization TAT to approve, modify or deny must be completed within 5 business days upon receipt of authorization request 3. Reinforce with continuous education on CBAS program and process TAT to staff 4. Department manager monitors and reviews CBAS TAT quarterly.	
ANALYSIS					
1. CBAS CEDT TAT Goal: 100% • From receipt of CEDT to determination response, the average TAT is 0.4 days in 2023. The CEDT TAT was met as the regulatory requirement is 5 business days or less. 2. CBAS Authorization TAT Goal: 99.7% • From receipt of Benefit Inquiry to Authorization of H2000, the average TAT is 19.8 days in 2023. The CBAS authorization for 2021 was 99.7%. The goal was met.					
Special Needs Plan (SNP) Regulatory Requirements					
CMS - Medicare Star Measures and NCQA	A. SNP Care Management Measure: 1. Complete initial Health Risk Assessment (HRA) within 90 days (before or after) of the most current enrollment effective date 2. Complete the annual HRA within 365 days of the initial assessment/1 year of the previous HRA date B. Care of Older Adults Measures: 1. Completion of SNP member medication review during the measurement year 2. Completion of SNP member functional status during the measurement year 3. Completion of SNP member pain screening during the measurement year	A. SNP Care Management Measure: The target for the completion of initial and annual SNP HRAs in 2022 is: 92% Minimum, 100% Maximum B. Meet KFHP set benchmarks for Care of Older Adult measures from 1. Medication Review = 95% 2. Functional Status = 93%	December 31, 2023	1. Care managers will outreach to all members who are due for the initial and annual HRA within compliance timeframes 2. Care managers will accurately document in KPHC the outreach outcomes to easily identify the number of Reached/Completed, Unable to Reach, Refused, Hospice/Home Based Palliative Care and Other 3. Region will provide education to care managers on the HRA process, and best practices 4. Region will monitor and track the number of "overdue" assessments weekly 5. Care managers will outreach to all members who are due for the initial and annual HRA and will perform functional status, pain screening, medication review and advocate for life care planning during the HRA 6. Performance data will be monitored monthly	Sloane Petrillo, Director of Care Coordination / Case Management Kim Kaiser, Regional Quality Administrator

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		3. Pain Screening = 94%			
ANALYSIS					
A. SNP Care Management Measure performance for timely initial and annual health risk assessments in 2023 was 77%. The goal was not met. Below are key factors for the decline in 2023 performance: a. Implementation of Compass Rose in early 2023 slowed care managers down as they acclimated to the new documentation system in KPHC. b. An unexpected increase in DSNP membership at the same time as the implementation occurred because DHCS implemented the Exclusively Aligned Enrollment(EAE) initiative in 2023 which attributed the significant increase in membership in EAE counties. i. All SNP locations except Kern, Orange County, Riverside and San Bernardino County were affected by the EAE membership increase. c. In addition to a large bolus of 7,000 new members in January 2023, membership continued to increase every month in 2023 by at least 400-700 members. d. Local DSNP care manager staff has not increased enough to meet the demand. e. Maintaining aggressive monthly benchmarks with the goal to meet the minimum threshold by the end of Q3 has helped drive performance in the past. This allows the local SNP teams the opportunity in Q4 of each year to catch up with previously unable to reach members and/or get ahead with near future due member health risk assessments. f. This approach will continue in 2024. g. A central regional staff relief pool was created to support locations with temporary gaps in care manager resources as well. B. Care of Older Adults Measures: a. Medication Review 2023 rate through November 31, 2023, was 98%. The 95% goal was met. i. This measure is driven by prescribing providers only. b. Functional Status 2023 rate through November 31, 2023, was 91%. The 93% goal was not met. c. Pain Screening 2023 rate through November 31, 2023, was 93%. The 94% goal was not met. While the Care of Older Adults measures are SNP specific, SNP care managers are not the only performance drivers for these measures. However, functional status and pain screening questions from the DSNP assessment are some of the data used to fulfill this measure. With the decline in DSNP assessment performance, in 2023 due to several factors, it is likely this data was also impacted.					
Special Needs Plan (SNP) Quality and Process Measure Compliance					
	A. Receive 90% or better on quarterly SNP Medicare Monitoring Metrics targeted at care coordination elements of the SNP Model of Care: 1. Timely Initial Health Risk Assessment (HRA) 2. Timely Re-assessment 3. Care Plan Completion 4. Care Plan Implementation	A. Reach 90% or better on the following SNP Metrics: 1. Timely Initial Assessment 2. Timely Re-assessment 3. Care Plan Completion 4. Care Plan Implementation	December 31, 2023	A. Medicare Monitoring Metrics: 1. Continue to address and provide training to care managers on all elements of care coordination and care management per the SCAL SNP Model of Care 2. Hold quarterly care manager meetings and/or trainings to share SCAL region best practices and care coordination topics 3. Provide trainings focused specifically on proper care plan development, implementation and documentation 4. Care managers will have knowledge of community-based services for referral and to provide coordination of care as appropriate	Sloane Petrillo, Director of Care Coordination / Case Management Kim Kaiser, Regional Quality Administrator

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				5. Care managers will accurately document outreach outcomes in KPHC by required timeframes to easily identify the number of Reached/Completed, Unable to Reach, Refused, Hospice/Home Based Palliative Care and Other 6. Conduct chart reviews for random sample of SNP membership quarterly	
	B. Care Transitions: 1. Outreach and health risk assessment will be performed for post-acute discharges within 72-hours of discharge notification	B. Care Transitions: 1. 90% call completion rate		B. Care Transitions: 1. Provide education to care managers on post discharge protocols 2. Post discharge and readmission reports provided regularly for transitional care management	
	C. Reduce the Health Risk Assessment (HRA) Overdue Rate	C. Reduce the number of overdue (unable to reach, refused, hospice, HBPC, and others) from the SNP population. Target is ≤ 8%		C. Reduce HRA Overdue Rate: 1. Care manages will outreach to all members who are due for the initial and annual HRA within compliance timeframes 2. Care managers will accurately document outreach outcomes in KPHC by required timeframes to easily identify the number of Reached/Completed, Unable to Reach, Refused, Hospice/Home Based Palliative Care and Other 3. Region will provide education to care managers on the HRA process and best practices	
	D. Increase the number of Health Care Decision Makers identified and documented in the Life Care Planning Tab in HealthConnect during Initial and Annual SNP Assessment Process	D. Target is ≥ 45% that a Health Care Decision Maker was identified on or before the encounter date		D. Life Care Planning: 1. Care managers will outreach to all members who are due for the initial and annual HRA and will advocate and document life care planning conversations during the HRA 2. Data will be monitored and reported monthly	
	E. SNP Member Satisfaction with the care coordination and SNP case management program by conducting quarterly analysis on Member Satisfaction survey results and receive	E. Do you think this case management program is helpful for you in		E. SNP Member Satisfaction: 1. Perform member satisfaction survey via interactive voice recognition monthly on sample population 2. Collect data 3. Report quarterly	

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	80% or better on the question "Do you think this case management program is helpful for you in achieving your goals?"	achieving your goals? = ≥ 80%			
	F. Controlling High Blood Pressure: The percentage of Medicare Advantage Special Needs Plan members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year	F. BP was adequately controlled (<140/90 mmHg) during the measurement year = 77%		F. BP was adequately controlled: 1. SNP Care Managers are not the only drivers for this measure 2. Performance data will be monitored monthly	
	G. Follow-Up After ED Visit for Mental Illness (2 Rates): The percentage of Medicare Advantage Special Needs Plan members assessed after an emergency department (ED) visit, includes adults and children 6 years of age and older with a diagnosis of mental illness and who received a follow-up visit for mental illness	G. Follow-Up After ED Visit For Mental Illness: Rate 1 - Within 30 days = 76% Rate 2 - Within 7 days= 63%		G. Follow-Up After ED Visit For Mental Illness: 1. SNP Care Managers are not the only drivers for this measure 2. Performance data will be monitored monthly	
	H. 30-Day Readmissions: The percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days to ensure affordability and appropriate utilization of services for preventative health and chronic conditions.	30-Day Readmissions = 0.86		H. 30-Day Readmission: 1. Provide education to care managers on post discharge protocols 2. Post discharge and readmission reports provided regularly for transitional care management 3. Performance data will be monitored monthly	

ANALYSIS

A. Medicare Monitoring – SNP Chart Audits

a. Chart audits for SCAL SNP large sample (130 charts) were conducted during 3 of 4 quarters in 2023. Q1 2023 presented an unexpected member increase and implementation of a new documentation system, which resulted in canceling chart audits to focus on the new challenges.

b. 130 random SNP member charts were reviewed Q2-Q4 2023 only.

c. In the larger sample, results for the completion of timely reassessments did not meet the overall 2023 90% target.

i. Unexpected member increase and implementation of a new documentation system, with no increase in local SNP care manager staff to meet the demands attributed to the inability to keep up with timely completions of annual reassessments

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d. KFHP Compliance also requires results from a smaller sample of 10 charts per report quarter for the Medicare Monitoring program and charts were reviewed in all 4 quarters of 2023.

e. Results from the small sample (10 charts) for Q1-Q4 2023 showed no issues.

f. As a result, no variance report was requested from SCAL SNP in 2023.

i. SCAL SNP will continue to complete a review of the larger sample (130 charts) to determine root cause of any low performance or documentation issues

Results were shared with the Medicare Monitoring team and subsequently with the SCAL SNP Managers in 2023.

Regular meetings with SNP care managers in 2023 reinforced the following:

a. Reinforcement of regulatory timeframes and required documentation for HRA completion, and

b. Reinforcement of workflow process for care plan completion

Below are the results for the large sample for quarters in 2023 (10 charts per SNP location, per quarter):

2023 SCAL SNP	2022 YE AVG	Q1	Q2	Q3	Q4	2023 YE AVG
SNP--Timely Initial Assessment	90%	n/a	96%	98%	97%	97%
SNP--Timely Re-assessment	95%	n/a	88%	90%	83%	87%
SNP--Care Plan Completion	100%	n/a	95%	98%	94%	96%
SNP--Care Plan Implementation	100%	n/a	95%	99%	97%	97%

Chart audit data in 2023 show all metrics except Timely Reassessment met the 90% goal. Again, the challenges in 2023 with the unexpected increase in SNP membership and not enough increase in SNP staffing to meet the demand caused delays in reassessing existing members throughout the year and missing the timeliness requirement.

B. Care Transitions:

a. Post discharge outreach call performance between January 1, 2023 to December 31, 2023 was 86% and did not meet the 90% target.

i. A CMS audit in 2021 revealed issues with discharge data and reporting for SNP that led SCAL SNP to improve daily reports and develop a performance monitoring report.

ii. SCAL SNP reviewed care transition data to understand areas for opportunity and streamlining. The focus was to ensure data was accurate and readily available for SNP care managers to easily access all SNP discharge data in one place. The goal was to ensure consistent data to enable seamless transitions for the SNP member and improve post transition outreach and assessment completions for the SNP care manager.

iii. Full implementation of the report took place in January 2022 and was emailed daily to all local SNP teams in 2023.

iv. A Discharge Summary Report was also developed in April 2022 and provided to leadership for close monitoring of post discharge performance. The report was available to local SNP management on demand via a Tableau dashboard in 2023.

b. Plan for 2024:

i. Launched electronic target tasks in Compass Rose for real time KFH discharge notifications in 2023 and will continue to enforce education and use of the system.

ii. Will continue to share and enforce operational post discharge workflows to ensure local SNP teams are following established protocols.

iii. Continue providing post discharge compliance reports for monitoring of transitional care management and share data monthly via the SNP executive dashboard, and also during 1:1 meetings with individual SNP managers and their leadership.

C. Reduce the Health Risk Assessment (HRA) Overdue Rate to ≤ 8 %:

a. The 2023 year-end HRA Overdue rate was 6%. The goal was met.

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

i. Overdue date includes SNP members who did not receive any outreach in 2023 and remain overdue in 2024.
ii. SNP members who resulted in a refusal or unable to reach outcome in 2023 are not included.
iii. SNP members who received a timely or untimely health risk assessment in 2023 are also not included.

b. In 2024, we will work on providing a new report to better identify members who remain overdue for completion and to reset the regulatory anchor date.

D. Increase the number of Health Care Decision Makers identified and documented in the Life Care Planning Tab in HealthConnect during Initial and Annual SNP Assessment Process:
   a. The 2023 year-end rate for total Health Care Decision Makers identified and documented during initial and annual SNP assessments was 68%. The target (45%) was met.
      i. To continue with enterprise efforts, SCAL SNP will continue to monitor and track the performance of this metric.

E. SNP Member Satisfaction survey results in 2023 for the question, "Do you think this case management program is helpful for you in achieving your goals?" met the target (80%).
   a. With a 5% response rate in 2023, below are the 2023 total SCAL region quarterly satisfaction rates, and final year end (YE) average:

Q1	Q2	Q3	Q4	2023 YE Avg
86%	85%	87%	87%	86%

F. Controlling High Blood Pressure for Special Needs Plan members 18–85 years:
   a. Rolling 12-month data through November 2023 show 85% compliance with this measure. The 77% target was met.
   b. SNP care managers are not the only drivers for this measure.

G. Follow-Up After ED Visit for Mental Illness (2 Rates) for Special Needs Plan members assessed after an emergency department (ED) visit:
   a. Within 30 days – Data through November 2023 show 84% compliance. The 76% target was met.
   b. Within 7 days – Data through November 2023 show 57% compliance. The 63% target was not met.
   c. SNP care managers are not the only drivers for this measure.
   d. Overall SNP care management of SNP members was challenged in 2023 due to the unexpected increase in SNP membership and not enough increase in SNP staffing to meet the demand, and likely contributed to not being able to meet the 7-day measure target.

H. The 2023 final 30-Day Readmission O/E rate for SCAL SNP was 1.15. The 0.86 target was not met.
   a. Reports in 2023 were not shared widely on an ongoing basis like in previous years due to needed report modifications.
   b. In 2024, modifications were made to the report and will be shared regularly with local SNP teams.

Medicare Advantage Chronic Care Improvement Program (CCIP) – new project pending

CMS	Diabetes control and disparity reduction for Hispanic/Latino Members	Exceed the national 90th percentile for HbA1c control (HbA1c < 8 mg/dL) in the overall Medicare population and close the disparity gap for Medicare SNP Hispanic Latino enrollees with diabetes	December 31, 2023	1. In-reach interventions to increase the percentage of members who have their HbA1c tested regularly Provision of language services to Hispanic/Latino enrollees with diabetes, including diabetes education classes and online education materials available in Spanish	Sloane Petrillo, Director of Care Coordination / Case Management Kim Kaiser, Regional Quality Administrator

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
Diabetes control and disparity reduction for Hispanic/Latino Members a. The goal for HbA1c < 8 mg/dL was adjusted to match enterprise targets. b. The goal was adjusted to 71% from 70% in 2022. c. Baseline data for diabetes control in SNP members: ▪ Non-Hispanic/Latino 75% ▪ Hispanic/Latino 73.6% ▪ 1.4 % disparity • Data for diabetes control in SNP members through November 2023: ▪ Non-Hispanic/Latino = 77% ▪ Hispanic/Latino = 75% ▪ 2% disparity HbA1c<8% performance in the white Medicare SNP population was at 77%, an increase from baseline. The Latino Medicare SNP population was at 75% control, an increase from baseline. • The goal of 71% was met and the goal to close the disparity was not achieved from baseline, but better than 2022's 3% disparity.					
Enhanced Case Management (ECM) and Community Supports Regulatory Requirements					
Health Plan Partners and DHCS	1. Outreach members identified through data mining for ECM per regulatory requirements: a. Outreach 100% of members eligible for ECM through data mining on monthly data mining population of focus outreach lists b. Assign member to Lead Care Manager within 10 days of ECM authorization 2. Outreach members referred for ECM within 5 days 3. Engage members in Community Supports a. Process Community Supports Referrals Process within 5-day Turn Around Time (TAT)	Document outreach of ECM members • 100% of members to receive proactive outreach within 5 days • Lead Care Manager assigned within 10-days of ECM authorization target =100% • Community Supports Referrals processed timely: • Community Supports Referral Process and 5-day Turn Around Time (TAT) target = 100%	December 31, 2023	Health Risk Assessment (HRA): 1. KFHP case managers utilize worklist in Compass Rose to outreach and assess transitioning members 2. Department manager to monitor completion performance of the assessments 3. Assessment chart reviews Community Supports: 1. Manager to monitor queue and inbox daily 2. Quarterly CS education 3. Development of team to process CS referrals	Sloane Petrillo, Director of Care Coordination / Case Management

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
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ECM: 1. All members (100%) have been outreached for those who were identified eligible for ECM through data mining. 2. All members (100%) have been assigned to Lead Care Manager within 10 days of ECM authorization. 3. All members were outreached within 5 days of ECM referral. 4. The average Community Supports Referrals TAT is 2.6 days in 2023 which meet the 5-day goal.					

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
HOME HEALTH AND HOSPICE					
Access					
CMS	Home Health 48-hour admission timeliness (Adjusted – 48 hours/per patient request with an MD order) (BPQI – source)	Target: 90%	Jan-Dec 2023	1. Optimized Referral Process & Risk Stratification 2. Improved Productivity and Capacity** (Technology dependent & Operational Standardization Structure dependent for accelerated improvement) 3. Supervisory oversight of schedules Monitoring Monthly and Quarterly	**Della Williams –** *Senior Director Quality & Safety -Continuum Quality* **Angel Vargas –** *Vice President, Care at Home*
CMS	Palliative Care 48-hour admission timeliness (Adjusted – 48 hours/per patient request with an MD order) (BPQI – source)	Target: 90%			
KP	Hospice 24-hour admission timeliness (Adjusted – 48 hours/per patient request with an MD order) (BPQI – source) **Source of timeliness, may change*	Target: Min: 85% Max: 95%			

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Home Health 48-hour admission timeliness (Adjusted – 48 hours/per patient request with an MD order) (BPQI – source)

	2022:2023			4th Qtr 2023		
	HH – Regional SCAL: 91% : 89%			HH – Regional SCAL: 86%		
	HO – Regional SCAL: 92% : 90%			HO – Regional SCAL: 89%		
	PC – Regional SCAL: 85% : 79%			PC – Regional SCAL: 72%		
	HH – Regional Hawaii: 58% : 64%			HH – Regional Hawaii: 56%		
AGENCY	**HH**	**HO**	**PC**	**HH**	**HO**	**PC**
Antelope Valley	83% : VA	78% : VA	71% : VA	VA	VA	VA
Tri-Central (DO, SB, BP)	96% : 92%	95% : 91%	94% : 93%	90%	97%	90%
Fontana	89% : 84%	79% : 80%	72% : 66%	85%	83%	57%
Metro	71% : 83%	89% : 84%	92% : 90%	94%	87%	98%
Orange County	94% : 93%	98% : 100%	92% : 97%	92%	100%	98%
Riverside	94% : 91%	94% : 91%	89% : 88%	76%	90%	81%
San Diego	97% : 93%	100% : 100%	94% : 83%	92%	100%	74%
Valley's (AV, Balboa)	85% : 84%	82% : 93%	72% : 67%	81%	66%	48%
Oahu	52% : 52%	n/a	n/a	55%	n/a	n/a
Maui	77% : 75%	n/a	n/a	57%	n/a	n/a

Analysis: Higher is Better; SCAL & HI Target is 90% for Home Health and Palliative Care Programs; Hospice is a Min of 85% and a Max of 95%. Note Hawaii Region currently does not have Palliative Care and Hospice took their first patient in 12/2023. Results rounded to whole numbers. Baldwin Park & South Bay now reported under Downey Parent, and Antelope Valley now reported under Valley's Parent as of 3rd Qtr. 2022.

Home Health:
4Q:
Met Goal: Four areas met the target: Tri-Central, Metro, Orange County, and San Diego.
Not Met: Five areas did not meet the target: Fontana, Riverside, Valley's, Oahu, and Maui
Areas Improved: from 3rd to 4th Qtr.: Metro and Oahu.
Areas Sustained: Fontana.
Areas Declined: from 2%-21%: Orange County, Riverside, San Diego, Tri-Central, Valley's, and Maui.
Annual 2023:
Met Goal: Four areas met the target: Tri-Central, Orange Country, Riverside, and San Diego.
Not Met: Five areas did not meet the target: Fontana, Metro, Valley's, Oahu, and Maui
Improved: Metro.
Sustained: Oahu.
Declined: from 1%-5%: Tri-Central, Fontana, Orange County, Riverside, San Diego, Valley's, and Maui.
Recommend continuing indicator for 2024 with regional PSDA hardwiring to improve access, quality & service and regional leadership ensuring areas not meeting targets have implemented best practices.

Hospice:
4Q: Min Goal 85% and Max Goal 95%.
Met Min Goal 85% - Two areas met target: Metro and Riverside.
Met Max Goal 95% - Three areas met target: Tri-Central, Orange County, San Diego.
Not Met: Two area did not meet the minimum target: Fontana and Valley's.

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Required By	GOALS			METRICS		TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
							Three areas reported improvement from 3rd to 4th Qtr. by 4%-15%: Fontana, Metro, and Tri-Central. Two areas sustained 100%: Orange County and San Diego. One area declined by 25%: Valley's. **Annual 2023: Min Goal 85% & Max Goal 95%.** **Met Min Goal 85%:** Three areas met target: Tri-Central, Riverside, Valley's. **Met Max Goal 95%:** Two areas met target: Orange County, San Diego. **Not Met:** Two areas reported did not meet the minimum target: Fontana and Metro. **Improved:** Fontana, Orange County, Valley's. **Sustained:** San Diego sustained at 100% **Declined:** from 3-5%: Tri-Central, Metro, Riverside. **Recommend** continuing indicator for 2024 with regional PSDA hardwiring to improve access, quality & service and regional leadership ensuring areas not meeting targets have implemented best practices. **Palliative Care:** **4Q:** **Met Goal**: Three areas met goal: Tri-Central, Metro, and Orange County. **Not Met:** Four areas did not meet the target: Fontana, San Diego, Riverside, and Valley's. **Improved:** Metro, Orange County, and San Diego. **Declined:** from 3%-22%: Fontana, Riverside, Tri-Central, and Valley's. **Annual 2023:** **Met Goal:** Three areas met target: Tri-Central, Metro, and Orange County. **Not Met:** Four areas did not meet the target: Fontana, Riverside, San Diego, and Valley's **Improved:** Orange County. **Declined:** from 1-11%: Tri-Central, Fontana, Metro, Riverside, San Diego, and Valley's. **Recommend** continuing indicator for 2024 with regional PSDA hardwiring to improve access, quality & service and regional leadership ensuring areas not meeting targets have implemented best practices. **Barriers:** Agencies report barriers in timeliness relate to staffing to process volume of referrals within 2 days of referral to start of care. Need for standardized process for referrals timely and scheduling system. Not all agencies following the standardized process to write a supplemental order when member request to delay care (unstable process for best practices not hardwired across region). **Future:** Local Agency Leadership to monitor processes for M102/M104 and assess drift of the operational process for securing physician orders when members request a visit beyond the 2 days from referral. Agency to return to identified Regional Best Practices in 2023 with assistance from regional operations leadership for oversight. Regional Quality assisting specific agencies in coaching and IRR. Perform random IRR sample reviews as indicated and monitoring universe data vs. sample data. Review processes for Agencies with scores declining by Operational Leadership in Agency and Regional Operations Leadership.	

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
Experience					
CMS	Home Health HHCAHPS 4.5 Talk About Purpose for Taking Medication - (NCEA & SHP)	Target: Min: 3 star (3 to 3.5) Max: 5 star (4.5 or higher) Baseline 85.0% Success 85.0 + 0.2 = 85.2% Excellent 85.0 + 0.5 = 85.5% Exceptional 85.0 + 1.0 = 86.0%	Jan -Dec 2023	1. Consistent use of "Hello Yellow" for standardized medication education for patients/caregivers 2. Agency education and/or Performance Improvement Projects 3. CAH Clinical Excellence/Agency Preceptor training Monitoring Monthly and Quarterly	**Della Williams –** *Senior Director Quality & Safety -Continuum Quality* **Angel Vargas –** *Vice President, Care at Home*
CMS/KP	Re-hospitalization Rate within 30 days from discharge from the hospital (SHP – source)	**SCAL Target:** Min: 9.00 Max: 7.00 2022 avg was 8.93 **HI Target:** Min: 11% Max: 9% 2022 Ave: 13.10%	Jan-Dec 2023	1. Use of SHP program to identify patients at high risk for readmission. 2. Development of care plan to include frequency and duration to prevent re-admission and interventions to address high risk areas. 3. Front loading visits 4. Multi-disciplinary conference for high-risk patients Monitoring Monthly and Quarterly	**Della Williams –** *Senior Director Quality & Safety -Continuum Quality* **Angel Vargas –** *Vice President, Care at Home*

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HHCAHPS 4.5 Talk About Purpose for Taking Medication - (NCEA & SHP) (All Payor, Linear Mean) – Analyst Report Published Quarterly: January, April, July, and October

Baseline Performance Year: Oct 2023 – Sept 2023

Current Performance Year: Oct 2023

Agency	Baseline Report Period	Star / Percentage	Report Period	Star / Percentage	Change
Baldwin Park	Oct 2022 – Sept 2023	4 Star 88.1%	Oct 2023	4 Star 82.6%	⇔ ↓
Downey	Oct 2022 – Sept 2023	5 Star 90.9%	Oct 2023	1 Star 60.0%	↓ ↓
Fontana	Oct 2022 – Sept 2023	4 Star 85.5%	Oct 2023	4 Star 88.2%	⇔ ↑
Metro	Oct 2022 – Sept 2023	3 Star 81.1%	Oct 2023	4 Star 87.5%	↑ ↑
Orange County	Oct 2022 – Sept 2023	4 Star 84.8%	Oct 2023	3 Star 81.5%	↓ ↓

Analysis: Data as of 2/1/2024; The baseline data reflects Oct 2022 – Sept 2023, current data reflects Oct 2023.

Performance Improvement activities that led to improvement were an increase of supervisory visits. Some agencies noted a need to continue to hardwire the practice to lead to performance improvement.

NCEA Star Rating Goals –
5 Stars: Six agencies and one Region: Riverside maintained 5 star and the following agencies and Region moved from 4 star to 5 star: San Diego, South Bay, Valley-AV, Valley-Balboa, Valley HHA, and SCAL Region.
4 Stars: Three agencies: Baldwin Park, Fontana, and Metro, with Metro improving from 3 star to 4 star.
3 Stars: Three areas: Orange County, Tri-Central HHA, and Maui, with Maui declining from 5 star to 3 star, and both Orange Country and Tri-Central HHA declining from 4 star to 3 star.
2 Stars: One agency and one Region: Oahu and Hawaii Region, with Hawaii Region declining from 5 star to 2 star and Oahu declined from 4 star to 2 star.
One Star: Downey reported at 1 star, declined from 5 star.

NCEA Percentage Goal –
Percentage Met (Success): None

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Required By	GOALS			METRICS		TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
Riverside	Oct 2022 – Sept 2023	5 Star	Oct 2023	5 Star	⇔			
		89.8%		100%	↑			
San Diego	Oct 2022 – Sept 2023	4 Star	Oct 2023	5 Star	↑			
		85.0%		91.1%	↑			
South Bay	Oct 2022 – Sept 2023	4 Star	Oct 2023	5 Star	↑			
		85.9%		100%	↑			
Tri-Central HHA	Oct 2022 – Sept 2023	4 Star	Oct 2023	3 Star	↓			
		88.3%		81.0%	↓			
Valley - AV	Oct 2022 – Sept 2023	4 Star	Oct 2023	5 Star	↑			
		83.9%		100%	↑			
Valley - Balboa	Oct 2022 – Sept 2023	4 Star	Oct 2023	5 Star	↑			
		86.0%		90.9%	↑			
Valley HHA	Oct 2022 – Sept 2023	4 Star	Oct 2023	5 Star	↑			
		85.6%		92.9%	↑			
SCAL REGION	Oct 2022 – Sept 2023	4 Star	Oct 2023	5 Star	↑			
		85.7%		88.9%	↑			
Oahu	Oct 2022 – Sept 2023	4 Star	Oct 2023	2 Star	↓			
		86.4%		76.5%	↓			
Maui	Oct 2022 – Sept 2023	5 Star	Oct 2023	3 Star	↓			
		96.1%		80.0%	↓			
HAWAII REGION	Oct 2022 – Sept 2023	5 Star	Oct 2023	2 Star	↓			
		91.2%		78.2%	↓			

Percentage Met (Excellent): None
Percentage Met (Exceptional): Eight agencies and one Region: Fontana, Metro, Riverside, San Diego, South Bay, Valley-AV, Valley-Balboa, Valley HHA, and SCAL Region, with three agencies reporting at 100% (Riverside, South Bay, and Valley-AV).
Percentage Goal Not Met: Six agencies and one Region: Baldwin Park, Downey, Orange County, Tri-Central HHA, Oahu, Maui, and Hawaii Region
Improvement in Percentage score: Eight agencies and one Region: Fontana, Metro, Riverside, San Diego, South Bay, Valley-AV, Valley-Balboa, Valley HHA, and SCAL Region
Declined in Percentage score: Six agencies and one Region: Baldwin Park, Downey, Orange County, Tri-Central HHA, Oahu, Maui, and Hawaii Region

Barriers: What was seen in Mock Surveys for Joint Commission – All agencies had citations during Mock Surveys for medication reconciliation not done consistently, medication lists not up to date, and not addressing all core components of medication education, such as the purpose of taking the medication, frequency of taking the medication, taking right dose, and understanding the side effects of the medications and knowing what to report. Found that patients were not taking medications properly. During the Mock Surveys and during joint supervisory visits and observations across the region and service areas, would be applicable to impacting this score.

Future: KPCAH will lead performance improvement activities to hardwire identified best practices, such as validation and observation of joint supervisory visits, to include medication reconciliation and medication education.

Re-hospitalization Rate - Source SHP 30 Day Readmission CCN and Provider Number Reports All Payers

Agency	Q3 : Q4	2022 : 2023	Q : Y
Fontana	8.09% : 5.62%	9.49% : 6.24%	↓ : ↓
Metro	6.24% : 5.54%	6.63% : 7.23%	↓ : ↑
Orange County	8.86% : 6.85%	10.52% : 8.48%	↓ : ↓
Riverside	9.28% : 8.38%	7.91% : 8.88%	↓ : ↑
San Diego	7.67% : 5.99%	7.27% : 6.81%	↓ : ↓
Baldwin Park	8.44% : 2.47%	9.90% : 7.01%	↓ : ↓

Analysis: Lower is better- ↓ Targets: SCAL – Min 9% and Max 7%; HI – Min 11% and Max 9%.
SCAL Region – State: 11.03%, National: 12.76%. Hawaii Region– State: 12.75%, National: 12.52%

4th Qtr.: Improvement in eleven of twelve agencies (Fontana, Metro, Orange County, Riverside, San Diego, Baldwin Park, Downey, South Bay, Valley-AV, Valley-Balboa, and Maui) and one of two regions (SCAL) noted.
Goal Met (Min): Three agencies met the minimum target: Riverside, and Valley-Balboa, and Maui.
Goal Met (Max): Six agencies and one Region met the maximum target: Fontana, Metro, Orange County, San Diego, Baldwin Park, Downey, and SCAL Region.
Goal Not Met: South Bay, Valley, Oahu, and Hawaii Region.
Annual 2023: Improvement reported in seven of twelve agencies (Fontana, Orange County, San Diego, Baldwin Park, Downey, South Bay, and Maui) and one of two regions (SCAL Region).
Goal Met (Min): Five agencies and one Region: Metro, Orange County, Riverside, Baldwin Park, SCAL Region, and Maui.
Goal Met (Max): Three agencies: Fontana, San Diego, and Downey.
Goal Not Met: Four agencies and one Region: South Bay, Valley's, Balboa, Oahu, and Hawaii Region.

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Required By	GOALS	METRICS		TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
Downey	8.16% : 1.92%	9.11% : 6.73%	↓ : ↓			
South Bay	16.16% : 11.64%	12.78% : 11.83%	↓ : ↓			
Valley's - AV	13.56% : 12.86%	13.33% : 14.75%	↓ : ↑			
Valley's - Balboa	8.70% : 7.89%	8.28% : 9.34%	↓ : ↑			
SCAL REGION	8.83% : 6.70%	8.93% : 8.15%	↓ : ↓			
Oahu	11.11% : 13.73%	14.89% : 16.27%	↑ : ↑			
Maui	50.00% : 9.23%	21.43% : 10.28%	↓ : ↓			
HAWAII REGION	18.18% : 12.39%	13.10% : 14.25%	↓ : ↑			

Barriers: In the 4th quarter of 2023, there was a resurgence of COVID-19 and Influenza, along with RSV. Masking requirements were relaxed during this quarter. Seasonal affect in this quarter. Agencies to do drill down on readmissions through the PAE (Potential Avoidable Events) process.

Future: Regional Operation Leadership to assure best practices are hardwired to prevent PAE's to mitigate/ or eliminate readmissions. Drill down on agencies hitting targets to identify pockets of best practice, such as front-loading visits and doing case reviews on readmissions within 30 days. Readmission task force initiated (June 2023).

Service

CMS	Home Health – Summary Star Rating (HHCAHPS NCEA – source)	Target: Minimum: 3 star (3 to 3.5) Maximum: 5 star (4.5 or higher) **SCAL:** Baseline 93.7% Success 93.7 + 0.2 = 93.9% Excellent 93.7 + 0.5 = 94.2% Exceptional 93.7 + 1.3 = 95.0% **HI:** Baseline 95.3% Success 95.3 + 0 = 95.3% Sustain/Maintain Excellent 95.3 + 0.2 = 95.5% Exceptional 95.3 + 0.7 = 96.0%	Rolling 12 months Oct 2023	1. Continue to hardwire improvement strategies of AIDET, Service Recovery, Golden Minute, Coaching for Excellence, Direct Report Rounding and Patient Rounding 2. Continue use of Rounding Plus and Agency Status Reports to validate completion of strategies. 3. Regional Service education for new staff, Supervisors and Quality staff 4. Track attendance for Regional Service training to ensure completed. 5. Improving service excellence by reward and recognition with DAISY and Rose award Monitoring Monthly and Quarterly	**Della Williams –** *Senior Director Quality & Safety -Continuum Quality* **Angel Vargas –** *Vice President, Care at Home*
CMS	Hospice – Rate of Agency (NCEA HOCAHPS – source)	Target: Minimum: 75th percentile Maximum: 90th percentile	Rolling 12 months Oct 2022-Sept 2023	1. Implement Performance Improvement strategies to improve after hours service. 2. Implement patient rounding on patients that utilize after hours service to identify service improvement	**Della Williams –** *Senior Director Quality & Safety -Continuum Quality* **Angel Vargas –**

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
		Baseline 78.6% Success 78.6 + 0.4 = 79.0% Excellent 78.6 + 1.0 = 79.6% Exceptional 78.6 + 2.0 = 80.6%		opportunities and provide service recovery if needed. 3. Identify opportunities for service improvement from complaints on returned surveys. Monitoring Quarterly	*Vice President, Care at Home*

ANALYSIS

HHCAHPS for Rate of Agency (9-10), Star & Linear

Baseline Performance Year: Oct 2022 – Sept 2023

Current Performance Year: Oct 2023

Agency	Baseline Report Period	Star	Report Period	Star	Change
		Percentage		Percentage	
Baldwin Park	Oct 2022 – Sept 2023	3 Star	Oct 2023	3 Star	⇔
		94.3%		93.8%	↓
Downey	Oct 2022 – Sept 2023	4 Star	Oct 2023	3 Star	↓
		95.3%		94.5%	↓
Fontana	Oct 2022 – Sept 2023	3 Star	Oct 2023	4 Star	↑
		93.5%		95.2%	↑
Metro	Oct 2022 – Sept 2023	3 Star	Oct 2023	3 Star	⇔
		93.6%		93.4%	↓
Orange County	Oct 2022 – Sept 2023	3 Star	Oct 2023	3 Star	⇔
		93.8%		94.1%	↑
Riverside	Oct 2022 – Sept 2023	3 Star	Oct 2023	4 Star	↑
		94.2%		95.8%	↑
San Diego	Oct 2022 – Sept 2023	4 Star	Oct 2023	3 Star	↓
		94.9%		92.7%	↓
South Bay		4 Star	Oct 2023	3 Star	↓

Analysis: Higher number of stars is better. **Min Target: 3 Star; Max Target: 5 Star**
Based on survey readiness, agencies did well overall in AIDET and AHEART and reporting customer concerns/dissatisfactions in MIDAS. All agencies participated in the Regional PI Project for Care Experience using the best practices for joint supervisory visits, AIDET and AHEART, Always Tell, and initiating the QR Code.

Star Goal Met (Min): Twelve agencies and one Region met minimum target: Baldwin Park, Downey, Fontana, Metro, Orange County, Riverside, San Diego, South Bay, Tri-Central HHA, Valley-Balboa, Valley HHA, SCAL Region, and Oahu.
Star Goal Met (Max): Two agencies and one Region that met maximum target: Valley-AV, Maui, and Hawaii Region.
Star Goal Not Met: None.
Improved in Star Status: Six agencies and one Region: Fontana, Riverside, Valley-AV, Valley-Balboa, Valley HHA, Maui, and Hawaii Region.
Sustained in Star Status: Four agencies: Baldwin Park, Metro, Orange County, and Oahu.
Declined in Star Status: Four agencies: Downey, San Diego, South Bay, and Tri-Central HHA.

Improved in Percentage: Seven agencies and two Regions: Fontana, Orange County, Riverside, Valley-AV, Valley-Balboa, Valley HHA, SCAL Region, Maui, and Hawaii Region.
Sustained in Percentage: None
Declined in Percentage: Seven agencies: Baldwin Park, Downey, Metro, San Diego, South Bay, Tri-Central HHA, and Oahu.

Barriers: Agencies periodically struggle with hardwiring best practices with joint supervisory visits and meeting all components of AIDET and AHEART despite ongoing training. Regional Quality Operations to deep dive into agencies not meeting targets to identify gaps and variances.

Future: Deep dive on agencies not meeting target and hardwire Regional best practice in 2024.

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Required By	GOALS			METRICS		TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	Oct 2022 – Sept 2023	94.7%		94.2%	↓			
Tri-Central HHA	Oct 2022 – Sept 2023	4 Star 94.8%	Oct 2023	3 Star 94.1%	↓ ↓			
Valley - AV	Oct 2022 – Sept 2023	3 Star 93.6%	Oct 2023	5 Star 96.8%	↑ ↑			
Valley - Balboa	Oct 2022 – Sept 2023	3 Star 94.0%	Oct 2023	4 Star 94.8%	↑ ↑			
Valley HHA	Oct 2022 – Sept 2023	3 Star 93.9%	Oct 2023	4 Star 95.3%	↑ ↑			
SCAL REGION	Oct 2022 – Sept 2023	**3 Star** **94.1%**	Oct 2023	**3 Star** **94.4%**	⇔ ↑			
Oahu	Oct 2022 – Sept 2023	3 Star 94.4%	Oct 2023	3 Star 94.3%	⇔ ↓			
Maui	Oct 2022 – Sept 2023	4 Star 95.4%	Oct 2023	5 Star 99.1%	↑ ↑			
HAWAII REGION	Oct 2022 – Sept 2023	**4 Star** **94.9%**	Oct 2023	**5 Star** **96.7%**	↑ ↑			

HOCAHPS for Rate of Agency (9-10): Rating of Patient Care from This Hospice, Topbox

Baseline Performance Year: Jul 2021 – Jun 2023

Current Performance Year: July 2023 – Aug 2023

Agency	Baseline Report Period	Percentage Percentile	Report Period	Percentage Percentile	Change
Baldwin Park	Jul 2021 – June 2023	83.3% 50-75	Jul 2023 – Aug 2023	94.9% + 90	↑ ↑
Downey	Jul 2021 – June 2023	73.5% 0-25	Jul 2023 – Aug 2023	56.0% 0-25	↓ ⇔
Fontana		81.0%		89.2%	↑

Analysis: Percentage: Baseline – 78.6%; Success – 79.0% to 79.5%; Excellent – 79.6% - 80.5%; Exceptional – 80.6 % and above.

Percentile Min Target: 75th Percentile, Percentile Max Target: 90th Percentile

Based on survey readiness, agencies did well overall in AIDET and AHEART and reporting customer concerns/dissatisfactions in MIDAS. All agencies participated in the Regional PI Project for Care Experience using the best practices for joint supervisory visits, AIDET and AHEART, Always Ask, and initiating the QR Code.

Percentage Met (Success): One agency met success in Percentage: Tri-Central HHA

Percentage Met (Excellent): None

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS		METRICS			TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	Jul 2021 – June 2023	25-50	Jul 2023 – Aug 2023	+ 90	↑			
Metro	Jul 2021 – June 2023	67.3%	Jul 2023 – Aug 2023	73.1%	↑			
		0-25		0-25	⇔			
Orange County	Jul 2021 – June 2023	80.6%	Jul 2023 – Aug 2023	92.2%	↑			
		25-50		+ 90	↑			
Riverside	Jul 2021 – June 2023	83.4%	Jul 2023 – Aug 2023	87.0%	↑			
		50-75		75-90	↑			
San Diego	Jul 2021 – June 2023	78.7%	Jul 2023 – Aug 2023	74.3%	↓			
		25-50		0-25	↓			
South Bay	Jul 2021 – June 2023	76.8%	Jul 2023 – Aug 2023	76.2%	↓			
		0-25		0-25	⇔			
Tri-Central HHA	Jul 2021 – June 2023	77.8%	Jul 2023 – Aug 2023	79.4%	↑			
		0-25		25-50	↑			
Valley – AV	Jul 2021 – June 2023	80.5%	Jul 2023 – Aug 2023	86.1%	↑			
		25-50		75-90	↑			
Valley - Balboa	Jul 2021 – June 2023	81.9%	Jul 2023 – Aug 2023	87.8%	↑			
		50-75		75-90	↑			
Valley HHA	Jul 2021 – June 2023	81.7%	Jul 2023 – Aug 2023	86.1%	↑			
		50-75		75-90	↑			
SCAL REGION	Jul 2021 – June 2023	**78.6%**	Jul 2023 – Aug 2023	**83.1%**	↑			
		25-50		**50-75**	↑			

Percentage Met (Exceptional): Seven agencies and one Region met exceptional in Percentage: Baldwin Park, Fontana, Orange County, Riverside, Antelope Valley, Balboa, Valley's HHA, SCAL Region
Percentage Goal Not Met: Four agencies did not meet the goal for Percentage: Downey, Metro, San Diego, South Bay
Improvement in Percentage score: Nine agencies and one region improved: Baldwin Park, Fontana, Metro, Orange County, Riverside, Tri-Central HHA, Antelope Valley, Balboa, Valley's HHA, and SCAL Region
Decline in Percentage score: Three agencies declined: Downey, San Diego, South Bay

Percentile Met (Min): Four agencies met the Min goal in Percentile: Riverside, Antelope Valley, Balboa, Valley's HHA
Percentile Met (Max): Three agencies met the Max goal in Percentile: Baldwin Park, Fontana, Orange County
Percentile Goal Not Met: Five agencies and one Region did not meet the goal in Percentile: Downey, Metro, San Diego, South Bay, Tri-Central HHA, SCAL Region
Improvement in Percentile score: Eight agencies and one Region improved: Baldwin Park, Fontana, Orange County, Riverside, Tri-Central HHA, Antelope Valley, Balboa, Valley's HHA, and SCAL Region
Sustained in Percentile score: Three agencies sustained: Downey, Metro, South Bay
Decline in Percentile score: One agency declined: San Diego

Barriers: Based on bereavement survey comments, family members sharing their top concerns are the following: Communication of the dying process and expectations; Coordination of care and services including visits, supplies, and equipment; and lastly having adequate social and spiritual support to meet the needs of their loved ones and themselves.

Future: Agencies will work on HOCAHPS questions related to social and spiritual support for performance improvement and identify trends in communication and coordination gaps with rapid cycle improvement projects.

KFHP Southern California Region
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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
LONG TERM CARE / SKILLED NURSING FACILITY					
Access					
KP	**SNF to Home Readmissions** % of patients discharged from SNF to home (including home with home health) and has a hospital readmission within 30 days of SNF discharge (KP Insight)	Target: 10% (lower is better)	Jan-Dec 2023	1. Standardize best practices for readmission strategies. 2. Drill down to individual medical record number for trends by Medical Center and region	**Della Williams RN–** *Senior Director Quality & Safety -Continuum Quality* **Jose John –** *Executive Director Care Coordination and Continuum* **Deepa Savani, MD –** *SNF Physician Champion* **Vacant –** *Regional Program Director for LTC Services* **Karen Sielbeck** *Vice President, Care Coordination and Continuum*

ANALYSIS

Medical Center	% of 30-Day Hospital Readmissions from SNF to Home (YTD)	30-Day Hospital Readmissions from SNF to Home (YTD)	SNF to Home Discharges
AV	13.3%	32	240
BP	8.2%	29	354
DO	10.2%	65	638
KC	11.3%	26	231
LA	11.2%	64	573
OC-A	9.4%	99	1,051
Out of Area	11.8%	4	34
PC	14.7%	61	415
RI	9.5%	95	1000
SBC	11.7%	110	944
SD	11.2%	145	1,289
SB	11.7%	62	532
WLA	14.9%	42	282
WV	13.8%	20	145
WH	10.9%	56	514

Analysis: Lower Readmission Rate is Better. SCAL did not reach the 10% target in 2023.

Met Goal: 3 medical centers met the target – Baldwin Park, Anaheim, and Riverside.
Not Met: 11 medical centers did not meet the target – Antelope Valley, Downey, Kern, Los Angeles, Panorama City, San Bernardino, San Diego, South Bay, West Los Angeles, West Ventura, Woodland Hills.

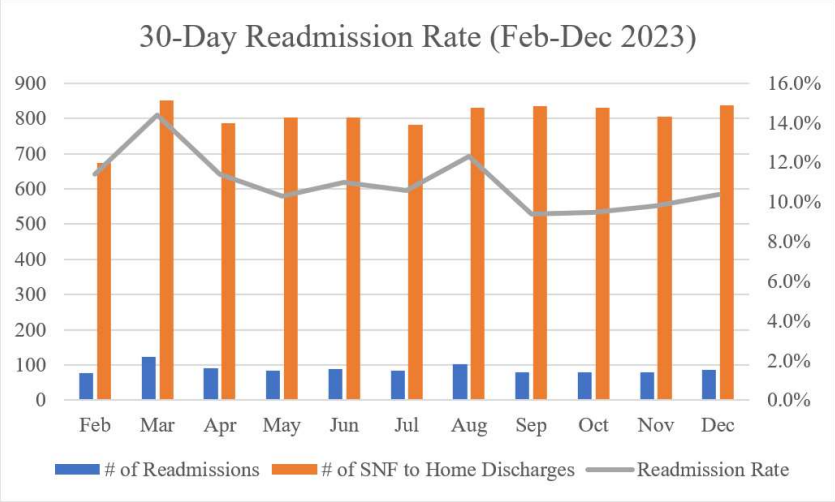
Trending:
Based on monthly trending, readmission rates were highest in March and August 2023, correlated with higher hospital volumes in February and July 2023.

Barriers:
Due to regional leadership transitions and overall focus on new regulatory requirements (contracting for the Medi-Cal Carve-In) and hospital to SNF throughput, quality goals were not implemented in 2023.

Future:
2024 goals will be socialized with the expectation that each medical center meets the 11% goal or have at least 1% reduction in readmission rates. The importance of 7-day POSH

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
Grand Total	11.0%	970	8,841	appointments and 3-day call backs will be emphasized. Quality oversight of contracted facilities will be standardized regionally and locally to ensure patient safety.	



Quality

KP	**Completion of Annual Review** % of annual site visits completed of all skilled contracted facilities within 12 months of the previous review. Includes the desktop review of LTC/Custodial facilities (KP Regional Long Term Care Tracker)	Target: 100% (higher is better) Site Visit Completion	Jan-Dec 2023	1. Continue to track completion regionally and update the local medical centers to ensure compliance. 2. Collaborate with Hospice for the visits. 3. Using the new tool to track the quality site visits.	**Della Williams RN –** *Senior Director Quality & Safety -Continuum Quality* **Jose John –** *Executive Director Care Coordination and Continuum* **Deepa Savani, MD –** *SNF Physician Champion* **Vacant –** *Regional Program Director for LTC Services* **Karen Sielbeck** *Vice President, Care Coordination and Continuum*

ANALYSIS

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Medical Center	% of Site Visits Completed	Site Visits Completed	Site Visits Needed
AV	100%	3	3
BP	86.7%	13	15
DO	100%	10	10
KC	100%	5	5
LA	100%	12	12
OC	100%	9	9
PC	70%	7	10
RI	86.7%	13	15
SBC	100%	18	18
SD	100%	49	49
SB	100%	19	19
WLA	87.5%	7	8
WV	100%	4	4
WH	100%	7	7
Grand Total	95.7%	176	184

Analysis: Higher Site Visit Completion Rate is Better. SCAL did not reach the 100% target in 2023.

Met Goal: 10 medical centers met the target – Antelope Valley, Downey, Kern, Los Angeles, Orange County, San Bernardino, San Diego, South Bay, West Ventura, Woodland Hills

Not Met: 4 medical centers did not meet the target – Baldwin Park, Panorama City, Riverside, West Los Angeles.

Barriers:
Due to regional leadership transitions and overall focus on new regulatory requirements (contracting for the Medi-Cal Carve-In) and hospital to SNF throughput, quality goals were not implemented in 2023.

Future:
2024 goals will be socialized with the expectation that each medical center sees 100% completion of site visits. Quality oversight of contracted facilities will be standardized regionally and locally to ensure patient safety. Current work in progress to clearly delineate distribution of responsibility between local and regional quality teams.

Satisfaction

KP	**7-Day POSH Scheduling** % of SNF discharges to home who had a Post-Hospital (POSH) visit booked appointment with within 7 days post-discharge from SNF (KP Insight) **3-Day Call Backs** % of SNF discharges to home who had a Post-Discharge Follow-up Phone Call within 3 days post-discharge from SNF (KP Insight)	Target: 85% (higher is better) POSH Scheduling Target: 78% (higher is better) 3-Day Call Backs	Jan-Dec 2023	1. Root-cause analysis with areas with the greatest and consistent opportunity 2. LTC Coordinators will ensure patients received POSH appointments prior to discharge. 3. 3-day call back completion calls will ensure members are aware of their appointments. 4. Monitor statuses on a quarterly basis.	**Della Williams RN–** *Senior Director Quality & Safety -Continuum Quality* **Jose John –** *Executive Director Care Coordination and Continuum* **Deepa Savani, MD –** *SNF Physician Champion* **Vacant –** *Regional Program Director for LTC Services* **Karen Sielbeck** *Vice President, Care Coordination and Continuum*

ANALYSIS

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Medical Center	% of 7-Day POSH Scheduled	7-Day POSH Scheduled	7-Day POSH Completed	SNF to Home Discharges
AV	93.8%	225	191	240
BP	47.2%	167	132	354
DO	81.8%	522	433	638
KC	51.9%	120	84	231
LA	86.7%	497	394	573
OC-A	54.1%	569	348	1,051
Out of Area	52.9%	18	12	34
PC	82.2%	341	278	415
RI	89.1%	891	731	1000
SBC	56.8%	536	429	944
SD	74.8%	964	755	1,289
SB	85.3%	454	420	532
WLA	96.5%	272	205	282
WV	40.0%	58	46	145
WH	84.0%	432	369	514
Grand Total	73.7%	6,515	5,166	8,841

Analysis: Higher 7-Day POSH Scheduled Rate is Better. SCAL did not reach the 85% target in 2023.

Met Goal: 5 medical centers met the target – Antelope Valley, Los Angeles, Riverside, South Bay, West Los Angeles.
Not Met: 9 medical centers did not meet the target – Baldwin Park, Downey, Kern, Anaheim, Panorama City, San Bernardino, San Diego, West Ventura, Woodland Hills.

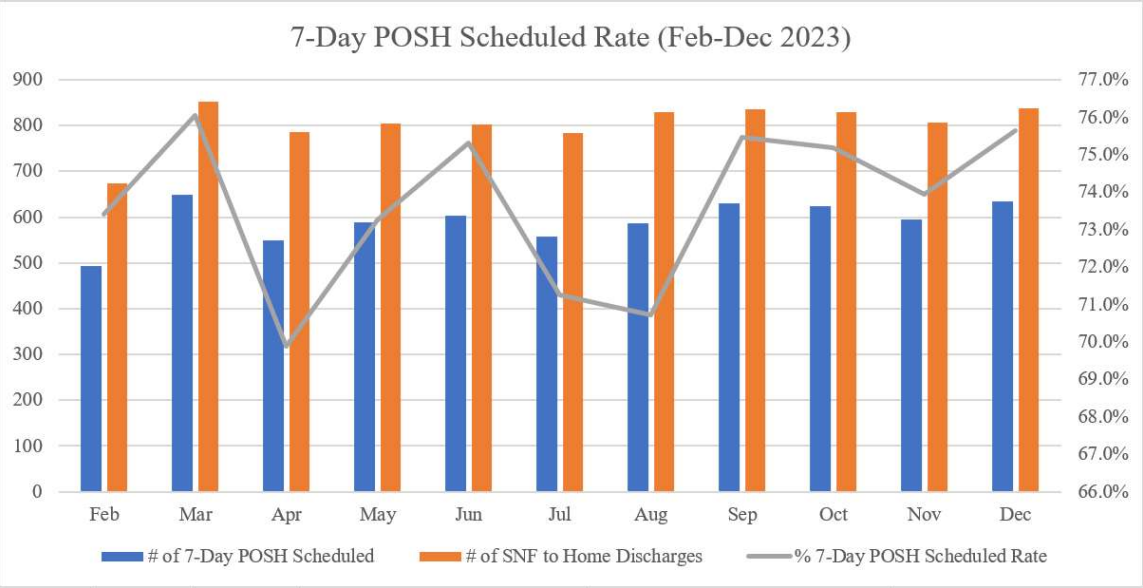
Trending:
Based on monthly trending, 7-Day POSH scheduling rates were lowest in April and August 2023, correlated with higher hospital volumes in March and July 2023.

Barriers:
Due to regional leadership transitions and overall focus on new regulatory requirements (Medi-Cal Carve-In), quality goals were not implemented in 2023. The process for SNF teams to book POSH appointments is not streamlined—they are not able to book directly and availability is limited.

Future:
2024 goals will be socialized with the expectation that each medical center meets 85% or has at least 5% improvement in 7-day POSH scheduling rates. The 7-day POSH appointment workflow will be revisited for opportunities for improvement and re-implemented with local medical center teams.

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES



Month	% 3-Day Call Back Rate
Feb	56.46%
Mar	56.34%
Apr	57.31%
May	60.95%
Jun	55.11%
Jul	52.23%
Aug	44.10%
Sep	45.22%
Oct	45.54%
Nov	48.39%
Dec	39.62%
Total	**50.85%**

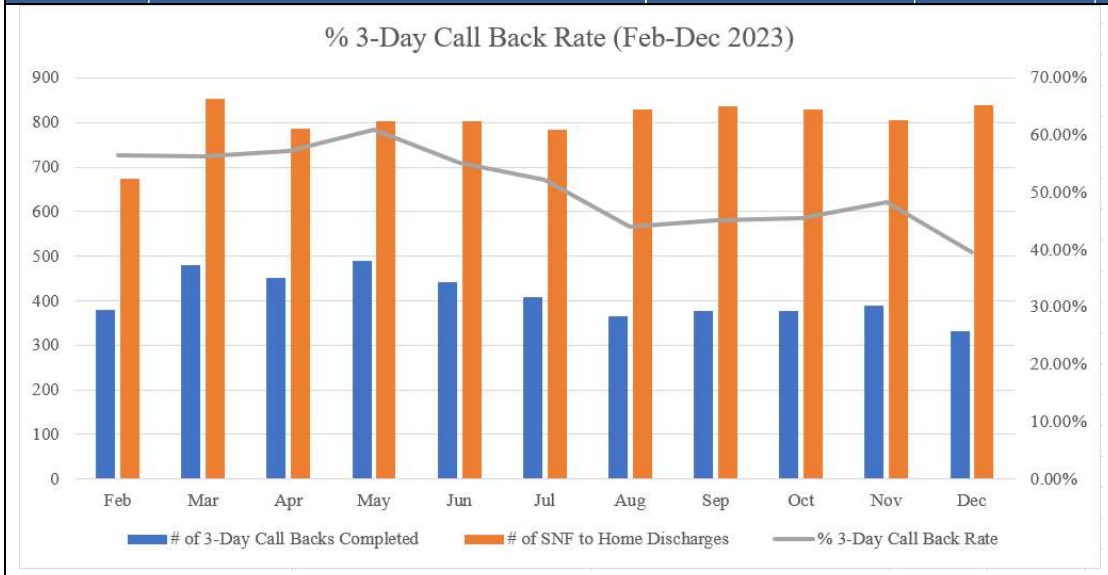
Analysis: Higher 3-Day Call Back Rate is Better. SCAL did not reach the 78% target in 2023.

Trending:
Based on monthly trending, 3-Day Call Back rates gradually decreased throughout 2023 and reached the lowest point in December.

Barriers:
Due to regional leadership transitions and overall focus on new regulatory requirements (Medi-Cal Carve-In), quality goals were not implemented in 2023. The process for SNF teams to perform 3-day call backs may have changed over time based on staff capacity.

Future:
An in-depth review of the 3-Day Call Back workflow in the SNF space will be conducted in collaboration with regional care transitions departments to ensure accuracy of historical reporting. 2024 goals will be determined and socialized upon the completion of this review.

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
					

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
MEMBER EXPERIENCE					
Member Experience					
NCQA and DMHC	Conduct an annual assessment of complaints and grievances to identify opportunities for improvement per ME7, Elements C and D; NET3, Element A, Factor 1; NET4, Element C) Conduct an annual assessment of publicly reported member experience results (Commercial CAHPS, Medicare CAHPS, and QHP Enrollee Experience Survey) to identify opportunities for improvement per ME7, Elements C and D Conduct an annual assessment of enrollee satisfaction with access to care (as measured in CAHPS) to meet DMHC Timely Access Standards	Commercial CAHPS Medicare CAHPS QHP Enrollee Experience Survey Complaints and Grievances data	4Q 2023	1. a) Conduct an annual assessment of complaints and appeals of all members and by: • Commercial • Medicare • Exchange • Medi-Cal b) Conduct an annual assessment of network adequacy complaints and appeals of all members and by: • Commercial • Medicare • Exchange • Medi-Cal 2. Conduct an annual analysis of Commercial CAHPS results against external benchmarks from Quality Compass and CAHPS accreditation index. 3. Conduct an annual analysis of Medicare CAHPS results. 4. Conduct an annual analysis of Qualified Health Plan (QHP) Enrollee Experience Survey. 5. Per DMHC Timely Access Standards, conduct an annual analysis of the enrollee survey (CAHPS Getting Care Quickly and Getting Needed Care Composites) against the organizational goal using the external benchmarks from Quality Compass; communicate analyses and key findings to the Access Committee. 6. Communicate analyses and key findings to the Member Concerns Committee and SCQC.	Rochelle A. McCauley, SCPMG Performance Assessment Paul Choe, Member Relations Ashley Mehrabi, HPSA & Consumer Experience Member Concerns Committee, Access Committee, SCQC
NCQA	Continue to close the gap to external benchmarks on measures that predict member rating of overall health care: 1. Personal doctor communication (close the gap to the Health Plan CAHPS Pacific 90th %ile) 2. Getting care quickly composite (close the gap to the Health Plan CAHPS Pacific 75th percentile) 3. Getting needed care (close the gap to the Health Plan CAHPS Pacific 75th percentile)	CAHPS Patient Assessment Survey (PAS) of California medical groups	4Q 2023	1. Use the annual KPSC Commercial CAHPS results to monitor and report performance on #1-4 and compare against the Pacific benchmarks. 2. Use the annual SCPMG PAS results to monitor and report performance on #5 and compare against the California benchmarks. Both reports are posted on the SCPMG Performance Assessment website and shared with the Care Experience and Access Leaders.	Rochelle A. McCauley, SCPMG Performance Assessment Dr. Wadie Marcos, Rebecca Grant, Anthony Encinas, SCPMG Service and Access Member Concerns Committee

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	4. Overall rating of specialist (maintain Health Plan CAHPS Pacific 75th percentile) 5. Helpful, courteous office staff composite (close the gap to the PAS California 90th percentile)				
NCQA	Enhance member care experience by targeted member experience improvement projects	n/a	4Q 2023	Develop and implement member experience improvement projects to address areas of opportunities identified in the 2022 complaint and grievance and CAHPS results analysis for ME 7, Elements C and D, which include Access and Care Coordination. To address areas of opportunity found within the Access to Care composite, improvement projects have ramped up as shifts in focus related to managing the COVID-19 pandemic have allowed for newer interventions: 1. Addition of new clinical positions to increase capacity for patient appointments 2. Addition of enhancements to kp.org to promote online scheduling of appointments 3. Continued efforts to increase the proportion of consult appointments that are booked directly to specialty care departments 4. Continued efforts to offer telephone and video appointments to patients as an alternative to office visit, when appropriate 5. Enhancing patient experience when waiting for Urgent Care visits by improving communication about wait times through digital displays and mobile text notifications 6. Providing offerings such as E-visits, an online self-directed care option, as well as “Get Care Now” appointments, which are a more efficient way to speak to a physician about urgent needs 7. Shifting diagnostic imaging scheduling systems to Radiant, which offers more options for identifying and addressing scheduling inefficiencies To address areas of opportunity found within the Care Coordination composite, specifically regarding the Medicare population, improvement projects include: 1. Continued collaboration with Systems Solutions & Deployment (SSD) to change	Rochelle A. McCauley, SCPMG Performance Assessment Dr. Wadie Marcos, Rebecca Grant, Anthony Encinas, SCPMG Service and Access Dr. Timothy Ho, Christopher Stewart, Jesse Velasquez, SCPMG Complete Care Member Concerns Committee

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
				patient After Visit Summaries (AVS) to communicate key information more efficiently to patients regarding how their care is coordinated; in 2023, this initiative will expand to additional departments/locations. 2. Expansion of implementation of text notifications to patients to alert them that their lab results are ready, allowing for timelier follow up of test results; in 2023, this initiative will expand to additional departments/locations. 3. Review and revision of clinician training materials (e.g., playbooks, videos) geared towards improving care coordination-related best practices and communication strategies; in 2023, training materials will highlight best practices learned through 2021-2022. 4. Addition of care coordination-related questions to the KP Rounding tool; this is a new initiative for 2023.	

ANALYSIS

ITEM #1:
Conduct an annual assessment of complaints and grievances to identify opportunities for improvement per ME7, Elements C and D; NET3, Element A, Factor 1; NET4, Element C)

Membership

	2022	2023
Commercial	3,491,543	3,217,938
Medicare	662,117	685,698
Medicaid	547,819	598,659

COMMERCIAL (includes Exchange product line)
Complaints

	2022			2023				
Category	Volume	% of Total	Rate per 10K	Volume	% of Total	Rate per 10K	Threshold Rate per 10K Goal	Met / Not Met
Access	13,865	11%	9.9	12,125	10%	9.4	8.9	Not Met

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS			METRICS			TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
Attitude / Service	60,758	50%	43.5	56,768	49%	44.1	39.2	Not Met	
Billing / Financial	26,106	21%	18.7	26,768	23%	20.8	16.8	Not Met	
Practitioner Office Site	920	1%	0.7	870	1%	0.7	0.6	Not Met	
Quality of Care	20,003	16%	14.3	19,873	17%	15.4	12.9	Not Met	

Appeals

	2022			2023				
Category	Volume	% of Total	Rate per 10K	Volume	% of Total	Rate per 10K	Threshold Rate per 10K Goal	Met / Not Met
Access	56	2%	0.04	71	2%	0.06	0.04	Not Met
Attitude / Service	4	0%	0.00	8	0%	0.01	0.00	Not Met
Billing / Financial	3,211	97%	2.30	3,284	97%	2.55	2.07	Not Met
Practitioner Office Site	0	0%	0.00	0	0%	0.00	0.00	Met
Quality of Care	30	1%	0.02	29	1%	0.02	0.02	Not Met

MEDICARE

Complaints

	2022			2023				
Category	Volume	% of Total	Rate per 10K	Volume	% of Total	Rate per 10K	Threshold Rate per 10K Goal	Met / Not Met
Access	7,378	10%	27.9	8,775	10%	32.0	25.1	Not Met

Required By	GOALS			METRICS			TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
Attitude / Service	45,552	61%	172.0	49,870	57%	181.8	154.8	Not Met	
Billing / Financial	12,381	17%	46.7	16,890	19%	61.6	42.1	Not Met	
Practitioner Office Site	1,022	1%	3.9	1,252	1%	4.6	3.5	Not Met	
Quality of Care	8,625	12%	32.6	11,189	13%	40.8	29.3	Not Met	

Appeals

	2022			2023				
Category	Volume	% of Total	Rate per 10K	Volume	% of Total	Rate per 10K	Threshold Rate per 10K Goal	Met / Not Met
Access	80	4%	0.3	90	5%	0.3	0.3	Not Met
Attitude / Service	0	0%	0.0	3	0%	0.01	0.0	Not Met
Billing / Financial	1,858	88%	7.0	1,685	86%	6.1	6.3	Met
Practitioner Office Site	0	0%	0.0	0	0%	0.0	0.0	Met
Quality of Care	177	8%	0.7	184	9%	0.7	0.60	Not Met

MEDICAID

Complaints

	2022			2023				
Category	Volume	% of Total	Rate per 10K	Volume	% of Total	Rate per 10K	Threshold Rate per 10K Goal	Met / Not Met
Access	1,965	10%	9.0	2,063	9%	8.6	8.1	Not Met

Required By	GOALS			METRICS		TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
Attitude / Service	12,383	61%	56.5	13,032	57%	54.4	50.9	Not Met
Billing / Financial	1,503	7%	6.9	2,126	9%	8.9	6.2	Not Met
Practitioner Office Site	236	1%	1.1	239	1%	1.0	0.97	Not Met
Quality of Care	4,373	21%	20.0	5,351	23%	22.3	18.0	Not Met

Appeals

	2022			2023				
Category	Volume	% of Total	Rate per 10K	Volume	% of Total	Rate per 10K	Threshold Rate per 10K Goal	Met / Not Met
Access	28	7%	0.128	67	15%	0.3	0.1	Not Met
Attitude / Service	6	2%	0.027	14	3%	0.1	0.0	Not Met
Billing / Financial	330	84%	1.506	336	73%	1.40	1.36	Not Met
Practitioner Office Site	0	0%	0.0	0	0%	0.0	0.0	Met
Quality of Care	29	7%	0.132	45	10%	0.2	0.1	Not Met

Quantitative Analysis:

Commercial (includes Exchange product line)

- Complaints: The total volume of complaints decreased by 4% in 2023 compared to 2022: 121,652 in 2022 compared to 116,404 in 2023. Although the Access, Attitude/Service, Quality of Practitioner Office Site, and Quality of Care categories experienced a volume decrease compared to the previous year, all five of the 2023 established goals were not met. The Billing/Financial category had a 3% increase in complaints from the previous year. The Attitude/Service category accounted for 49% of the total complaints followed by Billing/Financial which accounted for 23% of the total complaints.
- Appeals: The total volume of appeals increased by 3% in 2023 compared to 2022: 3,301 in 2022 compared to 3,392 in 2023. The appeal goals were met for Quality of Practitioner Office Site. There were no appeals in 2022 or 2023 for Quality of Practitioner Office Site. The rates for appeals of Access,

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Attitude/Service, Billing/Financial, and Quality of Care categories did not meet the established goal. The Billing/Financial category accounted for 97% of the total appeals.

Medicare

- Complaints: The total volume of complaints increased by 17% in 2023 compared to 2022: 74,958 in 2022 compared to 87,976 in 2022. All five complaint categories experienced a volume increase compared to the previous year and the 2023 established goals were not met. The Billing/Financial category had a 36% increase in complaints from the previous year and the Quality of Care category had a 30% increase in complaints from the previous year. Attitude and service accounted for 57% of the total complaints followed by Billing/Financial which accounted for 19% of the total complaints.
- Appeals: The total volume of appeals decreased by 7% in 2023 compared to 2022: 2,115 in 2022 compared to 1,962 in 2023. The appeal goals were met for two categories: Billing/Financial and Quality of Practitioner Office Site. There were no appeals in 2022 or 2023 for Quality of Practitioner Office Site. The rates of appeals in the Access, Attitude/Service, and Quality of Care categories did not meet the established goal. The Billing/Financial category accounted for 86% of the total appeals.

Medicaid

- Complaints: The total volume of complaints increased by 11% in 2023 compared to 2022: 20,460 in 2022 compared to 22,811 in 2023. All five complaint categories experienced a volume increase compared to the previous year and the 2023 established goals were not met. The Billing/Financial category had a 41% increase in complaints from the previous year and the Access category had a 22% increase in complaints from the previous year. The Attitude/Service category accounted for 57% of the total complaints followed by Quality of Care which accounted for 23% of the total complaints.
- Appeals: The total volume of appeals increased by 18% in 2023 compared to 2022: 396 in 2022 compared to 462 in 2023. The appeal goals were not met for four categories: Access, Attitude/Service, Billing/Financial, and Quality of Care. The appeal goal was met for Quality of Practitioner Office Site as there were no appeals in 2022 or 2023 for this category. The Billing/Financial category accounted for 73% of the total appeals.

Qualitative Analysis:

Top 2 Complaint Types by Product Line Percentage of Total

Categories	Commercial**
Attitude/Service	49%
Billing/Financial	23%

** Commercial includes Exchange product line

Categories	Medicare
Attitude/Service	57%
Billing/Financial	19%

Categories	Medicaid
Attitude/Service	57%
Quality of Care	23%

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Top 2 Appeal Types by Product Line Percentage of Total

Categories	Commercial**
Billing/Financial	97%
Access	2%

** Commercial includes Exchange product line

Categories	Medicare
Billing/Financial	86%
Quality of Care	9%

Categories	Medicaid
Billing/Financial	73%
Access	15%

Attitude/Service and **Billing/Financial** were the **top two complaint** categories for the Commercial and Medicare product lines accounting for more than 70 percent of total complaint volume in 2023. **Attitude/Service** and **Quality of Care** were the **top two complaint** categories for the Medicaid product line accounting for 80 percent of total complaint volume in 2023. **Billing/Financial was the top appeal category** accounting for more that 70 percent of total appeals across all product lines. **Access was the second highest appeal category for the Commercial and Medicaid product lines** at 2 and 15 percent, respectively. **Quality of Care was the second highest appeal category for the Medicare product line** at 9 percent.

Further drill-down analysis into the top three complaint subcategories for the top two complaint and appeal categories revealed the following in the tables below:

Complaints

Non-BH Grievances Top 2 Complaint Categories		
Commercial	**Prior**	**Current**
Attitude and Service	**2022**	**2023**
Top 3 Subcategories	**Rate per 10K**	**Rate per 10K**
Verbal Communication	6.01	6.60
Behavior	4.75	4.90
Delay/failure in contacting	5.25	4.54
Billing/Financial	**2022**	**2023**
Top 3 Subcategories	**Rate per 10K**	**Rate per 10K**

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Required By	GOALS	METRICS		TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	Billing	9.88	7.95			
	Benefits	3.31	4.50			
	Billing Statement	-	2.72			
	Medicaid	**Current**	**Current**			
	Attitude and Service	**2022**	**2023**			
	Top 3 Subcategories	**Rate per 10K**	**Rate per 10K**			
	Behavior	7.88	8.10			
	Verbal Communication	-	5.67			
	Delay/failure in contacting	6.30	5.31			
	Quality of Care	**2022**	**2023**			
	Top 3 Subcategories	**Rate per 10K**	**Rate per 10K**			
	Diagnosis Treatment or Care	15.95	17.13			
	Referral	1.39	2.12			
	Pharmacy	0.92	1.18			
	Medicare	**Current**	**Current**			
	Attitude and Service	**2022**	**2023**			
	Top 3 Subcategories	**Rate per 10K**	**Rate per 10K**			
	Telephone Services	27.14	23.80			
	Verbal Communication	19.15	22.02			
	Delay/failure in contacting	21.27	17.52			
	Billing/Financial	**2022**	**2023**			
	Top 3 Subcategories	**Rate per 10K**	**Rate per 10K**			
	Benefits	12.77	21.52			
	Billing	13.95	10.28			
	Billing Process	4.39	5.55			

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2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Further drilldown analysis into the three appeal subcategories for billing and financial access revealed the following in the tables below:

Appeals

Non-BH Appeals Top 2 Request Categories		
Commercial	**Prior**	**Current**
Billing/Financial	**2022**	**2023**
Top 3 Subcategories	**Rate per 10K**	**Rate per 10K**
Emergency Services	0.71	0.64
Ambulance	0.13	0.13
Hospital	-	0.12
Access	**2022**	**2023**
Top 3 Subcategories	**Rate per 10K**	**Rate per 10K**
CPAP Machine	0.01	0.01
Other DME Item	0.00	0.01
Referral to Specialty Care	0.00	0.01
Medicaid	**Prior**	**Current**
Billing/Financial	**2022**	**2023**
Top 3 Subcategories	**Rate per 10K**	**Rate per 10K**
Emergency Services	0.26	0.28
Other DME Item	-	0.14
Ambulance	-	0.13
Access	**2022**	**2023**
Top 3 Subcategories	**Rate per 10K**	**Rate per 10K**
Other DME Item	-	0.08
Referral to Specialty Care	-	0.02
Request for Specialized Expertise	-	0.02
Medicare	**Prior**	**Current**
Billing/Financial	**2022**	**2023**

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Top 3 Subcategories	Rate per 10K	Rate per 10K
ER & Post Stabilization Care	-	0.86
COVID	-	0.66
Prescription	-	0.43
Quality of Care	**2022**	**2023**
Top 3 Subcategories	**Rate per 10K**	**Rate per 10K**
Specialty Care Visit	0.13	0.18
Item Requested Under DME	-	0.09
SNF	0.08	0.08

Drill Down Analysis:

- Complaints: Similar to 2022, data analysis for 2023 revealed that the primary driver for complaints in the attitude and service category were attributed to complaints about Verbal Communication and Telephone Services for Commercial and Medicare members respectively. The primary driver for complaints in the attitude and service category for Medicaid members was Behavior. In the Quality of Care category, the primary driver was Diagnosis Treatment or Care for Medicaid members. Billing and Benefits were the primary drivers in the Billing/Financial category for Commercial and Medicare members respectively.
    - Commercial: Verbal communication was the top subcategory per 10K members in the Attitude/Service category. Further drill down revealed patient dissatisfaction with the Member Services Call Center giving incorrect information, long hold times, discourteous behavior, and wait times for return calls were the top complaints. Billing was the top subcategory per 10K members in the Billing/Financial category. Further drill down revealed patient dissatisfaction with confusing billing statements and surprise bills received after the point of service. Additional issues were related to being billed for amounts higher than expected and disputing collections / billing for preventive services.
    - Medicaid: Behavior was the top subcategory per 10K members in the Attitude/Service category. Analysis showed that patients perceived that the provider was being rude or discourteous. Diagnosis/Treatment or care was the top subcategory per 10K members in the Quality of Care category. Analysis showed that these were related to patient complaints around providers being dismissive of their concerns or not having their chief complaints heard or resolved resulting in multiple visits for the same concern, as well as multiple tests needed within a short period of time.
    - Medicare: Telephone Services was the top subcategory per 10K members in the Attitude/Service category. Further drill down revealed patient dissatisfaction with long hold times for pharmacy questions. Benefits was the top subcategory per 10K members in the Billing/Financial category. Patients complained about disparity in Medical Financial Assistance (MFA) at the pharmacy, where patients were charged for medications despite having an MFA on file – either the card on file was charged for MFA patients and/or the MFA not reflecting for mail orders. This is because the online ordering system for Pharmacy is not connected to the MFA system.
- Appeals: The appeal rates were relatively low across all product lines compared to complaints. The Billing/Financial category was the primary reason for appeals across all product lines.
    - Commercial, Medicaid, and Medicare: Under the Billing/Financial category, Emergency Services was the primary driver for the Commercial, Medicaid, and Medicare product lines. Most appeals were regarding payment or reimbursement for emergency services outside of KP, reimbursement for testing outside of KP, and DME orders that were delayed or not received.

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Opportunities for Improvement:
Analysis of 2023 member complaints indicated that the majority were attributed to two specific categories: 1. Attitude and Service and 2. Billing/Financial. These two categories accounted for more than 70 percent of total complaint volume for the Commercial/Exchange and Medicare product lines and for more than 50 percent of total complaint volume for the Medicaid product line. Analysis of 2023 member appeals indicated that the majority were attributed to Billing/Financial issues, which accounted for more than 70 percent of total appeal volume.

Members at KPSC receive care through an integrated model. KPSC does not differentiate care or services based or line of business at the point of service. Therefore, opportunities for improvement and interventions impact members across all product lines. Analysis revealed that complaints and appeals are across all medical centers and service centers and were not specific to any geographic areas. No specific medical center areas had particularly more complaints than others, however, Downey and Baldwin Park medical center areas did perform the best among all medical centers by the rate of complaints per 1k members.

In our analysis, we observed that attitude and service-related complaints constituted the highest volume of patient grievances. However, after careful consideration, we have decided to prioritize our opportunities for improvement by concentrating on billing and financial complaints since billing concerns present more actionable opportunities, allowing us to make tangible and immediate changes that will positively impact the patient experience and enhance overall satisfaction. The opportunities identified for improvement in priority order are:

Complaints

1. Billing and Financial – Billing issues:
    - Starting November 2023, hospital and professional bills were consolidated to a single document.
    - Best-in-Class Patient Financial Experience Program launched in Q4 2023. This program works on CGA prevention by providing additional insight into feedback driving focused improvements to the member experience.
    - Continue to remind staff to advise member of copays when appointment time is confirmed and again at point of service.
        - A pop-up message now appears when the member checks in for their appointment online or via smartphone.
    - Continue staff training on Believe Me policy and MFA options for members unable to pay for services due to financial hardship.
    - Continue to educate members about required copays, in-network requirements and non-covered benefits via member communication tools and at time appointment confirmed.
    - Identified that the system used to calculate MFA eligibility using member income was incorrect. This issue has since been corrected and efforts have been undertaken to enroll members into the programs for which they are eligible.
2. Attitude and Service – Delay/Failure in Contacting:
    - In Q4 2023, there was a shift to centralized call center where calls were triaged and forwarded to the appropriate department in order to help alleviate call volumes and hold times for specific departments, such as Billing and Pharmacy.
    - At the department level, a handful of the local medical centers have adopted a strategy of adjusting staffing by allocating RNs to triage messages when volumes are above a certain threshold. This has been a shared best practice and the service areas have been looking to implement this strategy across the board.

Appeals

1. Billing/Financial – Emergency Services:

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- Continue to train front line staff regarding scripting and operating procedures to communicate post-visit charges to members.
- Ensure transparency of bills and set member expectations for potential post-visit charges to prevent "surprise bills."

Conduct an annual analysis of publicly reported member experience results (Commercial CAHPS, Medicare CAHPS, and QHP Enrollee Experience Survey) to identify opportunities for improvement per ME 7, Elements C and D; conduct an annual assessment of enrollee satisfaction with access to care (as measured in CAHPS) to meet DMHC Timely Access Standards.

Results (Quantitative Analysis):
Data reported here highlight KP SCAL's performance on member experience measures for 2023.

Commercial CAHPS
The following sections detail results using Commercial CAHPS data. The sample and response rate are as follows:

- Sample: 8,030
- Response rate: 12%

2023 Commercial CAHPS Performance on NCQA Accreditation Index Measures
The table below details KP SCAL performance for Commercial CAHPS in 2023. To annually assess member satisfaction, KP SCAL compares the most recent Commercial CAHPS survey with the prior years' performance, as well as against the Pacific percentile ranking using the Quality Compass benchmarks. The measures are displayed here because they comprise the CAHPS measures contributing to the NCQA Accreditation Index.

CAHPS Results	2023 Commercial Score	2023 Pacific Percentile Ranking	2022 Commercial Score	2022 Pacific Percentile Ranking	Percentile Change from 2022 to 2023
Claims Processing	N/A	N/A	N/A	N/A	N/A
Coordination of Care	74.94%	<5th	76.79%	10th	↓
Customer Service	86.18%	50th	87.05%	50th	--
Getting Care Quickly	63.93%	10th	67.60%	5th	↑
Getting Needed Care	70.31%	10th	74.10%	10th	--
MD Communication	89.64%	5th	90.41%	5th	--
Rating of Health Care	47.36%	50th	47.76%	50th	--
Rating of Health Plan	47.68%	75th	50.91%	75th	--
Rating of Personal Doctor	62.16%	33rd	63.24%	33rd	--
Rating of Specialist See Most Often	63.11%	33rd	65.84%	50th	↓

- For all measures, scores decreased from 2022 to 2023; Coordination of Care and Rating of Specialist dropped in terms of relative position in the Pacific market, while Getting Care Quickly improved from the 5th Pacific percentile to the 10th.
- All overall rating items maintained their Pacific percentile ranking except for Rating of Specialist, which dropped from the 50th to the 33rd percentile.
- Getting Care Quickly and Getting Needed Care have historically been the lowest performing measures. However, Getting Care Quickly improved to the 10th Pacific percentile this year, driven by higher performances for Access to Care Needed Urgently.
- Customer Service remained at the 50th Pacific percentile, but Care Coordination fell from the 10th Pacific percentile to below the 5th due to a drop less than 2%pts in score.

Commercial CAHPS Goals/Thresholds

Since 2001, KP SCAL has focused on reaching the Pacific 75th percentile as a goal on four key areas. The table below highlights 2023 performance in for these measures. Based on these results, Access and MD Communication remain areas of opportunity for KP SCAL.

Measure	2023 Commercial CAHPS Score	Pacific Percentile Ranking - 2023	Pacific 75th Percentile Target	Goal Met?
MD Communication	89.64%	5th	95.25%	NO
Access to Specialty Care	67.42%	10th	76.85%	NO
Access to Routine Care	57.98%	5th	75.20%	NO
Access to Urgent Care	69.88%	10th	83.09%	NO

Medicare CAHPS

The following sections detail results using Medicare CAHPS data. The sample and response rate are as follows:

- Sample: 3,600
- Response rate: 35%

2023 Medicare CAHPS Results

Official Medicare CAHPS results reflect the combined performance of KP NCAL and KP SCAL (KP-CA), as both regions are under a single contract.
The table below lists the Medicare CAHPS measures that contribute to CMS Star Ratings. Each measure in the table below shows KP-CA's case-mix adjusted mean score, the national average for all Medicare contracts, and how the score compared to the national average. Additionally, the 2024 CMS Star rating for each overall or composite measure is included for reference. Comparisons are made with the last year of data available.

Medicare CAHPS Composites with Single Item Measures	2023 Reporting Year				2022 Reporting Year	
	National Average	KP-CA Performance	Comparison with National Average	2023 CMS Star Rating	KP-CA Performance	2022 CMS Star Rating
Overall Rating of Health Care Quality	8.6	8.6	Below	2 stars	8.7	4 stars
Overall Rating of Health Plan	8.8	8.8	--	4 stars	8.9	5 stars
Overall Rating of Prescription Drug Plan	8.8	9.2	Above	5 stars	9.3	5 stars
Getting Needed Care Composite	3.42	3.33	Below	2 stars	3.42	3 stars
Getting Appointments with Specialists	3.37	3.27	Below		3.40	
Getting Needed Care, Tests, or Treatment	3.47	3.40	Below		3.45	
Getting Appts and Care Quickly Composite	3.31	3.26	Below	2 stars	3.33	4 stars
Getting Care Needed Right Away	3.55	3.41	Below		3.55	
Getting Appointments for Check-ups or Routine Care	3.45	3.24	Below		3.36	
Getting Seen Within 15 Minutes of Your Appointment	2.94	3.12	Above		3.09	
Customer Service Composite	3.71	3.66	Below	2 stars	3.68	3 stars
Give Information Needed	3.47	3.39	Below		3.46	
Courtesy and Respect	3.81	3.74	Below		3.72	
Forms Were Easy to Fill Out	3.85	3.86	--		3.86	
Care Coordination Composite	3.59	3.52	Below	2 stars	3.49	1 star

Required By	GOALS	METRICS		TARGET COMPLETION DATE	ACTION STEPS & MONITORING		RESPONSIBLE LEADERS/ COMMITTEES
	Doctors Have Medical Records	3.84	3.86	--		3.82	
	Doctors Communicate About Tests	3.53	3.47	Below		3.44	
	Doctors Follow Up with Test Results	3.51	3.40	Below		3.37	
	Getting Test Results When Needed	3.55	3.54	--		3.50	
	Doctors Discuss Taking Medicines	3.48	3.32	Below		3.17	
	Getting Help to Coordinate Care	2.73	NA	--		NA	
	Doctors are Informed About Specialist Care	3.38	3.33	--		3.35	
	Getting Needed Prescription Drugs Composite	3.71	3.78	Above	5 stars	3.83	5 stars
	Ease of Getting Prescribed Medicines	3.69	3.76	Above		3.82	
	Ease of Filling Prescriptions	3.73	3.80	Above		3.85	

KP-CA earned a score above the national average for Rating of Prescription Drug Plan, earning 5 stars. Rating of Health Care Plan was at the national average, which resulted in a 4 star rating. However, Rating of Health Care Quality was below the national average, enough to earn 2 stars.
For the composite measures, KP-CA earned scores above the national average for the Getting Needed Prescription Drugs composites. KP-CA earned scores below the national average for all remaining composites, including Care Coordination, Customer Services, Getting Care Appointments and Care Quickly, and Getting Needed Care.

Medicare CAHPS Goals/Thresholds

KP SCAL has chosen to focus on the Medicare CAHPS composite measures that contribute the CMS Star Ratings for goal setting, which include Getting Needed Care, Getting Appointments and Care Quickly, Customer Service, Care Coordination, and Getting Needed Prescription Drugs. The threshold for each measure is the Medicare CAHPS national average for each measure. Please see below to review KP SCAL's scores against the performance thresholds for each composite measure. Based on these results, all items except for Getting Needed Prescription Drugs are areas of opportunity for KP SCAL, and KP SCAL will continue to work with key stakeholders throughout the organization to address them.

Medicare CAHPS Composites – 2023 Goals	National Average	KP-CA Performance	Goal Met?
Getting Needed Care Composite	3.42	3.33	NO
Getting Appts and Care Quickly Composite	3.31	3.26	NO
Customer Service Composite	3.71	3.66	NO
Care Coordination Composite	3.59	3.52	NO
Getting Needed Prescription Drugs Composite	3.71	3.78	YES

QHP Enrollee Survey (Marketplace Member Experience Survey)

The following sections detail results using QHP Enrollee Experience data. The sample and response rate are as follows:

- Sample: 1,690
- Response rate: 15%

2023 QHP Enrollee Experience Survey Results

Please note that official Qualified Health Plan (QHP) Enrollee Experience Survey results reflect the combined performance of KP NCAL and KP SCAL (KP-CA), as both regions are under a single contract with CMS.

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

The table below highlights KP-CA's performance on 2023 health plan composite measures against 2022 performance. KP scored below the national average on How Well Doctors Coordinate Care and Keep Patients Informed, but scored above the national average for Getting Information About the Health Plan and Cost of Care. The remaining measures were at the national average.

QHP Composite Measures	2023 KP-CA Average	2023 KP-CA Performance vs. Nat'l Average (p < .05)	Δ from 2022 to 2023	2022 KP-CA Average	2022 KP-CA Performance vs. Nat'l Average (p < .05)
Getting Care Quickly	67.06	Average	-1.04	68.10	Average
Getting Needed Care	67.13	Average	1.80	65.33	Below Average
Getting Information in a Needed Language or Format	68.24	Average	-0.71	68.95	Average
How Well Doctors Communicate	85.71	Average	3.75	81.96	Below Average
How Well Doctors Coordinate Care and Keep Patients Informed	76.46	Below Average	3.64	72.82	Below Average
Getting Information About the Health Plan and Costs of Care	59.46	Above Average	10.65	48.81	Average
Health Plan Customer Service	77.71	Average	5.57	72.14	Average
Enrollee Experience with Cost	81.16	Average	0.30	80.86	Average

The table below details KP-CA's performance on 2022 and 2023 overall rating measures. Scores for Rating of Health Plan, Rating of All Health Care and Rating of Personal Doctor improved from the previous year, with Rating of Health Plan scoring above the national average.

QHP Overall Ratings	2023 KP-CA Average	2023 KP-CA Performance vs. Nat'l Average (p < .05)	Δ from 2022 to 2023	2022 KP-CA Average	2022 KP-CA Performance vs. Nat'l Average (p < .05)
Rating of All Health Care	79.41	Average	3.08	76.33	Below Average
Rating of Personal Doctor	85.72	Average	2.69	83.03	Below Average
Rating of Specialist	83.36	Average	-0.94	84.30	Average
Rating of Health Plan	75.71	Above Average	4.66	71.05	Average

QHP Enrollee Experience Survey Goals/Thresholds

KP SCAL has chosen to focus on the QHP Enrollee Experience Survey composite measures that contribute to the Enrollee Experience domain as part of CMS' Quality Rating System, where KP-CA has earned 2 of 5 possible stars. The composite measures include Getting Needed Care, Getting Appointments and Care Quickly, Care Coordination, Rating of Health Care, Rating of Personal Doctor, and Rating of Specialist. The threshold for each measure is the 2023 QHP national average for each measure. Please see below to review KP-CA's scores against the performance thresholds for each composite measure. Based on the 2023 results, none of the goals for QHP Enrollee Experience measures were met.

QHP Composite Measures – 2023 Goals	National Average	KP-CA Performance	Goal Met?
Getting Needed Care Quickly	70.54	67.06	NO
Getting Needed Care	69.84	67.13	NO
How Well Doctors Coordinate Care and Keep Patients Informed	82.03	76.46	NO
Rating of Health Care	79.54	79.41	NO
Rating of Personal Doctor	87.20	85.72	NO

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	Rating of Specialist	85.01	83.36	NO	

Results (Qualitative Analysis):

- Response rates were highest among Medicare survey respondents (35%), followed by QHP survey respondents (15%), and Commercial survey respondents (12%). This reflects a decrease in response rates among all survey respondents is reflective of an ongoing trend for all KP opinion surveys and across the industry. Declining response rates have been a known issue in recent years.
- KP SCAL and KP-CA performance and standing relative to other health plans showed mixed results when comparing scores from 2022 to 2023:
    - Getting Care Quickly and Getting Needed Care: While scores dropped for the Commercial CAHPS survey, we saw Getting Care Quickly rise from the 5th to the 10th Pacific percentile. Similar score declines for Medicare CAHPS resulted in a loss of 2 stars for Getting Care Quickly and a loss of 1 star for Getting Needed Care. While scores also declined for the QHP/Marketplace survey's Getting Care Quickly composite, the scores improved for Getting Needed Care and moved this composite from below the national average in 2022 to being at the national average in 2023. Overall, scores declined across all LOBs, and access remains a key area of opportunity for the organization.
    - Care Coordination: For Commercial CAHPS, KP SCAL's position in the Pacific market fell from the 10th to less than the 5th percentile, while scores and relative performance improved for the Medicare and QHP/Marketplace LOBs. This may be attributed to the difference in lookback periods among the three surveys (Commercial at 12 months; Medicare and QHP/Marketplace at 6 months), as well as the Commercial CAHPS measure only being based on one of the six survey items that Medicare and Exchange star ratings include the composite. This measure remains a key area of opportunity for the organization, even as strong efforts in the past year helped move this measure from 1 star to 2 stars for Medicare CAHPS.
    - Overall Rating Items: Scores for all Commercial CAHPS Overall Rating items decreased from 2022 to 2023, which resulted in Rating of Specialist to drop from the 50th to the 33rd Pacific percentile. Medicare CAHPS Overall Rating items also declined, with Rating of Health Plan losing 1 star and Rating of Health Care Quality losing 2 stars. Even as QHP/Marketplace Overall Ratings rose slightly, the data suggest downward trends in member overall member experience driven by unfavorable experiences with Access.
- Similar to last year, KP's drop in relative position may be partially explained by lower survey response rates and a smaller number of health plans who have ample sample sizes to report on measures. With a smaller pool of health plans to rank, the chances of KP falling below average increase.
- The COVID-19 pandemic still exerted an influence on member experience survey results; members still experienced delays in care due to the staff shortages seen across healthcare systems across the country, and KP continues to implement strategies geared towards meeting patient demands for being seen in the ways that they prefer (virtual, in-person, within preferred timeframes, etc.).
    - This was seen throughout the United States health care system. National averages scores for member experience continued to decline for all measures; however, the data suggest that KP's performance has declined further than market competitors.
    - Declines have been occurring over time, falling from their peak in 2021. The declines have slowed, however, from 2022 to 2023.

Given these results, opportunities for improvement include:

1) Access to routine care
2) Access to urgent care
3) Access to specialty care
4) Care coordination as measured by publicly reported surveys, including timely reporting and follow up of test results and discussions of medications

All opportunities listed above are known areas of focus for KP SCAL and are currently being addressed by the organization. Operational teams that support patient access, provider and staff communication regarding medications, and timely reporting of test results have been notified of these survey results and are actively implementing strategies to address these areas of opportunity. There is continued work on improving access to multiple areas of care; additionally, the last three years have seen a robust effort led by Regional Quality to improve the care coordination composite. Care coordination-related interventions have largely focused on how providers and staff frame conversations with patients to highlight the coordination work that has been integrated into the KP system and is not always apparent to the patient.

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Data are shared annually with Service and Access and Quality leaders, as well as the Southern California Quality Committee, Member Concerns Committee, the Access Committee, Regional Service & Access, and Complete Care.

GOAL MET: No barriers noted.

ITEM #2:
Continue to close the gap to external benchmarks on measures that predict member rating of overall health care:

1. **Personal doctor communication (close the gap to the Health Plan CAHPS Pacific 90th %ile)**
2. **Getting care quickly composite (close the gap to the Health Plan CAHPS Pacific 75th %ile)**
3. **Getting needed care (close the gap to the Health Plan CAHPS Pacific 75th %ile)**
4. **Overall rating of specialist (maintain Health Plan CAHPS Pacific 75th %ile)**
5. **Helpful, courteous office staff composite (close the gap to the PAS California 90th %ile)**

Results (Quantitative Analysis):
In 2023, scores remained flat for KP-SC on all four CAHPS measures; two out of the three measures remained at the 10th Pacific percentile ranking.

- Personal Doctor Communication – down 0.77%pt to 89.64% and at the Pacific 5th %ile (same as 2022)
- Getting Care Quickly composite – down 3.67%pt to 63.93% and at the Pacific 10th %ile (up from 5th in 2022)
- Getting Needed Care – down 3.79%pt to 70.31% and at the Pacific 10th %ile (same as 2022)
- Overall Rating of Specialist – down 2.73%pt to 63.11% and at the Pacific 33rd %ile (down from 50th in 2022)
- Helpful, courteous office staff composite – up 1.2%pt to 77.0% and at the statewide 50th %ile (same as 2022)

Results (Qualitative Analysis):
Most KP SCAL results represent slight declines in scores, leading to either similar or lower relative position in the Pacific market. Exceptions include the PAS Office Staff composite with slightly improved scores and the Commercial CAHPS Getting Care Quickly composite, which improved to the 10th Pacific percentile from 5th in 2022. KP SCAL's scores are still largely due to access issues brought on by pent-up demand from the COVID-19 pandemic and associate office closures, as well as uneven health plan practices across the region in terms of these closures.

KP SCAL's performance declined to 89.64% on Personal Doctor Communication, leading to KP SCAL's position at the Pacific 5th percentile. Due to a high level of performance across health plans, NCQA does not report this measure on their annual health insurance plan ratings or accreditation index points.

Next Steps and Priority Areas:
As part of the 2024 Quality Work Plan, continue to close the gap to external benchmarks on measures that predict member rating of overall health care:

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

1. Personal doctor communication (close the gap to the Health Plan CAHPS Pacific 90th %ile)
2. Getting care quickly composite (close the gap to the Health Plan CAHPS Pacific 75th %ile)
3. Getting needed care (close the gap to the Health Plan CAHPS Pacific 75th %ile)
4. Overall rating of specialist (maintain Health Plan CAHPS Pacific 75th %ile)
5. Helpful, courteous office staff composite (close the gap to the PAS California 90th %ile)

GOAL MET: No barriers noted.

ITEM #3:
Develop and implement member experience improvement projects to address areas of opportunities identified in the 2023 complaint and grievance and CAHPS results analysis for ME 7, Elements C and D, which include Access and Care Coordination.

Results (Quantitative Analysis):
To address areas of opportunity found within the Access to Care composite, improvement projects have ramped up as shifts in focus related to managing the COVID-19 pandemic have allowed for newer interventions:

1. Addition of new clinical positions to increase capacity for patient appointments
   - Clinical positions were posted in 2023. Some have been filled, and some are in the process of being filled. We continue to recruit for the remaining open positions in 2024.
2. Addition of enhancements to kp.org to promote online scheduling of appointments
   - Expansion of offerings on kp.org continued in 2023, including the implementation of online bookings in some specialty departments.
3. Continued efforts to increase the proportion of consult appointments that are booked directly to specialty care departments
   - In 2023, the team increased the percentage of consult appointments that were booked directly with specialty care departments.
4. Continued efforts to offer telephone and video appointments to patients as an alternative to office visit, when appropriate
   - The team continued to monitor the percentage of appointments booked in person and virtually; in 2023, efforts were geared towards ensuring patients booked appointments for the visit modality (in person, video) that they preferred.
5. Enhancing patient experience when waiting for Urgent Care visits by improving communication about wait times through digital displays and mobile text notifications
   - The digital displays allowed for better communication of expected wait times; these displays continued to be available at multiple locations in 2023.
6. Providing offerings such as E-visits, an online self-directed care option, as well as "Get Care Now" appointments, which are a more efficient way to speak to a physician about urgent need
   - This year saw the expansion of Get Care Now and Care On Demand, both more efficient ways to speak to a physician about urgent needs.
7. Shifting diagnostic imaging scheduling systems to Radiant, which offers more options for identifying and addressing scheduling inefficiencies
   - All medical center areas have transitioned to the Radiant system

To address areas of opportunity found within the Care Coordination composite, specifically regarding the Medicare population, improvement projects include:

1. Continued collaboration with Systems Solutions & Deployment (SSD) to change patient After Visit Summaries (AVS) to communicate key information more efficiently to patients regarding how their care is coordinated; in 2023, this initiative will expand to additional departments/locations.

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- In collaboration with Systems Solutions & Deployment (SSD), streamlined the patient After Visit Summary (AVS) to communicate key information more efficiently to patients regarding their care plans.

2. Expansion of implementation of text notifications to patients to alert them that their lab results are ready, allowing for timelier follow up of test results; in 2023, this initiative will expand to additional departments/locations.
   - Deployment to members ages 65+ completed in KP SCAL. Patients are now receiving push notifications on their phones when kp.org has published their lab results.
3. Review and revision of clinician training materials (e.g., playbooks, videos) geared towards improving care coordination-related best practices and communication strategies; in 2023, training materials will highlight best practices learned through 2021-2022.
   - Continued ongoing review, revision, and development of clinician training materials (e.g., playbooks, training videos for physicians and staff) geared towards improving care coordination-related best practices and communication strategies.
4. Addition of care coordination-related questions to the KP Rounding tool; this is a new initiative for 2023.
   - Care coordination-related questions were added to the Regional KP Rounding Tool. Managers can now use the tool to track observations regarding Care Coordination scripting and patient education.

Results (Qualitative Analysis):

KP SCAL's efforts to address Access to Care and Care Coordination involve interventions intended to create systemic changes to address the Getting Needed Care, Getting Care Quickly, and Care Coordination composites within CAHPS instruments.

Next Steps and Priority Areas:

As part of the 2024 Quality Work Plan, continued efforts to implement the following improvement projects:

Access to Care:

1. Addition of new clinical positions to increase capacity for patient appointments
2. Addition of enhancements to kp.org to promote online scheduling of appointments
3. Increasing in person visit volume to meet patient demand
4. Enhancing patient experience when waiting for Urgent Care visits by improving communication about wait times through digital displays and mobile text notifications
5. Providing offerings such as E-visits, an online self-directed care option, as well as "Get Care Now" appointments, which are a more efficient way to speak to a physician about urgent needs

Care Coordination:

1. Expansion of implementation of text notifications to patients ages 18+ to alert them that their lab results are ready, allowing for timelier follow up of test results.
2. Continued development of clinician training materials (e.g., playbooks, videos) geared towards improving care coordination-related best practices and communication strategies. In 2024, training materials will highlight best practices learned from 2023-2024 Deep Dives. By the end of 2024, clinician training materials such as playbooks and videos will be developed to enhance communication strategies and best practices in care coordination, incorporating the lessons learned from Deep Dives in 2023-2024. Deep Dives focus on specific topics with each medical center to gain insight into their current process, suggestions, strategies, and barriers. This information is synthesized into an actionable document for local medical centers to use as a resource.
3. Regular assembly of the Care Coordination Plus Leadership Collaborative to spread best practices by highlighting high-performing areas to adopt their strategies.

GOAL MET: No barriers noted.

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
MEMBER-PRACTITIONER COMMUNICATIONS					
Member-Practitioner Communications					
NCQA KP-Goal	Member-Practitioner Communications: KP-SCAL annually makes information about its QI program available to our Members and our Practitioners Publication and distribution of 2023-2024 Annual Quality Letters Publication in the 2023 Member Resource Guide and other communications for members	Met/Not Met	Complete all by End of Q4 2023 Ongoing (website) Q4 2023 Jan 2023	Maintain a log of all communications and how they are distributed as the organization gets 'greener'. Ensure information provided on the KP website is up to date: https://healthy.kaiserpermanente.org/southern-california/pages/quality-safety/measuring-quality Ensure involvement from all standard owners and content experts for Annual Quality Letters. Ensure that the QI program information provided in the KP Member Resource Guide is up to date.	**Farnaz Meybodi**, Regional Director, Quality and Regulatory Services
ANALYSIS					
Goal Met. QI program information was updated on the KP website in July 2023. The SCPMG Practitioner Annual Quality Letter was distributed on 12/8/2023. The KP Staff Annual Quality Letter was distributed on 12/8/2023. The Contract Practitioner Annual Quality Letter was distributed on 12/18/2023. Review of Quality Section within the 2023 Member Resource Guide was completed on 8/18/2022. The 2023 Member Resource Guide was published in November 2022.					

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
Patient-Centered Medical Home (PCMH)					
NCQA PCMH (Patient-Centered Medical Home) Recognition					
F / G	Maintain PCMH recognition status for 105 practice sites (MOBs that offer adult primary care (family medicine, and internal medicine) and/or pediatric services) under NCQA's PCMH Program. Finalize achievement of PCMH recognition for Tehachapi Medical Offices; carried over from 2022 transition effort. Pursue obtainment of PCMH recognition for 1 new practice site, Chino Medical Offices. Documentation will need to be prepared for this practice site, a medical record review will be conducted, and virtual review session(s) will be conducted with an NCQA Surveyor.	Maintaining PCMH recognition requires meeting 12 core criteria per practice site. NCQA PCMH Recognition for transitioning (new) practice site requires meeting: • 40 core criteria • 25 elective criteria	Last quarter 2023	Q1-2023: • Participate in NCQA PCMH virtual sessions for 1 new practice site, Tehachapi Medical Offices. • Evaluate the timeline for 2023 PCMH recognition and re-recognition work for all MOBs that offer primary care services (FM, IM, and Peds). • Gather appropriate PCMH evidence (reports, policies, documented processes, etc.). • PCMH Leads to continue to attend training as needed. Q2-2023: • Communicate PCMH recognition performance throughout the Region. • Determine KPSC practice site structure for 2023-2024 PCMH Submission. • Pay NCQA fees for PCMH Recognition. • Continue to gather appropriate PCMH evidence (reports, policies, documented processes, etc.). • PCMH Leads to attend training as needed. Q3-2023: • Prepare practice site (MOB) evidence for 105 renewing practice sites. • Continue to gather appropriate PCMH evidence (reports, policies, documented processes, etc.). • Prepare practice site (MOB) evidence for Chino Medical Offices, new practice site submission. • Conduct Medical Record Review for Chino Medical Offices, a requirement for new practice sites recognition. Q4-2023: • Continue to gather appropriate PCMH evidence (reports, policies, documented processes, etc.). • Complete submission of evidence for 105 renewing practice sites. • Submit documentation for 1 new practice site, Chino Medical Offices.	**Executive Sponsor:** *Nancy E. Gin, MD, FACP* Executive Vice President and Chief Quality Officer, The Permanente Federation Regional Medical Director of Quality & Clinical Analysis, SCPMG **Leads:** Baleria Berumen, SCPMG Consultant V Nicole Ives, SCPMG Consulting Manager Mimi Hugh, SCPMG Director

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
				• Present PCMH evidence to NCQA for 1 new practice site (Chino Medical Offices) and participate in virtual session(s) for this practice site. • Receive PCMH re-recognition decisions back from NCQA. • Communicate PCMH recognition performance throughout the Region. *Ongoing work throughout 2023* • PCMH leads will continue to provide the NCQA with an update of clinicians attributed to our practice sites who have PCMH Recognition. Physicians are eligible to apply for a Maintenance of Certification (MOC) benefit though their respective boards (Family Medicine, Internal Medicine, Pediatrics) because of being affiliated with a NCQA PCMH recognized practice site. • Ongoing communication of PCMH updates will be maintained through the PCMH SharePoint site to assist physicians with completing Maintenance of Certification board credit; https://sp-cloud.kp.org/sites/SCPMG-PA/SitePages/PCMH.aspx?kp_shortcut_referrer=kp.org/scal/pcmh	

ANALYSIS

Q1-Q4 2023: All process timelines met the project milestones achieved.

RESULTS (Qualitative Analysis):

- Finalized PCMH recognition for Tehachapi Medical Offices; carried over from 2022 transition efforts and formally recognized in February 2023.
- Managed a successful Annual Renewal process, resulting in 106 practice sites (MOBs) being recognized under NCQA's PCMH Program through November 2024.
- 1 practice site, Indian Hills Medical Offices, was selected for audit during the annual renewal process. Focused effort spent on audit activities. Audit was successfully completed, and practice site-maintained recognition status.
- Presented PCMH evidence for 1 new practice site, Chino Medical Offices, and participated in a virtual review session with a NCQA Surveyor to achieve NCQA PCMH recognition. Recognition was obtained in January 2024.
- KP Southern California continues to have the greatest number of NCQA PCMH recognized practice sites for a single entity.
- Ongoing communication with Health Plan to support the auto-credit component of NCQA Health Plan Accreditation.

NEXT STEPS AND PRIORITY AREA:

This year, we achieved PCMH recognition for 106 renewing sites under NCQA's PCMH Annual Reporting Program and submitted documentation for 1 new practice site (Chino Hills Medical Offices) under NCQA's PCMH Program. In 2024, Chino Hills Medical Office, was formally NCQA PCMH recognized, and planning was initiated for the 2024 Annual Reporting process for all 106 practice sites under NCQA's PCMH Recognition Program. Ongoing communication of PCMH recognition work to leadership will continue through 2024.

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
POPULATION HEALTH MANAGEMENT (PHM)					
Segmentation (PHM 2D)					
NCQA DMHC DHCS	Annually collect, integrate, and assess member data to review and update the population health management programs, as needed. 1. Segment or stratify the member population into subsets for targeted intervention. 2. Assess for racial bias in its segmentation or stratification methodology.	Met/Not Met	Q1 2023	1. Segment or stratify the member population into subsets for targeted intervention. 2. Assess for racial bias in its segmentation or stratification methodology.	Timothy Ho, MD Regional Assistant Medical Director, Quality & Complete Care Michelle Pruitt, RN Director, Clinical Quality SCPMG Complete Care Support Programs Christopher Stewart Senior Consultant, Complete Care Support Programs

ANALYSIS

Population Health Programs Stratification Summary

The table below represents Kaiser Permanente's population health programs, effective as of January 2023. The table summarizes the reach and potential impact of the various Regional Population Health interventions. The total membership for January 2023 is **4,142,485**.

Commercial Population = 3,128,807 Highlighted Initiatives	**Targeted Program(s) (top) Intervention (bottom)**	**Number of Members**	**Percentage of Membership**
DM Care Management ages 18-75 with DM I or II	Disease Management and/or Complex Case Management	194,102	6.20%
	Care Management program where DM patients A1c >=8 followed by Care Manager (RN, Pharm D, or APP); in-reach and outreach for test; workshops, lifestyle, and/or surgical interventions; medication adherence, remote monitoring		
Heart Failure Management ages 18+ with Ejection Fraction ≤ 40%	Disease Management and/or Complex Case Management	14,596	0.47%
	Care Management program where HF patients EF≤40% followed by Care Manager (RN, Pharm D, or APP); in-reach and outreach for disease management; workshops, lifestyle, and/or surgical interventions; medication adherence, remote monitoring		
Post Hospital Discharge Follow-up ages 18+	Disease Management and/or Complex Case Management	41,995	1.34%
	Outreach to patients post discharge to ask a series of questions regarding recovery and address concerns if within scope or escalate to a higher level of care if needed.		

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
		Appointments within 7days of discharge with PharmD, Advance practice provider or physician for med reconciliation and addressing any concerns around recovery.			
Gross Hematuria		SureNet Outreach to patients 50 years and older, with a diagnosis of Gross Hematuria, who have not had a follow up assessment and diagnostic testing within the last 18 months; ensuring that the patient receives a phone call from a Licensed Vocational Nurse (LVN) to determine the need for follow up, along with orders for a CT urogram, cystoscopy, and referral to Urology, to aid with the detection of bladder cancer.	448	0.01%	

Medicare Risk Population = 667,317 Highlighted Initiatives	**Targeted Program(s) (top) Intervention (bottom)**	**Number of Members**	**Percentage of Membership**
DM Care Management ages 18-75 with DM I or II	Disease Management and/or Complex Case Management Care Management program where DM patients A1c >=8 followed by Care Manager (RN, Pharm D, or APP); in-reach and outreach for test; workshops, lifestyle, and/or surgical interventions; medication adherence, remote monitoring	190,211	28.50%
Heart Failure Management ages 18+ with Ejection Fraction ≤ 40%	Disease Management and/or Complex Case Management Care Management program where HF patients EF≤40% followed by Care Manager (RN, Pharm D, or APP); in-reach and outreach for disease management; workshops, lifestyle, and/or surgical interventions; medication adherence, remote monitoring	47,871	7.17%
Post Hospital Discharge Follow-up ages 18+	Disease Management and/or Complex Case Management Outreach to patients post discharge to ask a series of questions regarding recovery and address concerns if within scope or escalate to a higher level of care if needed. Appointments within 7days of discharge with PharmD, Advance practice provider or physician for med reconciliation and addressing any concerns around recovery.	58,128	8.71%
Gross Hematuria	SureNet Outreach to patients 50 years and older, with a diagnosis of Gross Hematuria, who have not had a follow up assessment and diagnostic testing within the last 18 months; ensuring that the patient receives a phone call from a Licensed Vocational Nurse (LVN) to determine the need for follow up, along with orders for a CT urogram, cystoscopy, and referral to Urology, to aid with the detection of bladder cancer.	524	0.08%

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Exchange Population = 255,819 Highlighted Initiatives	**Targeted Program(s) (top) Intervention (bottom)**	**Number of Members**	**Percentage of Membership**
DM Care Management ages 18-75 with DM I or II	Disease Management and/or Complex Case Management Care Management program where DM patients A1c >=8 followed by Care Manager (RN, Pharm D, or APP); in-reach and outreach for test; workshops, lifestyle, and/or surgical interventions; medication adherence, remote monitoring	37,773	14.71%
Heart Failure Management ages 18+ with Ejection Fraction ≤ 40%	Disease Management and/or Complex Case Management Care Management program where HF patients EF≤40% followed by Care Manager (RN, Pharm D, or APP); in-reach and outreach for disease management; workshops, lifestyle, and/or surgical interventions; medication adherence, remote monitoring	3,120	1.22%
Post Hospital Discharge Follow-up ages 18+	Disease Management and/or Complex Case Management Outreach to patients post discharge to ask a series of questions regarding recovery and address concerns if within scope or escalate to a higher level of care if needed. Appointments within 7days of discharge with PharmD, Advance practice provider or physician for med reconciliation and addressing any concerns around recovery.	3,371	1.32%
Gross Hematuria	SureNet Outreach to patients 50 years and older, with a diagnosis of Gross Hematuria, who have not had a follow up assessment and diagnostic testing within the last 18 months; ensuring that the patient receives a phone call from a Licensed Vocational Nurse (LVN) to determine the need for follow up, along with orders for a CT urogram, cystoscopy, and referral to Urology, to aid with the detection of bladder cancer.	77	0.03%

Population Health Management Impact (PHM 6A & 6B)					
NCQA DMHC DHCS	Annually measure the effectiveness of PHM strategy by: A. Measuring Effectiveness – conducting a comprehensive analysis of the impact of	Met/Not Met	Q1 2024	Administer a member survey to assess for each line of business (Commercial, Exchange, and Medicare) the impact of PHM strategy and efforts, identify opportunities, and act on one opportunity.	Timothy Ho, MD Regional Assistant Medical Director, Quality & Complete Care Michelle Pruitt, RN

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	the PHM strategy that includes the following: 1. Quantitative results for clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. B. Improvement and Action – Using results from the PHM impact analysis to: 1. Identify opportunities for improvement. 2. Act on one opportunity for improvement.				Director, Clinical Quality SCPMG Complete Care Support Programs Christopher Stewart Senior Consultant, Complete Care Support Programs
ANALYSIS					

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Reporting Period
The reporting period is January 1, 2022 through December 31, 2022. All years referenced below refer to the HEDIS year – e.g., 2023 equates to HEDIS 2023 with reporting data from 2022 – unless "measurement year" is otherwise specified.

1. Keeping Members Healthy: Influenza vaccine
Target population: members over 18
Goal: members report receiving a flu vaccine during the reporting period
Relevance: Influenza vaccination remains an important health priority for KPSC in our population aged 18 years and older. This is an important vaccine to prevent hospitalization and death in our members. KPSC has developed several strategies to help improve vaccination rates including offering free vaccinations, broad communication strategies informing members when and where the vaccines are given, using text, letters and e-mail. Follow up communications are sent to those members who have not been vaccinated earlier in the season, and easy to access vaccination sites are available at all service locations.

Flu vaccine outreach occurred via automated phone calls, kp.org electronic notices, automatic notes at the end-of-visit instructions, and in-reach during visits. It was included in tandem with much of the COVID-19 outreach.

Protecting members with chronic conditions, such as diabetes and cardiovascular diseases and those more vulnerable populations against influenza is important even though the vaccine won't prevent members from getting influenza. The influenza vaccine will help prevent complications (i.e., pneumonia, respiratory failure, and heart inflammation) and flu-related hospitalizations.

Results

	HEDIS 2021 (2020 performance)	HEDIS 2022 (2021 performance)	HEDIS 2023 (2022 performance)	Goal	Benchmark HEDIS 90th percentile	Met/Not Met
Commercial	61.10%	59.46%	61.74%	60%	66%	Met
Medicare	NR	84	83	80	78	Met
Exchange	57.59%	54.50%	51.37%	60%	66%**	Not Met

**Commercial HEDIS benchmark

Quantitative analysis:
- Commercial: the flu rate improved by 2.28% from HEDIS 2022 to HEDIS 2023. The goal of 60% was met.
- Medicare: the flu rate declined by 1 point from HEDIS 2022 to HEDIS 2023; however, the goal of 80 was met.
- Exchange: the flu rate declined 3.13% from HEDIS 2022 to HEDIS 2023. The goal of 60% was not met.

Qualitative analysis:
- The flu rate for the Exchange line of business has steadily declined at approximately 3% annually. It is highly likely that the COVID-19 pandemic created substantial issues related to flu vaccination. After the COVID pandemic, there has been a shift in vaccine beliefs, with a growing sense of fatigue and hesitancy, particularly among the younger demographic. For the 2023/2024 flu season, the CDC has issued a health alert to ensure that providers are aware of the current low vaccination rates and urging healthcare providers to emphasize the importance of vaccination. The CDC stated that one of the key reasons for low vaccination of influenza based on survey results from a nationally representative sample of U.S. adults is lack of time or forgetting to get vaccinated[1]. In this regard, Kaiser Permanente has increased efforts to enhance vaccine accessibility by offering additional vaccination clinics during after-hours and weekends. Teams are proactively reaching out to individuals through text messages or phone calls to ensure they are informed about these extended opportunities. The primary goal is to make it convenient for those who may not typically seek vaccinations to access them. Kaiser Permanente utilizes "hotspot" data to identify areas of low vaccination rates and creates customized outreach. Generally, vaccines are given at Hospital Medical Centers; however, for these "hotspot" areas, vaccines are given at medical office buildings closer to the members' place of residence.

Opportunity for improvement: Improve influenza vaccination rate. NOTE: Influenza vaccines are critical for members with chronic illnesses; therefore, initiative remains a critical focus to improve rates across all product lines.

Actions taken: * KPSC is an integrated network and does not distinguish members at the point of service. Therefore, any interventions impact members across all product lines.

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Intervention	Implementation Date
Continued use of regional SharePoint with guidelines, resources, and education available to all service areas. These resources are updated each year when new information becomes available/relevant and includes an ethnic, inclusion, and diversity focused section (see Appendix for example).	Ongoing
Continued outreach for flu vaccinations as well as including flu vaccination alongside COVID-19 vaccine reminders. This included English and Spanish automated calls, in-reach to patients attending clinic, and physical/e-flyers. Outreach is planned in advance for the upcoming flu season (see Appendix for e-flyer example and planned outreach for upcoming flu season).	Ongoing
Utilize "hotspot" data showing vulnerable areas of inequity – i.e., African American patients – to direct outreach and messaging.	Ongoing
Utilize special events, such as drive-thru or walk-up/drive-up vaccination sites, to make it more convenient for members to access vaccines.	Ongoing

Refer to Appendix for examples of ongoing interventions.

2. Managing Members with Emerging Risks: Diabetes HgbA1c <8

Target population: adults with uncontrolled diabetes and at-risk for diabetes 18-75 years
Goal: maintain or lower HgbA1c <8
Relevance: Tighter glycemic control in diabetics has been shown to reduce microvascular complications like nephropathy and neuropathy. This coupled with the high prevalence of diabetics in our population – roughly 9.8% -makes this an important area of focus. A multi-faceted approach has been developed to care for these large number of diabetic patients, including robust health education programs with integrated diet/nutrition teaching.

Each KPSC Service Area has dedicated Care Managers who follow up with patients with an A1c 8 or above, and work with the patient's primary care practitioner to titrate medications as needed and follow up closely with repeat labs until the patient is at goal.

Results

	HEDIS 2021 (2020 performance)	HEDIS 2022 (2021 performance	HEDIS 2023 (2022 performance)	2022 CSG Target Goal	National Benchmark HEDIS MY22 HMO 90th percentile	Met/Not Met Goal
Commercial	60.10%	60.13%	59.37%	69.5%	69.67%	*Not Met*
Medicare	77.52%	77.04%	77.51%	77%	78.83%	*Met**
Exchange	64.09%	63.94%	63.47%	69.5%	69.67%**	*Not Met*

[1] https://emergency.cdc.gov/han/2023/han00503.asp?ACSTrackingID=USCDC_7_3-DM118796&ACSTrackingLabel=CDC%20Health%20Advisory%20%E2%80%93%20Health%20Care%20Providers%20Urged%20to%20Recommend%20Vaccinations%20to%20Patients%20Now&deliveryName=USCDC_7_3-DM118796

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

* Indicates benchmark met; **Commercial HEDIS benchmark

Quantitative analysis:
The findings indicated that goal for the diabetes measure to maintain or reduce the HgbA1c <8 remained fairly consistent. Commercial and Exchange lines did not meet goal, and Medicare line did meet goal.

- Commercial: the HEDIS 2023 rate decreased slightly by 0.76% from 2022 and did not meet the goal or benchmark.
- Medicare: the HEDIS 2023 rate increased slightly by .47% from previous year and did meet goal but did not meet the benchmark.
- Exchange: the HEDIS 2023 rate continued to decline slightly by .47% from the previous year and did not meet goal or benchmark.

Qualitative analysis:

- Commercial: in measurement year 2022 there was still a backlog from patients hesitant to come into labs, but a steady increase in HbA1c testing rates was seen throughout the year. Normally, increased screening rates would also correlate to increased HbA1c < 8 by both allowing treatment to proceed and returning those who were grouped above 8% solely due to no test within a year, back into the numerator. (Members who did not have A1c labs conducted within one year are considered as being in "poor control" – i.e., HbA1c >9%" – despite their last HbA1c result). Our Latinx members and our patients aged less than 65 remain the most challenging group to bring their HbA1c under 8%.

  Patients in our Commercial population are difficult to outreach and face socio-economic, location, and other barriers - to see their provider, adhere to their medication regimen, get tested, and make lifestyle changes.

  KPSC is tailoring our performance improvement strategies in collaboration with *Equity, Inclusion, & Diversity* and *Center for Healthy Living* to better meet the needs of our members ages 65 and under, Latinx members, and other at-risk groups.

- Medicare: There was a slight increase in the percentage of HbA1c < 8%, meeting the goal. It continues to be the population with the highest hbA1c percentage under 8%.

- Exchange: Exchange HbA1c < 8% had the smallest dip. Like our Commercial membership, the Exchange population is a younger working population, similar to Medicare, and face the same challenges. Similar to Commercial, collaboration with *Equity, Inclusion, & Diversity* and *Center for Healthy Living* is taking place to drive initiatives to improve the health of this population, especially those LatinX patients who are the most vulnerable.

  KPSC recognizes the ethnic and age-related disparities for HbA1c Control (<8) and will continue to tailor our strategies to better meet the needs of our at-risk groups.

Opportunity for improvement: Improve HBA1c rates across all product lines.

Actions taken: * KPSC is an integrated network and does not distinguish members at the point of service. Therefore, any interventions impact members across all product lines.

Intervention	Implementation Date
Create lists of patients missing an A1c test, prioritizing more vulnerable patients based on previous tests, med-adherence, etc. (This included large amounts of our vulnerable Hispanic/Latino population.)	Ongoing
Renewed focus on training/re-training in DM-related standard workflows for large amounts of new staff	Ongoing
Distribute hot spot report to local medical centers for targeted outreach.	Q4 2022
Hotspot dashboard that addresses vulnerable populations by zip code, ethnicity, socio-economic status (Healthy Places Index) will be accessible to all medical centers.	Q4 2023-Q1 2024

Refer to Appendix for examples of ongoing interventions.

3. Managing Members with Emerging Risks: Persistence of beta blocker treatment after a heart attack
Target population: adults who experienced a heart attack 18+ years

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Goal: members treated with beta blockers post heart attack
Relevance: Beta-blocker therapy has been shown to improve survival rates after hospital discharge

Results:

	HEDIS 2021 (2020 performance)	HEDIS 2022 (2021 performance	HEDIS 2023 (2022 performance	2022 CSG Target Goal	Benchmark HEDIS MY22 HMO 90th percentile	Met/Not Met Goal
Commercial	81.76%	81.34%	82.69%	89%	90.15%	*Not Met*
Medicare	89.43%	86.65%	89.30%	92%	95.92%	*Not Met*

Note: measure not required for Exchange product line.

Quantitative analysis:

- Overall, the beta blocker rates for both product lines have improved when compared to last year.
- Commercial: the HEDIS 2023 rate improved by 1.35% from the previous year, however, did not meet the goal or benchmark.
- Medicare: the HEDIS 2023 rate improved from the 2022 rate by 2.65%, continuing to exceed the goal, but not the benchmark. No further qualitative analysis or actions required.

Qualitative analysis: Commercial

- Issues with some miss-diagnosed myocardial infarctions occurring outside of KP Southern California facilities, but still feeding into our reporting system via claims data
- Initial beta blocker therapy prescriptions vary on amount of days supply provided

Ongoing actions for continued improvement

- Live outreach to post MI patients who have active Beta Blocker therapy order and need to pick up prescriptions
- Partner with Hospital Chiefs on appropriate coding of MI vs elevated troponin or competing diagnoses that do not warrant MI
- Educated physicians and teams on proper allergy coding that could exclude members from Beta Blocker eligibility and remove them from the metric
- Established routine list of members that have been diagnosed with MI within a specific look back period and the corresponding Beta Blocker therapy to be used for outreach to patients by local areas or escalation to Cardiologist
- Deployed a documentation flowsheet to capture Beta Blocker dispenses for patients discharged outside of KP Southern California facilities.

Actions taken: * KPSC is an integrated network and does not distinguish members at the point of service. Therefore, any interventions impact members across all product lines.

4. Patient Safety: Medication Reconciliation: Medication review after inpatient discharge

Target population: adults discharged from an inpatient hospital admission ages 18-75 years
Goal: members with an inpatient admission will have a medication review documented in EMR within 30 days of discharge
Relevance: Medication reconciliation is a formal, systematic strategy to overcome medication information communication challenges and reduce unintended discrepancies that occur at transitions in care. Ideally, health care providers from different professions (physicians, nurses, pharmacists) work together and with patients (and their families) to ensure the accurate and consistent communication of medication information across transitions and various settings of care. Medication Reconciliation is done to avoid medication errors such as omissions, treatment duplications, dosing errors, or drug interactions. A comprehensive list of medications should include all prescription medications, herbal supplements, vitamins, nutritional supplements, and over-the-counter drugs taken PRN (as needed.) We have continued to prioritize this by establishing special appointments within seven days of hospital discharges for our members, so that medication reconciliation can happen in a timely, effective manner. To assist with patients were coming into the clinic isn't feasible, KPSC offers phone appointments, and a small program where a home Health nurse will reconcile the medications at home.

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Results:

	HEDIS 2021 (2020 performance)	HEDIS 2022 (2021 performance)	HEDIS 2023 (2022 performance)	2022 CSG Target Goal	National Benchmark HEDIS 90th percentile	Met/Not Met
Medicare	97.81%	97.32%	98.54%	n/a	89.29%	Met

Quantitative analysis:
The 2023 Medicare rate increased by 1.2% percent compared to the previous year, the goal was met. HEDIS benchmark was at 89.29% for this measure. Goal met; no opportunities identified for improvement. Ongoing strategies and interdepartmental collaboration have allowed KPSC to meet regulatory standards and provide high quality healthcare across the region. No further qualitative analysis or actions required.

5. Plan All Cause Readmissions

Target population: Members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for adult members
Goal: Reduce 30-day readmission rate by 10 percent for members with multiple chronic illnesses
Relevance: Although some readmissions cannot, and should not be avoided, others can be prevented. Proper follow up care post-hospital-discharge can help reduce readmission within 30-days. Included in this follow-up care is managing/reconciling medication and managing chronic conditions. To assist with this, ambulatory appointments are scheduled for soon after discharge. These appointments include medication reconciliation, discussing chronic condition care to avoid hospitalization, and may also involve intravenous infusions, coordinating care with home health, etc.
Results:

	HEDIS 2021 (2020 performance)	HEDIS 2022 (2021 performance	HEDIS 2023 (2022 performance)	Goal	HEDIS MY2022 90th percentile	Met/Not Met
Commercial	0.625	0.619	0.593	0.47	0.44	Not Met
Medicare	1.049	1.065	1.075	0.85	0.83	Not Met
Exchange	0.663	0.587	0.592	n/a	0.46	n/a

Quantitative analysis:
- The readmission rates have fluctuated slightly for the various product lines, however, the goals were not met.
- Commercial: The rate decreased slightly in 2022 compared to 2021 and exceeded the 90th percentile by .02 points. However, the goal was not met.
- Medicare: The rate showed a small increase in 2022, slowing from the more rapid increase in 2021. The goal was not met.
- Exchange: The rate increased compared to the previous year. This rate also shows to be above the 90th percentile.

Quantitative analysis:

- The rate for 2022 does not reflect an improvement from prior year in the Medicare and Exchange populations, falling below goal. However, the Commercial population did show an improvement in rates when compared to last year. Continued challenges with availability of post discharge appointments (i.e. both in-person and virtual) has limited the opportunity to engage patients timely.

Ongoing actions for continued improvement:

- As availability of appointments begin to increase, the pre discharge heart failure questionnaire will assist with identifying patients to participate in care management program aimed to reduce heart failure readmissions.

6. Member Experience Surveys – Diabetes and Heart Failure

Methodology

Member surveys were conducted to ascertain members' experience with complete care programs for those who were enrolled in 1) diabetes (DM), 2) heart failure (HF), or 3) both programs. Responses for those in "both programs" are included separately as they would be given care for medications, therapies, and lifestyle recommendations tailored for persons with both chronic diseases. For example, they may have more interactions with a PharmD to discuss medication titration for both diseases.

The survey was hosted on an online interface - Online Personal Action Plan (oPAP) – available to patients enrolled in kp.org. Electronic messages were sent to patients who were identified as meeting the criteria for the DM, HF, or both Care Management programs. As the previous survey had a low response rate, the survey timeframe was moved to July through November 2022 with several thousand additional surveys sent. This yielded a significant increase in responses, so the July through November timeframe will be used going forward.

Survey Questions

The survey begins with a gatekeeper question asking if the patient had an interaction with a Care Manager – in the past 12 months – for DM, HF, or both programs. Those answering no interaction were given a "thank you" message, were not prompted to complete additional questions, and removed from the following analysis. Those answering yes for an interaction were prompted to answer 5 questions for DM, HF, or DM and then HF as dictated by their response. Questions had a 5-point scale with 1 being the highest level of satisfaction and 5 being the lowest. A N/A choice was also available and questions with an N/A response were removed from the denominator.

Goal: 80% of patients satisfied for each question. Satisfaction is defined as a response of 1 or 2.

Reporting Period

The reporting period is January 1, 2023 through December 31, 2023.

Results

Commercial	# of Respondents
DM	83
HF	27
Exchange	**# of Respondents**
DM	31
HF	4
Medicare	**# of Respondents**
DM	112
HF	81
Medicaid	**# of Respondents**
DM	27
HF	8

Outcome by Program and Line of Business

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Diabetes

Commercial	# of Satisfied Patients / Total # of Respondents	% Members Satisfied	Met/Not Met (Goal = 80%)
Q1. Did the case manager help you understand the treatment plan?	55 / 72	76.39%	Not Met
Q2. Did the case manager help you get the care you needed?	23 / 41	56.10%	Not Met
Q3. Did the case manager pay attention to you and help with your problems?	23 / 31	74.19%	Not Met
Q4. Did the case manager treat you with courtesy and respect?	28 / 32	87.50%	Met
Q5. How satisfied are you with the care management program?	23 / 31	74.19%	Not Met
Exchange	# of Satisfied Patients / Total # of Respondents	% Members Satisfied	Met/Not Met (Goal = 80%)
Q1. Did the case manager help you understand the treatment plan?	24 / 26	92.30%	Met
Q2. Did the case manager help you get the care you needed?	13 / 16	81.25%	Met
Q3. Did the case manager pay attention to you and help with your problems?	14 / 16	87.50%	Met
Q4. Did the case manager treat you with courtesy and respect?	11 / 11	100%	Met
Q5. How satisfied are you with the care management program?	10 / 13	76.92%	Not Met
Medicare	# of Satisfied Patients / Total # of Respondents	% Members Satisfied	Met/Not Met (Goal = 80%)
Q1. Did the case manager help you understand the treatment plan?	87 / 92	94.57%	Met
Q2. Did the case manager help you get the care you needed?	63 / 70	90%	Met
Q3. Did the case manager pay attention to you and help with your problems?	45 / 51	88.23%	Met
Q4. Did the case manager treat you with courtesy and respect?	34 / 37	91.89%	Met

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Q5. How satisfied are you with the care management program?	39 / 48	81.25%	Met
Medicaid	# of Satisfied Patients / Total # of Respondents	% Members Satisfied	Met/Not Met (Goal = 80%)
Q1. Did the case manager help you understand the treatment plan?	18 / 22	81.82%	Met
Q2. Did the case manager help you get the care you needed?	10 / 16	62.5%	Not Met
Q3. Did the case manager pay attention to you and help with your problems?	9 / 12	75%	Not Met
Q4. Did the case manager treat you with courtesy and respect?	5 / 8	62.5%	Not Met
Q5. How satisfied are you with the care management program?	11 / 15	73.33%	Not Met

Heart Failure

Commercial	# of Satisfied Patients / Total # of Respondents	% Members Satisfied	Met/Not Met (Goal = 80%)
Q1. Did the case manager help you understand the treatment plan?	16 / 23	69.57%	Not Met
Q2. Did the case manager help you get the care you needed?	7 / 14	50%	Not Met
Q3. Did the case manager pay attention to you and help with your problems?	6 / 13	46.15%	Not Met
Q4. Did the case manager treat you with courtesy and respect?	7 / 13	53.85%	Not Met
Q5. How satisfied are you with the care management program?	10 / 16	62.5%	Not Met
Medicare	# of Satisfied Patients / Total # of Respondents	% Members Satisfied	Met/Not Met (Goal = 80%)
Q1. Did the case manager help you understand the treatment plan?	57 / 74	77.03%	Not Met
Q2. Did the case manager help you get the care you needed?	30 / 45	66.67%	Not Met
Q3. Did the case manager pay attention to you and help with your problems?	32 / 48	66.67%	Not Met

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Q4. Did the case manager treat you with courtesy and respect?	26 / 36	72.22%	Not Met
Q5. How satisfied are you with the care management program?	26 / 42	61.90%	Not Met
Exchange	# of Satisfied Patients / Total # of Respondents	% Members Satisfied	Met/Not Met (Goal = 80%)
Q1. Did the case manager help you understand the treatment plan?	2 / 4	50%	Not Met
Q2. Did the case manager help you get the care you needed?	0 / 1	0%	Not Met
Q3. Did the case manager pay attention to you and help with your problems?	0 / 1	0%	Not Met
Q4. Did the case manager treat you with courtesy and respect?	0 / 1	0%	Not Met
Q5. How satisfied are you with the care management program?	1 / 1	100%	Not Met
Medicaid	# of Satisfied Patients / Total # of Respondents	% Members Satisfied	Met/Not Met (Goal = 80%)
Q1. Did the case manager help you understand the treatment plan?	5 / 6	83.33%	Met
Q2. Did the case manager help you get the care you needed?	5 / 6	83.33%	Met
Q3. Did the case manager pay attention to you and help with your problems?	5 / 7	71.43%	Not Met
Q4. Did the case manager treat you with courtesy and respect?	4 / 5	80%	Met
Q5. How satisfied are you with the care management program?	5 / 6	83.33%	Met

Quantitative Analysis:

- Commercial: Goals of 80% satisfaction were not met.
- Medicare: Goals of 80% satisfaction were not met for Heart Failure but met for Diabetes.
- Exchange: Goals of 80% satisfaction were not met.
- Medicaid: Goals of 80% satisfaction were not met.

Qualitative Analysis:

- Kaiser Permanente does not focus on the patient's health plan line of business when providing care. Each patient is treated with the same high-quality healthcare regardless of the member's benefits or coverage. As responses were much smaller than anticipated, sub-dividing the programs by line of business does not provide meaningful data.

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

- It is believed that the questions failing to reach 80% patient satisfaction were greatly influenced by the low response rates. A contributing factor to the low response volumes may be survey fatigue, since there is interest from multiple groups on gauging the patient's experience. There is a significant drop off in responses when looking at the first question versus the last question being answered, this was seen across the various groups that completed the surveys. With the low sample size, there cannot be confidence in applying results to program participants.
- Still, findings can prove useful to investigate potential issues and as a comparison point to future surveys. Also, the lack of significance will greatly inform the next survey methodology; future surveys will be sent out to higher numbers of patients and survey mode will be evaluated to correct this issue and allow for meaningful analysis.

Conclusion:
Due to not achieving statistical significance a definitive conclusion cannot be formulated. However, the question types can help guide where possible follow-up may be necessary to proactively address any potential shortcomings. Discussions with local medical centers and data transparency will be used to improve outcomes and satisfaction.

Overall Summary:

The overall findings indicated that the following measures met the established goal for the 2022 reporting period which demonstrates the positive effectiveness of the current PHM program strategy.

- Annual flu vaccine: Medicare - *Keeping members healthy*
- Persistence of beta blocker treatment after a heart attack: Medicare – *Managing members with risk*
- Medication reconciliation: Medicare – *Patient Safety*
- Reduce readmission rate: Commercial, Exchange – *Outcomes across settings*

Opportunities for improvement: Based on collective analysis across all product lines, KPSC identified the diabetes HgA1c and influenza measures as opportunities for improvement. Influenza vaccines are essential for members with chronic illnesses; therefore, initiative remains a critical focus to improve rates across all product lines.

The findings are shared with all medical center leaders and suggested action items cascaded to each area. Challenges do remain given the high number of COVID-19 cases; nationwide healthcare worker shortages due to retirement, turnover, and illness; and the patient backlog. Proposed solutions are done with this in mind and may be modified as needed. As KP Southern California is an integrated network and does not distinguish members at the point of service, these interventions will impact members across all product lines.

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
PRACTITIONER AVAILABILITY – CULTURAL NEEDS & PREFERENCES					
Practitioner Availability: Cultural Needs & Preferences					
NCQA	Assesses the cultural, ethnic racial and linguistic needs of our members.	Complete Annual Assessment	Q4 2023	Analyze the demographic needs of our members to identify opportunities for improvement.	Rachel Sandoval, Director, Equity, Inclusion & Diversity

ANALYSIS

GOAL MET: 2023 Southern California Demographic Assessment (Race, Ethnicity, Language) Completed Q4 2023

RESULTS (Quantitative Analysis)

2021 - 2023 Race Data Comparison Table
(Membership, Community, Physician, Staff)

RACE	Membership			Community			Staff			Physicians		
	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
American Indian/Alaska Native	0.30%	0.29%	0.29%	0.30%	0.30%	0.34%	0.38%	0.32%	0.27%	0.24%	0.18%	0.18%
Asian/Pacific Islander/Native Hawaiian	11.35%	11.54%	11.71%	12.86%	12.96%	13.06%	30.08%	30.20%	27.32%	49.84%	50.11%	50.52%
Black/African American	7.82%	7.77%	7.71%	5.68%	5.71%	5.58%	10.94%	9.91%	8.81%	4.09%	4.05%	4.05%
Hispanic/Latino	34.70%	35.64%	36.16%	46.69%	46.62%	46.74%	30.55%	31.19%	28.67%	8.01%	7.98%	7.80%
White/Caucasian	30.15%	28.98%	28.27%	31.68%	31.57%	29.99%	28.04%	19.55%	17.12%	35.93%	35.75%	35.29%
Multiracial/Unknown/Other	15.68%	15.78%	15.87%	2.79%	2.84%	4.28%	0.01%	8.84%	17.82%	1.89%	1.93%	2.17%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

*For all business lines (i.e., Commercial, Medicare)

Sources	Membership	Community	Staff	Physicians
Race	KPHC	Claritas	HR Connect	MDPeople

RESULTS (Qualitative Analysis)

Demographic Data Collection/Assessments

Race/Ethnicity Collection – The Kaiser Permanente HealthConnect (KPHC) Q4 2023 reporting system indicated that 95.14% (4,363,882) of the members' race values were captured, which includes 4.03% for 'Unknown', 2.33% for 'Other', and 4.32% for 'Decline to State'. 4.86% of membership had no race entry. For members, 95.17% (4,365,089) had an ethnicity value, which includes 3.33% for 'Unknown', 1.30% for 'Other', and 3.97% for 'Decline to State'. 4.83% of members had no ethnicity entry.

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

In 2023, staff data is now pulled from HR Connect, which now allows more options for staff to self-identify two or more races. Results are generally consistent from year to year, due to the change in data source we do see a decrease in White/Caucasian and in increase in Multiracial. The data shows a slight decrease in the percentage of White/Caucasian members. The data also shows a slight increase in the percentage of Asian/Pacific Islander/Native Hawaiian physicians, staff and the corresponding membership and community percentages. There is slight decrease in the Hispanic/Latino staff and increase in corresponding membership and community percentages and a slight decrease in the Black/African American staff and corresponding membership percentage and decrease in community percentage.

RESULTS (Quantitative Analysis)

RACE	Membership		Community		Physicians		Staff	
	#	%	#	%	#	%	#	%
American Indian/Alaska Native	13,241	0.29%	81,727	0.34%	19	0.18%	220	0.27%
Asian/Pacific Islander/Native Hawaiian	536,925	11.71%	3,112,006	13.06%	5,406	50.52%	22,255	27.32%
Black/African American	353,440	7.71%	1,329,720	5.58%	433	4.05%	7,172	8.81%
Hispanic/Latino	1,658,401	36.16%	11,135,519	46.74%	835	7.80%	23,351	28.67%
White/Caucasian	1,296,800	28.27%	7,145,791	29.99%	3,776	35.29%	13,940	17.12%
Multiracial/Unknown/Other	727,980	15.87%	1,020,780	4.28%	232	2.17%	14,511	17.82%
Total	**4,586,787**	**100%**	**23,825,543**	**100%**	**10,701**	**100%**	**81,449**	**100%**

SOURCES	Membership	Community*	Physicians	Staff
Race	Dec 2023 KPHC	2023 Claritas	07/26/23 MDPeople	09/21/23 HR Connect

RESULTS (Qualitative Analysis)

- American Indian/Alaska Native members: The percentages of American Indian/Alaska Native staff (0.27%), members (0.29%), community (0.34%), and physicians (0.18%) are similar.
- Asian/Pacific Islander/Native Hawaiian: The percentage of physicians (50.52%) is more than four times that of members (11.71%) who identify as Asian/Pacific Islander/Native Hawaiian, while the staff's percentage (27.32%) is nearly three times that of members of the same identification.
- Black/African American members: The percentage of Black/African American members (7.71%) is almost double that of the physicians (4.05%) whereas the staff percentage (8.91%) is less.
- Hispanic/Latino members: The percentage of Hispanic/Latino members (36.16%) exceeds the percentage of physicians (7.80%) but is close to that of the staff (28.67%).

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

RESULTS (Quantitative Analysis)

2021-2023 LANGUAGE DATA COMPARISON TABLE- Top 20 Preferred Languages by Members other than English and Spanish (MEMBERSHIP, COMMUNITY, PHYSICIAN, STAFF)

LANGUAGE SPOKEN	Membership			Community*			Staff ***			Physicians**		
	2021	2022	2023	2019	2020	2021	2021	2022	2023	2021	2022	2023
English	88.29%	88.58%	88.76%	48.21%	51.02%	49.39%	85.08%	84.91%	84.98%	61.76%	58.73%	79.68%
Spanish	8.61%	8.43%	8.26%	32.24%	32.52%	31.92%	14.09%	14.27%	14.24%	14.37%	15.19%	10.29%
Chinese (Mandarin)	0.34%	0.36%	0.39%	0.79%	0.81%	0.75%	0.20%	0.21%	0.20%	3.96%	4.35%	2.77%
Vietnamese	0.24%	0.23%	0.23%	1.49%	1.69%	1.43%	0.17%	0.17%	0.16%	1.91%	2.07%	0.87%
Korean	0.14%	0.14%	0.14%	1.22%	1.17%	1.21%	0.07%	0.07%	0.07%	1.62%	1.88%	0.93%
Tagalog	0.11%	0.10%	0.10%	2.04%	2.01%	1.93%	0.19%	0.18%	0.17%	1.23%	1.33%	0.61%
Armenian	0.09%	0.09%	0.08%	0.77%	0.75%	0.86%	0.08%	0.07%	0.07%	0.90%	0.97%	0.50%
Chinese (Cantonese)	0.08%	0.08%	0.08%	0.41%	0.51%	0.11%	0.05%	0.04%	0.04%	0.77%	0.86%	0.40%
Sign Language	0.05%	0.05%	0.05%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
Arabic	0.04%	0.04%	0.04%	0.57%	0.53%	0.66%	0.00%	0.00%	0.00%	1.07%	1.17%	0.57%
Farsi; Persian	0.04%	0.03%	0.03%	0.57%	0.51%	0.58%	0.04%	0.04%	0.04%	2.62%	2.76%	1.22%
Thai	0.03%	0.03%	0.03%	0.15%	0.16%	0.13%	0.00%	0.00%	0.00%	0.16%	0.17%	0.05%
Japanese	0.03%	0.03%	0.03%	0.38%	0.39%	0.36%	0.00%	0.00%	0.00%	0.20%	0.18%	0.05%
Russian	0.03%	0.03%	0.03%	0.33%	0.32%	0.37%	0.02%	0.02%	0.02%	0.69%	0.75%	0.40%
Chinese(Other)	0.02%	0.01%	0.01%	1.36%	1.28%	1.26%	0.00%	0.00%	0.00%	0.95%	0.43%	0.00%
Khmer (Cambodian)	0.02%	0.02%	0.02%	0.16%	0.20%	0.16%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
Hindi****	0.02%	0.01%	0.01%	0.26%	0.20%	0.23%	0.00%	0.00%	0.00%	2.13%	2.28%	0.56%
Punjabi/Panjabi	0.01%	0.01%	0.01%	0.15%	0.12%	0.13%	0.00%	0.00%	0.00%	0.42%	0.45%	0.00%
Gujarati	0.01%	0.01%	0.01%	0.10%	0.14%	0.11%	0.00%	0.00%	0.00%	0.67%	0.86%	0.11%
Portuguese	0.01%	0.01%	0.01%	0.16%	0.14%	0.15%	0.00%	0.00%	0.00%	0.18%	0.18%	0.07%
All Other Languages	0.12%	0.12%	0.11%	2.59%	5.52%	2.61%	0.00%	0.00%	0.00%	4.37%	5.36%	0.93%
Languages not entered	1.69%	1.59%	1.57%	6.06%	0.00%	5.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

SOURCES	Membership	Community*	Physicians	Staff
Language Spoken	Dec 2023 KPHC	2021 ACS-IPUMS	07/26/23 MDPeople	09/21/23 HR Connect

* DATA PROVIDE FOR COMMUNITY– CENSES DATA IS ALWAYS BEHIND IN YEARS FOR LANGUAGE DATA

RESULTS (Qualitative Analysis)

The Kaiser Permanente HealthConnect (KPHC) Q4 2023 reporting system indicated that 98.43% (4,514,818) of the members' spoken language preferences were captured and 97.83% (4,487,359) of the members' written language preferences were captured. The data shows that 9.94% of members are limited English speaking or prefer to have healthcare delivered in a language other than English. Second to English, Spanish is the next most prevalent language, preferred by 8.72% of members.

KFHP Southern California Region
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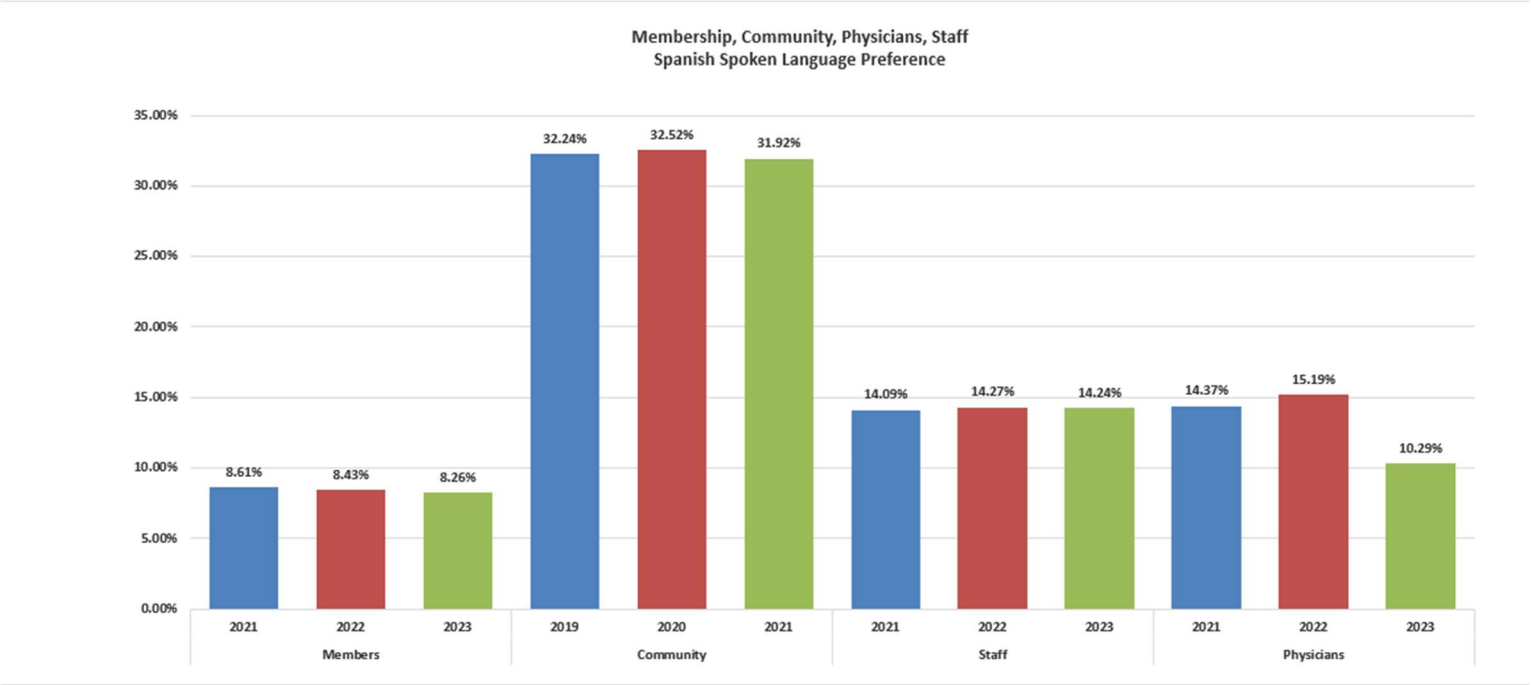
Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

RESULTS (Quantitative Analysis)



RESULTS (Qualitative Analysis)

At the community and membership levels, Spanish is clearly the most prevalent non-English language at 31.92% and 8.26%, respectively. 10.29 % of physicians self-reported as highly proficient in Spanish. 14.24% of staff are proficient in the Spanish language as indicated by testing and training through the Qualified Bilingual Staff (QBS) program. The percentage of members who prefer Spanish has slightly decreased over the last three years. The percentage of staff proficient in Spanish has slightly increased over the last three years.

Demographics are available Regionally and by Medical Center via several the Diversity website below:
https://sp-cloud.kp.org/sites/SCAL-EID

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
NCQA	Provide Cultural and Linguistic training to KP workforce to ensure the delivery of culturally competent care and linguistically appropriate services.	Increase the cultural sensitivity of our workforce to include how to provide appropriate language assistance services.	Q4 2023	75% of Health Plan employees of KPSC & KPHI to complete the self-paced online training "Providing Culturally and Linguistically Appropriate Services" (PCLAS) by Q4 2023.	Rachel Sandoval, Director, Equity, Inclusion & Diversity

ANALYSIS

GOAL MET

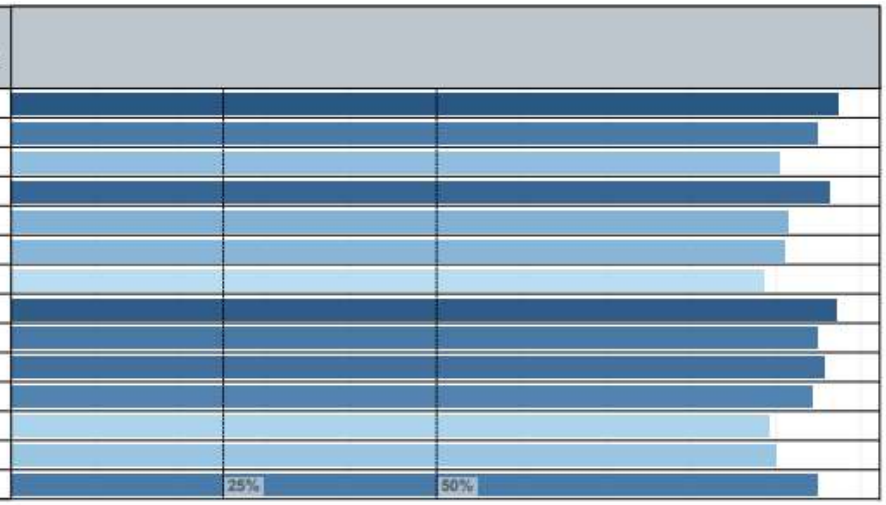
RESULTS (Qualitative Analysis)

At the end of 2023, 93.5% of Staff completed the "Providing Culturally and Linguistically Appropriate Services" (PCLAS) training meeting the goal of at least 75% completion from all staff.

NEXT STEPS AND PRIORITY AREA – Include at a minimum:

Revise the "Providing Culturally and Linguistically Appropriate Services" (PCLAS) training to meet new regulatory requirements and provide updated training on an annual basis.

MCA	Staff Total	Staff Complete	Staff Completion Overall	Staff Incomplete
Antelope Valley	1,126	1,096	97.34%	30
Baldwin Park	3,046	2,890	94.88%	156
Downey	4,132	3,741	90.54%	391
Kern County	875	843	96.34%	32
Los Angeles	5,328	4,865	91.31%	463
Orange County	6,862	6,246	91.02%	616
Panorama City	3,218	2,849	88.53%	369
Riverside County	5,458	5,297	97.05%	161
San Bernardino County	7,937	7,543	95.04%	394
San Diego	7,795	7,452	95.60%	343
South Bay	3,350	3,158	94.27%	192
West Los Angeles	2,483	2,215	89.21%	268
Woodland Hills	3,718	3,348	90.05%	370
Regional Offices	6,212	5,894	94.88%	318



KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

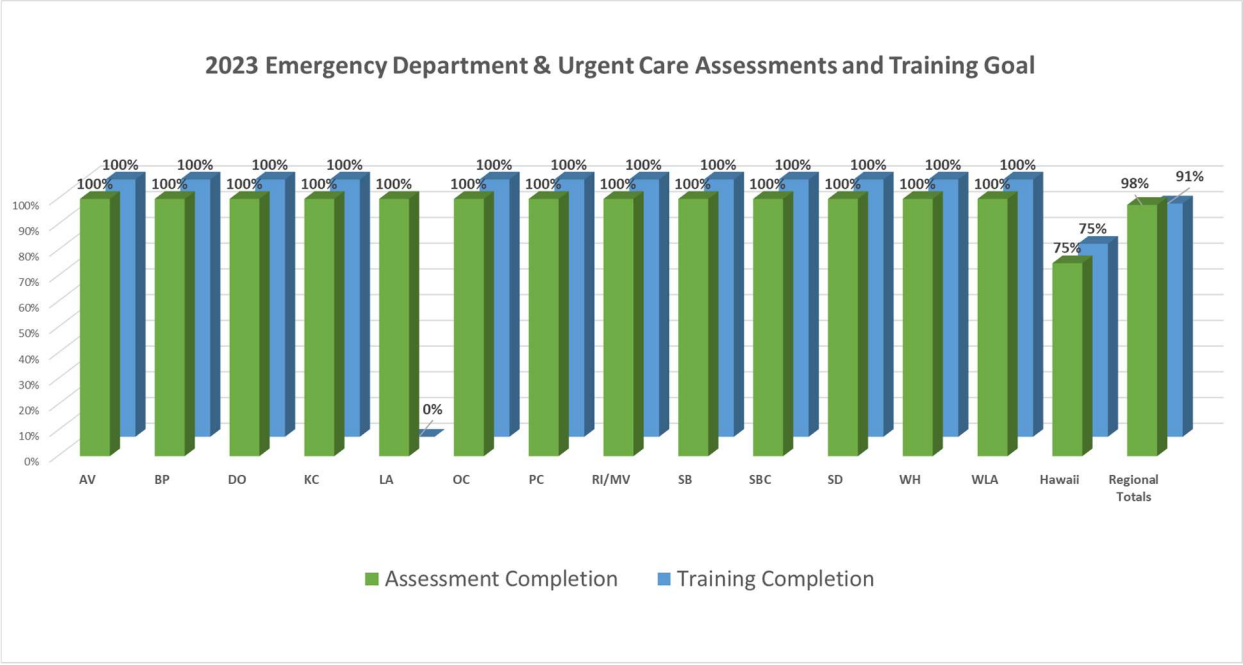
Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
NCQA	Ensure Emergency and Urgent Care departments have the appropriate tools and training to offer and document the use/refusal of language assistance services.	Language Services training for ED/UC Departments	Q4 2023	Complete language assessment and training for 100% of Emergency & Urgent Care departments for both KPSC & KPHI by Q4 2022.	Rachel Sandoval, Director, Equity, Inclusion & Diversity

ANALYSIS

GOAL NOT MET

RESULTS (Qualitative Analysis)

As the Emergency and Urgent Care Departments are high volume and fast paced, it was identified that an assessment of available language assessment tools was needed to ensure the easy access was available to assist LEP members/patients. After the assessment of the departments, the local EID Consultant was to ensure that the appropriate tools be provided to the department and training regarding how to use the tools. By the end of 2023, we completed 98% of our assessments and trained 91% of the departments overall. Overall, for both assessments and training we achieved 95% completion, just 5% shy of our goal.



NEXT STEPS AND PRIORITY AREA:

Complete assessment and training for Inpatient Units.

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
QUALITY MANAGEMENT					
Quality Management					
NCQA DMHC DHCS	• Review and revision of 2023 KFHP Quality Program Description • Evaluation of 2022 KFHP Quality Work Plan • Development and implementation 2023 KFHP Quality Work Plan and goals	Met/Not Met	April 2023	1. Review and update the 2023 Quality Program Description, 2023 Work Plan and 2022 Work Plan Evaluation to ensure appropriate scope, leadership, structure, adequacy of issues and function for both Medical and Behavioral Healthcare aspects. 2. Acquire approval of 2023 Quality Program Description and Work Plan and 2022 Evaluation of the Quality program. This Work Plan is reviewed, evaluated, and revised mid-year as needed and annually at a minimum. The results of the evaluation will be documented in the Quality Program Evaluation document, which will address results of focused reviews, strengths, barriers and limitations and opportunities for improvement for consideration to be included in the following year's work plan.	**Farnaz Meybodi**, Regional Director, Quality and Regulatory Services Southern California Quality Committee (SCQC)

ANALYSIS

Goal Met.

- All documents reviewed, revised, and approved in 2023.
- The 2022 Quality Work Plan was evaluated for progress and to guide the development of the 2023 Quality Work Plan to ensure an effective KFHP Quality Program in 2023.
- The 2023 KFHP Quality Program Description was reviewed and revised to include all regulatory requirements and was approved by the Southern California Quality Committee (SCQC) on March 24, 2023.

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
SAFETY AND RISK MANAGEMENT					
I. Primary Driver: Accountability					
Leadership Safety Culture	1.1 Communicate safety events that have a high risk of happening across other medical centers and/or across the program.	Met/Not Met	Ongoing	1.1 Biweekly Safety Huddle calls. Cause Map and Action Plans discussed. 1.1.1Focus on psychological safety and near misses. 1.1.2Continue share learnings at the Medical Center level by creating a Safety Call SBAR each time. 1.1.3Follow up on action items pertaining to Region.	Regional Safety & Risk Deepak Sonthalia, MD *Regional Physician Lead-Patient Safety* Robin Sustayta, *Sr. Director, Safety and Risk Management* Meg Shan, *Regional Director Risk Management* Medical Center RM/PS/WPS Teams
Oversight and Metrics: Compre-hensive System Analysis (CSA)	1.2 Oversight and review of all Risk Focus Study events, emphasis on Events required to conduct a CSA	Met/Not Met	Ongoing	1.2 Validate that the CSA was completed with cause map, executive summary, action items and measures of success included. 1.2.1CSA and reporting timeframes were met according to policy. 1.2.2Cause Maps are done correctly answering the "why's" to get to the causal factors of the incident. 1.2.3Monitor timeliness via the Risk Focus Study Audit, developed in 2022, by reviewing and presenting at Risk Pt Safety Peer Group meetings.	Regional Safety & Risk Medical Center Risk
Regulatory Reporting of Adverse Events	1.3 Working in collaboration with AR&L to ensure that all Adverse Events meet the reporting criteria from date of event to time of notification to AR&L. Verification through a shared repository.	Met/Not Met	Ongoing	1.3.1Reconciliation of adverse events reported through MIDAS validated against CALHeart with AR&L. 1.3.2In Q1 2023 finish development of a workflow outlining sentinel event communication between Risk and AR&L in order to document shared awareness of cases that may need reporting to outside agencies. 1.3.3The above action will help meet future sentinel event audits.	Regional Risk Regional AR&L Medical Center Risk Medical Center AR&L

ANALYSIS

All goals were met.

1.3 – Instead of a shared repository, a communication workflow between Risk and AR&L as specified in 1.3.2 was created. Also, a field in the risk focus study was added to capture whether the medical center uploaded the proof of CDPH report (email, CalHeart page).

KFHP Southern California Region
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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
II. Primary Driver: Resilience					
Individual: Good Catch Awards	2.1 Continue the regional Good Catch program, based on the TeamSTEPPS© domains of Leadership, Communication, Mutual Support, and Situational Monitoring for all Safety events.	Met/Not Met	Ongoing	2.1 Continue the Regional Good Catch program 2.1.1 Involve members in selection process for quarterly award 2.1.2 Continue to work with Risk Managers to distribute and acknowledge local award winners 2.1.3 Publish winners in the Regional Risk Pt Safety Newsletter.	Meg Shan, *Regional Director Risk Management* Brooke Jones-Pavon
Leadership Safe Culture	2.2 Team STEPPS	Met/Not Met	Ongoing	2.2 Continue to teach the dynamics around the Just Culture methodology by using the pillars of Team STEPPS 2.2.1 Use the same methodology to review CSAs to learn from and spread actions taken to promote a Speak Up culture	Christine Pak, *Regional Patient Safety Officer* Jason Cheng, *Regional Physician for Safety*
ANALYSIS					
All goals were met.					
III. Primary Driver: Reliability					
People: High Reliability Teams Med Safety	3.1 Participate on Medication Safety Oversight Committee	Met/Not Met	Ongoing	3.1 Collaborate with Pharmacy and Medicine to define, discuss and mitigate medication harm 3.1.1 Facilitate and coordinate the Medication Safety Oversight Committee	Christine Pak, *Regional Patient Safety Officer* Inpatient Pharmacy
People: High Reliability Teams PPSP	3.2 Reinforce the standardized work of Perinatal Patient Safety Program	Met/Not Met	Ongoing	3.2 Work with subject matter experts to continue & improve the multidisciplinary perinatal case review process at Med Centers. 3.2.1 Support the National Community of Practice 3.2.2 Track and trend MCH Perinatal case reviews 3.2.3 Continue participation in National SMM Workgroup & National PPSP.	*Perinatal Physicians;* *MCH Nursing;* Meg Shan, *Regional Director Risk Management* Brooke Jones-Pavon
People: High Reliability Teams SAHFE	3.3 Facilitate Regional SAHFE Committee	Met/Not Met	Ongoing	3.3 Oversight of the SAHFE (Safety and Human Factor Education) program for the SCAL and HI region	Christine Pak, *Regional Patient Safety Officer* Jason Cheng, *Regional Physician for Safety*
ANALYSIS					

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
All goals were met.					

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
UTILIZATION AND RESOURCE MANAGEMENT					
I.	**Ensure the Appropriate, Effective, and Efficient Utilization of Resources/Services to KP Members Across the Continuum in Compliance with Requirements of State/Federal and Accrediting Entities.**				
NCQA DMHC DHCS	• Review and revision of KFHP UM Program Description • Evaluation of 2022 KFHP UM Workplan • Development and implementation of 2023 KFHP UM Workplan and goals	Met/Not Met	Q1 2023	1. Review and update the 2023 UM Program Description, 2023 Work Plan and 2022 Evaluation to ensure appropriate scope, leadership, structure, adequacy of issues and function for both Medical and Behavioral Healthcare aspects. 2. Acquire approval of 2023 UM Program Description and Work Plan and 2022 Evaluation of the UM program from the appropriate utilization and quality committees within 12 months of the prior year approval.	Utilization Management Steering Committee (UMSC)
ANALYSIS					
Goal Met – 100% • All documents: The program structure; the program scope, processes, information sources used to determine benefit coverage and medical necessity; the level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program were reviewed, revised, as needed, and approved in 2023. • The 2022 UM program goals were evaluated for progress and to guide the development of the 2023 UM program goals to ensure an effective KFHP UM Program in 2023. • The KFHP 2023 UM Program Description was reviewed and revised to include all regulatory requirements and was approved by the Utilization Management Steering Committee (UMSC) on February 27, 2023 • The KFHP 2022 UM Program Evaluation was completed, reviewed, and approved by UMSC on February 27, 2023. • KFHP 2022 Workplan was completed and approved by UMSC on February 27, 2023				
NCQA DMHC DHCS	• Evaluation of KFHP UM Processes to ensure appropriateness and relevancy: o UM Policies and Procedures o UM Denial letter process o UM Criteria	Met/Not Met	Year End 2023	1. Review and update Regional KFHP UM policies and procedures to meet current 2023 UM standards as needed. 2. Review and update UM Denial Letters per regulatory standards as needed. 3. Review and update UM Criteria sets used for decisions to reflect updates based on evidence-based medicine, current medical literature, EOC, and formulary changes.	Utilization Management Steering Committee (UMSC)
ANALYSIS					
Goal Met – 100% • UM Policies and Procedures review was conducted by key stakeholders in 2023. • UM Policies and Procedures were reviewed and approved by UMSC, as needed. • UM Policies and Procedures will continue to be reviewed by key stakeholders in 2024; Utilization Management Steering Committee (UMSC) and SCQC will continue to review and approve UM Policies and Procedures as needed in 2024. • Medi-Cal, Medicare,and Commercial Denial Letter templates were updated in 2023 per regulatory updates.					

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
UM Criteria were updated, reviewed, and approved by UMSC in 2023.					
NCQA	• Distribution of required KFHP UM communication to providers, practitioners, members, and employees, as required	Met/Not Met	Year End 2023	1. Review and update the Annual Letter to all UM staff and practitioners (to include: Financial Incentive Statement, how to access the UM decision maker, and how to access or request for UM criteria) 2. Ensure that the UM Web Based Statement, which explains the UM process to members is in alignment with the UM Program.	Southern California Quality Committee (SCQC) Utilization Management Steering Committee (UMSC)
ANALYSIS					
Goal Met – 100% • Annual Letter distributed to all employees, practitioners, and providers via email on December 5, 2023 • UM Web Based Statement, which is the reference guide for members regarding UM processes, was reviewed and updated semi-annually.					
NCQA DMHC DHCS	• Inter-rater Reliability Testing	≥ 90%	Year End 2023	Monitor the accuracy and consistency of UM decisions through Inter-rater Reliability testing of physicians and non-physician licensed (RN) staff making UM decisions.	Utilization Management Steering Committee (UMSC)
ANALYSIS					

Goal Met - >90%

Kaiser Permanente ensures the consistency with which healthcare professionals involved in UM review apply UM criteria or guidelines in decision-making. Inter-Rater Reliability for Physician and Non- Physician Licensed (RN) UM Reviewers is measured using the following methodology:

- IRR testing is conducted annually.
- Participants are given 10 test questions. IRR questionnaire is reviewed and approved by the Health Plan Physician Advisor.
- The questions include theoretical UM case files to determine consistency in physician and licensed non-physician decisions.
- Threshold is set at 90% passing rate.

RESULTS and ANALYSIS:
Physician IRR:

- Total No. of Participants: 673
- Percent of Physicians who exceeded the threshold: 100% (673 of 673)

Non-Physician Licensed (RN) IRR:

- Total No. of Participants: 14
- Percent of non-physicians who exceeded the threshold: 100%

CONCLUSION:
Both the Physician and Non-Physician Licensed (RN) UM reviewers met the threshold.

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
• Physicians: 100% passing rate • Non-Physicians: 100% passing rate • Overall: 100% passing rate The following action items were identified: 1. Distribute regulatory timeliness requirement grid to all UM decision makers. 2. Review and update the UM training slide deck to clearly capture regulatory requirements. 3. Improve Training and IRR participation and completion by implementing the activity in Q2 of 2024 to give participants ample amount of time. 4. Continue educating decision makers on regulatory requirements during 2024 UM training.					
NCQA DMHC DHCS	• Oversight of all delegated UM functions for the following services: o American Specialty Health (ASH) o Delta Dental	Met/Not Met	Year End 2023	1. Evaluate effectiveness of the UM program to include compliance with state, federal, and NCQA standards. 2. Provide oversight of UM denials and appeals against regulatory standards for documentation and timeliness. 3. Discuss delegation oversight audit results at all applicable UM Committees.	Utilization Management Steering Committee (UMSC)
ANALYSIS					
ASH – Goal Met • Results from 2023 o UM Content: 100% o UM File Review: 98% o Annual Audit Score: 99% The plan for 2024: • Continue semi-annual review of ASH UM reports • Conduct annual audit of Policies and Procedures and files • Oversight audit will be jointly conducted with NCAL. • Report findings annually to Utilization Management Steering Committee/Southern California Quality Committee					
NCQA	• Develop and implement education and training programs for new UM processes and procedures for all stakeholders as appropriate.	Met/Not Met	Year End 2023	1. Develop and implement UM education and training programs: a. Utilization Management Department b. DME/P&O Department c. Outside Referral Department d. Regional Utilization Compliance department	Utilization Management Steering Committee (UMSC)
ANALYSIS					
Goal Met • Training opportunities were identified throughout the year and appropriate trainings were developed and provided.					

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
2023 UM Trainings.pdf The plan for 2024: • Ongoing education as needed • Training is based on regulatory standards and changes					
NCQA	• Review and update of Pharmaceutical Management policy and procedures	Met/Not Met	Year End 2023	1. Review, Revise and approve pharmaceutical management policies and procedures at least annually, update them as new pharmaceutical resource management information becomes available and provide them to practitioners	California – National Pharmacy Leadership Group
ANALYSIS					
Goal Met • Documentation of work completed to review and approve the 2023 pharmaceutical management policies and procedures is attached. • Policy (CAPHARM.1.1.1) regarding Policy Development, Review, Approval and Distribution Process is attached. CAPHARM.1.1.1 - HI.PHARM.037 Policy Accreditation PPR Listing_ver 01.31.202 The plan for 2024: • Continue to review pharmaceutical management policies and procedures.					
DMHC DHCS	• Over/Under Utilization	Met/Not Met	Year End 2023	1. Systematically and routinely analyze utilization data to monitor potential over- and under-utilization of services. 2. Action Teams or Appropriateness Committees periodically present utilization reports that include analysis, as well as action items of potential over- and/or under-utilization of services, to ensure professionally recognized standards of practice are maintained.	Utilization Management Steering Committee (UMSC)
ANALYSIS					
Goal Met The Kaiser Foundation Health Plan of Southern California Utilization Management Steering Committee (UMSC) conducts ongoing monitoring to identify potential UM practices within the KP delivery system to oversee the structure of the UM Program and to identify potential quality issues. This includes continues monitoring utilization of services to ensure they meet professionally recognized standards of practice. This entails review and analysis of over and underutilization measures and any action planned or implemented to improve performance.					

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
Reports: • Use of Imaging Studies for Low Back Pain – Dr. Benjamin Broder, • Use of Opioids – Dr. Benjamin Broder, Dr. Steven Steinberg, Stephen Cheng, PharmD 1. Opioid High Utilizers 2. (2) Concurrent Use of Opioids and Benzodiazepines/Non-Benzodiazepine Sedative Hypnotics (BZD/nBZD-SH) • Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis – Ralph Vogel, PhD • Metabolic Monitoring for Children and Adolescents on Antipsychotics – Ralph Vogel, PhD • Reports presented to UMSC on: 3/2023, 5/2023,6/2023 and 10/2023, 11/2023, 12/2023.					
II.	**Ensure the Provision of Healthcare Services at the Appropriate Level of Care (Right Care at the Right Setting)**				
DMHC NCQA DHCS	• Timely and accurate denial decision and notification processes in compliance with regulatory timeframes	Met/Not Met	Year End 2023	1. Monitor, analyze and evaluate denial decisions and notices for compliance with timelines as established by federal, state, contractual and NCQA requirements	Utilization Management Steering Committee (UMSC)

ANALYSIS

Overall Timeliness Performance

Metric	Compliance Rate	2023 Results	Goal Met
Decision Timeliness (Benefit)	95%	99.5%	Y
Decision Timeliness (Med Nec)	95%	83.8%	N
Twenty-four (24) hour Initial MD Notification Timeliness	95%	97.9%	Y
Member Notification Timeliness	95%	96.8%	Y

DME Timeliness

Metric	Compliance Rate	2023 Results	Goal Met
Decision Timeliness (Benefit)	95%	99.6%	Y
Decision Timeliness (Med Nec)	95%	81.2%	N
Twenty-four (24) hour Initial MD Notification Timeliness	95%	98.5%	Y
Member Notification Timeliness	95%	97.2%	Y

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Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES

Non-DME Timeliness			
Metric	Compliance Rate	2023 Results	Goal Met
Decision Timeliness (Benefit)	95%	94.2%	N
Decision Timeliness (Med Nec)	95%	91.3%	N
Twenty-four (24) hour Initial MD Notification Timeliness	95%	90.7%	N
Member Notification Timeliness	95%	91.4%	N

Behavioral Health (BH) Timeliness			
Metric	Compliance Rate	2023 Results	Goal Met
Decision Timeliness (Benefit)	95%	100%	Y
Decision Timeliness (Med Nec)	95%	88.9%	Y
Twenty-four (24) hour MD Notification Timeliness	95%	99.5%	Y
Member Notification Timeliness	95%	96.2%	Y

III. Reduce Inpatient Readmission Rate					
NCQA	• SCAL Readmission Rate	≤0.86 O/E	Year End 2023	1. Optimize Readmission Reduction Program in all KP Medical Centers	Southern California Executive Resource Stewardship Committee (SCERSC)

ANALYSIS

Goal Not Met: 0.87

2023 readmissions: 2023 goal was ≤ 0.86 and Year End rate xx.xx Avail Feb.

The plan for 2024: ≤0.85 O/E

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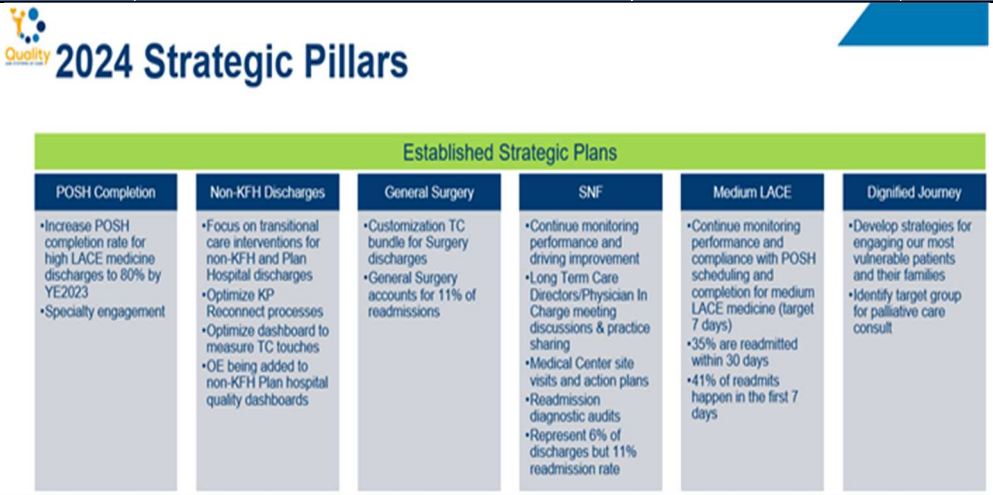
Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
					
IV.	**Ensure Effective and Efficient Behavioral Health Utilization Management**				
NCQA	• Ensure Behavioral health compliance through annual review and update of program protocol	Met/Not Met	Year End 2022	• Behavioral Health policies and procedures should include the following elements: 1. Address all relevant mental health and substance abuse situations. 2. Define level of urgency. 3. Define appropriate setting of care. 4. Have been reviewed or revised in the past two years. 5. Use licensed practitioners to make decisions that require clinical judgment • A Centralized triage and referral crisis line (Behavioral Health Care Help Line) has been established and is monitored on an ongoing basis.	Utilization Management Steering Committee (UMSC)

ANALYSIS

Goal Met

The 2023 BH triage and referrals policies and procedures:

1. Address all relevant mental health and substance abuse situations.
2. Define level of urgency.
3. Define appropriate setting of care.
4. Have been reviewed or revised in the past two years.
5. Use licensed practitioners to make decisions that require clinical judgment

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
A Centralized triage and referral crisis line (Behavioral Health Care Help Line) has been established and is monitored on an ongoing basis. The plan for 2024 is: • Monitor for compliance for Behavioral Health Care. • Review and update protocols.					
V. Maintain Practitioner and Member Satisfaction with the Utilization Management Program					
NCQA	• Ensure satisfactory Member and Provider Experience with UM processes	Met/Not Met	Year End 2023	1. Annually survey satisfaction with the UM process: Collect and analyze data on member and practitioner satisfaction to identify improvement opportunities and take action designed to improve member and practitioner satisfaction a. Report the annual survey results and opportunities to improve are approved by the appropriate UM and Quality Committees	Utilization Management Steering Committee (UMSC)

ANALYSIS

Goal Met

- Physician Satisfaction Survey completed in 2023, presented and approved by UMSC
- Physicians throughout SCPMG remain positive about the assistance they receive in helping them plan, coordinate, and carry out patient care activities.
- They gave favorable feedback regarding the assistance they received from various areas in helping them to provide quality patient care.
- The positive trend that was observed in most years from 2009 to 2022 continued in 2023for the most part.

Member Satisfaction Results:

	2023
Getting Needed Care Composite	
In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?	63.93 (10th percentile)
In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?	70.31 (10th percentile)

Physician Satisfaction Results:

Metric	Target	2023 Results	Goal Met
Physician Satisfaction with UM Programs;			
Communication	≥4.0	4.1	Yes
UM Physician Advisor Assistance	≥4.0	4.1	Yes

The plan for 2024:

- Continue to monitor for 2024.
- Provide updated resources and reference materials through the annual trainings

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
NCQA	• Monitor the rate of overturned UM appeals	Met/Not Met	Year End 2023	1. Review and analyze reports of UM denials, UM denials appealed and results of appeals of Independent Medical Review for UM denials	Utilization Management Steering Committee (UMSC)

ANALYSIS

Goal Met

- Reports are evaluated semi-annually for UM appeals trends.
- Detailed analysis was conducted to identify total volume of appeals, type of appeals, and services/items that are overturned.
- Impact analysis determined no identifiable trends to explore.
- 2023 review of UM denials and corresponding appeals completed and reviewed through UMSC on the following dates: March 2023, May 2023, July 2023, November 2023

The plan for 2024 is:

- Continue to monitor UM appeals in 2024
- Conduct a root cause analysis for appeals that are overturned for potential process and performance improvements.